

# Lebanon



An Informal Settlement during Storm Alexa in December 2013; Ahmad Baroudi, SC Lebanon, 2013

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*See also article on DRC experiences of cash assistance to non camp refugees in Turkey and Lebanon, page 141*

## Designing an inter-agency multipurpose cash transfer programme in Lebanon

By Isabelle Pelly



Isabelle Pelly was Save the Children's Food Security & Livelihoods Adviser in Lebanon until September 2014, and co-chair of the Lebanon Cash Working Group. She is a specialist in food security and livelihoods, and cash transfer programming, with experience spanning programme design and management, advisory roles at field office and headquarters, programme policy, and inter-agency cash coordination.

The author is very grateful to Maureen Philippon (ECHO), Joe Collette (Save the Children Lebanon) and Carla Lacerda (Senior inter-agency Cash Adviser in Lebanon) for their insight and support. This article is a reflection of the author's professional experience and does not necessarily reflect the position of Save the Children more broadly.

This paper reviews the inter-agency efforts to set up a multipurpose cash assistance programme in Lebanon, as part of the response to the Syrian refugee crisis, over the last year since the onset of winter 2013/14. It highlights lessons learned through large-scale cash programming in Lebanon to date, and the necessity of high quality technical and operational design supported by responsive coordination mechanisms. The paper discusses the challenges of a transition to multipurpose unconditional (from here-on 'multi-purpose') and inter-agency cash programming including the cross-sectoral engagement and strong leadership required for an effective programme that works across traditional

sector-based humanitarian coordination structures and sector-mandated agencies. The paper draws out key lessons for future programmes, and potential inter-agency preparedness measures to overcome coordination and technical hurdles.

### Background/lessons learned from Lebanon's winterisation cash programme

Since early 2014, the Syrian response in Lebanon has been a test-case for the establishment of an inter-agency multipurpose cash transfer programme. The design of this programme sought to build on the lessons learnt from the inter-agency 'cash for winterisation' programme which reached nearly 90,000 refugee households with an average of \$550 throughout the winter of 2013/14. This programme relied on harmonised targeting criteria<sup>1</sup>, and agreed-upon cash transfer values, intended to meet the costs of a stove per household, and monthly heating fuel for five months. The rapid operationalisation of this programme, delivered through a common ATM card across the majority of agencies involved, was a success. However, there were significant gaps in the programme design, which provided a learning platform for the design of a multipurpose cash programme for 2014 onwards and are outlined in the following section.

Firstly, whilst the delivery of the programme was harmonised, the approach was developed directly by UNHCR as lead of the non-food items (NFI) working group and lacked technical input from cash programming experts within the Lebanon Cash Working Group (CWG) (see Box 1).

Specifically, there was no baseline market assessment undertaken as part of the feasibility assessment for winterisation cash programming.

Rather, the decision to implement the cash transfer programme was based on agency concerns related to the delivery of an in-kind or voucher response for winter, following significant operational delivery challenges (including documented fraud) with these modalities in winter 2012/13. In October 2013, the Lebanon CWG commissioned a study of the stove market to assess market availability and access to this key winter item. This report did highlight the elasticity of the stove market in Lebanon, but also warned of a considerable gap if the majority of targeted refugees chose to purchase a stove unit at the outset of winter. The risk of additional stove demand being met through imports from Syria (thus to the detriment of the Syrian market) was also emphasised. However, the timing of the report, which was released when the decision on the choice of cash as an assistance modality had already been made, and the lack of sufficient buy-in within the wider inter-agency coordination structure (particularly the NFI working group), unfortunately reduced the value of this piece of work, and the take up of its recommendations, which included monitoring of supplies and prices; and mitigating efforts including in-kind contingency stock and very strong beneficiary communication regarding the upcoming cash programme.

In parallel, the lack of technical input into programme design resulted in a cash transfer value calculated based on perceived sector-specific needs (fuel and stove cost) rather than on overall understanding of household income gaps and needs. The downfall of this approach in the Lebanon context is reflected in the inter-agency impact evaluation of the winterisation programme led by IRC<sup>2</sup>. This analysis reveals that the majority of additional cash was spent on covering gaps in food, rent and water expenditure, whilst on average only 10% of the assistance was spent on heating fuel and clothing. Almost half of the beneficiaries reported that their heating supplies were not sufficient to keep warm. This is not due to unavailability of the supplies in the market, but because beneficiary income (through labour and assistance) income

#### Box 1: Lebanon Cash Working Group – Syria Regional Refugee Response

**Purpose:** Key forum for discussion on CTP across sectors and for design of multipurpose unrestricted cash assistance programme

**History:** Established in early 2013 in response to demand by NGOs to coordinate on design of CTPs.

**Participants:** Up to 50 agencies (including government, UN and NGOs); core group of 10 staff from representative agencies for decision-making

**Leadership:** Cash Coordinator, Senior Cash adviser (jointly hosted by UNHCR & Save the Children) and rotating NGO co-lead

**Frequency of meetings:** Monthly (previously bi-weekly).

**Weblink and resources:**

[http://data.unhcr.org/syrianrefugees/working\\_group.php?Page=Country&LocationId=122&Id=66](http://data.unhcr.org/syrianrefugees/working_group.php?Page=Country&LocationId=122&Id=66)

<sup>1</sup> Targeted families that had been found eligible for assistance as part of the overall targeting exercise conducted by UNHCR and WFP and living 500m above sea level; 2) Families (registered and unregistered refugees, and Lebanese) living in informal tented settlements (ITS) and unfinished buildings.

<sup>2</sup> See article by IRC Lebanon on the evaluation of the Lebanon winterisation programme.

is so low that they are forced to prioritise basic expenditures.

Secondly, the design of the winterisation response suffered from significant timing challenges due to a multiplicity of changes and competing priorities occurring simultaneously within the broader response. In September 2013, a targeting process for 'regular' food and NFI assistance was introduced, using a demographic burden score developed on the basis of the VASyR 2013<sup>3</sup> findings. This resulted in a reduction from blanket targeting to circa 70% of the registered population receiving assistance. Whilst targeting for winterisation cash assistance did build on this process (see footnote 1), it also introduced a parallel system by using different targeting criteria indicators (such as altitude), which created significant confusion for households, as well as agencies, which were ill-equipped to describe this process. The fear that households may be excluded from assistance during the often bitterly cold Lebanese winter led to an emergency 'verification' exercise through household visits, aiming to re-include wrongly excluded households, which further increased confusion for vulnerable households. In parallel, a significant change was made to the operational delivery of 'regular' food assistance, as WFP transitioned from a paper voucher to an e-voucher more or less contiguously with the roll-out of the UNHCR ATM card used for winter cash assistance. A large proportion of refugees, many of whom had never used electronic payment methods in the past, simultaneously received two cards, with very different functionalities (i.e. e-vouchers redeemed at POS at local pre-identified food shops and winter cash assistance withdrawn at ATMs), and often from two different agencies (i.e. WFP and UNHCR and their different partners). Despite significant efforts to create separate effective training and helplines to differentiate the cards this was sub-optimal from the beneficiary standpoint as well as from the perspective of value for money and operational efficiency.

Notwithstanding these challenges, the CWG was eventually able to influence the technical quality of the winterisation programme through the development and roll-out of common baseline and monitoring tools. The ATM card platform

also enabled parallel other cash programmes (i.e. conditional cash for livelihoods or shelter programmes) to be delivered through the same cards, through cross-loading of cards between agencies.

The experience of this winterisation cash programme, led to a desire and willingness to (a) further harmonize cash programme design including targeting, monitoring and delivery mechanisms and (b) transition to longer-term and scale-up of multipurpose cash assistance as a strategic shift within the response. This therefore required the CWG, through the broader coordination system, to draw on these technical and operational lessons learned and retroactively apply best practices.

The focus of early 2014 was therefore oriented around: checking assumptions on the feasibility of cash assistance (particularly relating to markets and banking system functionalities); developing common objectives and the resulting monitoring framework for multipurpose cash assistance; and improving and streamlining operational design, with the objective of establishing a one-card system for the delivery of WFP food assistance and multipurpose cash assistance, rather than the two systems outlined above. This ambitious workplan was set-out by the co-leads of the Lebanon CWG in February 2014 following an ECHO-led meeting in Brussels on cash coordination in Lebanon. The challenges encountered in delivering on this workplan are detailed in the section below.

### The programme design to date

The crux of the future inter-agency programme design, building on in-country lessons to date, was defined through a consultancy led by Avenir Analytics, which set out to outline and define the optimal operational set-up for multipurpose CTP. This model aspired to build on the scale and coverage of WFP's existing e-voucher programme (delivered through BLF bank) and use this delivery platform (through adding a separate cash 'wallet' to the same card), and WFP's implementing partners, as the basis for the delivery of cash assistance. This model is visualised in Figure 1, and other key components of the programme design which evolved through multi-agency consensus are summarised in Box 2.

### Box 2 : Multi-purpose inter-agency cash programme design

**Key objective:** To prevent the increase of negative coping mechanisms among severely vulnerable Syrian refugees during the period of cash assistance

**Target population:** Economically vulnerable Syrian Refugees

**Targeting methodology:** Proxy-Means Testing (PMT) through a pre-identification 'bio-index' applied to the UNHCR ProGres database, or through application of an economic vulnerability questionnaire

**Target numbers:** 28% of Syrian refugees identified as highly economically vulnerable (circa. 66,700 households as of June 2014), although funding shortfall is significant

**Monthly cash transfer value:** 175 USD per month intended to complement Monthly income to meet the Survival MEB; intention is to increase cash transfer value during the winter months

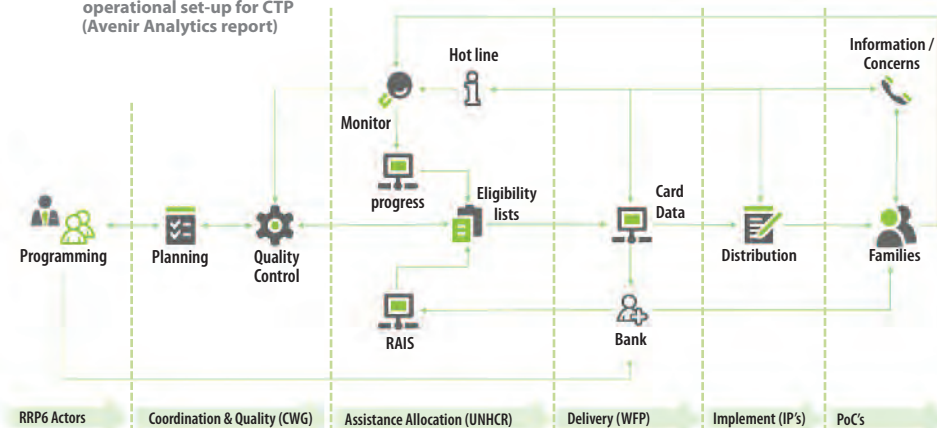
### Challenges transitioning to multipurpose inter-agency cash programming, and lessons learned for future responses

#### Aspiring to a common technical and operational approach

The CWG workplan and programme design outlined above aimed to address technical and operational issues specific to Lebanon, whilst designing a robust operation that makes the process in Lebanon innovative and valuable for future cash operations. This process aspired to move away from the outdated 'project and sector-based approach' and promote increasing coordination, at minimum to avoid duplication and ideally to harmonise the implementation modality. In Lebanon the ambition was also to go one step further in order to give the recommendations of the CWG a binding character. This was not formalised as such, as despite best intentions, no agency proved ready to relinquish its decision making ability. Rather, good will and strong harmonisation efforts have been the driver of successful coordination outcomes as has the alignment of donors (particularly ECHO and DfID) who have proven instrumental in ensuring that the recommendations of the CWG are followed.

The Lebanon experience demonstrated that building technical consensus requires strong and legitimate expertise, leadership and ownership of the process. However, no decision is purely technical and at a certain point potential technical refinements have to cease and a decision made to go with an optimal (albeit not perfect model). Technical programme design staff need to be supported by strong management, and acknowledge the balance to be struck in a refugee operation between technical good practice, and operational reality and scale at a time of funding

Figure 1: Recommended optimal operational set-up for CTP (Avenir Analytics report)



RRP6: Regional Response Plan 6; CWG: Cash Working Group; IP: Implementing Partner; PoC: Person of Concern

<sup>3</sup> Vulnerability Assessment of Syrian Refugees: <http://data.unhcr.org/syrianrefugees/download.php?id=3853>.

stagnation. As a specific example, the dialogue over the value of a monthly transfer and the number of people to be assisted was heated in Lebanon between advocates of a ‘broad but shallow’ approach contributing a minimal amount to a larger number of households versus a ‘narrow but deep’ approach ensuring survival needs were met for fewer households. Also, whilst statistically extremely robust, the targeting methodologies developed by the CWG and its ‘Targeting Task Force’ do not enable a ‘ranking’ of households within the 28% most vulnerable which makes ‘narrow’ targeting imperfect.

**Recognition of multi-purpose cash assistance as a cross-sectoral modality**

By definition, the multipurpose nature of the planned assistance requires coordinated engagement across traditional sector divides. Indeed, in the current context, the proposed assistance package (see Box 3) only provides a contribution towards meeting survival needs, thus leaving a gap between income and expenditure, particularly during the winter month. To date, all assistance monitoring reports for Lebanon demonstrated that the two priority expenditures are food and rent, but the exact prioritization of expenditures is not known. While there may be discussion at household level on what to spend the money on (see comments on winter assistance above), multi-purpose cash transfers must come with the acknowledgement that households will make their own choices anyway: to place the decision power with the people assisted may be the adult age of humanitarian assistance. Such an approach encourages a broader analysis of household needs from a holistic perspective, which typical coordination structures are not set up for, and risks the perception that the roles of specific sectors or institutions are being challenged. In Lebanon, a particular challenge was the convergence of the delivery of sectoral assistance towards the UN-led proposed models (WFP for food assistance; and UNHCR for NFIs), which remain relatively inflexible to changes in modality. Existing and well-documented limitations to cash coordination in the global hu-

Figure 2: Multiplier effect of cash-based assistance



manitarian coordination structure<sup>4</sup> manifested themselves again in Lebanon. This demonstrated the need to apply best practice when coordination structures are initially established, namely the distinction between strategic and technical coordination, and the need for formalised working linkages with all sector working groups and within the humanitarian coordination architecture.

In parallel, coordinated design of multi-purpose cash programming inevitably results in decisions that will affect agency sense of territoriality, particularly when there are questions of efficiency and how best to achieve economies of scale to be tackled. There are a slew of practical and political reasons why the humanitarian community may resist change. The clear recommendation from the consultancy on the optimal operational set up was to limit the number of partners possibly to the extent that in a given area WFP partners and the ‘cash’ partner should be the same. The basic principle of fewer partners is agreed. What is not is which partners are ready to relinquish or refine their role. A striking example of this is the fact that WFP has maintained a protective approach to food by using a food voucher, which has been perceived as territorial by certain stakeholders (whilst acknowledging some of WFP’s donor constraints). Against this backdrop, WFP intends to conduct a pilot study comparing the food security outcomes of cash vs. vouchers, before making any decision on a change to a pure cash modality. This, despite inter-agency monitoring analysis demonstrating that food is prioritised at household level relative to other basic needs. Acknowledging possible resistance and the desire amongst some to retain the status quo, the donor community needs to be clear and united in demanding a refined structural response.

**Engagement with the Government**

Multipurpose cash assistance design also requires proactive and continuous engagement with pre-existing government social protection schemes, to ensure optimum harmonization on targeting and assistance value, and appropriateness relative to the socioeconomic context - minimum wage, poverty line, national safety nets, etc. In Lebanon, two particular challenges were faced – firstly, the Government of Lebanon’s (GoL) reluctance to accept the proposed Survival Minimum Expenditure Basket (SMEB) for Syrian refugees, to which multipurpose cash assistance is intended

to contribute; and the value of the SMEB relative to the package of subsidized services (including education and healthcare) provided to poor Lebanese through the Ministry of Social Affairs’ National Poverty Targeting Programme (NPTP). Specific concerns of the GoL are the inequity between these forms of assistance, and institutional and political constraints in moving to a cash-based model of social protection for the Lebanese population (although WFP is partnering with the NPTP for an extension of the e-voucher programme to 5,000 Lebanese households by the end of 2014). Another concern alluded to by the GoL has been the broader economic impact of cash on Lebanese markets. IRC’s recent analysis of the multiplier effect of cash-based assistance has demonstrated that each dollar of cash assistance spent by a beneficiary household generates 2.13 dollar of GDP for the Lebanese economy; this figure is 1.51 in the food sector for the WFP e-voucher programme.<sup>5</sup> See Figure 2.

**Need for an over-arching budget**

The effectiveness of inter-agency discussions was also hindered by the absence of a dedicated planning budget for cash assistance in 2014: the idea was foreseen in the RRP6, but even where a cash modality was specified, the potential budget for multi-purpose cash assistance remained siloed under different sectoral headings, thus contributing to a projectised approach incompatible with the design of multi-purpose cash assistance. As a result, the technical and managerial decisions relating to targeting and transfer value versus scope and scale of programming, lacked direction as neither donors nor UNHCR were able to provide clarity on anticipated budgets, and resulting gaps in assistance. The principle adopted by the CWG was to advocate for an overall budget based on a package of assistance to meet the Survival MEB for all highly vulnerable households (28% of the registered refugee population), as outlined in Box 2. This amounted to over \$200m for a 6 month period; but uncertainty over agency capacity to meet this gap remains significant, with UNHCR reducing their initial

**Box 3: Calculating the transfer value of the severely economically vulnerable households**

**Survival Minimum Expenditure Basket (SMEB):**

This includes the minimum food required to meet 2100 kcal/day, the minimum NFI, rent in Informal Settlements, minimum water supply required per month. Clothes, communication and transportation are calculated based on average expenditures.

To Calculate Proposed Cash Assistance:	\$ value
SMEB	\$435
Minus midpoint of Severely Vulnerable income (using expenditure as a proxy)	\$110
Minus average food assistance package provided by WFP	\$150
<b>Transfer Value</b>	<b>\$175</b>

<sup>4</sup> CaLP, Comparative study of cash coordination Mechanisms, June 2012, and Fit for the Future – Cash Coordination, May 2014

<sup>5</sup> WFP Economic Impact Study: Direct and Indirect effects of the WFP value-based food voucher programme in Lebanon. August 2014

budget for cash assistance from \$36m at the beginning of the year to \$9m in June. This links to another critical budgetary issue which is the plateauing of funding for the Lebanon response in 2014 despite the ongoing increase in the number of refugees, which further lends credence to a common operational set-up designed to optimise effectiveness (see Figure 1).

#### *Current state of progress (August 2014)*

Notwithstanding the challenges outlined above, by August 2014, a critical mass of common recommendations had been produced by the CWG (as summarised in Box 2), making it almost impossible to fall back to stand alone projects: the targeting recommendations had been issued and initial beneficiary lists produced, the transfer amount agreed upon, the M&E framework designed, and clear recommendations on the optimal operational set up outlined. The fact that the CWG had laid out all these tasks early in its February 2014 workplan, supported by two meetings on multi-purpose cash assistance called by ECHO in Brussels contributed to clarity and accountability around the deliverables. Donors were interested and could use clear recommendations to make informed decisions on the relevance of the proposals received, and a number of agencies (including UNHCR) have begun implementing their cash programmes applying key elements of the common model.

Nonetheless, a few key stumbling blocks remain. The development of the targeting methodology was far more onerous and complex than expected, and as of August 2014, 2 different indices are proposed for targeting food assistance and cash assistance, which will inevitably lead to beneficiary and agency confusion with targeting, and will require additional resources to administer. Additionally, whilst in April 2014, the Avenir Analytics consultancy urged an immediate transition to a one-card system using WFP's e-card platform (administered by BLF bank), this has still not materialised as discussions on costs and legal constraints between WFP and UNHCR have not been resolved. Whilst M&E tools based on the common framework are under development, these remain to be rolled out across agencies, and the central analysis function has not yet been defined.

#### *Evolving role of Cash Working Group*

The role of the CWG has continuously evolved alongside the technical and operational discussions outlined above. In response to the need for strong leadership and decision-making, a core group (including UN, NGO and government representatives) was elected. The group has consistently drawn from the resources developed by CaLP around documenting Cash Coordination best practices globally. In addition, a senior cash advisor position was created under the inter-agency coordinator in an attempt to provide strategic oversight on the use of cash assistance across the response. The elected core group is tasked with making recommendations either through consensus or by a majority vote. Time will tell whether this proves to be a relevant model for effective and accountable decision-making, and its applicability in other contexts. At present donors are not part of this core group, but this may need to be revisited at a later date. In Lebanon, donors have consistently been pressed to align with and enforce CWG recommendations. DfID and ECHO in particular have been very engaged in supporting key decisions, and then feeding to the wider donor group. This coordination implies a need for a more strategic and transparent inclusion of donors.

#### **Conclusions and recommendations for future multi-agency processes**

Based on the ongoing challenges detailed here, fundamental lessons have emerged for applicability to future humanitarian contexts. Implementing a multi-purpose cash assistance programme inevitably implies agencies, donors and governments relinquishing control over the use of cash assistance at household level. This fact continues to create discomfort at agency level, and in engaging with governments, particularly in a refugee setting. Hence, as with all significant changes in the role and perception of cash assistance globally, robust M&E and impact evaluations (such as that led by IRC<sup>6</sup>) will continue to be necessary to demonstrate the effectiveness of cash assistance as a means of holistically addressing household needs. An over-arching technical take-away is the need for strong decision-making on divisive and debatable issues including targeting and transfer value, as these ultimately

need to be judgement calls based on best evidence, not a perfect science.

The successful design and set-up of a multi-purpose/sector cash assistance programme across agencies requires a radical change in the existing sectoral and agency-based structure that defines the majority of current humanitarian responses. While the Transformative Agenda, World Humanitarian Summit and Level 3 triggers have signalled a significant shift in this direction, more efforts need to be made to ensure that accountability, targeting frameworks and holistic approaches are prioritized for resources and coordination above sectoral divides. Until this approach becomes widespread, exemplary leadership and vision is required at individual agency managerial level, as well as through the UN-led coordination structures, optimally through an empowered CWG.

The Lebanon multipurpose cash assistance programme design has highlighted some of the broader political constraints in applying such leadership and direction, as well as the critical role donors can play in driving decision-making on issues as contentious as cash assistance. In due course, effective programming may be exemplified by one agency leading on delivery of cash assistance across a response. Whilst this may be operationally optimal, a formal set-up needs to anticipate the operational and legal challenges (including traceability of funds and reporting requirements) of inter-agency cash transfer programmes, i.e. through pre-agreed HQ-level framework agreements. Another way of conceptualising such a model is to envisage a distinct role for individual agencies in the overall design, implementation and monitoring of a cash assistance programme, building on agencies' unique strengths – NGO consortia are a prime example of such a set-up, and one which may be used to optimise the delivery of cash assistance in Lebanon in 2015.

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<sup>6</sup> See article summarising the evaluation of the IRC programme in this edition of Field Exchange

## Postscript

By UNHCR Lebanon and UNHCR Cash Section, Division of Programme Support and Management, Geneva

UNHCR is fully behind the move toward adapting its assistance to the specific needs of refugees and other persons of concerns, hence its preference for multi-purpose grants where appropriate and feasible. We are greatly appreciative of the effort the author has made to describe the process and lessons learned from winterisation assistance in Lebanon (2013-2014) and subsequent efforts to operationalise a multipurpose grant programme which started in August 2014. However we also feel that the topic

is too important not to get right. First of all, the winterisation programme was not an unconditional or multipurpose grant meant to compensate for shortfalls in minimum expenditures. It was a grant designed for the purpose of winterisation - to keep people warm. Two evaluations (both on implementation and on impact) have been completed and will inform the design of the 2014-2015 winterisation assistance programme. In relation to multi-purpose cash programming, the operational

constraints in general, and specifically in Lebanon, are complex and deserve thorough analysis. The ECHO Enhanced Response Capacity grant (2014-2015) and the careful consolidation of learning foreseen in the grant, will be used by UNHCR and partners to this end. UNHCR remains committed to working with partners in Lebanon to ensure the best possible platform for cash programming, enabling gains in providing effective and efficient humanitarian assistance.

A beneficiary of cash assistance in Lebanon holds medications she was able to purchase



International Rescue Committee

# IRC cash and livelihoods support programme in Lebanon

By Francesca Battistin



Francesca Battistin leads the International Rescue Committee (IRC) cash assistance and livelihoods recovery interventions in Lebanon. She has a background in economics, with ten years professional experience in managing livelihoods recovery programmes in post-disaster and post-conflict settings, including Pakistan, Iraq and Lebanon, and in supporting interventions in Latin America, Africa and South-East Asia, with the International Labour Organisation (ILO) and the IRC.

The author extends thanks for funding support to the UK Department for International Development (DFID), the main donor of IRC's economic recovery and development interventions in Lebanon, and to Stichting Vluchteling (SV).

## Background

The Syrian conflict is now in its fourth year. Since it started in spring 2011, over 150,000 people have died and more than 2.9 million people found had to flee in neighbouring countries as refugees. In Lebanon, the smallest country bordering Syria, the numbers have grown exponentially; by October 2012, 77,000 refugees had registered in Lebanon, a figure that, within one year only, had increased to 650,000. As of July 2014, Lebanon is hosting over 1.1 million refugees, a fourth of its own population. Tragically, there is no end in sight, as the conflict intensifies and refugees continue to flee to Lebanon each day. Upon arrival, they encounter few housing options or jobs, and women and girls in particular are vulnerable to protection risks as they cope with financial insecurity. The social and economic burdens on Lebanese host communities are also growing, and tensions between refugee and host populations are evident.

## The first phase of IRC response

Economic recovery and development interventions were among the first steps taken by the International Rescue Committee (IRC) in response to the Syrian refugee crisis in Lebanon, towards the end of 2012.

### Assessment of the situation and needs

In August and September 2012, the IRC's Emergency Response Team (ERT) conducted two rapid assessments in Lebanon – one focusing on the risks and violence faced by women and girls among the Syrian refugee population and the other an emergency livelihoods assessment carried out with Save the Children. Both assessments identified that refugee families were increasingly relying on negative economic coping strategies, such as taking on large amounts of debt, sending children to work, early marriage of adolescent girls and survival sex. The livelihoods assessment, in particular, found the conflict in Syria and the influx of refugees into Lebanon had produced a significant impact on the income and expenditures of both refugees and host communities.

The severity of the needs in Lebanon is most apparent in the Northern governorate, where IRC executes its cash and livelihoods promotion interventions. The North accounts for 21% of the Lebanese population (approximately 900,000 people) and hosts around 26% of the total Syrian refugees in the country (approximately 280,000 persons). Framed differently, Syrian refugees now comprise 31% of the North's population. The concentration of refugees in the North is even more alarming considering it is the most impoverished governorate in Lebanon; according to a 2008 study by the International Poverty Centre, 46% of the extremely poor and 35% of the poor Lebanese<sup>1</sup> reside in the North.<sup>2</sup>

## IRC response

In this context, IRC opted for augmenting refugees' purchasing power through unconditional and unrestricted (or multi-purpose) cash assistance grants. Unrestricted cash assistance is versatile; it can be spent for multiple purposes, without aid

agencies having to determine and closely monitor the use that each beneficiary makes of it. In a context where markets are functioning and elastic, beneficiary households can spend the full amount of the monthly transfers to access the items they need most. Furthermore, in urban refugee environments and protracted crisis like in the case of Lebanon, household needs are particularly diverse and change over time; by giving them the liberty to prioritise among these needs, interventions become more effective and – at the same time – less labour intensive and operationally costly for aid agencies. Unrestricted cash assistance also empowers households to make decisions, which results in a greater sense of dignity. Finally, cash assistance stimulates markets at local levels, whereas large-scale procurements for in-kind assistance tend to exclude small, local businesses from the deals. Recent research conducted by IRC in Lebanon showed that, for every \$1 given in cash assistance, at least \$2.13 is generated in the wider local economy.<sup>3</sup>

Cash assistance of 200USD per month is provided; this was set to harmonise with the amount offered by other agencies and is estimated to cover around 50% of the survival expenditure basket since if eligible, a family of six would receive food assistance vouchers worth the value of 180USD. Two subsequent projects were executed between November 2012 and March 2013, and between February and October 2013<sup>4</sup>, with funding from Stichting Vluchteling (SV) and from the United Kingdom's Department for International Development (DFID) respectively.

### A shift in targeting

The first project targeted exclusively women-headed households, while the second one included also men-headed households among the Lebanese beneficiaries. This shift was motivated by three assumptions:

First, IRC had observed that women-headed households were not necessarily more economically vulnerable than men-headed households. This assumption was validated by an analysis conducted in April 2014 on over 28,000 records of refugee households, as part of the work of the Targeting Task Force. Among Syrian refugees, head of household's gender was found not to be significantly correlated to capacity to earn an income. Secondly, IRC expected that within Lebanese host communities, women heads of households would have more developed and reliable safety nets compared

<sup>1</sup> The extremely poor live on an average of 2.40 USD per day, or 430 USD per month for an average family of six, while the poor live on an average of 4 USD per day, or 720 USD per month.

<sup>2</sup> Poverty, growth and income distribution in Lebanon, by Heba Laithy, Khalid Abu Ismail, and Kamal Hamdan, Country Study no.13 of the International Poverty Centre, issued in January 2008.

<sup>3</sup> Christian Lehmann and Daniel Masterson, 2014. Winterisation Cash Transfer Programme: Impact Evaluation Report. New York: International Rescue Committee (2014). See summary article: Impact evaluation of a cash-transfer programme for Syrian refugees in Lebanon. Field Exchange 48, p56.

<sup>4</sup> A summary of a case study of the IRC February-October 2013 programme is included in this edition of Field Exchange.

A beneficiary of cash assistance in Lebanon is briefed on the programme



International Rescue Committee

to Syrian female heads of household in a situation of displacement. Instead, Lebanese men in Akkar were particularly affected by the influx of Syrian refugees competing with them in the labour market; their struggle to get access to jobs and income would translate into impoverished households. In the long-run, this was feared as becoming a trigger for tensions among Lebanese host communities and Syrians. The third assumption of the programme team was that, by targeting exclusively women with a very attractive commodity such as cash, beneficiaries may be singled-out and eventually put at risk of exploitation and abuse. It should be noted that no evidence exists to date to corroborate this assumption. Nevertheless, a study by Oxfam and Abaad (Resource Centre for Gender Equality) carried out in Lebanon in 2013,<sup>5</sup> shows how the displacement has shifted gender roles. Syrian women may have become heads of household as a result of fleeing from their country, and had to take on roles and responsibilities they were not traditionally used to. Men reported feelings of powerlessness and stress, for not being able to fulfil their traditional roles of breadwinners and protectors. A cash programme targeting only women would further fuel such a sense of frustration and incapacity to cope with households' needs. Finally, IRC felt that such a simple and time-saving selection criteria may get easily manipulated, thus leading to unacceptable inclusion error.

Cash was distributed through ATM cards, a modality that IRC was the first to introduce in country and that in Lebanon, is possible due to the widespread presence of banks and ATM outlets. It was then being adopted within the largest multi-agency cash assistance programme during winter 2013-14. For implementing agencies, it is cheaper and safer than distributing cash-in-envelope on a monthly basis, as it requires only a wire transfer to beneficiaries' accounts.

## Challenges and opportunities

### Challenges

In April and May 2013, IRC led an inter-agency Emergency Market Mapping Assessment (EMMA), which showed labour markets of the analysed sectors (i.e. construction, services, and agriculture) are becoming increasingly competitive. Due to the increased competition, the EMMA informed of the difficulty for labourers in each of these sectors to secure consistent work; as a result most refugees work only sporadically. Furthermore, even if full-time work was available, the decreasing monthly wages only cover a portion of household expenditure needs. However, the report suggested that the humanitarian sector could intervene within these markets, and maximise the use of existing skills. The UN and WB study on the social and economic impact of the crisis on Lebanon, estimated that 170,000 Lebanese have been pushed into poverty and the unemployment rate has doubled to around 20%, mostly affecting unskilled youth.<sup>6</sup>

Since May 2013, when the EMMA report was released, the refugee population has grown

from around 350,000 to over 1 million persons, of which 45% are of working age. A workforce increase of this magnitude within three years would put a strain even on the most resilient labour markets and economies. It is felt even more so in a relatively small country like Lebanon, where the national labour force is around 1.5 million. At the moment, Syrian refugees of working age constitute almost one third of the national labour force, and this figure is likely to increase. In this context and even under the most optimistic scenario of an economy picking up, thanks to development and investments efforts that the Government of Lebanon called for, job opportunities will never be sufficient to absorb the entire additional workforce. This will be even more challenging in the most economically depressed areas of the country, namely Akkar and the Bekaa valley. Unemployment will remain high and wages low. Anecdotal information collected by the IRC ERD Programme shows that Syrian refugees accept full-time jobs paid for as little as 200 USD per month, well below the minimum wage of 450 USD. While self-reliance is the lynchpin of sustainable programming, with insufficient jobs opportunities, the continued reduction of humanitarian funding and the subsequent need for greater targeting of food and other assistance, there will continue to be many highly vulnerable households that will not be able to meet their basic needs. Hence, cash aid continues being needed, although more efforts will be made to concurrently create opportunities for income generation and to facilitate access to existing opportunities for the most economically vulnerable.

The Government of Lebanon is particularly concerned with the high competition in the labour market, which causes decline of wages and the parallel increase in unemployment and poverty among Lebanese. Therefore, the Government tends not to support interventions that make Syrian refugees even more competitive than they are. In this complex context, both Syrians and Lebanese men and women should be supported in making a living. On the other hand, the Government of Lebanon is also concerned about large-scale and long-term cash transfer programmes for Syrians, and so far has not supported this type of programme as part of social protection for Lebanese host communities either. Instead, the Government of Lebanon is implementing a social protection programme (i.e. the National Poverty Targeting Programme) that subsidises essential services, such as education, health and access to electricity. It is now introducing a food assistance programme with WFP, similar to the one that is targeting refugees.

The dilemma faced by the humanitarian community is that, by reducing cash assistance, refugees are prompted to look for job opportunities thus competing with the Lebanese workforce. A fine balance must be found between the two types of interventions.

### The second phase of IRC response

The current IRC ERD programme in Lebanon started in November 2013 and will run until

April 2015 with funding from DFID. It is centred on two types of interventions targeting refugees and poor Lebanese households: the provision of direct income support (i.e. cash assistance) and the promotion of access to income opportunities (i.e. livelihoods support). Cash assistance is given either unconditionally or upon certain conditions; in both cases, it is unrestricted. Appreciating the concerns of the Government regarding cash assistance and how this may create a dependency that they cannot accommodate or sustain, the IRC has enjoyed good dialogue with the Government about the programme. The scale of the IRC programme is small enough not to constitute a real threat/burden; in addition, the IRC programme assists also Lebanese and strives to make sure that they represent 50% of the beneficiaries of all livelihoods promotion activities.

The underlying intention of the programme is twofold. On one hand, cash assistance is mainly to preserve beneficiaries' assets and savings, and protect them from the abuse and exploitation that may arise from a situation of acute financial need. On the other hand, livelihoods support is to assist beneficiaries by increasing their ability to earn an income on their own, in view of diminishing humanitarian-aid funds in this protracted crisis.

Cash assistance within a humanitarian response has an immediate impact but, presumably, a short-lived effect. It contributes to satisfying essential, immediate needs but it is seldom invested in livelihoods improvements that increase self-reliance. These are not a priority for families in a 'survival mode'; which are typically more risk adverse than better-off families. Once cash assistance is discontinued, it is likely that recipients will resort (again) to negative coping strategies, unless they can rely on other forms of generating an income. The livelihoods support component of the programme is intended to facilitate the transition to means of making a living in the absence of external income support.

## Overview of current ERD interventions (July 2014)

### Unconditional cash assistance

Unconditional cash grants of 200USD are distributed on a monthly basis through ATM cards. Beneficiaries – newcomer refugees, as well as the most vulnerable Syrians and Lebanese – are selected through a process combining referrals and household surveys. Candidates are then ranked according to an economic vulnerability score, which considers living conditions and assets, food consumption and coping strategies. Both men-headed and women-headed households are targeted, as the main selection criteria is their economic vulnerability. While the recipients can use the cash as they see fit, the IRC's post-distribution surveys show that common expenses are food, health care and rent.

<sup>5</sup> Roula el Masri, Claire Harvey and Rosa Garwod, 2013. *Shifting Sands: Changing Gender Roles among Refugees in Lebanon*. Beirut: Oxfam and Abaad (2013).

<sup>6</sup> Lebanon: Economic and Social Impact Assessment of the Syrian Conflict. UN and WB (2013).

Households spend part of their cash grants on food even when receiving food e-vouchers.

### *Financial management training*

Around 60% of IRC cash-assistance beneficiary households in the current programme are headed by women. Prior to coming to Lebanon, they were not used to earning an income on their own and they mostly did not have to plan on the use of their household's money or make financial decisions - their spouses would take the lead on this. Receiving cash assistance is a great relief for these women. However, in spite of being aware of its temporary duration, they generally report not having a plan for when the assistance is over. In collaboration with the IRC Women Protection and Empowerment Programme (WPE), the ERD team provides financial literacy training to interested women heads of household receiving cash assistance. The programme is delivered over 12 sessions across six weeks; topics include household-level budgeting, debt management and negotiation, savings, and banking services. Trainees reported a greater sense of self-confidence and greater participation in decision making within their households, which according to IRC, can ultimately reduce use of negative coping strategies and exposure to gender based violence (GBV).

### *Livelihoods centre services*

In February 2014, the IRC opened its Livelihoods Centre (LC) in Akkar. This is a venue for training activities and provides information and employment-related services to job seekers, training providers, and employers. The goal is to help registered applicants find vacancies and training options and to assist employers in identifying employees that match their skills requirements. The LC also provides job seekers with information on legal matters related to work and business set-up in Lebanon. Finally, it assists employers with organising vocational training courses on skills areas where they encounter challenges in finding suitable workforce. The services are provided free of charge to all Lebanese and Syrians residing in Akkar, regardless of registration status. In only six months of operation, the LC has registered over 1,200 jobseekers and referred more than 600 of them to employers or – more broadly – providers of income generating opportunities. Employers that are clients of the LC's referral services are mostly non-governmental organisations (NGOs) and income generating opportunities include Cash for Work (CFW) and volunteering schemes. These are not jobs in a strict sense, nevertheless they offer temporary access to income for both vulnerable Syrians and Lebanese men and women.

### *Cash for work (CFW)*

The CFW project component creates temporary income opportunities for Syrians and Lebanese while helping to rehabilitate community assets or providing essential services and goods. Beneficiaries – willing and able-bodied Syrians and Lebanese – are selected through an economic vulnerability assessment and livelihoods profiling. Examples of projects include collecting garbage, disseminating information on ERD services,

disseminating information on health and hygiene, and providing child care when caregivers (generally mothers) are engaged in training or income-generating activities. Implementation started recently and 59 beneficiaries have been enrolled so far. In addition, 93 women have been enrolled in home-based Cash-for Product projects; these projects are particularly suitable for women who prefer working from home in order to fit in with the schedule of their other commitments. They are implemented to produce basic goods (e.g. clothing for children) and productive assets to support livelihoods of vulnerable households (e.g. fishing nets).

### *Skills training*

The skills training project component develops professional skills of Syrian and Lebanese beneficiaries to improve their chances of finding work, including opportunities in the expanding humanitarian sector, which is demanding specific skills. The trainings are geared towards occupational areas offering more employment (and self-employment) opportunities than others and are identified based on the information gathered through jobseekers and employers registered at the LC. The training curricula are also developed in consultation with employers, with a view to respond to their training needs. Syrian refugees are trained only on those professions that are allowed to them as per Lebanese labour regulations<sup>7</sup>. IRC collaborates with local vocational training providers develop the training curricula and conduct the courses. In total, so far IRC has enrolled 258 trainees in training courses: car repair and mechanics, cooking and catering, waiting and hospitality, marketing and sales, psychosocial support and recreational activities for children, knitting and fishing-nets weaving.

### **Conclusions**

While the conflict in Syria continues, in the midst of a widespread escalation of tensions and fighting in the whole region, the likelihood of refugees returning to their home country seems remote. When asked about this possibility last year, ERD programme beneficiaries would respond they were counting on an imminent return and were looking forward to that. Today, their scepticism is growing and their plans for the future are adjusting accordingly. Whilst influx trends in Lebanon are, in fact, decreasing, the challenges ahead are compelling. On the one hand, funds for humanitarian assistance are phasing out and will probably be diverted toward the emerging crises in Iraq and the Gaza Strip. On the other hand, refugees are looking for stability and continue needing aid; host communities are getting poorer.

The humanitarian community and the donors are called to move out of the “emergency mode”, which after three years is considered outdated, and to start laying out interventions aimed at strengthening and expanding community services, providing social protection to the most vulnerable, and finding creative ways of increasing job opportunities. Such interventions should target both refugees and host communities in an equal and need-based way. In this context,

the following recommendations may be considered:

- Continue cash and food aid for refugees, and adapt cash assistance programmes based on the learning through recent surveys.<sup>8</sup>
- Expand the outreach of the National Poverty Targeting Programme, based on an up-to-date assessment of the needs, and increase the assistance package taking into account the growing poverty and diminishing income from work.
- Strengthen community service providers and related infrastructures in essential sectors, such as health and education, as well as solid and water waste management. Capitalise on this for launching large-scale public work schemes, aimed at giving access to income to the vulnerable. In parallel, build the capacities of municipalities and assist them in handling bidding processes in a transparent and effective manner.
- Provide employment services to effectively match labour demand and supply, and convey information on the labour market and labour regulations. Such services should strategically specialise in targeting the humanitarian and development sector, which offer several employment and income-generating opportunities, including CFW and volunteering schemes.
- With an eye to the future, strengthen and expand cross-border livelihoods recovery programmes in areas of Syria where the security situation allows for it. In Syria, this would entail gaining better understanding of the livelihoods and market opportunities, and anticipating which occupational areas are likely to be in demand in the future and throughout the country reconstruction. In the hosting country, such interventions may include vocational training programmes for Syrians in professions with promising futures in Syria, complemented by self-employment kits and financial aid offered when in Syria.

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<sup>7</sup> The jobs from which Syrian refugees are excluded are: Manager, Deputy Manager, Chief of Staff, Treasurer, Accountant, Secretary, Clerk, Notary, Secretary of the archives, Computer officer, Seller, Jeweller, Bailiff, Driver, Waiter, Barber, e-business activities, Arabic Food chef, teaching in preliminary, intermediate and high school with the exception of teaching foreign languages when necessary, engineering works in various disciplines, nursing, all types of activities in pharmacies, drug warehouses and medical laboratories, and in general all activities and occupations for which Lebanese nationals are available. The jobs they are allowed to secure are: the technical professions in the construction sector and its derivatives (tiling, coating, installation of gypsum and aluminum, steel, wood and decoration works, electrical wiring, painting works, installation of glass and the like), commercial representative, marketing representative, Tailor, Mechanics and maintenance, Blacksmithing and upholstery, Work supervisor, Secretary of warehouse, keeper.

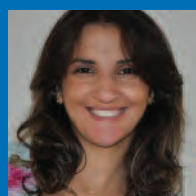
<sup>8</sup> See footnote 3.



IOCC field officer screens a Syrian refugee child for malnutrition in the Bekaa valley

# Institutionalising acute malnutrition treatment in Lebanon

By Linda Shaker Berbari, Dima Ousta and Farah Asfahani



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The authors extend thanks to UNICEF and UNHCR for funding the trainings and staff and for supporting the treatment of children with acute malnutrition. Thanks also to the MoPH for supporting and facilitating the establishment of the programme through its established network of primary and secondary health centres. Finally, the authors gratefully acknowledge the support of the American University of Beirut, particularly Dr. Hala Ghattas and Dr. Omar Obeid, and of Caroline Abla at International Medical Corps, for providing technical input and guidance on the development of the programme and training material.

Lebanon is a middle income country that has had to endure a number of wars and emergencies since 1975. Throughout those different emergencies, Lebanon has never had a nutrition crisis, even during previous periods of civil war. Today, with more than 1 million Syrian refugees hosted in the country, there is fear that due to the underlying causes of malnutrition, acute malnutrition may be a problem that the Lebanese health system may have to deal with. The Lebanese health system is considered one of the strong services in the country, especially within the private sector. However, most nutrition and health problems that the system is equipped to face include problems that are related to overnutrition rather than undernutrition. At the outset of this crisis, Lebanon did not have any protocols for treatment of acute malnutrition, health care providers were not familiar with the different forms of malnutrition that may arise during emergencies, and health services were not equipped to respond to such crises.

## Nutrition programme

International Orthodox Christian Charities (IOCC) started its nutrition programme in 2012, focusing on emergency preparedness that mainly involved capacity building activities for health care providers. From 2011 to 2013, as the number of refugees increased and cases of acute malnutrition started to appear, there was a need to provide case management. The ensuing acute malnutrition treatment programme is implemented by IOCC with support from UNICEF and UNHCR and in partnership with the Ministry of Public Health (MoPH) in vulnerable localities<sup>1</sup> in all six of Lebanon's governorates. Lebanon's six

governorates are made of 26 cadasters; IOCC works in more than 15 cadasters to support the nutrition programme. The IOCC programme aims to institutionalise acute malnutrition treatment to ensure primary health centres (PHCs) have or will have the capacity to treat acute malnutrition; it is both a preparedness activity and an intervention. Key activities are as follows.

*Activation of PHCs for the screening and management of acute malnutrition through capacity building and provision of on-the-job support*  
As Lebanon already has an established network of PHCs providing health services to both the Lebanese and the Syrian refugee community, the acute malnutrition treatment programme relies on this existing structure. There are more than 800 centres in Lebanon that provide health services that are registered with the MoPH. However, only around 180 are part of the Network of PHCs; these are PHCs accredited by the MoPH that provide a comprehensive list of services. Many of these centres are pri-

- 1 Map from UN Children's Funds (2013). Equity in Humanitarian Action: Reaching the most vulnerable localities in Lebanon, October 2013, [online], Available through: [www.data.unhcr.org](http://www.data.unhcr.org)
- 2 Harmonised Training Package: [http://www.unicef.org/nutritioncluster/index\\_67812.html](http://www.unicef.org/nutritioncluster/index_67812.html)
- 3 See article by AUB regarding the training initiative. <http://www.nietraining.net/>
- 4 A 'contracted' centre is where UNHCR or an NGO subsidises the cost of treatment for medical consultations for Syrian refugees. Instead of paying the full fee for a medical consultation, the refugee pays a minimal fee. IOCC has prioritised contracted PHCs so as to make sure that the cost of acute malnutrition treatment is covered by UNHCR (in most cases) or an NGO.
- 5 Weight and height are measured but weight for height only is calculated.



Håkon Haugsbo/NCA, Lebanon, 2014

An IOCC field officer carefully monitors the malnutrition treatment of two and a half year old, Mataab, in the Bekaa valley

vately owned or supported by local organisations. Whether part of the Network of PHCs or not, at the outset of this crisis, none of the centres was equipped to, or even knew about, how to screen and manage acute malnutrition. Therefore, IOCC's programme targeted 50 PHCs across the country with facility-based trainings.

Since May 2012, this training of health care staff (doctors, nurses, social workers) has been implemented by IOCC with technical assistance from the American University of Beirut (AUB) and International Medical Corps (IMC). The training material is a translated adaptation of the harmonised training package (HTP)<sup>2</sup>. As the training progressed, IOCC began to conduct its own trainings using IOCC staff who have been trained through either the Nutrition in Emergencies Regional Training Initiative (NIERT)<sup>3</sup> or other nutrition in emergency trainings. To date (July 2014), the team has trained more than 250 health care staff across the country.

Capacity is also built through provision of on-the-job support to selected PHCs whose staff have received the facility based training outlined above. These 'activated' centres, are selected for on-the-job support based on a number of criteria:

- They are located in the most vulnerable areas based on UNICEF's priority list.
- The centre is contracted<sup>4</sup> by UNHCR/ non-governmental organisation (NGO)/to cover the cost of treatment.
- The centre has a paediatrician who is willing to be trained.
- The centre is willing to participate in the programme.

Activated PHCs provide a variety of services including screening for malnutrition amongst children under 5 years<sup>5</sup>, acute malnutrition treatment, education on nutrition and infant and young child feeding (IYCF), and provision of micronutrients for children under five years. Other population groups are only assessed or

referred where acute malnutrition is suspected. IOCC provides on-the-job support by supplying IOCC staff who assist in screening for malnutrition amongst children under five years. IOCC staff also assist in case management and follow up on case treatment.

So far, IOCC has activated 30 centres across the country. Within the Syria response, there are around 97 centres that are contracted by UNHCR or international NGOs. Within those centres, only those activated by IOCC provide the acute malnutrition treatment services. Even where a centre is contracted by another INGO that subsidises the acute malnutrition treatment service, the training and follow up is all implemented by IOCC<sup>6</sup>.

Programme materials and supplies, including lipid-based Ready to Use Therapeutic Food (RUTF), Ready to Use Supplementary Food (RUSF)<sup>7</sup> and equipment (e.g. height boards, scales, and MUAC tapes), are provided by UNICEF. With funding from UNICEF, IOCC has devised forms in Arabic to use at the PHCs for follow up on malnutrition cases.

Within each activated PHC, children under 5 years are assessed using mid-upper arm circumference (MUAC) and weight for height (WFH) measurements and for oedema. Children are admitted to the supplementary feeding or therapeutic feeding programme depending on the diagnosis. Children are provided with treatment at the PHC level through weekly or bi-weekly visits and are followed by trained staff at the community level as needed. Children with complicated severe acute malnutrition (SAM) are referred to secondary care for in-patient therapeutic treatment. On average, the IOCC-supported PHCs assess a total of around 125 children under 5 years per month, out of which around six children are admitted for acute malnutrition. It is important to note that the programme is still in development.

IOCC has also trained eight hospitals across the country on in-patient treatment of malnutrition using the WHO revised protocol for the treatment of malnutrition<sup>8</sup>. All of these hospitals are contracted by UNHCR to provide services for Syrian refugees and cover the cost of treatment of malnutrition. Within each hospital, paediatricians and nurses on paediatric wards are trained in a one-day training. A dietician and paediatrician from IOCC then follow up with the staff on each case upon admission. An understanding was reached with each of the hospitals in terms of the roles and responsibilities of each party with regards to the treatment and follow up of admitted cases, as well as on the use of materials and supplies. Again, supplies such as F75, F100 and RUTF are provided by UNICEF.

An important step remains to integrate the management protocol within existing national and hospital protocols. To-date, IOCC has to rely on close follow up with hospital staff in order to make sure treatment protocols are followed.

### Community screening for malnutrition

A major component of the IOCC programme involves screening for malnutrition within the community. IOCC deploys a group of trained screeners to different areas within Lebanon on a rotational basis to conduct community screening for acute malnutrition amongst children under 5 years using MUAC and oedema. This helps in early identification of cases who are then referred to activated PHCs for confirmation of diagnosis and treatment. Screeners have also been deployed

<sup>6</sup> Relief International provides treatment of malnutrition in mobile units and in specific areas of Lebanon but not in PHCs. See article in this issue of Field Exchange.

<sup>7</sup> Products are Plumpy'nut, Plumpy'sup and NRG5.

<sup>8</sup> Ashworth, A, Khanum, S, Jackson, A, and Schofield, C. (2013). Guidelines for the inpatient treatment of severely malnourished children. World Health Organisation. Available at: <http://whqlibdoc.who.int/publications/2003/9241546093.pdf?ua=1>

to UNHCR registration and vaccination centres. Screening teams have mainly targeted informal tented settlements (ITSs) and collective shelters all over Lebanon and have conducted house to house screening in particular situations (e.g. in the village of Aarsal, at the time when a high influx of refugees fled from Syria in November 2013; a large number of refugees have been hosted by Aarsalis and have settled in unfinished houses since the beginning of the crisis in 2011). To-date, over 27,000 children have been screened (in the community and at registration centres) of which 450 were identified as malnourished and referred for treatment to the activated PHCs.

#### *Education and awareness*

In addition to screening and treatment, PHC staff provide education and raise awareness on nutrition for children, pregnant women and lactating women. Education topics include nutrition, IYCF, and hygiene. Resource material has been developed with UNICEF, UNHCR and the MoPH focusing on both acute malnutrition and IYCF.

#### *Integration of anthropometric indicators within existing health information system (surveillance)*

An integral and very crucial part of the nutrition programme involves establishing a pilot surveillance system within the MoPH. With the help of the primary health department at the MoPH, anthropometric measures (weight, height and MUAC) in addition to bilateral oedema were incorporated into the existing health surveillance system. Indicators include weight for height and height for age and an IYCF indicator (exclusive breastfeeding). The system is to be piloted and launched at the activated primary healthcare centres around October 2014.

#### *Resource development*

An important output of the project has been the development of resource material for screening and management of malnutrition. Referral sheets and treatment sheets for severe and moderate acute malnutrition were devised in Arabic and provided to activated PHCs. Staff were trained on the use of these forms. Another significant component of the programme included the development of training material in Arabic based on the HTP.

As Lebanon does not have a national protocol for the treatment of malnutrition, the team had to draw on protocols from other similar countries, such as the Yemen. These were adapted given the unique nature of, and accumulated experiences from, the Lebanon context. For example, the use of Amoxicillin in Lebanon has been debated by paediatricians due to high resistance to the antibiotic; thus, paediatricians were advised to replace with an alternative antibiotic. IOCC is working with the MoPH to formalise a national protocol for treatment that will be adopted by paediatricians.

#### **Issues, challenges and lessons learned**

There have been a number of challenges implementing acute malnutrition treatment in

Lebanon. A primary challenge has been implementation in an urban context through existing health services in a country that has never had to provide these services before and with a view to long term sustainability.

A limiting factor has been the ability of PHC staff to accommodate additional services for patients visiting the PHCs. Multiple training at each centre was necessary to ensure appropriate capacity. It was essential to provide on-the-job support through additional staff, especially for regular growth monitoring (weight and height measurements). Finding physical space for the additional services was also a challenge.

There have been difficulties gaining understanding and uptake of treatment protocols amongst health care providers, notably paediatricians, who are not familiar with acute malnutrition. IOCC staff sometimes faced resistance from health care providers to implement supplementary feeding or therapeutic feeding programmes. Paediatricians sometimes did not recognise and diagnose acute malnutrition as a condition.

The urban setting has rendered the follow up of cases more difficult. Given the movement of families within different areas and the reluctance of some families to address the issue of malnutrition, IOCC had to deploy health and nutrition educators to follow up cases at the community level in order to ensure regular attendance at centres. It was difficult to convince some families about the importance of seeking and finishing the treatment. For some, there was a perception that treatment for acute malnutrition was not a lifesaving intervention. Due to the distances between refugee residence and the activated centres, families often did not attend due to lack of transport. IOCC therefore had to fund transport costs for some cases.

A common challenge in the programme relates to the acceptability of RUTF and RUSF. Families and children are not used to receiving food/medicine in the form of a paste. In many cases, children do not accept the taste of RUTF and staff have to resort to alternatives such as mixing other nutrient dense products (e.g. NRG-5) with milk and juices, or adding RUTF to the child's favourite foods (topping on bananas or biscuits).

The cost of attending PHCs can be prohibitive for some families, even though a number of PHCs are subsidised by UNHCR/NGOs, since families are required to cover 25% of the cost of consultation. IOCC has worked only with PHCs that are subsidised by other NGOs who have been covering 100% of the cost of acute malnutrition consultations. However, recent cuts in health care funding for the Syria crisis means that refugees are having to pay for some of the cost of treatment of malnutrition. This is hindering the success of care. In addition, often the medical treatment requires further testing for underlying causes of malnutrition (e.g. laboratory tests for anaemia, immunoglobulins, intolerances,

Ryan Erickson/IOCC, Lebanon, 2013



**A child is fed RUSF for the treatment of malnutrition (Bekaa valley)**

CT-scans, endoscopies etc.) all of which are only subsidised at 85%<sup>9</sup>.

In many cases, children with acute malnutrition are also diagnosed with congenital or other associated diseases such as neurological disorders (e.g. cerebral palsy), cystic fibrosis, congenital heart disease, cow's milk allergy, celiac disease, galactosemia, which often are the underlying cause of the acute malnutrition. In such cases, treatment of malnutrition has to be adapted to the case and condition.

#### **Conclusions**

The most important investment lies in institutionalising nutrition services within primary health, including those targeting both acute and chronic nutrition related diseases. Lebanon provides a unique context for implementation of an acute malnutrition treatment programme but building such capacity takes time. Other nutrition related problems need to be addressed as well, such as stunting, micronutrient deficiencies and other chronic nutrition related diseases that are endemic to the area. The establishment of a clinic-based surveillance system through the MoPH is expected to act as an essential step towards the strengthening of the primary healthcare structure in collecting growth monitoring data. This will act as a platform for capacity building to deal with acute and chronic nutrition-related conditions at the primary healthcare level.

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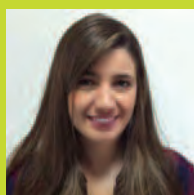


Pressila Derjany/IOCC, Tripoli, Lebanon, 2014

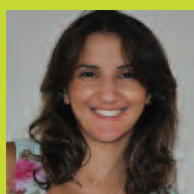
After receiving individual counselling, a woman is cup feeding her child with expressed breastmilk

# Infant and young child feeding support in Lebanon: strengthening the national system

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## The policy and social context

In 2011, the International Orthodox Christian Charities (IOCC) launched the Preparing for the Next Generation Initiative that builds on the importance of the first 1000 days of an infant's life. Through this initiative, IOCC is working to create a strong national mother and child nutrition programme that will not only prepare the nation against any emergency but also improve the wellbeing of Lebanese children for generations to come. IOCC's programming on infant and young child feeding in Lebanon is located within this initiative. This article describes IOCC's role in a recently established national programme to strengthen policy guidance and support around IYCF-E in health services in Lebanon, including additional activities that were developed to respond to the Syria crisis.

In Lebanon, the only government regulation on infant feeding was a 1983 law related to the 'Marketing of Breastmilk Substitutes'. However, an updated version was issued in 2008 (Law 47/2008) that is currently considered even stricter than the International Code of Marketing of Breastmilk Substitutes (BMS) (the Code). Unfortunately, although efforts are being put in place to enforce this law, there is evidence that health workers and even government representatives are not aware of it. It is also evident that much more is needed in order to identify potentially available guidelines so that these can be included within a reliable policy framework. In the absence of effective government policies, the private sector and non-governmental organisation (NGO) sector in Lebanon play a large role in influencing the type of service provided. The only available study, conducted by Save the Children after the latest Lebanese war in July 2006, showed some key findings around policy and infant and young child feeding practices:

- A lack of awareness amongst NGOs, the government and health workers about the Operational Guidance on IYCF-E and the Code
- A large number of Code violations, including inappropriate distribution of infant formula
- Most intervening agencies – including international NGOs and United Nations (UN) agencies – did not ensure their partners followed Ops Guidance on IYCF-E

- Mothers were not adequately supported to continue breastfeeding
- Infant feeding was not a priority.

These factors had a negative impact on prevalence of breastfeeding and proper infant nutrition<sup>1</sup>. In addition, eight years after this July 2006 war, reports from INGOs currently intervening in Lebanon in response to the high influx of Syrian refugees as a result of the Syrian crisis, show that there are still a large number of Code violations and that infant feeding is not on the priority list of interventions. Hospitals are still distributing infant formula and paediatricians continue to inappropriately prescribe it to mothers.

The prevalence of exclusive breastfeeding is currently low in Lebanon, with only 14.8% of infants 0-5 months of age exclusively breastfed (MICS, 2009). Rates of childhood<sup>2</sup> and adult obesity, hypertension and high cholesterol<sup>3</sup> in Lebanon are comparable to those in the United States. The prominent misconceptions, lack of proper supportive environment, and the heavy marketing of artificial feeding<sup>4</sup> all contribute to the low rate of breastfeeding in addition to the absence of a global and solid policy framework in the area of infant and child feeding.

In order to address this, since 2011, IOCC has partnered with World Vision, the Ministry of Public Health (MOPH) and other local institutions including the Lebanese Association for Early Children Development. A National Programme on IYCF was established at the MOPH with support from IOCC and World Vision. IOCC works through this programme in order to execute activities that support IYCF, such as celebrations for the annual

<sup>1</sup> MacLaine A (2007). Infant Feeding during Emergencies: Experiences from Lebanon. Humanitarian Exchange Magazine. Issue 37. Sibai,

<sup>2</sup> A et al (2003). Prevalence and Covariates of Obesity in Lebanon: Findings from the First Epidemiological Study. Obesity Research. 11, 1353-1361.

<sup>3</sup> WHO Lebanon Health Profile, 2008. [www.who.int/gho/countries/lbn.pdf](http://www.who.int/gho/countries/lbn.pdf)

<sup>4</sup> Nabulsi M. (2011). Why are breastfeeding rates low in Lebanon? a qualitative study. BMC Pediatr Aug 30;11:75., Saadé N et al. (2010). Maternity leave and experience of working mothers in Lebanon. East Mediterr Health J. Sep;16(9):994-1002., Osman H et al. (2010). What do first-time mothers worry about? A study of usage patterns and content of calls made to a postpartum support telephone hotline. BMC Public Health. Oct 15;10:611.



## Case study **Supporting Syrian refugee mothers who choose to breastfeed**

By Tiziana Cauli and Rana Hage, IOCC Lebanon

Aamer is 3 months old. He lives in the tented Syrian refugee settlement of Khaled el Homs, near the town of Saadnayel, in Lebanon's Bekaa valley, with his mother Mufida Al Hamsi and his 18-month old brother Jassem. Mufida did not breastfeed her first child and was not planning to breastfeed baby Aamer, until she was approached by IOCC lactation specialist, Zeinab Hillani. Briefed on the benefits of breastfeeding, she decided to defy the widespread misconception, common among refugee mothers in the area, that formula milk-fed babies are healthier than breastfed ones, especially in times of uncertainties and emergencies. As a result, baby Aamer is healthy and big enough for his age.

"He is heavier than his brother was at 3 months," Mufida says. "And he is healthier. Jassem suffered from gastroenteritis while he was fed with infant formula and he was always sick. He still has digestion problems."

The 27 year old mother from Aleppo says that breastfeeding her child has also helped her financially. Her husband is missing in Syria and she has no money to buy formula milk, she says. "It's too expensive and I can't afford it. And I am convinced my baby will benefit from breastfeeding."

When she first met Hillani, Mufida didn't know how to breastfeed. She had fed her first child with infant formula and had been advised against breastfeeding her newborn baby because she had recently been sick with measles. She was approached by Hillani at the hospital, right after giving birth and started breastfeeding her baby within a few days.

"I wish I had met Zeinab beforehand," Mufida says. Many mothers like Mufida and their babies are victims of misconceptions.

"At the paediatric ward, I speak to mothers and ask them why they are giving infant formula to their babies," says Hillani. "Some of them refuse to breastfeed because they think or are told that infant formula is healthier. This is not true."

"I give her vitamins and support and I am going to give her the food she needs to add to her baby's diet after his first six months," Hillani says.

"And they gave me this," Mufida says proudly, pointing at the baby romper suit Aamer is wearing.

The vitamins Hillani mentioned are part of the support given by IOCC to lactating mothers. Micronutrients are given to those who are not receiving them from other healthcare institutions. When babies reach 6 months of age, IOCC helps mothers integrate their children's diet by providing them with the proper food, when necessary.

In addition, lactating mothers within IOCC programme receive a kit with clothes and other items for their babies and a personal hygiene kit for themselves as a form of encouragement<sup>6</sup>.

World Breastfeeding Week, media campaigns and other promotional activities. Within the National Programme, a sub-committee was created in 2011, mainly supported by IOCC, focusing on IYCF-E.

### Response on IYCF-E to the current crisis

In 2012, with UNICEF funding, IOCC implemented a programme to support upholding the Code during the Syria crisis in Lebanon. Workshops were implemented targeting NGOs and agencies responding to the Syria crisis. In addition, the publication of a joint statement was facilitated and endorsed<sup>5</sup>. Since August 2013, IOCC with support from UNICEF and UNHCR, has been implementing a programme to support, promote and protect IYCF amongst both the refugee and host populations affected by the Syria crisis in Lebanon. The programme includes the following activities which endeavour to promote three objectives:

#### 1) Promotion of optimal IYCF practices

Education and awareness activities on optimal IYCF are administered at the primary health centres (PHCs), in hospitals and at the community level. To-date, IOCC has targeted more than 10,000 mothers with awareness on IYCF. Educational material were developed and tailored to the Middle Eastern context. The UNICEF Infant Feeding counselling cards were translated, tested, and adapted. Staff at health care centres were trained on the use of the counselling cards (see Figure 1 for a sample card).

#### 2) Supporting mothers to ensure optimal IYCF

Mothers receive IYCF counselling during and after delivery (see case study for one woman's experience). The service is provided at the hospital, PHC and community levels. In contracted hospitals, IOCC lactation specialists are present to ensure early initiation of breastfeeding, as well as correct positioning for feeding, etc. Follow up is provided in the community as necessary. Also, through community outreach, mothers are identified and are referred by other NGOs to the lactation support service. Typically, lactation specialists counsel mothers of infants under 6 months of age who are not exclusively breastfed. Mothers are helped to re-establish milk supply and exclusively breastfeed. In most cases, this intervention is successful.

Mothers who have not breastfed at all or have stopped breastfeeding

are counselled on relactation and helped to re-establish milk supply if they so choose. In most cases, the intervention is successful, which depends greatly on the dedication and commitment of the mother. There are instances when relactation is not possible, for example, when the mother is not willing, or the child is old and not able to latch on, or the child/mother has health problems. In these cases, mothers are referred for artificial feeding support (see below) where they are provided with BMS supplies, and guidance and education on proper use. About 30% of the cases choose not to or cannot breastfeed.

Since January 2014 till end of June 2014, 3,150 mothers were counselled by lactation specialists in all the Lebanese regions, assisting mothers with breastfeeding difficulties, such as painful nursing, latching problems and low breastmilk production.

All children under 2 years are considered equally viable for re-lactation, but the under 6 months age group are given priority. Lactation specialists also work with the nutritionist to counsel the mother on optimal complementary feeding practices. This service is available in hospitals and in the community. There are cases of infants over 6 months of age who have not been introduced to complementary foods and are still exclusively breastfed or exclusively bottle fed. This negatively impacts the child's nutritional status.

IOCC, as part of the IYCF National Programme, has trained more than 200 health care staff within PHCs and hospitals to provide infant feeding support and increase awareness of mothers. This has increased the pool of available qualified lactation specialist to support breastfeeding. Training material, including the WHO 20-hour and 40-hour lactation courses, were adapted and used in collaboration with the National Programme on IYCF. Working within PHCs, IOCC is helping create mother friendly spaces where mothers can meet

<sup>5</sup> Ministry of Public Health – Lebanon and Ministry of Social Affairs. 2012. Joint Statement on Infant and Young Child Feeding in Emergencies – Syria Crisis – Lebanon. Endorsed by UN agencies and NOGs.

<sup>6</sup> Two kinds of 'baby kits' are distributed to women with children under 2 years within the IYCF programme, as encouragement to breastfeed: 1) infant kit containing pyjamas, towels, shampoo, diapers, etc. for newborns and infants. 2) hygiene kit which is the standard hygiene kit containing detergents and personal hygiene products.

and share their experiences. The spaces are used to conduct sessions targeting mothers with children under 2 years of age.

### 3) Protecting IYCF through up-holding of the Code and Law 47/2008

As mentioned above, Lebanon has a history of Code violations, in both 'normal' and emergency situations. In many instances during crisis, NGOs accept donations of infant formula and then distribute through a general distribution. These mostly happen during special events such as periods of holidays (Eid el Fitr and Christmas). In order to mitigate such practices and prevent the flooding of Lebanon with donations and inevitable Code violations, as experienced in 2006, NGOs intervening within the Syria Crisis were targeted by IOCC. Workshops to ensure compliance with the Code and Law 47/2008 were conducted for NGOs and local partners including health care staff. In addition, a reporting mechanism was put in place to report on Code violations. Within hospitals, the Baby Friendly Hospital Initiative (BFHI) was supported through trainings and capacity building, especially in hospitals that have been contracted to provide services for Syrian refugees. As mentioned above, most hospitals in Lebanon distribute infant formula for new mothers and are not supportive of breastfeeding. In many cases, mothers are wrongly advised to provide formula for their infants based on lack of knowledge. To address this, IOCC worked on prioritising hospitals that are providing services to Syrian refugees in order to mitigate practices that may jeopardise breastfeeding. Hospitals are also provided with essential equipment and tools to support the initiative.

### Artificial feeding support

Mothers are first and foremost counselled on the importance of breastfeeding, especially in the current crisis context. If still a mother is not willing to relactate, she is provided with support on artificial feeding. Although not a large component of the programme, IOCC has also supported interventions to manage artificial feeding amongst Syrian refugees. Instances where this is necessary include when a mother is not able to breastfeed and where an infant's mother is not present. Another situation is where an infant has a congenital disease that contraindicates breastfeeding.

In non-medical cases, the lactation consultant makes the decision to prescribe a BMS (infant formula) suitable for the infant. IOCC staff work with the family to provide education on proper use of infant formula including hygiene practices. Cups and clean water is also provided. The mother is provided with infant formula on a monthly basis. Supplies are purchased from the market by IOCC, then unbranded (the brand is hidden with a label so only the Arabic instructions are visible) and provided to the family. One main challenge that is often encountered relates to sustaining the infant formula supply. Ideally, the infant is provided with infant formula until 1 year of age, however, in some cases, funding is not adequate to continue over this period. Staff are faced with either purchasing a

supply of milk with IOCC funds (when available) until the infant is 1 year of age or stopping the assistance. The number of infants assisted with artificial feeding support by IOCC does not exceed 50 children.

### Programming challenges

The main challenge around IYCF resides in addressing strongly established misconceptions around breastfeeding and the fact that many women are used to mixed feeding. Many women believe that their breastmilk is not enough and therefore resort to supplementing with infant formula. Others are influenced by the doctor's prescription of infant formula. Some believe that breastmilk production is highly affected by the stressful situation they are experiencing. As a result, mothers mixed feed or fully artificially feed.

Another challenge relates to artificial feeding support and the fact that this assistance is considered a benefit. As previously mentioned, support for artificial feeding is provided by IOCC to non-breastfed infants within the Syria crisis according to the protocol and only when relactation is not possible. Non-breastfed infants are supplied with formula milk, clean water and cups until of year of age. It is a major challenge for IOCC to provide and maintain a supply of infant formula to 1 year of age. When refugees find out that a neighbouring family is supplied with infant formula, they often come up with ways to benefit from this assistance, even if the mother is breastfeeding with no difficulties. Here, the lactation specialist intervenes by educating families about benefits of breastfeeding versus risks of artificial feeding.

The surrounding environment is not always supportive so often mothers in law, neighbours, husbands, all influence the mother's choice. IOCC works on this by inviting all members of the family to awareness sessions in order to positively engage them into the decision making process of feeding the infant.

There is a need to formalise the protocol for artificial feeding within the Lebanon context in order to minimise harm. Just like for infant feeding in general, there is a need to have clear guidance on artificial feeding support. In a context such as Lebanon where artificial feeding rates are high, there is a need to have guidance on who to provide support to, how and for how long. The problem with funding, for example, is a big one, since once artificial feeding support is started, infants need to be supported until one year of age. Many times, programmes are less than 6 months in duration, which creates a challenge to be able to continue support.

Although the number of artificially fed infants who are supported is small, the actual need is much higher. With the rates of exclusive breastfeeding being low, the number of infants who will need artificial support is higher than the existing capacity to ensure safe and adequate artificial feeding or in the case when mothers are willing to breastfeed, relactation. Frontline support should include preliminary screening for infants less than 6 months of age needing support and capacity should be increased as to providing such support.

### Conclusions

It has been (and still is) a challenge to increase visibility and awareness on IYCF and its importance during the refugee crisis. Emphasis is still put on other "life saving" interventions, although IYCF-E is considered one. Progress has been made in the last two years, but more needs to be accomplished in terms of establishing clear guidance on IYCF support in Lebanon and ensuring sustainability. In addition, more emphasis needs to be made on creating support groups for mothers within their own communities in order to be able to face environmental challenges that hinder breastfeeding.

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A Syrian refugee mother successfully breastfeeds her child after receiving individual counselling from an IOCC lactation consultant

Tiziana Cauil/IOCC, Bekaa valley, Lebanon, 2014

Zeinab Hillani, one of IOCC's lactation specialists in Bekaa, is committed to ensuring that mothers are given support and education on optimal IYCF-E practices and are aware of the potential dangers of artificial feeding. Below is an interview that was conducted with Zeinab describing a day in the life of our lactation specialist.

**How and why did you join IOCC as a lactation specialist?**

"As a nurse, I first attended a training that IOCC had organised on breastfeeding. I was very interested in the kind of work that a lactation specialist would undertake. I am a breastfeeding advocate myself and believe this is an essential and crucial practice that should be strongly encouraged amongst mothers. In parallel to my work as a nurse, I decided to join IOCC to contribute to this noble cause and help women in difficulty provide the most natural food for their babies".

**Can you describe what you usually do as part of your duties as a lactation specialist?**

"Lactation specialist is a new concept in Lebanon, and I believe it is an important one. Actually our responsibility is to promote, support and protect breastfeeding and IYCF practices in Lebanon. Therefore, I conduct awareness sessions targeting mothers, grandmothers, and husbands when possible to spread knowledge about IYCF topics, and provide individual counselling to mothers with breastfeeding difficulties. Those duties are conducted at hospital, community and PHCs levels. At the hospital level, I visit the maternity ward to perform bedside lactation rounds daily in order to counsel mothers immediately after delivery, in addition to the paediatric floor where I counsel mothers who have children under 2 years of age that have been admitted to the hospital. I usually teach the mother how to position the baby for breastfeeding so the baby can nurse at the breast with comfort. Breastfeeding is a pleasurable experience for mother and baby, so I make sure both of them are comfortable and enjoying it".

Zeinab visits the nearby Taanayel hospital regularly to meet with and conduct awareness campaigns among mothers. There, she says, around 18 women give birth every week, about 16 of whom are Syrian refugees from the settlements. Last week she held group sessions for 178 women and met individually with 59 at the hospital, she explains. In addition, she carries out individual sessions for ten women she visits in the settlements once a week.

**What are some of the challenges that you encounter during your daily visits and interventions?**

"You know in Lebanon, having a lactation specialist within the health care team is not common, so at first, people are surprised. Once mothers know what I do, they start seeking help and talking openly about their cases. Sometimes, I encounter mothers that are not really cooperative, so I have to use some creative teaching approaches. But the majority of mothers show interest, are cooperative, interactive and are thankful for the help we are providing. In fact, many women feel more confidence and pride when they learn that this is something they can succeed in, when they learn that their own milk is superior to an external source of nutrition. They feel in control and empowered. So the main challenge relates to convincing the mother that I am here to help and once they realise this, they happily listen and strive."

"One main challenge that I encounter actually is not related to mothers, but rather to the health care team, including doctors and nurses. Many times, I spend days supporting mothers to ensure successful breastfeeding, then suddenly she gets the wrong advice from her doctor asking her to introduce infant formula. This shows the importance of raising awareness amongst staff in the hospital. But not only that, I sometimes feel that they know the answer but they resort to the easy way out of giving infant formula only because they don't have time or don't want to deal with a crying baby".

**What is one major gap in knowledge amongst mothers?**

"A main gap relates to mothers realizing that they CAN actually breastfeed again even if they stopped. It is called relactation. Many women I meet did not breastfeed at all or breastfed for a while and then stopped. They don't know they can re-initiate breastfeeding. Our role is to educate mothers on optimal IYCF practices and especially the importance of breastfeeding, where we introduce the concept of relactation and we explain it to the mother. The aim of relactation is to develop milk supply which requires nipple stimulation (baby nursing, pumping) and thus frequent pumping and nursing will be very helpful. The technique is taught to the mother, as well as training her on pumping.

Relactation is a process that requires effort and willingness from the mother. Often mothers accept the idea of relactation since it comes after long counselling sessions on breastfeeding. They usually get excited and

astounded since they had no idea that they can get back their milk supply. Usually successful re-lactation differs from mother to mother. I believe that there are factors affecting results such as the gap between weaning and re-lactating and also the willingness and dedication of the mother and the support of people around her. To make sure a mother is always supported, close follow-up is needed (this could be daily)."

**How do you intervene if re-lactation was not successful or the mother did not want to breastfeed again?**

As a lactation specialist, I advise mothers on optimal feeding practices and risks of artificial feeding. If a mother is not able to breastfeed, relactate or the mother is not present, children under 6 months of age will have to rely on formula milk. It is important to teach mothers or caregivers how to prepare the formula milk with clean water and especially how to cup feed their child. Risks of bottle feeding are always highlighted, especially in emergencies, since it is not possible for them to clean and properly sterilise the bottles. IOCC always abides strictly by the law and therefore we make sure that the can [of infant formula] is unbranded, that the label is written in Arabic and that it contains only information about ingredients and preparation methods.

Supply for artificial feeding is also considered when mothers undergo the relactation process. At the beginning, mothers won't have enough breastmilk supply, so we provide them formula milk, clean water and cups until breastfeeding is re-initiated successfully.

**What are some of the observations and misconceptions that you encounter during your visits?**

Zeinab has noticed that older women are breastfeeding more than the younger generation. Also, according to Zeinab, women have many misconceptions regarding breastfeeding and optimal infant feeding, below are some of the misconceptions she has encountered in her work:

- Mother give water with sugar to newborn babies since they believe that their brain needs energy. Sometimes, mothers offer dates to their babies to supply them with the sugar they need.
- The most common misconception is that mothers think that their milk is not enough. They also believe that giving infant formula is essential and more nutritious, thus mixed feeding is very common and used to boost breastmilk. This is, of course, supported by the fact that they receive samples of infant formula from doctors or hospitals. Many mothers also give water believing that milk does not provide sufficient water. Herbal teas are also commonly given as means to sooth colic or indigestion.
- Belief that the early milk (colostrum) is not sufficient or should not be given to babies because it has a strange colour.
- A common misconception relates to the idea that if mothers are stressed or sad their milk becomes "spoiled" and thus should not be given to their babies.
- Mothers who are pregnant immediately stop breastfeeding and there is little knowledge that pregnant women can continue breastfeeding.
- During the month of Ramadan, women believe that they should not breastfeed because they will not have enough milk.
- Women who are sick believe they cannot or should not breastfeed their children.
- Another misconception relates to introduction of solid food. Sometimes mothers either start with solid food very early (such as giving starch, bread, tea) or wait a long time before introducing complementary food.

**Have you encountered any Code violations during your visits and what do you do in that case?**

"Unfortunately, there are lots of violations of the Lebanese law 47/2008 where many organisations or persons distribute formula milk to the refugees having good intentions to help them. Whenever I encounter such a case, I report it to the office and we address the violating party with a workshop to increase awareness of the law 47/2008. Usually, we sense cooperativeness since most of the time; the distributing party does not know about the law and the harm that this practice may be causing. In case the violation continues, the MOPH is informed to take action."

**What kind of impact do you think your work is having on the ground?**

"I believe that I am contributing to saving lives through improved breastfeeding practices. I am here to correct major misconceptions regarding IYCF. I am hoping I will be able to increase the rates of exclusive breastfeeding amongst babies and help mothers having difficulty breastfeeding be able to continue this journey. Mothers need support and I think by providing them with close counselling I am also contributing to their feeling of confidence and self-esteem. There is nothing more rewarding than seeing a mother believe that she and only she can provide the most natural nutrition for her baby."



Syrian children enrolled in the ACF 'Safe Haven' Project in Lebanon

Yolanda Romero/ACH/Lebanon

# Challenges of IYCF and psychosocial support in Lebanon

By Juliette Seguin



Juliette Seguin is currently Health and Nutrition Coordinator for ACF Lebanon. She has been working with ACF since 2011 in Haiti, Guinea, Bangladesh, Turkey and Lebanon, managing nutrition projects on IYCF including mental health and care practices activities, CMAM, and Ministry of Health capacity building.

The author gratefully acknowledges the support of the Kayany Foundation, which enabled ACF to start nutrition activities in Lebanon, specifically in Aarsal. Thanks also to the ACF nutrition team in Lebanon for their work on the field and for sharing their experiences reflected in this article and to Anusara Singhkumarwong (ACF regional nutritionist) and Marisa Sanchez Peinado (ACF-Spain nutrition advisor) for their helpful review and comments.

**N**utrition interventions targeting undernutrition are not common in many countries in the Middle East. Lebanon does not suffer from a high burden of undernutrition and is still categorised as a country in early nutrition transition, according to the WHO 2010-2019 strategy<sup>1</sup>. This categorisation is based on the fact that in Lebanon, there are moderate levels of undernutrition, overweight and obesity in certain demographic and other population sub-groups, as well as widespread micronutrient deficiencies. However, the Syrian crisis and the continuous influx of refugees into Lebanon have, after more than three years, brought attention to undernutrition in Lebanon.

The preliminary results of a Joint Nutrition Assessment on Syrian Refugees undertaken at the end of 2013<sup>2</sup> (still under analysis) does not indicate an increase in the prevalence of acute malnutrition compared to the 2012 assessment results<sup>3</sup>. In the 2013 assessment, it is expected that the prevalence of acute malnutrition in the Bekaa Valley will be above the national average, as this is a region of the country particularly affected by the conflict in Syria due to its proximity to the border. Although the nutritional situation in Bekaa and other refugee impacted areas of Lebanon is not alarming, it is still a concern and remains one of the main priorities of the health sector. A number of stakeholders have therefore been working on programming to prevent deterioration of nutrition amongst Syrian refugees in Lebanon, as well as programmes to treat cases of acute malnutrition where these arise.

Prior to the crisis, a large proportion of Syrian caregivers was not practicing appropriate infant and young child feeding (IYCF). In 2009, according to the Syrian Family Health Survey, the national prevalence of exclusive breastfeeding amongst infants under 6 months was 42.6% while the proportion of newborns introduced to breastfeeding within the first hour of birth was 42.2%. The 2013 Joint Nutrition Assessment of the Syrian refugee population in Lebanon confirmed these practices and has raised more concerns about the nutritional situation of children under two years old in particular. This assessment found that only 25% of infants under 6 months of age were exclusively breastfed and only 64.7% of children were still breastfeeding at 1 year of age in Lebanon. By the age of 2 years, 70% of children were not breastfed (see Table 1).

The health situation is also a concern with the potential for outbreaks of polio, measles, hepatitis and widespread waterborne diseases. At the end of May 2014, according to the Epi-Monitor Update of the Lebanon Ministry of Public Health (MoPH), several cases of acute flaccid paralysis, measles, viral hepatitis A and viral hepatitis B were reported among the Syrian population living in Lebanon<sup>4</sup>. These health threats could also have a significant adverse impact on the nutritional situation of the affected population. Living conditions in the Informal Tented Settlements (ITS) and the chronic nature of the crisis are also perceived by Action Contre la Faim (ACF) as potential factors that could lead to both acute and chronic undernutrition.

## ACF programme context

ACF has been present in Lebanon since 2006, working mainly in the southern region of the country, to provide humanitarian assistance to populations affected by the conflict between Lebanon and Israel. Until the latest crisis, the focus of assistance was mainly on food security and improvement of access to water, sanitation and hygiene (WASH). ACF scaled up activities in Lebanon in 2012 by developing programmes in the Bekaa Valley focusing on WASH in ITSs and collective shelters. ACF WASH interventions in this region aim at providing a comprehensive response to the refugee needs, including access to water and sanitation, waste management and hygiene promotion. In 2014, after assessments and resulting concerns about the nutrition situation of the refugee population, ACF began developing a nutrition programme in the Bekaa Valley. Raising awareness and providing appropriate support on IYCF was considered by ACF to be the most appropriate first response to prevent further deterioration of the nutritional situation. This programme was launched in March 2014 focusing on Aarsal, the area most impacted by refugee influx in the Bekaa Valley.

<sup>1</sup> WHO Regional Strategy on Nutrition (2010–2019) and Plan of Action

<sup>2</sup> Joint Nutrition Assessment Syrian Refugees in Lebanon, MoPH and UNICEF, Final Report, February 2014 (pending confirmation of results)

<sup>3</sup> Nutrition Assessment Report for Syrian Refugees in Lebanon using SMART methodology. UNICEF and WFP. Final Report, January 2013

<sup>4</sup> [http://www.moph.gov.lb/Prevention/Surveillance/documents/N10\\_2014May26.pdf](http://www.moph.gov.lb/Prevention/Surveillance/documents/N10_2014May26.pdf)

<sup>5</sup> Conceptual models of Child Malnutrition. The ACF approach in Mental Health and Care Practices. ACF International. Written by Cécile Bizouerne, first version 2005, revised 2012

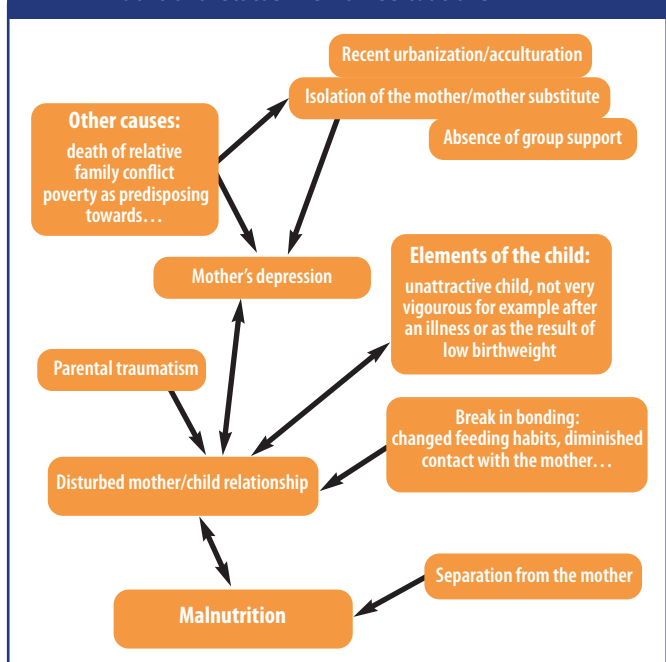


**Table 1: Infant and young child feeding practices in Lebanon (2013)\***

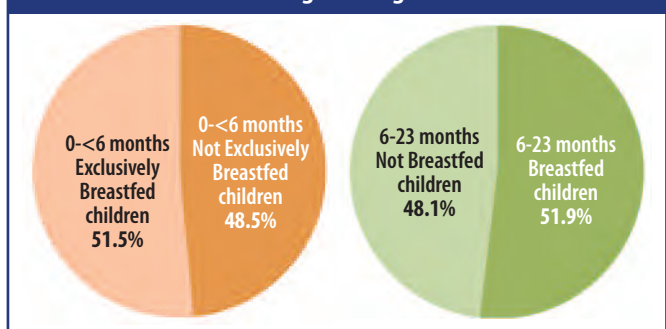
Assessment area	All Lebanon		Bekaa	
	N/Total	% (95%CI)	N/Total	% (95%CI)
Timely Initiation of Breastfeeding (First time to put child to the breast)	< 24 hours	157/502 31.3% (27.37-35.45)	31/102	30.4% (22.31-39.89)
	1-24 hours	201/502 40.0% (35.85-44.39)	34/102	33.3% (24.93-42.94)
	≥ 24 hours	144/502 28.7% (24.91-32.8)	37/102	36.3% (27.6-45.95)
Exclusive breastfeeding <6 months	22/88	25.0% (17.13-34.96)	4/16	25.0% (10.18-49.5)
Continued breastfeeding at 1 year	44/68	64.7% (52.85-75.0)	9/12	75% (46.77-99.11)
Continued breastfeeding at 2 year	19/63	30.2% (20.24-42.36)	4/12	33.3% (13.81-60.93)

\*Preliminary results.

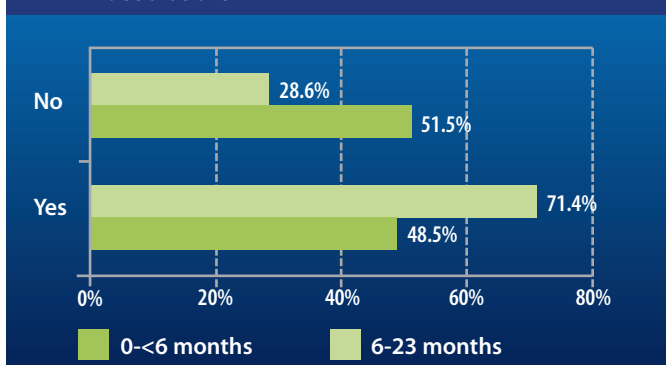
**Figure 1: Psychological and sociological factors affecting nutritional status in chronic situations<sup>6</sup>**



**Figure 2: Percentage of exclusively breastfed and not exclusively breastfed children at programme admission according to caregiver declarations**



**Figure 3: Percentage of children receiving or not infant formula at programme admission according to caregiver declarations**



**Project approach**

ACF's approach to prevent undernutrition is to combine nutrition and psychosocial support<sup>5</sup>. Psychosocial support is promoted by ACF as an essential component of nutrition programmes, which focuses and emphasises the caregiver-child relationship. The psychosocial situation of caregivers and young children are identified as potential factors which can interfere with the capacity to recover from malnutrition, as well as influencing the causes of undernutrition (see Figure 1). The objective of ACF's approach is to support caregivers to rediscover their self-confidence in order to increase their caring aptitudes and capacities. In the current context of Lebanon, this psychosocial component is essential given the stress and trauma experienced by the population targeted by the nutrition project as well as the duration of the crisis.

ACF's nutrition project in Lebanon targets pregnant women and caregivers with children under 2 years of age. In this initial phase of the project, which started in March 2014 and ends in August 2014, ACF is providing the caregivers with a set of learning sessions on IYCF practices including hygiene sensitisation and care practices, as well as distribution of hygiene and baby kits comprising essential articles for children (soap, blanket, baby spoon, cup, etc). These services are provided in ACF tents ("Safe Havens") set up within the ITSs to ensure access and reduce barriers of distance and potential transport costs. Each child admitted to the programme has his/her nutritional situation monitored monthly through mid-upper arm circumference (MUAC) and oedema assessments. Children suffering from acute malnutrition are referred to a nutrition centre for supplementary or therapeutic treatment but also continue to attend ACF's programme. For children identified as suffering from malnutrition (MUAC < 125 mm) or at risk of malnutrition (125 mm ≤ MUAC < 135 mm), their nutritional situation is monitored weekly. By the end of June 2014, 174 pregnant women and caregiver-child couples had benefited from this project.

**Results from the field experience**

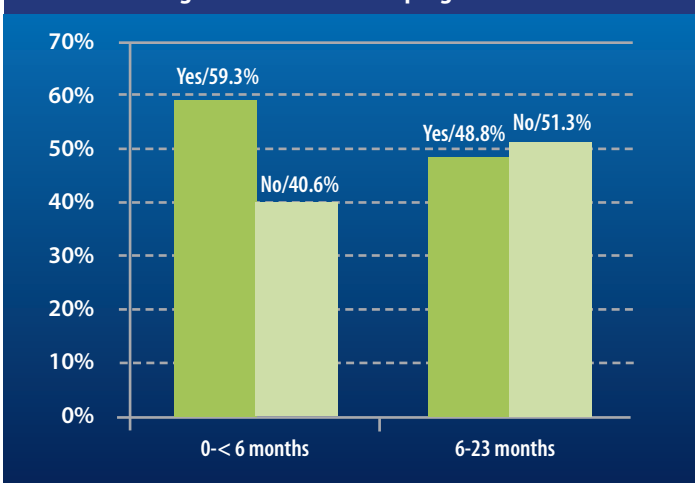
ACF has identified different practices hampering appropriate feeding and care for young children. Breastfeeding practices specifically as observed and assessed by the ACF field team are not optimal. Data collected from caregivers' declaration at admission to the programme show that almost half of the children under 2 years old are not optimally breastfed according to WHO global recommendations (see Figure 2). According to field observations and discussion with caregivers, it also appears that caregivers spend little time breastfeeding and routinely supplement their breastmilk with water, sugar, tea and infant formula. Almost half of the infants aged 0- < 6 months admitted to the programme have received infant formula. This figure was more than 70% for children aged between 6-23 months (see Figure 3).

Early introduction of complementary food (at 4 months) is common and infants can be introduced to food tastes at an even earlier age (from 1 to 3 months of age). This partly relates to the widespread belief that breastmilk is not nutritious enough to meet infant needs. Caregivers also report breastfeeding difficulties, especially for infants under 6 months (see Figure 4). These difficulties are linked to a perceived lack of breastmilk by the caregiver and a child "refusing" the breast or breast pain. The lack of perceived breastmilk could be linked to the established practice of using infant formula as an early food introduction. The common practice of mixed feeding through supplementation of breastmilk can then have a physiological impact on breastmilk production (i.e. less suckling leading to less milk production).

Some women are also facing difficulties providing complementary food. It is, for instance, quite common that children above 6 months of age are fed mainly with breastmilk and infant formula. Child refusal of food is also a recurrent complaint received by ACF staff working within the programme. By looking in more depth at this complaint, it seems that women might not have the appropriate knowledge about complementary feeding practices and the quantity of solid food that a young child should receive per day. They complain about children "not eating" but in actuality they do, just not in sufficient quantity according to their mother's expectation. These findings should be further explored and analysed to determine the extent of problems around complementary feeding.

<sup>6</sup> Conceptual models of child malnutrition. The ACF approach in Mental Health and Care Practices, Page 35, ACF International, written by Cécile Bizouerne, first version 2005, revised 2012

**Figure 4: Breastfeeding difficulties reported by caregivers according to the age of their children at programme admission**



In the ACF tent in Aarsal, Syrian refugees receive support and baby kits with essential items for their children: soap, blanket, baby spoon and cup

Yolanda Romero/ACF Lebanon

In a more general way and despite the efforts of the Ministry of Public Health to build dedicated programmes and provision of guidelines on IYCF in emergencies, the lack of information for health staff on IYCF can lead to the promotion of artificial feeding and limited support for breastfeeding at health facilities for the affected population. ACF considers also that these difficulties might be, for some cases, more psychosocial than physiological, especially perceptions of lack of breastmilk and child refusal of the breast. These difficulties could be linked to mother-child relationship difficulties, as well as less caring attitudes due to their current situation. Some women attribute their difficulties and incapacity to provide appropriate care for their children to their psychological status, i.e. they are depressed and/or anxious. It is also a common belief amongst Syrian refugee caregivers that stress and trauma affect their breastmilk quality, thus preventing them from breastfeeding.

## Discussion

Reflecting on our field experiences, we propose a number of recommendations to strengthen ACFs IYCF programming in Lebanon.

### *Reflection 1: Influence of family members and impact on project quality*

Grandmothers and mothers-in-law exert a powerful influence on household decision-making and may promote inappropriate feeding, such as early introduction of complementary food before 6 months of age. The ACF team has also observed some very young caregivers (under 18 years old) who are unable to act effectively on advice provided by ACF, due to conflicting advice and guidance from grandmothers and mothers-in-law. The perceptions of male members of the community also have an impact. Some men express concerns that this type of project, by gathering women together, is empowering them, hence they might not allow their wives to attend the sessions. This poses a challenge for ACF as the space provided is meant to be exclusively for women to receive support and express their concerns.

In order to make this type of project more accepted by the community, these spaces may need to be more open to men for specific sessions, as well to grandmothers and mothers-in-law. Without commitment and participation of the whole community, the impact of the programme may be reduced. ACF will address this by developing a strategy that will target these influential groups as part of the programme.

### *Reflection 2: Promotion of breastfeeding in a mixed feeding practices context*

In efforts to promote breastfeeding, ACF is facing three main difficulties:

- Promotion of artificial feeding at health facilities, against MoPH guidance.
- Untargeted distribution of Breastmilk Substitutes (BMS) in ITSs.
- Established practices of artificial feeding of infants and young children in the population.

ACF adheres strictly to a policy of not promoting or supporting inappropriate use of BMS. However, there are practical considerations that must be taken into account, as well as the need for some form of pragmatic response, to meet the humanitarian needs of non-breastfed infants. ACF's role, in addition to protection and support of breastfeeding, is also to ensure safe and appropriate artificial feeding. Even though there have been no studies or evidence available in this context, it is highly probable that artificial feeding is not safe in many of the poorly served ITSs. A few organisations are supporting non-breastfed children at health centres by providing kits to prepare infant formula safely. This is a start but a greater emphasis is needed to scale up and provide this type of service for non-breastfed infants, in conjunction with the development and dissemination of context-specific guidelines.

While ACF has no plans to develop a project on artificial feeding, this type of programming needs careful consideration from the wider humanitarian community as a practical response to this specific context.

### *Reflection 3: Psychosocial considerations*

At this stage of the project, ACF has two main concerns. The first relates to caregiver capacity to care for their children appropriately due to their own or their children's psychosocial status. Further assessments are needed in order to have a better understanding of the impact of psychosocial difficulties on child nutritional status. The second concern relates to the current living conditions of the refugees and their impact on children's feeding ability. Even though there are no quantitative data currently available, the fact that some caregivers are complaining about their children's refusal of solid food should be investigated<sup>7</sup>. Many caregivers also seem concerned about the impact of the living conditions on their children's development as they see changes in their behaviours, e.g. children playing more violently and a regression to bedwetting.

### Ways forward

ACF will, by August 2014, scale up its project by opening more Baby Tents in Aarsal and in other places in Bekaa Valley. While group counselling will remain a strong component of the project, ACF will also dedicate more time to individual counselling in this new phase. New activities will be added and ACF will support the national on-going effort on screening and treatment of acute malnutrition.

ACF will continue to work closely with its WASH department in order to improve hygiene practices among the caregivers participating in the programme. ACF will also investigate how best to deal with non-breastfed infants, while also ensuring that breastfeeding is protected and enabling caregivers to make informed decisions about feeding practices.

Psychosocial support will continue to be an important element of the programme for both IYCF and CMAM. This will be strengthened by the deployment of psychologists in the programme.

For more information, contact Juliette Seguin, email: [jseguin@lb.acfspain.org](mailto:jseguin@lb.acfspain.org)

<sup>7</sup> On this matter, ACF is not planning any official investigation but is expecting to collect more information through the implementation and scaling up of its activities.

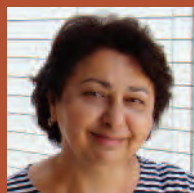


Medical screening in Beirut programme

Relief International, Lebanon, 2014

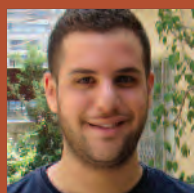
# Relief International nutrition and health programme in Lebanon

By Jamila Karimova and Jo Hammoud



Jamila Karimova is the Health and Nutrition Programme Manager at Relief International (RI) Lebanon. She has been working with RI for 12 years; three years as a

national staff in Azerbaijan and nine years within RI's Health and Nutrition programmes in Darfur, Southern Sudan, Haiti, Somalia, and Lebanon.



Jo Hammoud is the Communications and Reporting Officer at RI Lebanon. Jo had been working with Lebanese and international civil society organisations in

Lebanon and Europe for seven years on different issues ranging from communications and access to information, sexual and reproductive health, national humanitarian development programmes, Palestinian and Iraqi refugee programs, and the regional response for the Syrian crisis.

The authors acknowledge the support of Philippe Clerc, Former Regional Country Director, Relief International, and UNICEF. This article grew out of a meeting with Philippe Clerc during ENNs April 2014 visit to the region.

Relief International (RI) is a humanitarian non-profit agency that provides emergency relief, rehabilitation, development assistance, and programme services to vulnerable communities worldwide. RI is a non-political and non-sectarian organisation exclusively dedicated to reducing human suffering. Since 2006, RI has been working in Lebanon to provide emergency relief and long-term support to communities across the country. Through partnering with several organisations, RI Lebanon successfully launched several projects in the field of information and communications technology, local economic development, education, and nutrition.

On March 15, 2011, the unrest in Syria began as a part of the Arab Spring in the Middle East. In spite of the willingness of the Lebanese people to host Syrian refugees, with over 1,000,000 Syrian refugees currently living in Lebanon, the resulting strain on resources, including jobs, education, health, and housing, has made relations between the refugee and host communities tense and prone to incidents of harassment. In 2012, RI set up life-saving operations in Lebanon to assist Syrian refugees and host Lebanese families living in vulnerable host communities.

The programme responds to the specific objectives prioritised within UNHCR's Syria Regional Response Plan 6 (RRP6) as well as the Health Cluster, through the improvement of primary health and nutrition services and increased access to emergency quality nutrition and health services. These needs were identified as key concerns in informal tented settlements (ITS) and host communities. The current RI health and nutrition programme is funded by UNICEF (November 2013 to June 2015 as a minimum).

To date (June 2014), RI has reached 193,553 beneficiaries living in ITSs in Beirut, Mount Lebanon and North Lebanon, and is currently expanding to West Bekaa and Rashayya. The programme aims to increase the availability, awareness, and access to emergency nutrition and health services for refugee and host communities, with a special focus on children under the age of five years, as well as pregnant and lactating women (PLW).

## Health programme

With the support of the management, operations, human resources and communications departments to the nutrition programme, RI's four medical doctors, four midwives, seven nurses, two vaccinators, 13 community nutrition promoters, and 12 psychosocial workers implement the activities and services in the field. Five mobile clinics operate regularly in the governorates of Beirut, Bekaa, Mount Lebanon, Tripoli, and Akkar. These are the sites with most vulnerable refugee and host communities in ITSs and collective shelters as identified by

UNHCR. The mobile clinics provide a variety of free services, such as consultations and treatment for acute illnesses, reporting on early warning information about morbidity (EWARN), paediatric consultations, vaccinations, essential medication and supplies, and health education. Moreover, reproductive health services are provided (ante and post-natal care) as well as family planning and support for victims of sexual and gender based violence (SGBV). In addition to healthcare delivery, RI also maintains a stock of medical supplies and resources such as Ready to Use Supplementary Food (RUSF), Ready to Use Therapeutic Food (RUTF), NRG-5<sup>1</sup>, micronutrients (doses of Vitamins A and C, Iron Syrup, Folic Acid, and/or Ferrous Sulphate are prescribed as needed), and protein rich biscuits. There are trained staff on SGBV healthcare, counselling and a referral mechanism operating in the mobile clinics and offering treatment for sexual transmitted infections (STIs), Post-Exposure Prophylaxis (PEP Kits) in response to HIV, hepatitis and tetanus vaccinations, contraceptive pills, pain relief, wound care and antibiotics. RI also has in place a referral system to UNHCR and the Lebanese Ministry of Public Health's secondary or tertiary health facilities that ensure a rapid medical response<sup>2</sup> and care of SGBV survivors who require a more specialised assistance.

*Souad a 29-year-old pregnant refugee in Bourj Barajneh said [translated to English]: "I was pregnant, in my first trimester, when Relief International visited our camp. I was suffering from weakness in my body due to shortage in food, water and increasing stress due to our situation. Relief International provided me with micronutrients and folic acids, which helped me, restore my energy. I have a new child now, and Relief International are still following up with me and him; giving both of us supplements for breastfeeding and general health consultations."*

## Nutrition programme

An RI network comprised of 15 Community Nutrition Promoters (CNPs), coordinated by three Nutrition Monitors, was activated in refugee settings and vulnerable locations in ITSs and collective shelters in Beirut, Mount Lebanon, North (T-5) and the West Bekaa Valley. A simplified community screening system has been established in the current health and nutrition programme and is the direct link to RI mobile clinics and MOPH primary health care facilities<sup>3</sup> for referral of cases of acute malnutrition identified. CNP outreach activities include Mid-Upper Arm Circum-

<sup>1</sup> A compressed high energy biscuit (14.5% protein, 17.3% fat, 60.2% carbohydrate, 1,150 per 250g)

<sup>2</sup> These medical costs fall under the budget of the external UN agency/government

<sup>3</sup> Acute malnutrition treatment services as 'activated' PHCs are supported by IOCC. See field article in this edition of Field Exchange.

ference (MUAC) screening of children under five years and PLW twice a week in the community during home visits. CNPs also work with RI mobile clinics and primary health care sites to detect undernourished children. If CNPs find any child or PLW with malnutrition, they refer them to the RI mobile clinics for further case management as per UNICEF's protocols on the management of malnutrition in Lebanon. The beneficiaries identified by CNPs from their catchment area and admitted to the outpatient therapeutic programme (OTP) are closely followed up at household level on a weekly basis, as well as after treatment for two consecutive weeks. Critical cases are immediately referred to UNHCR contracted hospitals or the PHC of the Lebanese Ministry of Public Health who have been trained on malnutrition treatment by UNICEF/IOCC. Cases are then monitored by health providers of those agencies.

The duration of treatment varies on how the patient responds to medication, time since diagnosis, and whether they have only malnutrition or malnutrition in combination with diarrhoea. For cases who are moderately or severely acutely malnourished, RI provides UNICEF's in-kind supplies in the form of micronutrients and vitamins for malnutrition, oral rehydration salts for diarrhoea, and/or other medication, as indicated. This component of the programme, in conjunction with outreach and community participation, helps ensure the appropriate coverage of identified cases via close communications with parents and families of the patients.

### Caseload

As of June 2014, RI has identified 519 acute malnutrition cases. Table 1 details the progress of acutely malnourished children under 5 years referred to the RI mobile clinics and treated by the nutrition programme, covering the period of December 2013 to June 2014. Because there were no existing protocols in Lebanon for treating PLWs with malnutrition, RI provides them with

support and supplements, such as NRG-5, folic acids, and vitamins throughout pregnancy. The discharge rate is low where patients have only been recently admitted and are still undergoing treatment, and also due to the poor water and sanitation conditions in the home environment that are contributing to diarrhoea and hence complicating management and extending their stay. The number of defaulters is high in some areas (e.g. Akkar/Halba, Minieh/Del Amar) due to the mobility of the refugees seeking seasonal agricultural farming work, security issues, or their return to Syria. Defaulting is less of a feature in Beirut/Mount Lebanon (an urban population with no migration and a low caseload) and Bekaa valley (an informal settlement with a stable population involved in local agricultural activities – the main seasonal migration from the North to Bekaa happens during the summer and autumn).

RI actively engages local religious and community leaders in order to support health and nutrition activities within the target areas. The cooperation with the local leaders from refugees' communities has been very successful, with the Batroun municipality, for instance, where RI has easy access. Also, in Mount Lebanon, municipalities, political and local government authorities provided RI team with strong support to conduct and operate the nutrition programme. RI has worked closely with the Ministry of Social Affairs in Bourj Barajneh and Ain Annoub areas to conduct screening for children under the age of 5 years and PLW.

A total of 193,553 beneficiaries have accessed RI programme services (e.g. contacts with doctors, nurses, CNPs, etc) between November 2013 and May 2014, exceeding the target number of beneficiaries by 196%.

### Discussion

The level of insecurity in target locations has been the primary difficulty that the RI team has

faced during the implementation of the programme. The security situation in Tripoli has been particularly difficult, which has not allowed the teams to proceed with activities as planned. Teams did their best to navigate the security impediments in order to maintain the quality of the services provided. Additionally, in the southern suburb of Beirut, the RI team engaged in long negotiations with municipalities in order to get permission to start the programme for Syrian refugees in that area.

Despite high numbers of non-profit organisations, such as RI, providing refugee care and assistance, resources are still lacking. Thus relying on the dedicated and concerted efforts of field officers/workers, educators, doctors, programme managers, and support teams is essential to implement the work.

*Rand, a 24 year old refugee from Ain Annoub said "I'm really concerned about our condition during summer. I fear there will be less water and food, yet more disease in the immense heat. Living outdoors is horrible. But we are hoping that people like Relief International field workers will continue working with us and providing us with medicine, water, and lessons on how to take care of our children and ourselves during this season. I hope this situation will all be over soon."*

Another obstacle faced by the team has been the high number of defaulters. Because many of the refugees are agricultural families, the majority migrate from one area to another in order to find work in the potatoes and fruit fields. Additionally, lack of awareness and common misconceptions among mothers and caregivers contribute to the lack of commitment to prescriptions and techniques that help in the patient recovery. In some cases, refugees have refused treatment for religious, political or personal reasons. In other cases, the mother, who is often a young woman herself, has numerous children, which results in a lack time to attend to her sick child. However, the RI nutrition team does its best to track and follow-up on the cases, specifically the children, contacting the beneficiaries and parents by phone and visiting them in their home.

Unfortunately, RI is anticipating that the living conditions and health situations will deteriorate in the hot months of summer with decreasing availability, quality of water and poor water, sanitation and hygiene (WASH) facilities in some areas where informal refugee settlements are located, such as Minyeh-Denniyeh and Akkar. RI, in collaboration with partners and donors, is exploring additional ways to rehabilitate water sources and other WASH programmes within ITs in 2014-2015. While RI's nutrition programme began as a pilot study for Syrian refugee response in Lebanon, RI fully expects to continue to expand the programmes coverage and impact in the coming year.

For more information, contact: Jo Hammoud, email: jo.hammoud@ri.org or telephone (Lebanon): +961 3 834 105

**Table 1: Acute malnutrition caseload and progress for children under 5 years in the RI nutrition programme (Dec 2013 to June 2014)**

Areas	Total SAM	Total MAM	Total no. of malnutrition cases	No. of cases discharged	% of discharged cases	Total no. of defaulters	% of defaulters
<b>North</b>							
Koura/Kalamoun/Zgharta	5	25	30	15	50.0%	1	3.3%
Minieh/Der Amar	6	45	51	41	80.4%	7	13.7%
Danieh	2	3	5	0	0%	1	20%
Tripoli	4	18	22	18	81.8%	3	13.6%
Akkar/ Halba	38	176	214	160	74.8%	12	5.6%
<b>Total North Lebanon</b>	<b>55</b>	<b>267</b>	<b>322</b>	<b>234</b>	<b>72.7%</b>	<b>24</b>	<b>7.5%</b>
Bekaa	46	122	168	148	88.1%	0	0%
Beirut	1	5	6	6	100%	0	0%
Mount Lebanon	6	17	23	23	100%	0	0%
<b>Total Bekaa/ Beirut/ Mount Lebanon</b>	<b>53</b>	<b>144</b>	<b>197</b>	<b>177</b>	<b>89.8%</b>	<b>0</b>	<b>0%</b>
<b>Total in RI localities</b>	<b>108</b>	<b>411</b>	<b>519</b>	<b>411</b>	<b>79.2%</b>	<b>24</b>	<b>4.6%</b>

A community health worker heading into an informal settlement in Bebnine (Akkar region) to give an awareness session

# Integrating community-based nutrition awareness into the Syrian refugee response in Lebanon

Margaret Aguirre/International Medical Corps, Lebanon, 2014

By Julie Davidson and Christina Bethke



Julie Davidson is currently the Team Leader for International Medical Corps Emergency Response in

Erbil, Iraq. She lived in Beirut for 5 years working for local organisations in the Palestinian refugee camps and as the Programme Coordinator for International Medical Corps.



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Previously, Christina served for three years as Country Director for Last Mile Health in Liberia.

International Medical Corps wish to thank its donors including UNHCR, Bureau of Population, Refugees and Migration (BPRM) and Department for International Development (DfID). Special thanks to Dr. Ali Zein of the Lebanon Ministry of Public Health for his ongoing support and technical contributions to International Medical Corps' health education programme. Additionally, the Lebanon team is very grateful to Caroline Abla, Director of Nutrition and Food Security for International Medical Corps, for her continuous guidance. Finally, International Medical Corps acknowledges the leadership and dedication of Lamia Aassaf, Health Education Programme Manager.

## International Medical Corps in Lebanon

International Medical Corps commenced operations in Lebanon in response to the July 2006 war, playing an integral role in the provision of relief to conflict-affected populations. International Medical Corps remained in Lebanon following the August 2006 ceasefire to assist with reconstruction efforts, maintaining a strong presence in the country by implementing a diverse set of development initiatives, ranging from health and mental health activities to education, livelihoods development, and water and sanitation programmes. In response to the influx of Iraqi refugees in the country in 2007, International Medical Corps commenced a targeted refugee assistance programme consisting of support to clinics and capacity building for health care professionals, civil society organisations, and communities to improve access and quality of health care service available to Iraqi refugees. This platform of programmes formed the basis of International Medical Corps' role in the Syria response in Lebanon.

## Context overview

Syrian refugees began arriving in Lebanon in March 2011, following anti-government protests. Most took refuge in villages in northern Lebanon and were accommodated by Lebanese communities. Initially, the number of refugees grew slowly, allowing the humanitarian response to keep apace. However, beginning in January 2013, the rate of influx increased sharply reaching nearly 50,000 new registrations on a monthly basis<sup>1</sup>. Newly arrived refugees settled mainly in Bekaa valley and southern areas of the country and eventually moved into the Beirut and Mount Lebanon regions. The population of registered Syrian refugees in Lebanon hit the one million mark in May 2014, making Lebanon the country with the highest number of refugees per capita in the world<sup>2</sup>. The actual ratio may be even higher due to large numbers of refugees that have chosen not to register with UNHCR, thus complicating the tracking and monitoring of population figures. The Government estimates the number of unregistered Syrian refugees may be as high as 400,000 individuals<sup>3</sup>.

The response required to meet the needs of such a rapid and proportionately massive influx of refugees into Lebanon has been in a context of declining shelter options, as host communities are increasingly unwilling or unable to accommodate such large numbers and formal camp settings for Syrians have yet to be established due to political sensitivities. Consequently, informal settlements and collective shelters spread rapidly across the country and provide shelter ranging from basic plastic sheeting to housing in unfinished and abandoned buildings. Sixteen percent of the Syrian refugee population now resides in these settings<sup>4</sup>.

The speed and geographic spread of the refugee population has presented numerous challenges for all sectors, especially within the health sector, including:

- *Access and information:* New arrivals are difficult to monitor – often relocating numerous times within the country, thus resulting in ever-changing demographics at the community level. Providing health care for a population in constant flux is particularly challenging for health care actors. Presently, the humanitarian response is lacking a uniform system for informing the newly arrived population of services available to them. The health care system in Lebanon is highly privatised and differs significantly from that in Syria, resulting in unexpected expenses and often confusion about how refugees should access care. Additionally, many refugees have reportedly faced discrimination from the community and/or health care providers while seeking treatment at certain facilities.

<sup>1</sup> Based on UNHCR population figures from: <http://data.unhcr.org/syrianrefugees/country.php?id=122>

<sup>2</sup> <http://www.unhcr.org/533c1d5b9.html>

<sup>3</sup> <http://globalnews.ca/news/1247786/un-syrian-refugees-hit-million-mark-in-lebanon/>, <http://www.independent.co.uk/news/world/middle-east/syria-civil-war-lebanons-refugee-count-passes-one-million-9235344.html>

<sup>4</sup> Lebanon: Inter Agency Mapping Platform (IAMP) – Informal Settlements, 1 September 2014

- **Lack of standardisation:** To date, there is no standard package of services among health actors and the quality of services often varies dramatically between facilities. While some donors provide subsidised services exclusively to refugees registered with UNHCR, their targeted populations. Further, eligible beneficiaries may be limited to certain vulnerable groups, such as children under 5 years or pregnant women, while other providers offer coverage to anyone in need. Finally, the cost of services at supported facilities also ranges from free to cost-sharing models. Combined with the factors mentioned above, this creates a confusing system that refugees must navigate in order to receive the most basic health care services, such as vaccinations and ante-natal care.
- **Secondary health care:** Prior to the crisis, Syria's public sector health system provided nearly all patients with access to heavily subsidised care. In contrast, the secondary health care system within Lebanon is privatised with patients bearing a significant portion of the cost. The UNHCR model for secondary health care for Syrian refugees designates primary health care (PHC) centres as the entry point for specialised and hospital care. However, the practice of PHC centres as "gate keepers" is not fully developed within Lebanon's health system nor is it familiar to many refugees. With the additional challenges of large case loads and limited funding support for hospital care, proper referral and follow-up of refugee patients is difficult.
- **Determinants of health:** Acute respiratory infections, diarrhoeal diseases, and skin diseases are the top contributors to morbidity among refugee patients who seek treatment at International Medical Corps supported facilities. These conditions relate directly to hygiene and sanitation conditions, and are also linked to malnutrition. As growing numbers of refugees settle in informal settlements and collective shelters, overcrowding and insufficient water and sanitation are likely to cause an increase in communicable diseases and may also trigger the onset of secondary conditions, such as malnutrition in children suffering repeated incidents of acute watery diarrhoea<sup>5</sup>.

### International Medical Corps' Syrian refugee response

International Medical Corps' participation in the Syrian refugee response in Lebanon commenced in March 2011 after an initial influx of 5,000 Syrians to north Lebanon. The team established a mobile medical unit (MMU) in the Wadi Khaled area, becoming the first health actor to offer services to the arrivals. Since that time, the programme has expanded significantly, growing from its initial focus in the North to include the Bekaa, South, and Beirut and Mount Lebanon, thus mirroring the migration of refugees within Lebanon as they spread across the country. In addition to existing offices located in Beirut



A community health worker provides an awareness session to women about breastfeeding in Akkar region

International Medical Corps, Lebanon, 2014

and South Lebanon, the expansion of Syrian refugee response operations necessitated the establishment of three new offices, in Akkar, Bekaa, and Tripoli, between December 2011 and August 2013. Simultaneously, the team grew dramatically to include more than 350 staff and volunteers.

In order to respond to the dynamic nature of the Syrian response in Lebanon and address the challenges facing the health sector, International Medical Corps has implemented a comprehensive health programme with three main components<sup>6</sup>:

**Primary Health Care (PHC) centres:** International Medical Corps now supports more than 40 PHC centres across the country, concentrated in areas where vulnerable Syrian and Lebanese populations are located. International Medical Corps provides a standardised package of support to all its donor-funded PHC facilities. PHC centres receive funds to offset the impact of increased patient load and running costs, thus enabling affordable care. At the core of International Medical Corps' support are cost-sharing mechanisms designed to address the protracted nature of the crisis; patients receive reduced-rate consultations and vulnerable persons also receive partial coverage for diagnostic procedures. Patients seeking services for specific conditions, such as gender based violence (GBV), malnutrition and TB, are provided with full coverage for both consultations and necessary diagnostic tests. Medications for acute conditions listed on Lebanon's Essential Drugs List are also provided in-kind to clinics and dispensed to patients free of charge. At certain centres, vulnerable Lebanese patients may also benefit from this package of services.

In addition to standardised training on primary health care topics such as quality, communicable diseases, non-communicable diseases (NCDs) and reproductive health, International Medical Corps actively solicits specialised training from technical partners to further build capacity of clinical staff within its supported facilities. Topics include detection and treatment of malnutrition, early warning systems for communicable disease, and GBV referral. To reinforce training and monitor the quality of service delivery, International Medical Corps' team of health officers, pharmacists and physicians regularly visit clinics and collect and analyse aggregate data on number of beneficiaries. Between

January and July 2014, PHC facilities supported by International Medical Corps provided more than 135,000 primary health care consultations with an average case load of more than 16,400 patients per month. International Medical Corps is now rolling out a programme to support a focal point who provides health education services, helping patients understand when to seek care, how to prevent onset or worsening of conditions, and what follow up is needed.

**Mobile Medical Units (MMUs):** In the early phase of the response, MMUs played a critical role in International Medical Corps' response and the programme now supports eight MMUs – each operating within a specific region of the country. MMUs, by their very nature, can bring services to remote and/or vulnerable communities and ensure that they are able to access basic health services and receive appropriate referral information for more serious conditions, and have proven pivotal in an emergency where many refugee communities are in rural areas with little-to-no access to health care services. International Medical Corps' MMUs are composed of at least one doctor, nurse, and outreach worker and are able to provide screening, basic PHC consultations, immunisation, referrals, and medication to anyone seeking care. All MMU services are provided free of charge.

In addition to basic service provision, MMUs have also allowed International Medical Corps to immediately respond to urgent situations. For example, MMUs were effectively deployed to border areas in the Bekaa in late 2013 and early 2014 to respond to the rapid influx of thousands of refugees following spikes in fighting in Syria. These units are able to treat, triage and refer patients as necessary, forming a key component of a frontline response.

Additionally, MMUs have been used in the detection of, and response to, disease outbreaks. Upon receiving reports of possible outbreaks or urgent health conditions from its community outreach team or other actors, International Medical Corps is able to rapidly deploy supported MMUs to the area to confirm the presence of the diseases and provide immediate treatment

<sup>5</sup> <http://www.who.int/mediacentre/factsheets/fs330/en/>

<sup>6</sup> Note that IMC Lebanon also implements robust mental health programming for Syrian refugees using a community-based case management model and integration of mental health into PHC centres, though this has not been addressed in this article.

where appropriate. All findings are channelled through International Medical Corps' strong links with surrounding PHC centres and Ministry of Health actors.

**Community outreach:** In order to address challenges related to information and health-seeking behaviours, International Medical Corps places particular importance on giving communities the tools and knowledge to be self-reliant and be their own best 'First Responders', targeting refugees in their own communities. A cadre of more than 130 outreach workers, mainly Syrian women, provides health education, promotion, early detection and referral services and support to refugees living in informal settlements and collective shelters.

To ensure sustainability and promote community acceptance of health messages, potential candidates are recruited from within the surrounding community. At present, all International Medical Corps community workers in Lebanon are female because they are culturally appropriate messengers for topics relating to the health of women and children. Recruitment of the women is a time intensive process. In addition to motivation and experience, cultural factors must be taken into consideration and the families of the women are often involved in initial discussions. It is standard practice to recruit more candidates than are needed because some level of attrition is expected due to demands of the work, difficulty grasping the training material and/or disapproval by family members. Following recruitment, in-depth group training sessions are provided for all potential candidates.

Rather than focusing on a single priority area, training for International Medical Corps' community health workers covers a broad range of key health education topics, including breastfeeding, nutrition during pregnancy, antenatal and postnatal care, infectious and respiratory diseases, and the importance of immunisations,

as well as topics related to complex emergencies such as water, sanitation and hygiene (WASH), food-borne diseases, and food safety. This intensive training lasts for seven days. Refresher trainings are periodically provided to strengthen participants' knowledge, improve their communication skills and enhance their ability to effectively implement individual and group awareness sessions. In-depth trainings are also offered regarding key health priorities such as WASH and IYCF in emergencies.

International Medical Corps provides a modest stipend to its community outreach workers which improves overall retention of workers and allows in-depth investment in a woman's learning and skills over time. A robust programme management structure with low ratios of workers to supervisors further bolsters opportunities for mentoring and retention of staff.

As a result of these strategic investments in recruitment, training, incentives and supervision, International Medical Corps' community health workers possess broad core competencies. Strategically, this enables the outreach team to prioritise and respond to extremely urgent health topics as they emerge while continuing to play a key role in prevention and health promotion. For example, International Medical Corps' community outreach workers have been involved in hand washing campaigns, polio mobilisation and mop-up campaigns, identification of potential outbreaks – such as lice and scabies, and referrals to PHC centres while also providing a foundation of health knowledge to the community – particularly health messages about antenatal care and nutrition. Recently, the outreach team took part in a nutrition screening campaign of more than 16,000 children between 6 months and 5 years old living in Bekaa. This was easily integrated into the effort with minimal additional training because the outreach workers had already been properly oriented on key nutrition topics and information as part of their core training.

Preliminary results of Bekaa nutritional screening point to moderate acute malnutrition (MAM) levels of less than 0.5%<sup>7</sup>. Additionally, a recent refugee household vulnerability assessment by WFP found that 62% experienced mild food insecurity; 12.4% moderate food insecurity and just 0.4% severe food insecurity<sup>8</sup>. Appropriate response for community health actors should therefore include nutrition monitoring and prevention activities. As part of their routine health education and promotion activities, International Medical Corps community outreach workers continue to provide regular messages related to nutrition, breastfeeding and hygiene while referring any suspected malnutrition cases to the nearest treatment centre. Because nutrition is so heavily linked to other health determinants, ongoing attention to topics such as water, sanitation and hygiene (WASH) and antenatal care, for example, is key. If malnutrition prevalence increases markedly, it will trigger the team to initiate intensive focus on relevant nutrition response following a brief refresher from their supervisors.

## Lessons learned

Funding streams in an emergency response are variable and thus, sustainability should always be considered. To support lasting impact, International Medical Corps does not operate its own facilities but rather works to build the capacity of existing PHC centres through the provision of supplies and equipment, training of staff members and regular monitoring and support. This approach prepares local residents to be their own best First Responders and ensures the Lebanese population will benefit from this support – both immediately and in the long-term.

This strategy of investing in existing community resources is further integrated into the four key components of International Medical Corps' community health worker programme – recruitment, training, retention, supervision. By identifying and training local women, the community outreach workers, and providing a stipend to encourage long-term commitment to the programme, International Medical Corps is able to ensure core public health knowledge and capacity for response are embedded directly within the community.

This approach is especially appropriate for nutrition preparedness and response in a low prevalence setting such as Lebanon. In a dynamic crisis setting, it is difficult to predict which health priorities will emerge and when. Through our training programmes, we pass essential skills into local hands, preparing those in crisis-prone areas to better withstand adversity. International Medical Corps' community outreach workers are broadly trained, thus enabling maximum flexibility and efficiency. International Medical Corps can quickly "train up" its team to respond to a specific emergency with minimal expense, rather than relying on community workers who are exclusively devoted to a single health topic such as nutrition.

Furthermore, a strong, community-based team enables the health programme to extend its reach from the PHC facility into the community itself, creating strong links, offering up-to-date knowledge about health conditions in the community and encouraging appropriate health-seeking behaviours.

International Medical Corps will continue building on its existing programming in order to respond to the needs of Syrian refugees, as well as vulnerable Lebanese host communities who have become overwhelmed due to the population influx. A continued focus on cost-efficiency, sustainability, and quality of services will be key components of all response programming over the coming months and years as levels of funding are likely to decrease.

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A community health worker gives a health awareness session in the Bekaa region

International Medical Corps, Lebanon, 2014

<sup>7</sup> Preliminary results released by UNICEF during Bekaa Health Coordination Meeting, 28 August 2014

<sup>8</sup> VASyr 2014. Preliminary results released by WFP, 2 July 2014. See article in this edition of Field Exchange.

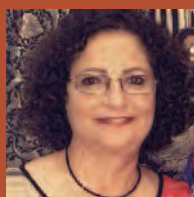
Syrian refugees in Lebanon



UNICEF

# UNICEF experiences of the nutrition response in Lebanon

By Najwa Rizkallah



Najwa Rizkallah was Nutrition Specialist with UNICEF Lebanon until September 2014, having led the nutrition in emergencies programme in Lebanon for Syrian refugees since

October 2013. Before that she worked as a nutrition specialist in the State of Palestine (SoP) office. She has many years of nutrition experience in emergency and non-emergency settings. Previously she was head of the Nutrition Department at UNRWA, as well as consultancy positions and lecturing. She has a Doctoral degree in Epidemiology and Population Health and a Master's Degree in Nutritional Sciences. She is currently an Emergency Nutrition Specialist, El Fasher, Darfur, North Sudan.

Thanks to the International Orthodox Christian Charities (IOCC) and Relief International for sharing the data included in this article.

Undernutrition is a silent, yet growing concern in Lebanon amongst children under 5 years, as Syrian refugee numbers increase steadily and the economic resources of both refugees and host communities diminish. Those who are most at risk of malnutrition are the least likely to seek medical attention, as they cannot afford the cost of travel, doctor's fees or medication. While the Lebanese public health system is willing to respond, it lacks the resources and expertise to do so without support from other agencies.

One of UNICEF's foremost priorities in emergencies is to prevent death and malnutrition in the affected population, particularly amongst vulnerable groups: infants, children, pregnant women and breastfeeding mothers. This role includes screening children and women, supporting treatment of acute malnutrition, and raising awareness around appropriate infant and young child feeding (IYCF) practices, as well as prevention of micronutrient deficiencies.

## UNICEF supported programming to date

A nutrition assessment of the Syrian refugees in Lebanon conducted in Sept 2012 recorded a global acute malnutrition (GAM) rate of 4.4%, which is categorised by WHO as an 'acceptable' prevalence of malnutrition. The management of acute malnutrition was a very new area for the health care system in Lebanon. Prior to the Syria crisis, acute malnutrition was not at all common in Lebanon and only tended to occur where there was co-morbidity. Given the low capacity and in preparedness for a rise in caseload, UNICEF and IOCC moved to scale up capacity of public health providers for the detection, monitoring, and

treatment of acute malnutrition. This decision was also informed by anecdotal reports by partners at the health working group of emerging cases of malnutrition among children and poor know-how of how to manage them, and the deaths of four SAM children, at one hospital in Beqaa Valley, attributed to lack of experience in SAM treatment. In addition to these activities, UNICEF undertook to ensure the timely and efficient distribution of programme supplies, including micronutrient supplements for children and pregnant and lactating women (PLWs), as well as the development of Behaviour Change Communication (BCC) materials on malnutrition management and IYCF in emergencies (IYCF-E) in partnership with IOCC.

## Capacity development

As part of the scale up effort, UNICEF supported the capacity building and skills development of people at international, United Nations (UN) and national organisation levels working on nutrition in Lebanon<sup>1</sup>. A Nutrition in Emergencies (NIE) training course was conducted in Jordan and the main partners of UNICEF Lebanon attended an NIE training in Jordan in June 2013. This training helped International Orthodox Christian Charities (IOCC) and Relief International (RI) to scale up their work on management of acute malnutrition with the support of UNICEF. Later on, UNICEF contracted IOCC to train community mobilisers, nurses, and paediatricians on CMAM and IYCF-E. More than 240 doctors, nurses, paediatricians and community mobilisers from the MOPH, IMC, RI, ACF, WFP, UNHCR and AVSI were trained by IOCC and UNICEF staff.

<sup>1</sup> See also the article by UNICEF on capacity development in the region, in this edition of Field Exchange.



**Table 1: Number of children under 5 years with MAM and SAM managed as outpatients through the home based treatment as part of RI programming, November 2013-June 2014**

Cases	SAM cases	MAM cases
Identified	58	461
Discharged	42	411
Defaulters	9	43
Under treatment	7	7

In June 2014, an NIE training was conducted in collaboration with the American University of Beirut (AUB) and University College London (UCL). This professional training has been established over a number of years<sup>2</sup>. Thirty-five participants attended the training from Lebanon and other countries in the region affected by the Syrian crisis (including those working in Syria) as well as MOPH staff. This training helped attendees improve their skills to respond better to nutritional needs of those affected by emergencies.

#### Acute malnutrition treatment services

In Lebanon, UNICEF is responsible for programmes that treat SAM cases without complications at community level (within primary health care centres (PHCs)), programmes that treat SAM cases with complications as in-patients (in hospital) in collaboration with UNHCR<sup>3</sup> and programmes that treat MAM children (at PHC level). WHO is not involved in acute malnutrition treatment (though WHO protocols are used) and WFP is focused on food security. UNHCR covers the cost of hospital stay and primary healthcare level consultations for all malnourished children (SAM with complications) and supports the salaries of IOCC lactation specialists who provide one-on-one breastfeeding counselling. UNHCR also supports the salaries of IOCC health and nutrition staff. All of this work is undertaken in coordination and cooperation with the Ministry of Public Health (MOPH) and other main partners such as International Orthodox Christian Churches

(IOCC), Relief International (RI) and Action Contre la Faim (ACF).

UNICEF is supporting two work modalities to scale up the treatment of malnutrition. The first modality, which is conducted through IOCC<sup>4</sup>, is community based screening and active case finding for acute malnutrition, then treatment at primary health and secondary health centre depending on the cases. This involves community mobilisers screening children aged 6-59 months for acute malnutrition at the community level using mid upper arm circumference (MUAC) and bilateral oedema. Children identified with either severe acute malnutrition (SAM) without complications or moderate acute malnutrition (MAM) are referred to PHC clinics for treatment<sup>5</sup>. Children with complicated SAM are referred to secondary care for treatment. The second modality is similar in terms of screening but the treatment is conducted at home in the informal tented settlements (ITS) and children are followed up on a weekly basis after receiving either Ready to Use Supplementary Food (RUSF) or Ready to Use Therapeutic Food (RUTF) as appropriate. More than 55,000 children have been screened for malnutrition since January 2014.

IOCC supports acute malnutrition treatment at PHCs and at the inpatient level and RI supports management in mobile clinics. For IOCC programming, at the outpatient level (until end of July 2014) a total of 826 cases were treated (593 cases of MAM and 233 cases of SAM). At the

inpatient level (until end of July 2014), 218 cases were admitted including complicated SAM, complicated MAM, children with malnutrition secondary to disease, and infants with malnutrition. For RI programming, 519 children have been admitted and 453 discharged (87.3% cure rate, 10% defaulter rate). Fourteen children are currently under treatment (July 2014). For breakdown for SAM and MAM cases, see Table 1.

UNICEF also supplies anthropometric equipment and therapeutic and supplementary foods (RUTF, RUSF, high protein/energy biscuits, and emergency food rations BP5) for home based treatment and or treatment at the PHC clinics. For hospitals, UNICEF provides anthropometric equipment, therapeutic food and medications such as F75, F100, ReSomal and antibiotics.

#### Data quality issues

To inform ongoing nutrition programming in Lebanon and with concerns that the nutritional status of refugees had deteriorated, the nutrition community (involving UNICEF, UNHCR, WFP, IOCC and WHO) undertook an inter-agency nutrition assessment of Syrian refugees between October and December 2013 to obtain an update of the nutrition situation. It was led by a UNICEF consultant. It revealed that GAM rates (based on WHZ) in the Beqaa Valley and in Northern Lebanon had almost doubled compared to the 2012 assessment. The GAM rate for refugees was 5.9% in all Lebanon, 8.9% in Beqaa and 6.7% in Northern Lebanon. In the assessment, MUAC identified no cases of acute malnutrition. Translating these figures into numbers meant that an estimated 10,504 children in all of Lebanon (including 5,279 children in Beqaa and 3,410 children the North) were acutely malnourished and in need of treatment. The nutrition situation was reported as worst in areas where access to safe water, hygiene and sanitation were inadequate.

The interagency 2013 nutrition survey results presented to the nutrition stakeholders in Jan/Feb 2014 endorsed the rationale for scale up of acute malnutrition treatment. However inconsistencies in the findings were noted by the Centres for Disease Control and Prevention (CDC) and by UNICEF MENARO when compared with assessments conducted among Syrians in neighbouring countries such as Jordan. This led to a data quality verification exercise by UNICEF

**Table 2: Original and corrected acute malnutrition prevalence amongst Syrian refugees in Lebanon (2013 assessment)**

	Original analysis: prevalence in 2013		Corrected analysis: prevalence in 2013	
	%	n	%	n
GAM	5.9%	81/1384	2.2%	30/1352
MAM	4.8%	67/1384	1.8%	24/1352
SAM	1%	14/1384	0.4%	6/1352
Oedema	0.4%	6/1384	0.4%	6/1384

**Table 3: Original and corrected GAM prevalence amongst Syria refugees in specific locations (2013 assessment)**

	Original analysis: prevalence in 2013	Corrected analysis: prevalence in 2013
Bekaa valley	8.9%	4.5%
Northern Lebanon	6.7%	3.9%
South Lebanon	4.3%	0.3%
Beirut/Mount Lebanon	4.1%	0.5%

<sup>2</sup> See article by AUB in this edition of Field Exchange (p67) and visit [www.nietraining.net](http://www.nietraining.net)

<sup>3</sup> UNICEF provides all supplies and technical knowhow and UNHCR pays for the hospital stay and salaries of IOCC dietitians.

<sup>4</sup> See field article by IOCC in this edition of Field Exchange.

<sup>5</sup> In the field and at the initial screening at the PHC facilities, MUAC is used and the cut off points used are: <11.5 cm for SAM, 11.5-12.4 cm MAM, >12.5 cm normal. In addition to MUAC measurements, heights and weights of children are measured and weight for height z scores are used to classify children using the following cut-offs: MAM ( $\geq -3$  and < -2) and SAM (WHZ < -3 z scores)

Lebanon facilitated by UNICEF MENARO with support from CDC.

It was found that the original height data of multiple children was altered after data collection in an irregular way, creating additional cases of GAM in all children for whom the height was changed without any notification of the height change in the methodology or anywhere else in the assessment. After changing the height values to their original levels and recalculating the prevalence of anthropometric indicators, the aggregate GAM for children aged 6-59 months from Syria was 2.2%, considerably lower than the original assessed prevalence of 5.9% (see Table 2). Differences were observed across the assessed locations (see Table 3).

In addition, UNICEF and its partners undertook a nutrition screening campaign in the Beqaa Valley in May to June 2014 to identify cases of acute malnutrition and to verify the results of the 2013 nutrition assessment. Of 16,531 children under 5 years screened using MUAC, 828 cases were referred to the PHC facilities for further investigation. This included children whose MUAC was 12.5-13.5cm since routine screening by Relief International (RI) identified children whose MUAC was normal but whose WHZ was not. Referral was made to ensure children were caught as soon as possible. Only 518 children visited the PHC facilities for further check-up and treatment, of whom 25 children were found to have SAM (5% of referrals) and 77 cases (15% of referrals) found to have MAM, based on MUAC. When data were classified based on WHZ, the prevalence amongst referred cases was 1.8% (6/336) for SAM and 9.5% (32/336) for MAM<sup>6</sup>. Data on co-morbidity are not available.



An infant in an informal tented settlement in Saida, Lebanon

N. Rizkalla/UNICEF, Lebanon 2014

## Challenges

### Issues of data quality

The issue with data quality that has unfolded in Lebanon around the 2013 nutrition assessment has been significant. The consultant leading on the survey was trained in SMART but, it later transpired, had outdated training. The problem was compounded by difficulties accessing the raw data from the consultant engaged by UNICEF before the results were released. At the time, no organisation doubted the figures, but many expressed surprise with the high GAM rate compared to the previous year. WFP queried the GAM rates and requested data access which was not granted at the time, except for anaemia data which were shared with UNHCR only. This all came at a time when there were reports of increased caseloads of acute malnutrition from organisations working in the field and the SAM-associated deaths in Bekaa Valley hospital. UNHCR and WFP requested the data to undertake additional analysis. However, data were never shared until the consultancy was over and the results were announced.

To learn from the experience and ensure data quality in future assessments, a 3 day workshop was held by UNICEF MENARO in Amman, Jordan in July 2014, to update the participants with techniques on data quality verification based on SMART software for data management and data analysis techniques. The workshop was facilitated by Dr. Oleg Bilukha and Ms. Eva Leidman from CDC Atlanta. Sixteen participants attended the workshop from UN agencies (UNICEF, UNHCR, and WFP), Save the Children, Medair, MOPH representing Lebanon, AUB, Iraq, Syria, Geneva, Jordan and the regional office. The target audience was UNICEF nutrition focal persons who had been involved in nutrition assessments and UNICEF immediate counterparts collaborating in these assessment exercises in Syria, Lebanon, Iraq and Jordan, particularly the MOH and UNHCR. All attendees were focal persons involved in data management and will be expected to play a critical role in ensuring data quality in future assessments. The primary purpose of this data quality clinic was to review the data generated to date by a series of nutrition assessment in response to the Syria crisis, subjecting it to quality checks and updating the participants with techniques on data quality verification. Participants were exposed to the Emergency Nutrition Assessment (ENA) for SMART software for data management and data analysis techniques; for the majority it was their first time using ENA for SMART. During the workshop, a brainstorming gave rise to the recommendations for the way forward outlined below.

### The case for scaled up treatment of acute malnutrition

The corrected GAM prevalence figures, the programme admission figures and the 2014 screening results confirmed that there was no nutrition crisis in Lebanon. On reflection this indicated a need to shift attention in the nutrition pro-

gramme. The 'true' scale of risk of acute malnutrition has proven to be lower than originally believed and therefore requires a different approach/programming emphasis than that adopted until now. On the positive side, nutrition programming has helped develop capacity to treat cases of acute malnutrition in country, and there are examples of success in individual case management in this regard. However, we believe that through collective effort, we have managed to reach children before developing MAM and SAM. Two outstanding challenges are the management of acute malnutrition among infants less than 6 months, especially SAM cases, and management of acute malnutrition among pregnant/lactating women.

### Micronutrients

The prevalence of anaemia in the 2013 assessment was unaffected by data quality issues. The prevalence of anaemia in children 6-59 months for all Syrian refugees in Lebanon was 21.0%; children aged 6-23 months were most affected (31.5%). Regionalised data found the highest prevalence in North Lebanon (25.8% amongst 6-59 months, 42.9% amongst 6-23 months). The total anaemia prevalence for non-pregnant women of reproductive age (15-49 years) were for all Syrian refugees in Lebanon 26.1%. Women who live in Beirut and Mount Lebanon had the highest prevalence (29.3%).

Micronutrient provision has been a challenge. In Lebanon, no one organisation was willing to undertake blanket distribution of micronutrient powders (MNPs) for children aged 6-59 months except RI through their mobile medical units. Hence the nutrition sub-working group, led by the MOPH, recommended that MNPs be distributed at PHCs after the child is seen by the paediatrician. Pregnant and lactating women were receiving iron folic acid tablets through the Medical mobile units and or the PHC centres of the MOPH.

The problems of high pre-crisis prevalence of anaemia and stunting and the risks of increased prevalence in the crisis were discussed amongst UNICEF and the nutrition community involved in the response. Most recently, this has led to a move to develop strategies and national protocols for the management of malnutrition and the micronutrient supplementation. A draft nutrition strategy has been developed and discussed with the technical committee that emerged from the nutrition sub-working group. This strategy is based on the UNICEF-MOPH work plan and work with partners. More meetings will take place to finalise the strategy

### The way forward

The reviewed and corrected nutrition data from Lebanon shows that there is not a nutrition crisis and the feared decline in nutrition status has not materialised. Given this, emphasis on

<sup>6</sup> Weight and height data was available for a reduced number of children due to some discrepancies in measurement. There remain challenges in sustaining quality measurement of height and weight with high staff turnover.

acute malnutrition treatment can be reduced and more emphasis placed on prevention of stunting, anaemia prevention and treatment, and improvement in IYCF practices including exclusive breastfeeding. Advocacy will be necessary to position nutrition as a priority sector in order to sustain the low levels of acute malnutrition.

Recommendations for nutrition programming were developed at UNICEF regional level together with participants at the data quality workshop in Amman, for UNICEF country offices to adapt as appropriate. In Lebanon, these were shared with the nutrition sub-working group led by the MOPH, which has led to modifications to existing draft nutrition strategies (prepared with the MOPH and other partners including IOCC, RI, WFP, and ACF as the main nutrition players in Lebanon). Recommendations for nutrition programming are as follows:

#### *Recommendation 1: Infant and young Child feeding*

- Strengthen positive IYCF practices (breast feeding & complementary feeding, including awareness raising through community mobilisation)
- Integrate education and communication strategies in health centres

#### *Recommendation 2: Micronutrient intervention*

- Improve dietary diversity through food security initiatives
- Support food fortification as part of the national programmes rather than refugee/IDP specific programmes
- Support supplementation – Vitamin A, iron and folate – in PHC services
- Support delivery of micronutrient powders (MNP) as anaemia is a proxy for other micronutrient deficiencies. UNICEF provides the micronutrient supplements and sprinkles to MOPH, IOCC, RI and others who distribute at the community level after the child has been seen by a physician and or PHCs staff
- Support maternal nutrition through micronutrient supplementation

#### *Recommendation 3: Treatment of acute malnutrition at minimal scale*

For ethical reasons, case management should be in place, therefore:

- Ensure the capacity, guidelines and minimal supplies exist (preparedness) for treatment of acute malnutrition
- Ensure integration of the nutrition programme in PHC facilities (screening and treatment of malnutrition cases) which will allow for sustainability and provide services in both emergency and non-emergency situations

#### *Recommendation 4: Rigorous monitoring of the situation (screening/surveillance/periodic survey)*

- Screening of the refugee population on arrival



A Syrian refugee and her child arrive in Lebanon

Photo credit: McConnell/UNHCR

- Integrated screening in regular public health work (eg EPI campaigns)
- Facility based screening
- Periodic assessment/surveys where there are substantial treatment programmes/caseloads for acute malnutrition (these surveys should include coverage assessment) or if requested by country offices
- Establish a nutrition surveillance system in collaboration with the MOPH and IOCC. This is in the early stages of development and will aim to monitor the growth of children and inform policy-makers on where malnutrition problems exist for taking further actions.

#### *Recommendation 5: Integrated response*

Promote an integrated response through delivery of a minimum package of health and nutrition response, including immunisation, disease treatment, awareness raising, food security, water and sanitation services, shelter, to prevent malnutrition with a focus on the first 1000 days (pregnancy and until the child is 2 years of age) to prevent stunting, reduce LBW and to improve maternal nutrition

- Strengthen coordination and advocacy for nutrition as a priority sector. The recently formed nutrition sub working group and its respective members has a key role and responsibility for effective coordination, gap analysis, information flow, strategy development and harmonisation, and to foster partnership.

A nutrition work plan was developed in May 2014 (signed June 2014) with the MOPH and its partners in an attempt to institutionalise the nutrition programme within the MOPH PHC centres and hospitals with a view to building resilience and a sustainable capacity in-country. This has involved a number of activities:

- Establishment of a coordination body (nutrition sub-working group) in May 2014

to respond to nutrition in emergencies. Prior to May 2014, there was no official coordination body on nutrition; ad hoc meetings were hosted by UNICEF to coordinate activities and nutrition was covered as a topic in the health and nutrition working group. The MOPH is lead agency with UNICEF as co-lead, in addition to IOCC and WFP who will co-lead alternatively on a six month basis with UNICEF. UNICEF proposed this co-lead approach to build capacity of partners. The group meets every month and reports to the health and nutrition working group.

- Capacity building of doctors, paediatricians, nurses and community mobilisers.
- Community based screening and active case finding for acute malnutrition
- Screening children under 2 years regarding breastfeeding practice at the PHC and community levels. The identified mothers with suboptimal feeding practices are supported by lactation specialists who provide one-on-one counselling. This component is supported by UNHCR.
- Outpatient management of acute malnutrition. This service is integrated within the PHC centres/facilities of the MOPH. UNICEF is supporting IOCC in activating 40 PHC all over Lebanon (see article by IOCC in this issue of Field Exchange).
- Inpatient management of acute malnutrition. Five hospitals have been 'activated' to treat inpatient malnourished children.
- Supporting IOCC in initiating a clinic based nutrition surveillance system at the MOPH primary health centres (PHC) centres that screen, track, monitor and interpret the nutritional status data of children under five years old affected by the crisis.

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Paper vouchers  
in Lebanon

# WFP e-voucher programme in Lebanon



WFP/Laure Chadraoui

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## Context

WFP began delivering food assistance in June 2012, following an official request from the Government of Lebanon in May 2012. The Lebanese High Relief Commission (HRC), UN High Commissioner for Refugees (UNHCR), local organisations and private citizens, who had been assisting Syrians up to that point, found their capacities challenged to meet the rising demand. In northern Lebanon, WFP began by taking over half of UNHCR's caseload of some 15,000 refugees and started distributing food vouchers to 1,550 refugees in the Bekaa Valley. By May 2014, WFP's operations had expanded dramatically, providing monthly assistance to over 744,000 Syrian refugees, mainly through the provision of food vouchers, and with one-off food parcels for newly arrived refugees. The e-voucher programme, also known as the 'e-card' programme, is WFP's primary means of providing food assistance to Syrian refugees in Lebanon, accounting for over 90% of the monthly caseload. This article describes WFP's experiences in the evolution of what is currently WFP's largest voucher programme worldwide.

## Programme implementation

WFP began transitioning from paper food vouchers to electronic pre-paid vouchers (e-cards) in September 2013. As the caseload of refugees in Lebanon continued to increase exponentially, the printing, distribution and rec-

onciliation of paper vouchers became a major challenge for WFP and partner staff, absorbing considerable staff time. Abandoning the voucher system was not an option as it had made a significant contribution to the Lebanese economy and the approach had proved highly suited to the urban context in a middle income country. As a result, WFP Lebanon shifted to an electronic, pre-paid voucher system. E-cards were adopted as the primary modality of assistance due to Lebanon's inherent ability to meet an increase in consumer demand without affecting its current supply lines and price levels. This ambitious move ensured that the benefits continued to be realised by the host country, while simultaneously addressing many of the outstanding programmatic issues relating to the vouchers.

Families in need received one e-card that is automatically uploaded with US\$30 worth of credit per person each month. The e-cards can then be redeemed in any of 340 small and medium size shops spread across the country. The automatic reloading of credit means beneficiaries no longer need to attend large-scale monthly distributions<sup>1</sup>, thereby reducing their transportation costs; the number of distributions is reduced simply to those who have newly arrived. Furthermore, e-cards provide beneficiaries with greater purchasing flexibility as they can purchase by preference and need and make multiple purchases throughout the month. In addition, merchants receive their payments more promptly since shops, partners and WFP no longer need to manually collect and (re-)count the vouchers before payment. Since December 2013, the e-card modality has covered the entire country and has been implemented by some of the same extended network of cooperating non-governmental organisations (NGO) partners that conducted the paper voucher system. The cooperating partner NGOs include the Danish Refugee Council, World Vision International, Premiere Urgence-Aide, Medical Internationale, Action Contre la Faim, Save the Children, Mercy Corps and InterSoS.

WFP also provides monthly food parcels to vulnerable newly arrived refugees awaiting reg-

istration. These parcels, which contain mixed rations of some 19 different items (including rice, wheat, flour, canned foods, packaged cheese, sugar, tea and coffee, etc.), help to cover a family's food needs for a period of one month. Parcels are transferred directly to WFP's cooperating partners in the field who store and distribute the parcels each month. In addition, WFP had a contingency stock of approximately 35,000 food parcels that could be used in case of a sudden influx of refugees, such as with the Aarsal influxes in November 2013 and February 2014.

## Vulnerability assessment

In May and June 2013, WFP, UNHCR and UNICEF conducted the Vulnerable Assessment of Syrian Refugees (VASyR), a multi-sectoral annual survey aimed at understanding the living conditions and vulnerability profiles of Syrian refugees in order to guide respective responses. The survey concluded that approximately 30% of households could meet their basic food and non-food needs. The remaining 70% of households were deemed to be either highly or severely vulnerable. Furthermore, the VASyR found that Syrian refugees were highly reliant on food assistance as their main food source, and thus WFP assistance remained a high priority to prevent the deterioration of refugees' food security status. The assessment showed that nearly 30% of Syrian households surveyed relied on some type of assistance as their main livelihood source; mainly food vouchers (24%). Furthermore, food assistance deters the adoption of additional negative coping strategies, thereby freeing up cash resources to be used for other immediate needs (shelter, health, water, sanitation and hygiene, education, etc.). On average, a refugee household's

<sup>1</sup> How the paper vouchers operated: Upon registration with UNHCR, each Syrian refugee was entitled to a paper voucher, which was distributed by WFP's cooperating partners at sites throughout Lebanon. The value of the vouchers was calculated to meet the basic nutritional requirements of refugees, based on the results of long-term monitoring of prices in the country. If a beneficiary registered in the same month as the distribution, they were entitled to a half-value voucher to hold them over until the next distribution. The vouchers had to be spent in one go at the WFP contracted shops throughout the country.



e-card Lebanon

WFP/Laure Chadraoui



Preparing a meal

expenditure was US\$774 per month; nearly half of this amount was spent on food. In addition, the survey found that the income versus expenditure gap, caused by limited livelihood opportunities, rising rent, food and services prices, induced greater use of negative coping strategies as the Syrian crisis becomes more protracted, increasing the financial pressure on vulnerable refugees. The assessment also showed that more and more families were taking on debt as households spent their savings and sold their remaining assets to meet their basic requirements.

### Monitoring

The VASyR collects information to help understand the scale and nature of vulnerability, e.g. dietary diversity, coping strategies, which can then be used to re-evaluate targeting criteria. WFP also conducts a range of monitoring activities for the e-voucher programme including post-distribution monitoring (PDM) and price monitoring. PDM of a sample of refugees allows collection of a range of data including percentage of refugees awaiting registration, percentage of refugees with income sources, food consumption based coping strategies (e.g. reducing number of meals per day), timing of voucher redemption, amounts of fresh food purchased and percentage of refugees exchanging the voucher for cash or non-food items (NFIs)<sup>2</sup>.

Highlights from PDM between January and March 2014 included the fact that households were eating limited fruit, pulses and vegetables and that households who have been the longest in Lebanon have better food consumption scores, apply less food consumption based coping strategies but seem to be applying more negative livelihood coping strategies in order to cope with the lack of food. The same PDM also reported that sixty eight percent of households used the WFP voucher as their main source of income. Close to half of households stated that they earned an income (casual or waged labour) as one of their three main source of income. Seventeen per cent of households reported exchanging their e-cards for cash to cover rent, health/medicine and to buy other types of food.

By March 2014, WFP Lebanon had contracted 282 shops and \$179 million was injected into the Lebanese economy from January 2013 to March 2014. Furthermore, after the transition from paper voucher to e-cards, WFP and its partners were able to significantly increase their

presence at the shop level in order to conduct more regular monitoring. Food price monitoring takes place in all WFP shops that are involved in the voucher programme. Food price reports estimate the value of the WFP food basket, the total value of a minimum food expenditure basket, differences in prices between areas of Lebanon, and price variability for all commodities that can be purchased with the e-voucher. Any impact of WFP's activities on local prices is also assessed.

### Targeting

The concept of targeted food assistance is based on responsible programming so that assistance reaches those who cannot feed themselves or their families. It is particularly important to target assistance to the most vulnerable given the very high funding needs in the region. WFP along with UNHCR and UNICEF started targeting assistance in Lebanon in October 2013 refocusing assistance on vulnerable families. As a result, 70% continued to be assisted monthly with food assistance. One-day workshops for WFP and UNHCR field staff were held at the onset of the targeting to clarify and agree on the referral mechanism for these urgent cases. In addition, a verification system was put in place for those families who stopped receiving WFP food assistance but who appealed the decision. Families living above 500 metres were also automatically verified even if they did not appeal.

The verification consisted of a household visit to assess the socio-economic and food security status. A total of around 31,000 families have been visited (over 97% of all planned visits) and of these, 23% (over 7,000 families) have been re-included for assistance. WFP, working closely with UNHCR and other partners, conducts regular outreach and verification visits throughout Lebanon to check that families who need the assistance are receiving it. WFP has also been reviewing cases referred by UNHCR, believed to be vulnerable. In May 2014, 159 cases were referred by UNHCR and 51 of them were deemed valid. This interim exercise will be in place until a new comprehensive targeting and review system, currently being developed by WFP and UNHCR through the inter-agency Targeting Task Force, is implemented (target date not yet confirmed).

### Developments and plans for 2014

Already severely economically impacted by the conflict, Lebanon now officially hosts over one million refugees. It is expected that this number will keep increasing in 2014 to over 1.6 million, most of whom are anticipated to need humanitarian assistance. In addition, it is anticipated that 1.5 million affected Lebanese will need assistance, as well as tens of thousands of Palestinian Refugees from Syria (PRS). WFP began to expand its food assistance in 2014 with the overall objective to ensure that food security and livelihood opportunities are provided to vulnerable Lebanese and PRS, in addition to vulnerable Syrian refugees. By the end of 2014, WFP is planning to provide monthly assistance

to some 70% of registered refugees (approximately 1,125,000 individuals) through the provision of e-cards. Inclusion is based on the VASyR 2013 findings and targeting will be further refined based on the results of VASyR 2014.

WFP closely collaborate with UNRWA (United Nations Relief Works Agency) to provide food assistance to Palestinian Refugees from Syria (PRS). The Needs Assessment for PRS was finalised with WFP's extensive technical support to UNRWA, including training enumerators, supervising the collection of data, cleaning the databases and advising on the format of the questionnaires. WFP has also been supporting UNRWA development of solid monitoring and evaluation tools. UNRWA is taking the lead on providing assistance to PRS and already provides ATM cards through which cash is withdrawn for food and non-food needs. A Memorandum of Understanding (MoU) was recently signed by UNRWA and WFP to commence the joint food assistance to PRS. The activity will be funded jointly and primarily implemented through UNRWA's existing distribution mechanism.

WFP will also collaborate with the MoSA to supplement the targeted social assistance package to assist vulnerable Lebanese host communities (approximately 36,000) under the National Poverty Targeting Programme. Assistance to low-income Lebanese will start in August 2014, in line with Track 1 of the Roadmap of Priority Interventions for Stabilisation recently presented by the Government of Lebanon (GoL) with the support of the World Bank and the UN. The aim of this programme is to reduce inter-community tension and help build national capacity, to supplement the GoL's targeted social assistance package. The eligibility criteria were negotiated with the World Bank and MoSA – consisting of 'the most extreme poor' using Proxy means Test (PMT) criteria<sup>3</sup>, which will be further refined to include standard food security indicators once the project starts.

WFP and partners will intensify monitoring and verification activities in the coming year to ensure that all those in need of assistance continue to receive support. Verification activities may be further intensified as banking/transaction reports are better utilised and as a revised shop strategy is implemented (see below). WFP will also intensify sensitization efforts with beneficiaries to inform them of the advantages of the e-cards. WFP will continue to assist newcomers and refugees pending registration through the one-off food parcel programme. Furthermore, WFP and partners have placed significant emphasis on enhancing the capacities of the government institutions most impacted by the refugee influx.

Through its cooperating partners, WFP achieved 94% of its operational plan for May 2014 reaching over 744,000 beneficiaries through e-cards and food parcels. Of this figure, the ma-

<sup>2</sup> In June 2013, 34% of respondents reported exchanging one or more of their vouchers for cash or non-food items (NFIs).

jority of beneficiaries (96%) were reached through the e-card modality. Through the technical expertise of the partner bank, WFP has been analysing spending patterns of its beneficiaries over time, using data collected from shop interviews and household visits. Research shows that most households use the entire value of the e-card at once to buy dry goods and staple items, and use other sources of cash to buy additional items throughout the month as necessary.

An independent consultancy firm reviewed the cash transfer programming's operational set-up in Lebanon and a report was presented with the results including a set of suggested options on sharing a common OneCard platform, which would see several agencies providing assistance via a single electronic card. In the report and during follow-up management meetings, it was recommended that WFP's e-card platform, inclusive of data management, service delivery and implementation, be used. UNHCR – as well as various other actors – expressed interest in joining WFP's e-card platform to form the OneCard platform, with a caseload of 12,000 households selected by UNHCR being provided with multi-purpose unconditional cash assistance.

### Challenges and lessons learned

Security remains a serious concern for WFP operations. While there have been some delays, suspensions and even cancellations of food and voucher distributions, monitoring visits and other activities, WFP has successfully delivered assistance to its entire caseload each month. However, the worsening security situation and the increasing prevalence of violence in WFP areas of operations are threatening to disrupt distribution cycles and prevent WFP from reaching all beneficiaries. The prospect of deteriorating security in the wake of an escalation in conflict in Syria, or due to any escalation in

sectarianism within Lebanon, remains a genuine concern. It appears refugees are increasingly mobile within Lebanon, either as a result of eviction, searching for better shelter or jobs or joining other family members. Some reports also indicate that some refugees may have returned to Syria. These unrecorded movements of population within Lebanon can make the analysis of gaps and impact of assistance more challenging for WFP.

The rapidly increasing number of refugees and the expectation of continuing conflict in Syria will lead to growing financial requirements for the operation. As e-cards are pre-paid, WFP is now required to have the necessary cash in their accounts at the beginning of each cycle.

WFP is constantly seeking out new and reliable partner shops that can adequately provide for the needs of beneficiaries. Finding such shops in areas close to refugee concentrations continues to be a challenge. In order to respond to the changing context and increased needs, WFP Lebanon is proposing to send out an expression of interest to all vendors interested in participating in the e-card programme and who meet the minimum criteria. This strategy is in response to stakeholders request for a transparent process which gives equal opportunities to all retailers and is clear on the requirement of participating in the process.

WFP Lebanon is working on integrating monitoring data from the bank to traditional monitoring activities in order to better monitor the cash and voucher programme. WFP receives transaction data from the bank at the shop's level. This allows sub-offices to implement tighter controls over WFP shops by looking at monthly redemption scores, transaction densities, and transactions outside business hours. This has led WFP to also engage in discussions with the financial service providers on how to impose anti-fraud measures at their level. For example, WFP is able to monitor shop transactions almost in real time and to freeze the POS machine as soon as a threshold of US\$36,000 is reached in some sensitive (insecure) areas in Lebanon. Every month, sub-offices receive data from the bank on e-cards that have either not been distributed or used. WFP sub-offices conduct follow-up phone calls to these beneficiaries to inquire why they have not collected their e-cards or why they have not redeemed the full value of their entitlement. Based on these results, WFP is able to adjust its programming (information, location of the shop...) and ensure that the most vulnerable have access to food assistance.

Monitoring and evaluating a project with such a vast caseload remains a considerable challenge. With 340 shops, eleven cooperating partners, two food parcels suppliers and a beneficiary list dispersed throughout the country, monitoring activities have proven to be a difficult task, even without the added obstacle of insecurity in many areas. Monitoring highlights that beneficiaries do not always know their rights with regard to shop owners and there has been a few

issues with shop keepers keeping e-cards at the shop to force beneficiaries to come back and redeem in their shops. On a positive note, monitoring results show that just as many female and male are redeeming the e-card and therefore the assistance is not generating any gender imbalance at the household level.

As the number of Syrian refugees continues to significantly rise, tensions between host communities and refugees are growing. Local communities are feeling the strain of this major influx, impacting shelter, food and job opportunities. Furthermore, most of the international support is going to Syrian refugees when there are vulnerable Lebanese in need of assistance too; this is why WFP is now working in close collaboration with the Ministry of Social Affairs and the World Bank to provide needed food assistance to the most extremely poor Lebanese to mitigate the impact of the Syrian crisis.

### Conclusions

The provision of the voucher modality as compared to in-kind has given the beneficiary increasing dignity, flexibility, and choice in purchasing food at WFP-selected shops. The shift from voucher to e-cards has reduced the distribution requirements and reduced protection incidents linked to the distribution process. It has freed up partners and WFP staff to monitor the implementation of the project, to better address problems of fraud, and most importantly, ensure that the most vulnerable and hungry are receiving the food assistance that they need.

The choice of how WFP delivers assistance, whether by cash, vouchers, or food is made after numerous assessments to determine which approach the most appropriate is, given the context. Cash is not necessarily a simpler or cheaper way of providing assistance. WFP chose to provide assistance through vouchers following consultation with partners (especially the Government) and carrying out financial infrastructure assessments. However, WFP is constantly reassessing the situation, and WFP do not rule out a move to cash if it were to be more appropriate. In this regard, WFP in Lebanon and Jordan will start a cash assistance pilot which will better inform our programming. The pilot will involve Syrian families, who are existing beneficiaries and will be allowed to use e-cards to withdraw cash from an ATM or will have the option to either withdraw cash from an ATM or continue using a point-of-sale (POS) terminal for a period of six months. An external evaluation company will assist WFP with the study from the inception, through to implementation and follow-up stages.

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Shopkeeper in a participating shop

WFP/Fredrik Copper

<sup>3</sup> Proxy means tests generate a score for applicant households based on fairly easy to observe characteristics of the household such as the location and quality of its dwelling demographic structure of the household, education and occupations of adult members. The indicators used in calculating this score and their weights are derived from statistical analysis



J Dumont/WFP, Lebanon

Rama, a 7-year-old Syrian refugee girl who now lives in Mount Lebanon. Through WFP's e-cards, Rama can eat fresh vegetables and fruits.

# WFP experiences of vulnerability assessment of Syrian refugees in Lebanon

By Susana Moreno Romero

Susana Moreno Romero is the Food Security Specialist and responsible of the VAM (Vulnerability Analysis and Mapping) team in WFP Lebanon since 2013, from where she has coordinated the 2013 and 2014 VASyR amongst other assessments in country. She has worked as a food security and nutrition analyst in Rome WFP HQ, South Sudan, Bolivia, Sierra Leone, Niger and Argentina with WFP, INGOs and governmental institutions. She holds a PhD in nutritional anthropology.

The author would like to highlight that other contributors to the article, providing extensive analysis support, include Catherine Said and Mazen Makarem from the VAM team in WFP Lebanon.

The author extends thanks to all Syrian refugees, stakeholders and field monitors that have participated in and made possible the 2013 and 2014 VASyR. Partners involved in 2013 and/or 2014 VASyR included ACF, ACTED, Care, HI, Intersos, Mercy Corps, MPLP, NRC, REACH, Shield, SI, UNHCR, UNICEF and World Vision.

## Background

Since the outbreak of hostilities in Syria in early 2012, there has been a massive influx of refugees into Lebanon. By the end of July 2014, the official UNHCR figure for registered Syrian refugees had risen to 1,110,863 individuals, not including thousands of Lebanese returnees and Palestinians refugees from Syria (PRS).<sup>1</sup> Lebanon shares the biggest burden in terms of the influx of refugees, hosting 38% of Syrian refugees in the region. In Lebanon, one in five people is now a Syrian refugee. (For comparison, the 2010 pre-crisis population in Lebanon was estimated to be approximately 4.2 million.) The sudden increase in the assistance required, together with increasingly limited resources, required the humanitarian community to focus efforts on optimising the cost-effectiveness of assistance.

To improve knowledge of the living conditions of Syrian refugees, and to inform decision-making and the redesign of programmes, UNHCR, UNICEF and WFP agreed to conduct a joint household survey of the registered and pre-registered Syrian refugee population in Lebanon. The assessment was designed so that accurate, multi-sectoral vulnerability criteria could be derived for the implementation of humanitarian assistance. A concept note for the Vulnerability Assessment of Syrian Refugees (VASyR), complete with the methodology and a multi-sectoral questionnaire, was agreed upon by the United Nations (UN) and Government of Lebanon (GoL) partners, and was shared and discussed with stakeholders through regular multi-agency and multi-sectoral meetings and workshops. The first VASyR was conducted in 2013 and the second one in 2014.

The article considers two aspects of the VASyR:

- A description of the approach and methodology, how this has evolved in response to the Syria crisis situation in Lebanon, and lessons learned from implementation.
- Findings relevant to food security and nutrition from the 2013 and 2014 VASyR

## VASyR methods

### VASyR 2013

More than 1,400 Syrian refugee households were interviewed in May and June 2013, following: 1) a two-stage cluster random sampling proportional to population size, and 2) a stratified sample according to registration date: awaiting registration, registered between zero and three months, registered from three to six months, and registered for more than six months. A total of 350 households in each stratum were interviewed.

Sector-specific criteria were discussed and agreed upon at the sector working group level (water, sanitation and hygiene (WASH), education, food security, protection, and economic), or through internal discussions (shelter, health, non-food items (NFIs)). According to the criteria agreed by the eight sectors, households were classified under four categories of vulnerability: severe, high, mild and low. The classification of households according to their food security situation is based on a composite indicator that considers food consumption, food expenditure share and coping strategies (see Box 1). In addition, extensive data were collected on the health and nutritional status of 1,690 children between six and 59 months (52% males; 48% females) including mid upper arm circumference (MUAC) measurement. Infant and young child feeding (IYCF) practices were assessed for 618 children under two years of age (6 - 23 months).

## VASyR 2014

The main objective of the 2014 VASyR was to provide a multi-sectoral overview of the vulnerability situation of Syrian refugees in Lebanon one year after the original 2013 VASyR. The study analysed the main changes in the Syrian refugees' living conditions compared to 2013, taking into consideration the major factors affecting any change and rec-

### Box 1: Food security classification

The formula used provides a score that reflects two key dimensions of food security: the actual status of the households (particularly, in the short term), for which the food consumption score (FCS) is the key indicator, and the forward looking perspective/access to long-term food security, which is measured through food expenditure share and the coping strategies.

The three factors considered (FCS, food expenditure share and coping strategies) are converted in a 4-point scale and the score is the result of an average of points assigned to each factor. Based on this, households were classified into four food security categories: food secure, mildly food insecure, moderately food insecure and severely food insecure.

The full method known as CARI (Consolidated Approach for Reporting Indicators on Food Security) is available in: 2013 VASyR report<sup>2</sup>.

<sup>1</sup> UNHCR Lebanon Portal: <http://data.unhcr.org/syrianrefugees/country.php?id=122>

<sup>2</sup> <http://54.225.218.247/wfp/documents/Lebanon/VASyR.pdf>

Fatmeh, a 26-year old Syrian refugee mother and her children in Wadi Khaled in North Lebanon



J Dumont/WFP, Lebanon

ommends steps forward. The target population was Syrian refugees in Lebanon registered and awaiting registration by UNHCR, considering those included and excluded for assistance. It took place exactly one year later (May/June 2014), to ensure comparability.

For the VASyR, there is a variation in the population stratification. The sample was stratified geographically, using five regions and taking into consideration governorate administrative boundaries, operational areas and numbers of Syrian refugees registered in each region. This approach allowed for information to be collected at administrative and operational levels so that it may be used for decision making and to maintain consistency with the UNHCR-led sixth Regional Refugee Response Plan (RRP6) for Lebanon. The sample of 1,750 households (350 per strata) is representative of each of these strata and followed a two-stage cluster random sampling methodology.

### VASyR 2013: Key findings on nutrition and food security

#### *Food security and coping strategies*

Nearly 70% of the households had some degree of food insecurity, with the majority falling under the mild food insecurity classification. Some 12% households were classified as moderately or severely food insecure. Food insecurity seemed to decrease with the length of stay in Lebanon. Most households showed acceptable food consumption and dietary diversity however there was a risk of a micronutrient deficiency. Nearly half of the sampled refugees had applied coping strategies in the previous month; around 90% applied coping strategies related to their food consumption. The most common food-related coping strategies were:

1. Relying on less preferred or inexpensive food (89% of households)
2. Reducing the number of meals and portions sizes per day (69% of households)
3. Reducing portion size of meals (65% of households)
4. Restricting women or adult's food consumption so that children may eat (8% and 49% respectively)

Most of the refugees surveyed relied on the assistance of friends, family or humanitarian organisations to meet their basic needs. Adult food consumption patterns implied a risk of micronutrient deficiencies.

#### *Health and nutrition of children*

Almost half of the surveyed children under the age of five years (45%) were reported as having been sick during the two weeks prior to the survey. The most common symptoms were fever (63%), coughing (51%) and diarrhoea (35%), while 19% of the sick children showed other symptoms like allergies, infections, asthma and measles. Children under two were significantly more likely to be sick, including a much higher incidence of diarrhoea.

The prevalence of acute malnutrition amongst survey children was very low; out of 1,690 children between six and 59 months, 22 (1.0%) were found to be moderately acute malnourished (MUAC 124-115 mm) and 0.4% severely acute malnourished (MUAC <115 mm). There had been no increase since 2012 (SMART survey).

Out of the 618 children between six and 23 months old that were included in the survey, only 6% had a minimum acceptable diet according to WHO IYCF indicators.<sup>3</sup> About 50% of children between six and 23 months were breastfed the day prior to the survey. Breastfeeding practice decreased significantly with child age; three-quarters (75%) of infants under the age of one year were breastfed, dropping to about half of children between one and one and a half years old, and decreasing to 25% in children between one and a half and two years old.

Infant and young child feeding practices were found to be poor among Syrian refugees in Lebanon representing a risk factor for malnutrition due to some of the following issues:

- Delayed introduction of complementary foods (after the recommended 6 months of age) was common. Over 40% of children under the age of one, and 25% of children between one and one and a half years old had not received complementary foods

(based on 24 hour recall). Of the children between one and a half and two years, 10% had not received complementary foods.

- About three quarters of children surveyed did not meet recommended minimum meal frequency and 85% of the children surveyed did not meet the minimum dietary diversity requirements the day prior to the survey.
- Only 5% of children under the age of two consumed vitamin A rich fruits and vegetables and meat or fish. The food groups most consumed by children were dairy products (54%), grains, roots and tubers (46%), followed by fruits and vegetables not rich in Vitamin A (26%) and eggs (24%). This child food consumption pattern inferred a risk of micronutrient deficiencies.

#### *How VASyR 2013 informed programming*

The 2013 VASyR was used as a basis to determine the level of vulnerability in the population and informed targeted assistance interventions. WFP along with UNHCR started targeting assistance in Lebanon in during September and October 2013 refocusing assistance on vulnerable families. As a result, 70% of registered Syrian refugees continued to be assisted monthly with food assistance from WFP, as well as baby and hygiene kit assistance from UNHCR.

### VASyR 2014: Key findings on nutrition and food security

#### *Food security and coping strategies*

According to the 2014 VASyR, 13% of Syrian refugees are moderately or severely food insecure, 62% are mildly food insecure and some 25% are food secure. These results show a decline in food secure households by 7% compared to 2013, mainly due to the fact there is a higher percentage of households that need to cope because of lack of food or money to buy food. The food security situation is worse in Akkar (North Lebanon) and the Bekaa Valley, where 22% and 16% of households respectively were found to

<sup>3</sup> WHO 2008. Indicators for assessing infant and young child feeding practices. Part 1: Definitions and Part 2: Measurement. <http://www.who.int/nutrition/publications/infantfeeding/9789241599290/en/>



be moderately and severely food insecure. The situation is best in Beirut and Mount Lebanon where 6% of households were found to be moderately and severely food insecure.

In 2014, 28% of Syrian refugee households had to apply crisis or emergency coping strategies, which is 6% more than last year. The percentage of households spending savings as part of their coping strategies has decreased significantly compared to 2013; it moved from the most important assets-depletion coping strategy to the third most important, after borrowing money or reducing essential non-food expenditures like education or health. The majority (82%) of Syrian refugee households borrowed money in the last 3 months, which is 11% more than last year. Half of the households have debts amounting to US\$400 or more. Thirteen per cent of households have poor and borderline consumption in 2014, which represents a 6% increase as compared to 2013.

These results highlight a trend towards a worsening of the general food security situation of Syrian refugees, without dramatic changes.

### *Health and nutrition of children*

Nearly 70% of surveyed children under the age of 5 years were reported as being sick during the 2 weeks prior to the survey. The most common symptoms were fever (51%), cough (45%) and diarrhoea (35%); 14% of the children who were sick had other symptoms including allergies, infections, asthma or measles. Approximately 48% of children were reported to be sick with more than two symptoms. Children under 2 years old were significantly more likely to be sick, mainly due to diarrhoea and fever.

IYCF practices continued to be poor, much like 2013, with the meal frequency and diet diversity being the main limiting factors. The minimum acceptable diet was met by 4% of children aged between 6 and 23 months. Half of the children in this age range were breastfed, 63% received complementary feeding, 18% had the minimum acceptable meal frequency and 18% had the minimum diet diversity of four food groups. Similar to 2013, the most consumed food groups for children were cereals and tubers (56%), dairy products (54%) and eggs (26%). The risk of micronutrient deficiencies continues to be an issue due to the low consumption of Vitamin A rich vegetables and fruits and meat and fish that were consumed by 9% and 6% of children, respectively.

### **How VASyR 2014 will inform programming**

The 2014 VASyR is being used as a basis to refine the level of vulnerability in the population and further inform targeted assistance interventions. VASyR results have also been the key source of information on refugees' household living conditions, for the Regional Refugee Resilience Plan 2015-16, which is currently under discussion. At the same time, the regional multi-sectoral vulnerability profile provided by the VASyR allows activities and objectives within sectors to be prioritised.

## **Evolution of the VASyR**

### *Context of the VASyR assessments*

Since the 2013 VASyR took place in May/June 2013, the context in Lebanon and the situation of Syrian refugees in-country may well have been affected by the following factors:

- The number of Syrian registered refugees in Lebanon has surpassed 1 million. The Syrians currently in-country could account for one quarter of the population living in Lebanon, which may clearly have further implications on the increasing tension with the host community, the strain on the infrastructure in Lebanon and access to shelter, employment and essential basic services (health, education, water, sanitation, electricity).
- As part of responsible programming, various types of assistance (food, hygiene and baby kits) shifted from blanket to targeted assistance during September and October 2013. Targeting of assistance was aimed at households most in need, with some 70% of the Syrian refugee population thus continuing to receive the above assistance. Although 30% of the registered population was deemed as able to cover their basic needs without engaging in irreversible coping strategies (and thus no longer qualifying for assistance), it is also part of responsible programming to monitor how the targeting of assistance affects the Syrian refugee population as a whole.
- The time spent by Syrian refugees in Lebanon may have positive or negative effects. Refugees may have increasingly adapted to the new context, may have a better awareness and network facilitating access to some services, and may have a better knowledge of assistance benefits. On the other hand, time implies a higher risk of exhaustion of resources (e.g. savings and/or assets) and difficulties to continue coping through loans.

VASyR 2014 provided the follow-up to the 2013 study to explore the impact of these issues.

### *Stratification by region*

Since the 2013 VASyR, there was evidence of regional disparities within Lebanon for different indicators, but a lack of comprehensive and representative information at regional level based on sound assessments or standard methodology. There was mounting interest coming from the humanitarian community to better understand these regional differences in the refugees' situation and fill this critical information gap. This geographical stratification was used in the 2014 VASyR.

### *Stratification by registration date*

Stratification by registration date was included in VASyR in 2013 but not in 2014. One of the main reasons behind the stratification by registration date in the 2013 VASyR was to explore whether this variable affected household vulnerability and could therefore help better define the need of assistance. The 2013 VASyR showed that refugees awaiting registration or recently

registered did tend to show poorer living conditions for some indicators compared to those registered for a longer period of time. Yet overall, vulnerability was not significantly different among these strata. Information about living conditions by registration date is available from the 2013 VASyR, and if repeated in 2014, strata would have changed given the disproportionate number of refugees in each strata in 2014, most of them registered over 6 months ago. Thus the analysis by registration date was carried out with the 2014 VASyR data, but with no representativeness by registration group.

### *Nutrition indicators*

MUAC and oedema results in the 2013 VASyR indicated a 1% prevalence of moderate acute malnutrition (MAM) and 0.4% severe acute malnutrition (SAM) (1.4% global acute malnutrition GAM)). These results were lower than malnutrition prevalence determined by weight for height in the SMART nutritional survey of 2012 (4.4% GAM), as well as the results that were later released in the 2013 SMART nutritional survey<sup>4</sup>. The decision to remove MUAC from the 2014 survey was based on the following reasons:

- In this population, MUAC underestimates acute malnutrition compared to weight for height.
- Given the low acute malnutrition prevalence in the population based on MUAC, the precision needed to track potential changes would have required a larger sample size than needed for the VASyR purposes.
- Due to the lack of significant changes in acute malnutrition rates found in the 2013 SMART nutritional survey compared to 2012, it was not deemed worthy to introduce, to the 2014 VASyR, the added complexity of training and implementing the MUAC exercise (including the standardisation test for enumerators).

Weight for height and micronutrient status data were not collected in 2013 or 2014, as this would have added undue complexity to the VASyR which is meant to be an emergency multi-sectoral assessment and given the availability of results from the SMART nutritional surveys conducted in 2012 and 2013. The nutrition component of non-communicable disease (NCD) was not assessed as this was not selected at the sector working group level, although chronic diseases (self-reported) are included in the 'specific needs' module of the VASyR.

## **Conclusions**

The VASyR provides a very valuable comprehensive picture on living conditions for Syrian refugees to better inform decision-making. The assessment is statistically sound with representative data at different levels (registration date, regional). At the same time, it is operationally feasible to undertake in an emergency context

<sup>4</sup> The SMART survey results were subsequently reviewed and corrected. This found a lower prevalence of acute malnutrition than initially estimated. For more details, see article by UNICEF in this issue (p32).



Ahmad (in yellow) and his friends with donated dates distributed by WFP in Bekaa

J Dumont/WFP, Lebanon

when information is needed in a short period of time so as to re-design programmes according to evolving needs. It strongly contributes to identifying main needs as well as areas where more detailed information would be required to better address any sector-specific concerns.

The VASyR has a set of implementation challenges to overcome and one broad limitation. The main limitation is that the VASyR does not provide all the detailed information needed for each sector; it does not replace in-depth sector-specific surveys. Only the most critical indicators are selected per sector so that the overall questionnaire can be feasibly rolled-out. The approach was to conduct a wide-ranging multi-sectoral, higher-level survey that can be carried out without requiring an overly long assessment of interviewees. Challenges and means to address these are as follows;

**1) Improve on information collected**, through identifying key sector-specific questions that provides the essential information needed for decision-making and help better define the thresholds that more accurately identify vulnerability. This process requires intra and inter-sectoral discussions with each sector attempting to attain the most information possible for their own purposes<sup>5</sup>. Although the questionnaire should be contextualised and revised in line with lessons learnt from previous assessment exercises, efforts carried out at the international level to standardise vulnerability questions, categories and thresholds would facilitate this process significantly. Such work should take account of specific contexts like urban or semi-urban areas, refugees not residing in camps, and situations in middle income countries.

**2) Further enhance data quality.** The number of enumerators needed for an assessment of this scale where field data collection takes about 2 weeks, ranges between 64 and 82. These enumerators need to be trained in different sector-specific questions, as well as in the VASyR methodology. Training of trainers has been identified as the best approach but this requires extensive efforts in standardising training modules, providing clear guidelines on the methodology, process and questionnaire along with

close supervision at different levels. These three factors are key to minimising regional differences in interpreting questions, methodology and in standardising how to manage unpredictable situations. One of the main objectives of 2014 VASyR has been to improve data quality by introducing these elements but it is a continuous process. In addition, in VASyR 2014, quality monitors from UN agencies accompanied the enumerators during the field data collection. There were two monitors per region, to strengthen and support the supervision role, and it especially revolved around quality of information collected during the interviews.

**3) Clarity around the definition of households used.** For the VASyR, a household is considered to consist of family members that live together or in different living structures, eat out of the same pot, and share the same budget that is managed by the head of the household. The definition of households registered with UNHCR is more stringent and considers protection factors so that registration cases are considered as separate households regardless of the common expenditure shared. Since the household definitions are not the same, this implies that some 'VASyR households' have more than one UNHCR registration case number. Establishing the limits of the household remains a challenge due to the high number of combinations that are found in the field.

The food security situation of Syrian refugees in Lebanon has deteriorated in the previous year. As savings and assets are being exhausted or becoming more limited, households engaged in more severe strategies to cope with the lack of food or money to buy food. These coping strategies included reducing expenses on health or education. The average household size is 6.6 members and generally, only one individual is able to work, mainly in temporary employment. This is insufficient to cover the US\$762 on average that a given household reportedly spends on a monthly basis. Also, about one fourth of households do not have any member working. Almost half of refugee households live below the poverty line of US\$3.84 per person day. Compared to last year, refugees depend more

on external sources of cash like WFP's food vouchers or loans, and less on skilled work or their own savings. Borrowing money is occurring more frequently and debt amounts are higher than last year. Female-headed households and single-headed households with dependents have also increased compared to 2013, exacerbating the difficulties to access work. Despite the fact that households are employing coping strategies, food consumption of most food groups as well as diet diversity has also reduced; this year, households are less likely to have acceptable food consumption. Expenditures on health, water and hygiene items have increased. This has occurred possibly in response to the reduction in hygiene and baby kits in-kind assistance and also to the water scarcity situation in Lebanon. In 2014, there are proportionally more refugee households without access to bathrooms, sufficient access to water, soap or hygiene items. The security situation is also deteriorating for Syrian refugees who experience an increasing harassment and extortion.

As the conflict in Syria continues and there is no expectation of an early resolution, the number of refugees in Lebanon continues to increase. It is estimated to reach 1.5 million registered by the end of 2014. It is expected that the Syrian refugees' living conditions will continue to deteriorate and the impact of the crisis will also worsen the situation for the most vulnerable Lebanese population. This will be compounded by the security situation, which is tenser in the last months due to the increasing number of refugees but also to the recent events in the northeast part of the country (Aarsal) as well as in Iraq. The combination of these ingredients constitutes a risky context for Lebanon's stability, especially if overall assistance is reduced by any given funding constraints.

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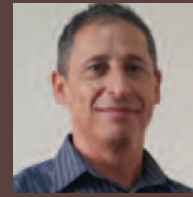
<sup>5</sup> Each sector proposed their key questions based on international agreements and tools but also considering the nature of the assessment and context (assessment at household level in urban and semi urban refugee population in a middle-income country) as well as the indicators used by the sectors for the regional response plan.

A Syrian mother from Homs, Syria bakes bread outside her shelter in Turbide, Bekaa, Lebanon

# Characteristics and challenges of the health sector response in Lebanon

Addario/UNHCR

By Frank Tyler



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Many thanks to all Lebanon health sector stakeholders that contributed to the Lebanon health chapters of the Multi Sector Needs Analysis (MSNA) and the regional resilience and response plan, which in part are summarised and referenced throughout.

*A Multi Sector Needs Assessment (MSNA) was conducted in 2014 by a team of UN agencies and NGOs and the findings shared by sectors in the form of chapters. The MSNA team aimed to provide an objective overview of the available data and Sector Working Group (SWG) views. It involved identification of information needs, secondary data collation, data categorisation, together with consultation with sector working groups. This article shares some of the key observations and recommendations emerging from this review which are documented in the MSNA Health Chapter<sup>1</sup>. It also draws on findings from a subsequent health access and utilisation survey by UNHCR in July 2014<sup>2</sup>.*

## The context

During the past two and a half years, Lebanon has experienced an unprecedented influx of refugees from Syria numbering over 1 million and projected to rise to 1.5 million. As of March 2014, Lebanon reached its 2050 projected population figure (4.6 million) and this will continue to increase over the next year. The population surge has put severe strain on finite resources, the already over stretched public services and the capacities of authorities at central and local levels. This strain is keenly felt in the health sector. The World Bank estimates that USD 1.5 billion (3.4% of Lebanon's GDP) will be needed to restore services to pre-crisis levels, of which USD 177 million is for health services alone. The Ministry of Social Affairs (MoSA) and Ministry of Public Health (MoPH) report an average 40% increase in the use of their services with ranges of between 20-60% across the country.

The Lebanese healthcare system is dominated by the private sector which is geared towards hospital-based curative care (48% of total public health expenditure) rather than primary and preventive health measures. The refugee crisis has exposed the fragile nature of the pre-existing public health system where 50% of the Lebanese population have no formal health insurance, are exposed to very high health care expenditures and lack basic means of social protection such as pensions and unemployment insurance. A struggle over access to public services that has seen a 40% increase in use (MoSA), is a key driver of increased tensions between host communities and the refugee population. Lebanese without private medical insurance rely upon the MoPH and the National Social Security Fund to reimburse a portion of their medical bills. Those on low incomes must often choose between

paying for health and for other necessities including food. According to the World Bank, the Lebanese social security systems, including health, are "weak, fragmented and poorly targeted".

## Challenges in coordination

The political landscape in Lebanon is dynamic. The unstable administration and the political divides in the Lebanese government meant there was a lack of an effective, rapid and strategic response to the refugee crisis. This vacuum with regard to the responsibilities and accountabilities of government actors, particularly at national level, resulted in the municipalities playing a greater role in responding to and coordinating the crisis. There is no national administrative or legal framework for the management of refugee affairs and the response to the refugee crisis must be coordinated across a number of Ministries. The central authority is weak, and with refugees scattered across the country, all activities on their behalf have to be carefully negotiated with local religious leaders and municipal representatives. Communities across Lebanon are largely confessional based and the same groups fighting each other within Syria are also present in Lebanon. All humanitarian efforts therefore have to carefully navigate a complicated web of often competing political agendas so as to ensure the real and perceived impartiality of the humanitarian response to ensure access and security of staff. The predominance of the private healthcare sector provides a unique situation compared to other humanitarian situations and hampers effective coordination of health services for refugee populations.

Under these circumstances, the UN System and the international community involved in

the humanitarian response established a mechanism to support government efforts in ensuring basic access to protection and assistance to the increasing number of Syrian refugees in Lebanon. UNHCR, in line with its mandated responsibilities, is the designated UN lead agency for the response to the Syrian refugee crisis and is ultimately accountable for the well-being of the refugees. UNHCR supports the Government in addressing existing gaps, and plays a lead role in coordinating the response to the Syrian crisis with other UN agencies, NGO partners, donors and local stakeholders<sup>3</sup>.

The UNHCR Mission in Lebanon was in operation with approximately 70 staff at the beginning of the Syrian crisis in May 2011, mainly catering for Iraqi and Sudanese refugees. Entering its fourth year in the Syrian crisis, UNHCR now have more than 600 staff throughout Lebanon supporting 1,154,580 registered refugees and almost as many vulnerable host populations. The UNHCR co-leads the health sector response with WHO. The health sector facilitates planning and strategy development, undertakes health assessments and analysis of needs, coordinates programme implementation, provides direct

<sup>1</sup> MSNA Health Chapter. Available at: <http://reliefweb.int/report/lebanon/msna-sector-chapters-health>

<sup>2</sup> Health access and utilisation survey among non-camp Syrian refugees. Lebanon, July 2014. <http://data.unhcr.org/syrianrefugees/download.php?id=7111>

<sup>3</sup> Dedicated coordinators lead working groups on protection, education, shelter, WASH (water, sanitation and hygiene), health, food security, core relief items and social cohesion and livelihoods. All sectors are co-led with other UN agencies: education and WASH with UNICEF, health with WHO, social cohesion and livelihoods with UNDP, and food security is led by WFP. OCHA, UNDP, UNRWA and IOM are also active in the country and participate in the coordination structure. Correct as of September 2014.

**Box 1: Services covered by UNHCR and partners**

- Consultation fees for primary healthcare services at UNHCR designated facilities are between 3-5,000 Lebanese Pounds (USD 2 to 3.3); the remainder of the cost is covered by UNHCR and other health partners.
- All routine childhood vaccinations are free for children <12 years.
- Medications for acute illness are free for all refugees at Ministry of Public Health (MOPH) and Ministry of Social Affairs (MOSA) linked clinics.
- For chronic medications, a handling fee of LP 1000 (USD 0.67) is paid by refugees for each refill of prescriptions.
- Family planning services including pills, condoms, insertion of IUDs are provided for free.
- Dental care is subsidised through designated primary healthcare centres.
- For lab and diagnostic tests, UNHCR covers up to 85% of costs for children <5 years old, seniors ≥60 years, and pregnant women; the remaining 15% is paid by the patient or other agencies. In certain instances involving refugees with special needs, the proportion paid by UNHCR and UNHCR partners can be increased to 90%.
- UNHCR pays up to 75% of the total cost of hospital services only if admission is for life-saving emergency healthcare, obstetric and neonatal care. Refugees and/or other agencies are expected to pay the remaining 25% of the cost. If expensive care (≥ USD 1500) is needed, treatment is first approved by an Exceptional Care Committee. The committee considers the need for, and adequacy of, the suggested treatment, the cost and the need for financial assistance, and feasibility of the treatment plan and prognosis.

Source: Health access and utilisation survey among non-camp Syrian refugees. Lebanon, July 2014

**Box 2: Sources of health information and data on Syrian refugees in Lebanon**

The three major national sources of health data and information in Lebanon are the UNHCR Health Information System (HIS), the Early Warning and Response Network (EWARN) and the GoL health monitoring system.

- *The Early Warning and Response Network (EWARN)* was established in 2007 by the MoPH, with support from the World Health Organization. This network monitors the number of persons affected by communicable disease across the country; it does not disaggregate by demographic groups as identified in the RRP.
- *The MoPH* operates its own system of routine health surveillance on communicable diseases, which sources information from hospitals and primary healthcare centres.
- UNHCR and six key partner agencies operate a refugee *Health Information System (HIS)* which covers a range of health conditions of Syrian refugees in selected PHC centres. Reports are on a monthly basis from areas across Lebanon. An annual report is produced.

Data on communicable diseases is provided by all three sources. Data and information regarding the magnitude and prevalence of NCDs and chronic conditions among refugees are provided by the UNHCR HIS. Information on NCDs among other vulnerable groups is limited.

monitoring, evaluation and reporting, and provides advocacy and resource mobilisation for refugees and host communities.

**Health service provision**

UNHCR's public health approach is based on a primary healthcare strategy. The Lebanese government and UNHCR in collaboration with partners provide healthcare services to Syrian refugees in Lebanon. In the highly privatised/fee charging health system context, refugees can receive care for free or at a subsidised cost at designated facilities across the country. Services covered by UNHCR and partners are summarised in Box 1. In addition, some health partners provide free access for Syrians to primary health care services.

The country has more than 950 dispensaries (offering limited services) and primary healthcare (PHC) centres (providing a range of services of variable quality). The MoPH has chosen 193 PHC centres to establish a primary healthcare network, of which more than 70% belong to non-governmental organisations (NGOs); many were established pre-crisis to fill shortfalls in the public health system. Less than 10% belong to the public sector (MoPH or MoSA). Public secondary and tertiary healthcare institutions in Lebanon are semi-autonomous and referral care is expensive<sup>4</sup>. Not all adhere strictly to the MOPH flat rate for hospital care. To harmonise access to secondary healthcare and manage costs, UNHCR has put in place referral guidelines in Lebanon<sup>5</sup>.

**Health sector issues of relevance to nutrition**

In terms of nutrition and health, key considerations are communicable disease (linked to a potential acute malnutrition risk), the prevalence and incidence of nutrition-related non-communicable disease (NCDs) (nutritional factors related to aetiology and/or management), reproductive health (influencing neonatal nutrition status and feeding modality), and access to primary health care services (support on breastfeeding, infant and young child feeding). Also healthcare costs may impact on household expenditure on food.

**Health information and data**

Sources of health data are summarised in Box 2. There are significant information gaps on health; the MSNA in March 2013 noted gaps in real time/up to date data for specific geographical areas (reporting is done on a national level with a time-lag of a few months), limited information on the prevalence and severity of health conditions such as NCDs and mental health issues across target groups, lack of information on utilisation rates of hospitals and response capacity in terms of quality of health services, availability of medications, and lack of data on how social determinants of health (e.g. education, shelter housing) are linked to the health status. Recommendations on health emerging from the MSNA included:

- To strengthen disease surveillance (EWARN), and the Health Information Monitoring

Systems of UNHCR and the MoPH.

- To establish a national population based health survey. This could be an expanded version of the UNHCR household assessment and utilization survey to provide a health and wellbeing profile of Syrian refugees and vulnerable host communities. This is planned for January 2015.

**Communicable diseases**

The top five communicable diseases/conditions are viral hepatitis A, mumps, dysentery, measles, and typhoid (EWARN system, October 2014).<sup>6</sup> To date, and to the credit of the humanitarian effort, disease outbreaks have been largely prevented. However, measles and increased risk of epidemics such as polio, and waterborne diseases remain. Data on immunisation and coverage rates in Lebanon prior to the crisis is of variable quality. Access to vaccination services have improved but vaccination coverage for measles and polio remains lower than the herd immunity threshold needed (90%)<sup>7</sup>. Deteriorating WASH conditions in informal settlements pose serious health risks for the spread of communicable diseases<sup>8</sup>. According to the UNHCR HIS annual survey 2013 (preliminary annual health report), consultations for acute illness were the primary reason for accessing healthcare, accounting for 74% of clinic visits. The same survey found that approximately 38% of visits for 33 acute illnesses were by children younger than five years (19% of population). Assessments in Beirut and its suburbs have found that 65% of Syrian refugee patients suffer acute illness, the most common being respiratory tract infections and skin infections<sup>9</sup>. The health needs among elderly Syrian refugees are particularly acute with limited access to care and medications<sup>10</sup>.

**Non-communicable diseases**

The demographic and disease profile of Syrian refugees is that of a middle-income country, characterised by a high proportion of chronic or non-communicable diseases (e.g. diabetes, cancer, cardiovascular and respiratory disease). Pre-crisis, 45% of all deaths in Syria were attributed to cardiovascular diseases (CVDs)<sup>11</sup>, half of 45-65 year old women had hypertension, and 15% of older men and women had ischemic heart disease. Type II diabetes was common (15% prevalence)<sup>12</sup>. In Lebanon, in line with rising population numbers, the incidence of

<sup>4</sup> Syrian refugees in Lebanon. Secondary and tertiary health care at a glance. January - June 2014

<sup>5</sup> See footnote 4.

<sup>6</sup> Republic of Lebanon Ministry of Public Health Notifiable Communicable Diseases <http://www.moph.gov.lb/Prevention/Surveillance/documents/lebanon.htm>

<sup>7</sup> See footnote 2.

<sup>8</sup> See footnote 1.

<sup>9</sup> Health Information System 2013

<sup>10</sup> Chahada N, Sayah H, Strong J Varady C (2013), *Forgotten Voices: An insight into older persons among refugees from Syria in Lebanon*, Caritas Lebanon Migrant Center.

<sup>11</sup> Maziak W, Rastamb S, Mzayekc F, Warda K, Eissenberg T, Keile U (2007) Cardiovascular health among adults in Syria: a model from developing countries. *Annals of Epidemiology*. 17(9): 713-720

<sup>12</sup> MEDCHAMP (2011) Project Title: Mediterranean studies of Cardiovascular disease and Hyperglycaemia: a analytical Modelling of Population Socio-economic transitions. European Union, 7th Framework programme.

various NCDs (cardiovascular, diabetes and hypertension) has risen; amongst older refugees, the prevalence of chronic diseases such as hypertension, diabetes, and cardiovascular diseases is high<sup>13</sup>.

A UNHCR survey in July 2014 found that 14.6% of households had at least one chronic condition amongst  $\geq 18$  years<sup>14</sup>. The proportion varied by age, increasing from 4.5% among 18 to 29 year olds to 46.6% for household members who were 60 years or older. The main reported chronic conditions were hypertension (25.4%), diabetes (17.6%), other cardiovascular disease (19.7%), lung disease (10.3%) and ischaemic heart disease (6.2%).

### Health care access

A UNHCR household health access and utilisation (HAUS) telephone survey of 560 refugee households was conducted in July 2014<sup>15</sup>. It found an estimated 12.1% of refugees needed health care services in the month before the survey and a majority (73.2%) were able to seek care mostly through a government-affiliated PHC facility (24.9%), private facilities (21.9%), NGO-operated PHC centres (15.2%), government hospitals (8.3%), traditional or religious healer (2.3%) and mobile clinics (0.2%). However, over half (56.1%) of Syrian refugees with chronic conditions were unable to get access to care. The main reasons were inability to afford fees (78.9%), long wait at the clinic (13.3%), and not knowing where to go (11.6%). The HAUS 2013 found broad improvement in level of knowledge about available healthcare services, such as vaccination, prescription procedures and costs of medications for acute and chronic conditions. However, overall the level of knowledge about available health services was low.

### Healthcare costs

According to the HAUS survey, refugees who needed care spent an average of USD 90 in the month preceding the survey. That is equivalent to an estimated expenditure of USD 12.1 million over 1 month by all refugees in the country. The main areas of expenditure were services and treatment at outpatient and inpatient centres (52.5%), outside facilities for medicine and supplies used for treatment (29.0%), transport (8.2%) and self-treatment (3.5%). To cope with the healthcare expenditure, refugees borrowed money (53.9%), used household income (39.4%), and/or relied on relatives or friends for payment (27.8%).

Referral for secondary and tertiary medical care is expensive. According to UNHCR analysis<sup>16</sup>, the estimated total hospital bill for January to June 2014 was USD17.5 million. The estimated share of the cost for UNHCR was 13.1 million (75%). The estimated annualised per capita hospital cost was USD37 per registered refugee. Approximately 48% of referrals were for obstetric care, followed respiratory infections (8%), gastrointestinal conditions (7%) and trauma and other injuries (7%). Deliveries (births) account for 92% obstetric admissions (92%); the caesarean section rate among refugees reduced from 35% to 32%<sup>17</sup>.

### The future

The longer term goal of the health sector's response is to deliver cost effective initiatives that reduce mortality and morbidity of preventable and treatable illnesses and priority NCDs and, to control outbreaks of infectious diseases of epidemic potential. The healthcare sector is exploring innovative healthcare delivery and financing models to ensure access to quality essential healthcare for the targeted population. As part of two year regional planning, a resilience component is bringing together a more aligned focus with development actors and funders. For example, the MoPH is being funded by the World Bank in the Lebanon Road Map Plan. New initiatives, such as the Instrument for Stability – Strengthening Health Care in Lebanon<sup>18</sup> are being established by the GoL in collaboration with UN agencies and the European Union to address tensions around access to healthcare between Syrian refugees and host communities in some areas. Additional priority health sector considerations centre on:

#### a) Primary healthcare

Healthcare is prioritised at the PHC level with emphasis on the quality of care, with a shift in focus from parallel healthcare services to providing intensified support through the expanding MOPH PHC network. The PHC network of centres of excellence will be supported to provide more comprehensive services for expanded numbers of patients with improvements in quality of care, availability of resources, number and quality of staff, minimum packages of services, community healthcare at the nursing educator level, community-based awareness for better health seeking behaviour, investing in performance standards and longer opening hours. This will benefit both refugees and the host population. The approach involves engagement with local civil society groups and facilities of the MoSA that work within the network and with private health care providers.

#### b) Hospital care

Referral healthcare to secondary and tertiary services continues to need improved support to cope with limited government finance and additional utilisation of Syrian refugees. The national referral system presents a number of challenges in terms of its approach to refugees entering into the system. Delivery care and its complications (obstetrics) account for nearly 48% of referral healthcare utilisation of Syrian refugees<sup>19</sup>. The health sector will continue to support the MoPH in assessing and improving alternative modalities for deliveries with a community based focus, with a view to decreasing the utilisation of high cost referral care and the medicalisation of normal deliveries for the target population. The health sector also supports the MoPH to reduce unnecessary referrals from PHC centres to reduce costs and improve efficiencies. Alternative solutions, such as strong advocacy for task shifting to allow a broader range of services that can be offered at the PHC level through PHC centres of excellence, the necessity of direct international procurement

of medical supplies, and allowance for foreign healthcare staff to work within Lebanon will continue to be explored within the MoPHs health plan. A major barrier to overcome is accessing the data on utilisation rates, which is deemed financially sensitive in Lebanon.

#### c) Disease control and outbreak prevention

Strong focus is being placed on ensuring disease control measures and that outbreak prevention is not only integrated within all outcomes of the health sector strategy, but is also a stand-alone outcome. Disease does not recognise borders or differing groups within the population. Infectious diseases in Lebanon of epidemic potential will be a threat to both Lebanese and refugees. Resources are devoted to institutional strengthening of the MoPH at the national and local levels. The MOPH health surveillance system and Disease Early Warning System (EWARS) continue to be supported for expansion and improvement. In addition, response plans and capacities are being further developed, particularly at the local level and in areas designated as having higher levels of risk of outbreaks.

Greater effort is being provided to ensure full coverage of routine vaccinations and appropriate vaccination campaigns are conducted where vaccine preventable disease risk is particularly high. Efforts to ensure cold chain logistics and management are maintained will be reinforced to obtain greater immunisation coverage which is of benefit to the entire population.

### Conclusions

The complex and highly privatised healthcare system in Lebanon in itself provides a major barrier to ensuring accessible, affordable and quality healthcare services, not only to the refugees but also host communities supporting them. If the health response budget is not achieved, this will greatly affect which groups can be covered by the response<sup>20</sup>. It would mean focusing entirely on ensuring access to the most vulnerable and emergency care only. The ability of the health actors to provide financial support to refugees to access health care services would have to be revised, exposing refugees to increased healthcare costs and rates of disease and illness. The health actors will need to maintain strong advocacy positions supporting the Government of Lebanon with respect to advantageous legal and political solutions that will allow for improved healthcare services and reduced financial demands on the response.

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<sup>13</sup> Forgotten voices. An insight into older persons among refugees from Syria in Lebanon. Caritas Lebanon. This report is summarised in this edition of Field Exchange.

<sup>14</sup> See footnote 2.

<sup>15</sup> See footnote 2.

<sup>16</sup> See footnote 4.

<sup>17</sup> See footnote 4.

<sup>18</sup> <http://www.emro.who.int/lbn/lebanon-news/improving-health-care-services-in-lebanon-in-the-context-of-the-syrian-crisis.html>

<sup>19</sup> See footnote 4.

<sup>20</sup> See footnote 1.

# NRC shelter programme in Lebanon

NRC, Lebanon, 2014

By the Norwegian Refugee Council, Lebanon and Jordan

*This article represents the combined efforts of many members of the NRC teams both in Lebanon and Jordan.*

The arrival of over one million refugees into Lebanon, a small country with just over four million residents, has outstripped the capacity of the local housing market to meet the escalating demands for shelter. Such demands have not been matched by supply. As a result, prices throughout the property markets have significantly increased and the consumer price index has registered a clear increase in rental costs since July 2012. Prices are likely to further increase as refugee numbers continue to rise and supply of suitable housing options remains limited. Increases in rent prices are also contributing towards the eviction of refugees, as landlords ask for higher rents which many refugees cannot afford. As resources are depleted, more people are likely to be forced to sleep on the streets.

The Norwegian Refugee Council (NRC)<sup>1</sup> is one of the largest humanitarian actors responding to shelter needs of tens of thousands of people affected by the Syrian crisis in both camp and non-camp settings in the neighbouring countries of Jordan, Lebanon and Iraq. NRC's shelter activities aim to facilitate both the physical and social needs of targeted beneficiaries. This article describes the shelter experiences of NRC in Lebanon, and includes a postscript on the NRC shelter approach in a Jordan as a further example of NRC's shelter programming in non-camp settings in the region.

## NRC's shelter programme in the Lebanese context

Since mid-2011, NRC Lebanon has been involved in the humanitarian response for refugees arriving from Syria. With an initial focus on the most immediate needs identified, NRC through its shelter programme has been a main actor in providing shelter solutions in the host community for displaced people from Syria, including for Palestinian refugees from Syria (PRS).

North Lebanon and the Bekaa Valley between them host the bulk of the displaced population,

where extremes of heat and cold make adequate shelter especially important. These areas are also substantially affected by the conflict in Syria spilling over the border and causing tensions between Lebanon's communities. South Lebanon and Beirut also host substantial numbers of displaced, and the Palestinian camps and gatherings<sup>2</sup> are usually the destination for PRS, exacerbating the already overcrowded conditions frequently found in those places.

In addition, there are 260,000-280,000 long-term Palestinian refugees in Lebanon. Living conditions in official camps and unofficial gatherings are substantially worse than in the country as a whole, with significant overcrowding and often inadequate infrastructure. The general prohibition on Palestinians owning property in Lebanon is interpreted in such a way as to make ad-hoc repairs and maintenance of their homes illegal, and this is often enforced. In Nahr el Bared camp, and in gatherings in South Lebanon, many buildings have not yet been rebuilt after the 2007 conflict, with former residents living in sub-standard temporary structures.

NRC assists displaced people from Syria who reside within the host community. They may live in homes shared with Lebanese or Lebanon-resident hosts, in unfinished buildings, in collective shelters or in other structures. They may also be homeless and seeking accommodation in the host community. They may be Syrian, PRS, or Lebanese citizens normally resident in Syria. NRC also assists extremely vulnerable members of the local Lebanese community. To date the displaced people have settled overwhelmingly (78%) in the host community, often supported by familial or co-religionist bonds but often also where these do not exist (and sometimes where these bonds are under strain due to the sectarian nature of, and Lebanese involvement in, the conflict in Syria). The economic and social burdens on the host community can be acute, especially in marginal border areas for

which cross-border trade was a core livelihood. The hosting sector needs support, both tangible and symbolic, in order to maintain its ability and willingness to host the displaced population.

For displaced people from Syria in the host community, NRC supports the hosting process by offering a package of upgrades for unfinished buildings and other structures in exchange for the rent-free hosting of a displaced household. The building upgrades package provides minimum standard shelter for the primary beneficiaries. This is rent-free for a period, usually one year, in which they have the possibility to become established and financially stable and so able to pay rent when the period is over. The provision of shelter with sanitation also gives the attendant health and security benefits. The Lebanese or Lebanon-resident hosts are supported tangibly, with the transfer of economic assets for the future, and visibly, by which the hosting sector as a whole may recognise that they are not bearing the burden alone. Most importantly, every housing unit created is added to the general rental stock, helping reduce the impact of inflation, benefiting displaced people from Syria who are renting and also Lebanese people living in the rental market. Bonds between the communities are strengthened and the risk of large-scale evictions is reduced. Since 2012, NRC Lebanon has rehabilitated over 6,800 housing units across Lebanon in exchange for 12-month occupancy free of charge periods for vulnerable refugee households. NRC Lebanon is currently planning to rehabilitate a further 3,600 housing units in 2015.

<sup>1</sup> For more information on the agency, see: <http://www.nrc.no/>

<sup>2</sup> "Gathering: It is a place of residence for Palestinians outside the refugee camps and includes 25 households or more living near each other, in the same neighbourhood. UNRWA does not serve the smallest gatherings." <http://www.fao.no/pub/rapp/418/418defeng.htm>. There are 12 official camps in Lebanon and 42 gatherings. UNRWA provides healthcare and education services to all Palestinian refugees, but housing, water and electricity are only provided to refugees residing in the official camps.



NRC, Lebanon, 2014

A building undergoing rehabilitation in Lebanon

An evaluation is planned for the last quarter of 2014. Because of restrictions of the kinds of work that refugees from Syria are permitted to do without a work permit (limited to unskilled labour such as agriculture and construction) coupled with the significant numbers of refugees competing to make a living, it is not certain that economic stability will be achieved. However anecdotal information from contracts already ended suggest that in some cases, refugees are able to negotiate to stay on in the accommodation that NRC has upgraded. The evaluation will help us to understand further.

### The shelter needs of Palestinian refugees from Lebanon

NRC also assists Palestinian refugees who have been resident in Lebanon since before the Syrian crisis, and are in need of shelter support. Many of these are second or third generation refugees. They live in official camps and unofficial gatherings – NRC works in the gatherings and is ready to assist in camps should United Nations Relief Works Agency (UNRWA) request it. Thirty-eight per cent of the 260,000-280,000 long-term Palestinian refugees in Lebanon live outside the formal camps and so are ineligible for full support from UNRWA and the rights and services it ensures. Residents are generally not permitted to repair buildings they do not legally own, and so the property stock is consequentially of a very low overall standard. As well as compromising their attainment of the right to shelter, there are implications in terms of health, security and economic well-being<sup>3</sup>. Since 2013, NRC Lebanon has supported over 2,000 Palestinians with direct shelter support in order to improve their living conditions. NRC Lebanon will continue with assistance to the Palestinian Camps and gatherings in 2015.

NRC acquires the necessary permissions and supports rehabilitation of these properties, setting a precedent for rehabilitation taking place while also advocating that this be allowed to happen

without NRC intervention. For the same reasons, NRC also works in the reconstruction of totally destroyed buildings (mainly those destroyed during the 2007 conflict in the Nahr el Bared camp) and the capacity building of beneficiaries (be it committees or individual families) on care and maintenance of the dwellings. In most cases, NRC resources the acquisition of building materials; the assistance does not extend to furniture, equipment, etc. Palestinian refugees benefit from rehabilitation or reconstruction of their homes which they could not carry out themselves, often for financial reasons but certainly for legal ones. They attain an improved standard of living with consequent health, security and economic benefits.

### NRC's selection of shelter beneficiaries

NRC selects its shelter beneficiaries based on vulnerability criteria, which include existing sub-standard living conditions and inability to find adequate shelter alone, female or child-headed households, disability and people with other special needs. An important aspect of NRC's shelter programme is to mainstream aspects of disability (physical, sensory and cognitive) and specific shelter needs related to severe medical conditions (injury, chronic disease). NRC tries, as much as possible, to match properties and families according to specific needs. For example, a household with a member with limited mobility would, wherever possible, be provided with accommodation on the ground floor. In addition, NRC's shelter teams have made specific adjustments to shelters to facilitate mobility and independence for beneficiaries with physical disabilities, such as constructing disabled access ramps to enable wheelchairs to move in and out of the house, or adjusting bathrooms for such purposes. An important element of NRC's programming is the consultation which the social teams carry out with disabled beneficiaries in order to understand from them – and their families where relevant and appropriate – how to best meet their specific needs.

### Looking ahead: a protracted shelter crisis

More than three years into the Syrian conflict, which has led to a protracted humanitarian crisis with regional dimensions, over 3 million people have sought safety and protection in neighbouring countries and North Africa. According to UNHCR, the average rate of monthly registrations continues to exceed 100,000 so far in 2014. In Lebanon alone, over one million UNHCR-registered refugees are living across the following four settlement options – 82% of Syrian refugees are in existing structures, 2% are in collective centres, 16% are in informal settlements and less than 1% are in formal settlements.

The lack of affordable housing has led to hundreds of thousands of refugees from Syria living in substandard, overcrowded and unsuitable accommodation without security of tenure and

exposed to risks of exploitation and forced eviction. Cycles of secondary displacement in Lebanon have been increasing, as refugee families move from place to place in search of adequate and affordable shelter and income generating activities. Recent NRC assessments indicate actual – or fear of – rising rental prices and competition to secure adequate housing as the two main areas of tension between refugees and host communities.

In Lebanon, where the government has not authorised the establishment of camps for Syrian refugees<sup>4</sup>, it is estimated that 67% pay rent for privately owned (finished) apartments, which equates to an estimated monthly minimum contribution of USD 32 million to the Lebanese economy. In addition, 14% are estimated to be renting unfinished buildings and another 14% pay rent in informal settlements, which are characterised by basic, self-built shelters with poor access to water and sanitation services and uncertainty over status of the land. The majority of the 52,000 Palestinian refugees who were displaced from Syria live in pre-existing Palestinian refugee camps and gatherings, hosted by Palestinian refugees already in Lebanon, increasing the strain on already overcrowded areas and on the limited services available.

### Depleted income and high cost of living

A November 2013 Oxfam survey on the livelihoods of Syrian refugees in Lebanon<sup>5</sup> found that, on average, monthly rent represented 43% of a Syrian refugee household's monthly expenditure and 90% of its monthly income. This is particularly significant because of the depressed Lebanese economy, lack of employment opportunities in Lebanon and increased pressure from the Lebanese authorities to minimise livelihood opportunities for refugees from Syria. While the main household expenditures are rent for shelter and food, the majority of refugees (almost 70%) do not receive shelter assistance and many are forced to pay rents they cannot afford. The impact of high rental costs on household food purchase was not examined in this study and we are not aware of any other study that looks at this. Other forms of humanitarian assistance, such as food and non-food items (NFIs), are further reducing through the targeted assistance programme, as humanitarian funding for Lebanon plans to reduce. When Syrian refugees were asked in a recent UNHCR (telephone)

<sup>3</sup> For more information, see the NRC report: No Place like Home: An Assessment of the Housing, Land and Property Rights of Palestinian Refugee Women in Camps and Gatherings in Lebanon, available at [http://www.flyktinghjelpen.no/arch/img.aspx?file\\_id=9166459&ext=.pdf](http://www.flyktinghjelpen.no/arch/img.aspx?file_id=9166459&ext=.pdf)

<sup>4</sup> On 11th September 2014, the Government of Lebanon announced its intention to set up two 'experimental' camps in border areas in the east of Lebanon.

<sup>5</sup> Available at: <http://www.oxfam.org/en/policy/survey-livelihoods-syrian-refugees-lebanon>

<sup>6</sup> The total percentages add to more than 100% because more than one answer could be given to the question as refugees may combine sources of income in order to pay for shelter.

survey about their sources of income to cover shelter and other living costs, 62% said their income came from their own earnings, 37% depended on humanitarian assistance and 18% borrowed money. A further 7% reported that their income came from their children working, 3% received assistance from family abroad and the remaining 4% responded 'other'<sup>6</sup>.

For refugees from Syria that have arrived across official border crossings (and are considered to have 'legal' entry and stay by the Lebanese authorities), the annual cost of renewing expired legal stay documentation (i.e. the residency permit for every person over the age of 15 years) is prohibitive (200USD). For those who entered Lebanon across unofficial border crossings, they are required to submit a 'petition of mercy' for the consideration of the Lebanese authorities. This is a discretionary procedure. If the conclusion is positive, then they are required to pay the equivalent of 600USD to regularise their status in Lebanon and obtain a residency permit for one year. The opportunity cost (see Table 1) demonstrates the difficult choices refugee families from Syria have to make when considering what to spend monthly income on.

**The risk of eviction for refugee families**

NRC has recorded an increase in cases of mass forced eviction of refugees from informal settlements, especially those perceived as becoming 'too permanent', as well as reports of higher rates of forced evictions of refugees from rental accommodation. Initial findings from a recent NRC assessment in Lebanon found that, like Jordan, the majority of Syrian refugees do not have secure tenure, are often at risk of forced eviction and that many are at risk of homelessness if they are evicted from their current shelter. In

**Table 1: Opportunity cost of paying the fee to renew legal stay for families deciding whether to renew residency visa documentation.**

The average family earns USD250 per month which they need to cover a range of household needs. The table below captures a selection of competing priorities for household expenditure, and gives an indication of what households consider when deciding whether they can afford to renew their residency visas.

Renewal of residency visa documentation (2 adults for one year)	Rent	Self-Built Shelter	Food	Fuel	Birth	Monthly Minimum Expenditure Basket (MEB)
USD 400	Equal to 4 months of rent for one room in an unfinished building	Equal to Material for 1 low standard shelter in an informal settlement	Equal to Food for 1½ months	Equal to Heating for 4 months	Equal to 1 non-caesarean birth in hospital	Equal to 55% of MEB

addition, from its fieldwork, NRC has noted that forced evictions are often related to disputes between refugees themselves or between refugee and host communities, often related to sharing utilities, the number of people living together or use of land.

**The lack of security of tenure**

For the purposes of this article, security of tenure refers to mechanisms to ensure protection against the threat of eviction or forced eviction. As the number of refugees who have to manage their own shelter situation is increasing, it is important to have an improved understanding of the circumstances leading to potential evictions (particularly forced evictions, where lawful procedures are not applied). In particular, refugees without any clear agreement with a landlord or landowner, such as a written lease contract, have been at a heightened risk of eviction. Being at risk of eviction and facing uncertainty about their living situation means that refugees do not have security of tenure. The risk of eviction concerns refugees living in all types of housing situations, including private apartments or houses, informal settlements or in collective centres on private or public land.

In order to understand these housing, land and property matters more, NRC initiated a pilot project in the Bekaa valley. Through the pilot project, NRC collected information and data in order to determine the most appropriate ways to respond to and prevent evictions. Qualitative and quantitative data were collected through 46 interviews with individual refugee tenants and six focus group discussions, including with landlords and tenants. Set out below are initial findings of the pilot project, regarding security of tenure and the role and importance of written lease agreements or other types of agreements between landlord and tenant:

- Syrian refugees face severe insecurity of tenure in their housing arrangements and state that they do not know where to seek help when they face a dispute and/or an eviction.
- All refugees who identified a current eviction or threat of eviction stated that they would be homeless as a result of an eviction.
- Refugees face significantly different challenges depending on whether they access

their housing through the private rental market or through informal settlements.

- Although written agreements contribute to improved security of tenure, the top two reasons that refugees hesitate to clarify rental terms with written agreements are:
  - Refugees are unaware of the benefits of a written agreement; and/or
  - Refugees are afraid to approach the landlord or the informal refugee representative (often known as a Shaweesh) about a written agreement.
- Landlords report that they are willing to sign a written agreement in order to protect their interests.
- Female refugees face specific protection issues that weaken their access to secure housing.

Preliminary results from a joint NRC and Save the Children assessment in Beirut and Mount Lebanon<sup>7</sup>, which is seeking to identify statistically relevant correlations between move outs (when tenants leave a property they have been renting) and host community acceptance, rental burden, and livelihoods, are:

- The majority of refugees in Beirut and Mount Lebanon believe they are at risk of eviction due primarily to unlawful rent increase and diminishing host community acceptance.
- The priority areas for intervention by humanitarian agencies in the opinion of refugees and vulnerable Lebanese communities in Beirut and Mount Lebanon are water and electricity projects in addition to improved living conditions (housing rehabilitation).
- Direct intervention with refugees would require strong contextual understanding which so far indicates that Community Support Projects (CSPs) are a key entry point to working in Beirut and Mount Lebanon in order to reach the most vulnerable refugee communities while relieving tensions with host communities.

For more information on the Lebanon programme, contact Neil Brighton, email: [neil.brighton@nrc.no](mailto:neil.brighton@nrc.no)

<sup>7</sup> The assessment comprised discussions with 668 refugee households as well as interviews with key informants in host communities.



An informal settlement in Lebanon



# Postscript

## NRC Jordan's urban shelter approach

*This article was developed from a case study produced by NRC.*

As in Lebanon, the influx of Syrian refugees into Jordan has put considerable strain on the local housing market. There are now more than 600,000 registered Syrian refugees in Jordan, 80% of whom are living outside of formal camps in cities, towns and villages throughout the country. The Syrian crisis has exacerbated the existing shortage of affordable housing in Jordan. The Government of Jordan noted that in the seven years prior to the Syrian conflict, the Jordanian housing market faced an annual shortfall of 3,400 housing units (a housing unit is defined as the space needed to accommodate an average family). To respond to growing shelter needs, NRC is putting new housing units on the market through an innovative integrated Urban Shelter programme which provides tangible support to Jordanian host communities while meeting the immediate shelter needs of vulnerable Syrian refugees.

An additional 120,000 new housing units are needed to accommodate the current numbers of Syrian refugees in Jordan. The refugee influx is now impacting poor Jordanian households with recent assessments indicating actual or fears of rising rental prices and competition to secure adequate housing as the two main areas of tension between refugees and host communities. Many Syrian refugee families are therefore struggling to find adequate and secure accommodation. In 2014, UNHCR noted that more than half of Syrian refugee shelters assessed outside of formal camps are substandard. For those managing to find accommodation, many are not able to pay rising rents, which in some refugee influx

areas has risen by more than 25% between 2012 and 2013. Syrian refugee families assessed by NRC often tell of multiple moves inside Jordan as they try to find adequate and affordable shelter impacting their ability to access basic services such as keeping their children in schools, stay connected to their family and support networks and crucially stay legal as they are required to update their place of residence on government-issued service cards in order to access local services.

NRC is providing financial incentives and technical support to Jordanian landlords in northern Jordan to bring new units onto the rental market. In return, vulnerable Syrian refugee families identified by NRC are provided with rent-free accommodation of between 12 – 24 months. Since July 2013, NRC has put an additional 1,500 housing units on the market, benefiting more than 5,000 Syrian refugees. NRC has more than 8,400 Syrian beneficiaries currently on waiting lists for the project now operating in 48 villages across the Greater Irbid and Jerash areas.

The Integrated Urban Shelter Programme is supported by NRC's Information, Counselling and Legal Assistance (ICLA) teams who conduct regular follow up house visits with beneficiaries to provide information and counselling and monitor and respond to any landlord-tenant relationships.

Unlike other shelter approaches (i.e. cash for rent or repair of substandard dwellings), this project crucially contributes towards the

creation of additional housing units. The development and increase of available and secure housing opportunities in local communities will help stabilise rents and reduce current inflation rates within the rental market – the main concern facing urban refugees and host community residents alike.

NRC Jordan currently has funding for 4,000 housing units by end of 2014. NRC estimates that it will have invested some USD 10 million (JOD 7 million) in the local Jordanian economy through construction materials, labour-costs and other income generating opportunities. NRC is the only organisation currently implementing this shelter methodology in Jordan. It is one of the key approaches outlined in the Syria Crisis Regional Response Plan (RRP) and highlighted in the Government of Jordan's National Resilience Plan (2014 – 2016). The project is being developed in collaboration with community-based organisations and in coordination with the relevant governmental departments.

For more information on the Jordan programme, contact Amjad Yamin: [amjad.yamin@nrc.no](mailto:amjad.yamin@nrc.no)

*For more information on the shelter response in the region, read: NRC, June 2014. A precarious existence: the shelter situation of refugees from Syria in neighbouring countries. <http://reliefweb.int/sites/reliefweb.int/files/resources/9179861.pdf>*

*For further information on NRC's shelter work, go to: <http://www.nrc.no/>*



NRC Jordan engineering team assessing unfinished housing units in northern Jordan

# Save the Children's child centred shelter programming in Lebanon

Community mobilisers from SC run a mobile Child Friendly Space during a distribution of shelter kits and NFIs in an Informal Settlement in Akkar District, North Lebanon

Ahmad Audi, SC Lebanon

By Thomas Whitworth



Thomas Whitworth is Save the Children Lebanon's Shelter and Non Food Items (NFI) Adviser and for the past 18 months, has led the Save the Children's Shelter and NFI programme in Lebanon. A civil engineer through training, he worked in the private sector. He has subsequently worked on a range of different responses, ranging from capacity building local staff in Libya, school construction in Liberia and South Sudan and building bridges in Vietnam.

The author gratefully acknowledges the contributions of Mais Balkhi, Danielle Fares, Dipti Hingorani, Dominic Courage and Valentina Bidone to the work reflected in this article.

Save the Children (SC) has been working in Lebanon since 1953. It has scaled up its operations in Lebanon significantly as a response to the huge needs created by the Syrian crisis. It currently employs 400 staff across four geographic areas of Lebanon. It has expanded the scope of its operations beyond its traditional mandate involving large Education, Child Protection and Child Rights Governance (CRG) programmes, to include Food Security and Livelihoods (FSL), Health, Water, Sanitation and Hygiene (WASH), Shelter and Non Food Items (NFIs).

SC began implementing its integrated Shelter, WASH and NFIs programme in November 2012 in response to the deteriorating living conditions being experienced by Syrian refugees and vulnerable Lebanese families in Lebanon. In 2013, SC provided assistance to 10,680 vulnerable families (57,930 individuals including 33,763 children). It is on target to assist a further 20,000 vulnerable families in 2014. As a non-traditional shelter actor, SC has brought a different perspective and way of working to the Shelter, Water, Sanitation and Hygiene (WASH) and non-food item (NFI) sectors in Lebanon.

## Context

As of 31st July 2014, the registered Syrian refugee population is 1,110,863 individuals.<sup>1</sup> In addition, there are thought to be a further 167,000 un-registered Syrian refugees, 17,000 Lebanese returnees from Syria and 53,070 Palestinian Refugees from Syria (PRS). This makes Lebanon the host of the largest number of refugees per capita in the world.<sup>2</sup> In addition, approximately the same number of vulnerable Lebanese individuals is likely to have been adversely affected by the crisis and there are estimated to be

between 260,000 and 400,000 Palestinian Refugees in Lebanon (PRL).

Lebanon was experiencing a shortage of affordable housing even prior to the Syrian crisis due to lack of a national housing strategy.<sup>3</sup> The large influx of Syrian refugees into Lebanon has resulted in further saturation of the regular rental market and rental inflation. The lack of adequate and safe shelter supply has pushed many of the poorest Syrian and Lebanese families into sub-standard shelters.<sup>4</sup> This has resulted in many thousands of families living in unhealthy, overcrowded and unsuitable accommodation where they are exposed to risks of exploitation and forced eviction.<sup>5</sup> Based on available data, it is estimated that approximately 750,000 individuals live in sub-standard conditions such as Informal Settlements (unplanned small camps), unfinished houses and converted garages.<sup>6, 7, 8 & 9</sup> UNHCR's own estimate is that the proportion of refugees living in sub-standard conditions will continue to increase dramatically in the coming 12 months.<sup>10</sup>

Despite its Mediterranean location, Lebanon's mountainous terrain leaves it exposed to low temperatures and relatively high rain and snowfall.

Zahle (Bekaa Valley, eastern Lebanon), for example, experiences around 600mm of rain and seven days of snowfall per winter. Temperatures regularly drop below 0 degrees centigrade from November to March.<sup>11</sup> Approximately 40% of the refugee population inhabit shelters without adequate protection from these severe conditions, 25% of refugees don't own blankets and 40% don't own winter clothing.<sup>12,13</sup> Acute respiratory tract infections were the leading cause of morbidity (35%) amongst Syrian refugees from January to March 2014 inclusive, largely as a result of cold, wet and sometimes smoky living conditions.<sup>14</sup>

To date, the Government of Lebanon has not sanctioned large-scale formal camps. One of the outcomes of this policy is that the Syrian Refugee population is dispersed amongst 1,700 different communities throughout Lebanon. Though this may allow the better integration of some refugees into host communities, it also creates challenges for non-governmental organisations (NGOs) in terms of access, understanding needs and the delivery of assistance. Many of the refugees are hidden amongst the host population which adds challenges to the identification of specific needs.

The majority of refugees have accessed their shelter through existing informal market channels.<sup>15</sup> The low income rental market is subject to limited regulation and legal protection. It is considered dysfunctional and irregular but highly profitable to a minority. A recent market assessment has shown that refugees typically pay higher-than-average market prices for often very poor forms of shelter.<sup>16</sup> Families pay between \$50 to \$150 USD per month for a plot in an Informal Settlement and between \$100 to \$200 USD per month to live in a sub-standard buildings

<sup>1</sup> Syrian Refugees Registered in Lebanon (UNHCR, July 2014)

<sup>2</sup> The number of Syrian refugees in Lebanon passes the 1 million mark (UNHCR, April 2014). Retrieved from [www.unhcr.org/533c1d5b9.html](http://www.unhcr.org/533c1d5b9.html)

<sup>3</sup> A Precarious Existence; The Shelter Situation of Refugees from Syria in Neighbouring Countries (NRC, June 2014)

<sup>4</sup> Development of a Framework for Multipurpose Cash Assistance to Improve Aid Effectiveness in Lebanon: Support to the Market Assessment and Monitoring Component (KDS, July 2014)

<sup>5</sup> A Precarious Existence; The Shelter Situation of Refugees from Syria in Neighbouring Countries (NRC, June 2014)

<sup>6</sup> Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)

<sup>7</sup> Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)

<sup>8</sup> Household Database (SC Lebanon, 2014)

<sup>9</sup> Mapping of Sub-standard Buildings (SC Lebanon, 2014)

<sup>10</sup> Shelter Update (UNHCR, May 2014)

<sup>11</sup> Annual Average Meteorological data (American University of Beirut)

<sup>12</sup> Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)

<sup>13</sup> Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)

<sup>14</sup> July Quarterly Regional Analysis Syria (RAS) Report (Syria Needs Analysis Project, July 2014)



(e.g. a converted garage or to share part of an unfinished house).<sup>17</sup> Rent typically accounts for a quarter of a refugee family's expenditure.<sup>18</sup> The supply of adequate housing is relatively inelastic resulting in competition between Lebanese and Syrians, and ever increasing rents.

The Syrian crisis is now well into its fourth year. Consequently, it is widely recognised that the humanitarian sector needs to adapt its programming to address the needs of a protracted crisis. However, considerable peaks in emergency needs remain, as demonstrated by the internal displacement caused by recent armed conflict in Aarsal (Bekaa Valley).<sup>19</sup> It is likely that the on-coming winter will again highlight the severe life-threatening needs experienced by many vulnerable Syrian refugee and Lebanese families.

### Save the Children's shelter approach

The Save the Children shelter team was established in November 2012. To date, it has provided shelter, NFI and WASH assistance to over 20,000 of the most vulnerable families in Lebanon (over 100,000 individuals). SC has focused its interventions in the sub-standard buildings (unfinished houses, converted garages, abandoned buildings, etc.) and Informal Settlements. These shelter-types represent 25% and 15% respectively of the registered Syrian refugee population accommodation and also house Palestinians, Lebanese returnees and an increasing number of economically vulnerable Lebanese.<sup>20</sup> SC provides five different packages of assistance depending on the needs and circumstance. These are summarised in Table 1.

Children are always amongst the most vulnerable in an emergency. Shelter may not initially appear to have a direct link to SC's core mandate. However, in the context of Lebanon, shelter is a life-saving sector for children. Under-5s and pregnant women are amongst the most vulnerable to the effects of sub-standard living conditions. These include respiratory diseases due to cold and wet living conditions and diarrhoea and other water-borne diseases due to poor access to safe water, sanitation and hygiene practices. A lack of physical protection to cold and wet conditions for under-5s can cause developmental problems in later life.

Based on an analysis of available data, there are a higher proportion of children living in sub-standard conditions when compared to other refugees and Lebanese families. This is due to a correlation in family size, socio-economic vulnerability and shelter-vulnerability. The average

family living in sub-standard shelter has one additional member (6 instead of the overall average of 5) who is typically a child.<sup>21,22,23</sup> Therefore, children are the worst affected by poor-living conditions and represent a disproportionately large part of the affected population.

SC has implemented a large-scale shelter programme in order to address one of the core needs of children in Lebanon. The programme is designed to alleviate the health and protection vulnerabilities that are most severe for children through improving physical protection to cold and wet weather, providing security and privacy and increasing access to safe water and sanitation. Addressing the basic needs of children and their families can reduce negative coping mechanisms (such as child labour and early marriage) and increase investment in human capital such as education and health care.

As a non-traditional shelter actor globally, SC was able to break away from the "business as usual" mind-set associated with more typical humanitarian contexts. Key elements of SC's Shelter and WASH programme that were tailored to the specific context of the Syrian crisis in Lebanon are outlined below.

**a) Supporting Lebanese and Syrians.** The vast majority of Syrian refugees live in the same communities as the majority of economically poor Lebanese.<sup>24</sup> An increasing number of vulnerable Lebanese are being forced to live in sub-standard conditions. They face many of the same issues as Syrian families. SC targets its beneficiaries on need alone and regardless of nationality.

**b) Targeting the most vulnerable families.** SC provides assistance to the most vulnerable families living in the worst conditions. Families who have limited access to economic opportunities or have a large numbers of children and dependents are typically the most affected by the scarcity of adequate, affordable accommodation. Selection is based on a combination of:

- Socio-economic vulnerability, as defined by the Targeting Task Force. This is the inter-agency agreed tool for selecting families for multi-purpose cash assistance. It provides a vulnerability score based on the family's composition, economic vulnerability and specific needs<sup>25</sup>.
- Shelter-vulnerability, as defined by simplified criteria that ranks the families existing living conditions (protection to poor weather, security, safety, privacy, action to safe water, sanitation and hygiene conditions).

**c) Community outreach.** All shelter programming is delivered as a household-level response which allows us to target the most at risk families, build relationships and trust with them and the host communities. All field staff are trained in child safe-guarding, key messaging for Child Protection and basic identification of Child Protection vulnerabilities. Through this approach, the Shelter and WASH field teams are able to identify specific vulnerabilities and make referrals to other services such as the SC Child Protection Case Management team and health providers. Eighty per cent of the Akkar Case Management cases were referred by the SC Shelter and WASH team. The highly visible nature of shelter and WASH programming can be a very strong entry point for more "soft" programming.

**d) Working in the most challenging environments.** Lebanon is a very diverse country and is home to a large range of different economic conditions and religious and political confessions. Through supporting both Syrian and Lebanese families and building strong relationships at community level, SC was able to access some of the most challenging geographic areas in Lebanon where many other agencies have faced challenges. SC was the first agency to respond to the then unmet shelter needs in the Informal Settlements at scale.

**e) Occupied buildings.** As discussed previously, the vast majority of refugees have accessed their shelter through market channels and are party to an informal commercial arrangement with their landlord. Analysis of SC Lebanon's household database indicates a strong correlation between socio-economic vulnerability and shelter vulnerability. Consequently, many of the most severely vulnerable families are living in the worst conditions. Though SC would always aim to provide above the appropriate minimum standards, assistance is sometimes constrained by practical limitations or the landlord's own requirements. In some extreme cases, we have to recognise the need to improve the worst con-

<sup>15</sup> Housing, Land and Property (HLP) Issues in Lebanon – Implications of the Syrian Refugee Crisis (UN-Habitat & UNHCR, August 2014)

<sup>16</sup> Development of a Framework for Multipurpose Cash Assistance to Improve Aid Effectiveness in Lebanon: Support to the Market Assessment and Monitoring Component (KDS, July 2014)

<sup>17</sup> A Precarious Existence; The Shelter Situation of Refugees from Syria in Neighbouring Countries (NRC, June 2014)

<sup>18</sup> Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)

<sup>19</sup> Inter-Agency Update on the Situation in Aarsal & Surrounding Areas (UNHCR, August 2014)

<sup>20</sup> Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)

<sup>21</sup> Syrian Refugees Registered in Lebanon (UNHCR, July 2014)

<sup>22</sup> Survey on the Livelihoods of Syrian Refugees in Lebanon (Oxfam, November 2013)

<sup>23</sup> Winterisation Cash Transfer Programme. Impact Evaluation Report (IRC, August 2014). See also article in this edition of Field Exchange.

<sup>24</sup> Equity in Humanitarian Action - Reaching the Most Vulnerable Localities in Lebanon (UNICEF and UNHCR, August 2014)

<sup>25</sup> For cash assistance see article by Isabelle Pelly in this 48th edition of Field Exchange.

ditions without necessarily being able to achieve “minimum” standards. Household interviews have demonstrated that the majority of beneficiary households would prefer to remain in sub-standard shelters rather than be relocated away from their support networks and informal protection mechanisms. As agencies are not working in the “traditional” camp context, we have to deal with much more variable conditions where a “one size fits all” intervention is not applicable.

**f) Integration.** SC Lebanon provides an integrated package of shelter and WASH assistance. This is part of the wider country programme strategy to address the holistic needs of vulnerable children and their families. Through rehabilitating a shelter, immediate shelter and WASH needs are addressed. By providing security of tenure fear of eviction is reduced and a family has greater stability and is able to plan and engage in income generating activities which in turn reduces reliance on negative coping mechanisms. The household’s resilience increases whilst the overall shelter capacity of the community is given a lasting investment and improvement.

**g) Emergency and long-term solutions.** SC provides a range of shelter and WASH assistance packages in order to provide effective assistance to vulnerable families across a range of circumstances and level of needs. SC’s programme provides emergency life-saving interventions (e.g. weather-proofing) through to programmes that provide long-term stability and shelter capacity (e.g. rehabilitation) as there is a strong need for both.

## The way forward

The registered Syrian refugee population is continuing to grow and is projected to reach between 1.5 and 1.8 million individuals by the end of 2015<sup>26</sup> whilst the funding climate is likely to become more challenging. Despite the best efforts of humanitarian agencies, living conditions for many Syrian and Lebanese families are continuing to deteriorate.<sup>27</sup> Consequently, agencies need to amplify the impact of their programming with limited resources by reducing their cost base, increasing efficiency and maximising effectiveness. Many agencies are already looking to improve their evidence base, gap analysis and use more specific targeting of communities and beneficiary households. However, a shift in sector strategy is also needed in order to successfully assist the most vulnerable whilst also contributing towards increased social cohesion and stabilisation.

Three and a half years into the crisis, the majority of inter-agency shelter programming remains focused on addressing immediate needs rather than addressing the underlying causes of poor living conditions and escalating rents. Future programming needs to redistribute its allocation of resources in order to focus more on increasing long-term, adequate shelter capacity.<sup>28</sup> A sharp rise in social tensions between Syrian and host communities is considered very likely in next six months which will have a major humanitarian impact.<sup>29</sup> This reduction in host community acceptance is likely to result in an increase in forced evictions which in turn

is likely to cause increased humanitarian needs. SC is planning to encourage social cohesion and host community acceptance through layering its household-level shelter interventions with Community Support Projects (CSPs) that can provide much needed upgrades to host community infrastructure (e.g. water supply, sanitation networks, drainage rehabilitation, electricity supply, etc.) and increased livelihoods opportunities. This will be coupled with programming to improve security of tenure through improved information sharing and increasing the use of formal rental agreements.

The year 2013 saw many agencies scale up their operations in Lebanon at an unprecedented scale; 2014 has seen many consolidate and improve the quality of those same interventions. The year 2015 will require SC and other agencies to go beyond the standard shelter and WASH activities in order to address the escalating needs faced by Lebanon and Syria’s children.

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<sup>26</sup> RRP6 projections

<sup>27</sup> Housing, Land and Property (HLP) Issues in Lebanon - Implications of the Syrian Refugee Crisis (UN-Habitat & UNHCR, August 2014)

<sup>28</sup> Housing, Land and Property (HLP) Issues in Lebanon - Implications of the Syrian Refugee Crisis (UN-Habitat & UNHCR, August 2014)

<sup>29</sup> Scenarios – Where is Lebanon Heading (Syria Needs Analysis Projects, August 2014)

**Table 1: Summary of activities**

Intervention/ Output	Shelter Component	Wash Component	Modality	Indicative unit cost \$ USD /household	Lifespan	Delivery time <sup>1</sup>	Informal settlements	Unfinished houses, etc.	Outline description	Advantages/Disadvantages
Weather-proofing in Informal Settlements	✓	✗	In-kind kit	\$150 direct (\$250 total)	6 to 12 months	3 months	✓	✗	Families in Informal Settlements or scattered tents receive a shelter kit (plastic sheeting, timber, tools, etc.) to allow them to repair, reinforce or extend their existing shelter	<ul style="list-style-type: none"> <li>✓ Relatively cheap and quick</li> <li>✓ Doesn't require any formal approvals</li> <li>✗ "Temporary"</li> <li>✗ Only partially addresses core needs</li> </ul>
Temporary Emergency Shelter (i.e. Full Shelter Kit)	✓	✗	In-kind kit	\$400 direct (\$600 total)	2+ years	3 months	✓	✗	Families who are without shelter receive a full shelter kit in order to build a tent in an Informal Settlement	<ul style="list-style-type: none"> <li>✓ Relatively cheap and quick</li> <li>✓ Doesn't require formal approvals</li> <li>✗ "Temporary"</li> <li>✗ Only partially addresses core needs</li> </ul>
Site Improvements	✓	✓	In-kind & casual labour	\$150 direct (\$250 total)	2+ years	3 months	✓	✗	Communities implement semi-permanent site improvements to Informal Settlements in order to reduce health and safety risks and improve the basic quality of living	<ul style="list-style-type: none"> <li>✓ Relatively cheap and quick</li> <li>✓ Give major improvement in living conditions and is highly visible</li> <li>✗ "Temporary"</li> <li>✗ Only partially addresses core needs</li> </ul>
Emergency Shelter & WASH	✓	✓	Voucher	\$250 direct (\$400 total)	2+ years	3 months	✓	✓	Families in Unfinished Houses and Converted Garages receive a voucher that can be redeemed for Shelter and WASH materials that address their individual immediate needs	<ul style="list-style-type: none"> <li>✓ Relatively cheap and quick</li> <li>✓ Doesn't require any formal approvals</li> <li>✗ "Temporary"</li> <li>✗ Only partially addresses core needs</li> </ul>
Rehabilitation	✓	✓	Conditional cash grant (3 tranches)	\$1,500 direct (\$2,350 total)	5+ years	6 months	✓	✓	Families living in Unfinished Houses and Converted Garages receive a conditional cash grant to upgrade their shelters. This is given in exchange for a 12 month period of secure tenure and a rental reduction negotiated with the landlord	<ul style="list-style-type: none"> <li>✓ "Permanent" improvement in living conditions</li> <li>✓ An investment in Lebanese infrastructure</li> <li>✓ Secure tenure for the beneficiary family</li> <li>✓ Rental reduction</li> <li>✗ Relatively expensive and slower</li> <li>✗ Required formal approval process</li> </ul>

Source: Thomas Whitworth, Shelter Advisor, Save the Children Lebanon. 22nd August, 2014

<sup>1</sup> Excluding preparatory works (e.g. recruitment, procurement, etc.)

Hygiene promotion with Syrian refugees



ACH Lebanon

# Competing for scarce resources: the new concern for Syrian refugees and host communities in Lebanon

By Bassem Saadallaoui



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## WaSH context and ACF intervention: The state of play

The Water and Sanitation sector in Lebanon has constantly faced several challenges in terms of resources, capacities and management. Indeed, water access remains always the main concern for service users living either in a refugee settlement or in one of the Lebanese towns. The Syrian conflict has resulted in a series of massive influxes of refugees in 1,500 different areas in Lebanon with a concentration of 62% in Bekaa and the North<sup>1</sup>. According to the United Nations High Commissioner for Refugees (UNHCR), there are 1,119,585 Syrian refugees in Lebanon (30th of June 2014), including 48,783 waiting for registration. This significant figure is added to the 4.5 million Lebanese<sup>2</sup> already struggling to acquire water and sanitation services at the community level. According to the Lebanon Country Water Sector Assistance Strategy 2012-2016, the deficiency of water supply networks, the imbalance between seasons and the fast rising demand (communal and industrial) are leading to chronic water shortages<sup>3</sup>. Already, dry season shortages are emerging and water quality is deteriorating. For instance, tap water is intermittently available and the general public perception of water quality is not positive. A Knowledge, Attitude and Practices (KAP) survey conducted in some vulnerable refugee settlements in central and western Bekaa affected by the water scarcity, found that more than half (51%) of households considered available water as unsafe. Host community and Syrian refugees have already started to compete for rare resources, such as water, food and accommodation, as well as basic facilities, such as municipality solid waste disposal, and other services, e.g. water trucking and latrines (toilets) desludging.

## ACF WaSH programme

Action Against Hunger (ACF-Lebanon) started to support the affected population at the beginning of the Syrian conflict. The beneficiaries are not only the Syrian refugees fleeing the war in their country but also the Lebanese

community and governmental institutions, such as Bekaa Water Establishment and several municipalities in Bekaa and South Lebanon. According to ACF WaSH assessments conducted inside informal tented settlements (ITS) and collective shelters, the main identified needs are associated with access to safe water and sanitation infrastructures.

In terms of water, ACF has followed a household approach. In practice, each tent may be occupied by more than one household. The average household size is roughly five members and may be up to 14 in some cases. Given the significant need, ACF established a priority list according to vulnerability criteria based on the level of access to basic services. Families with lowest access to water and sanitation facilities are prioritised with a short timeframe of intervention. The beneficiaries are provided with water tanks in order to increase the storage at household level; water tanks were distributed as a practical and successful solution during a snowy winter to help beneficiaries ensure a minimum quantity of water at household level. During this time, the water trucking services were reduced due to slippery roads and communal water tanks and tap stands were frozen. These water tanks have also proved a useful solution to ensure household storage during times of water shortage in the summer. Indeed, it was observed that beneficiaries' water consumption is more rational when it comes to their own reserves.

A recent survey conducted in several ITS in central and western Bekaa showed that the average water consumption inside the settle-

<sup>1</sup> UNHCR. (2014). Lebanon. Récupéré sur Syria regional refugee response: <http://data.unhcr.org/syrianrefugees/country.php?id=122>

<sup>2</sup> World Bank. (2012). Lebanon Country Water Sector Assistance Strategy. Middle East and North Africa Region: Sustainable Development Department.

<sup>3</sup> World Bank. (2012). Lebanon Data. Récupéré sur World Bank Data: [http://data.worldbank.org/country/lebanon#cp\\_gep](http://data.worldbank.org/country/lebanon#cp_gep)

ments is 63 litres/per person/per day<sup>4</sup> which is well above the standard of 35 litres/person/day suggested by the WaSH sector in Lebanon. Moreover, the survey showed a large disparity in water consumption, from less than 35 litres/p/day to more than 120 litres/p/day depending on the family's social level (according to vulnerability assessments) or habits (daily cleaning in front of the tents using water). However, 23% of ITS households are still below the standards of the WaSH sector due to limited access to water sources (scarcity or absence of resources, shared resources, and conflict with landlords).

ACF is working to improve the water access situation of these households by compensating with water trucking action as a short term action and by rehabilitating the existing water points and networks in coordination with Bekaa Water Establishment and the concerned municipalities. For instance, ACF identified some non-operational wells and boreholes in Taanayel, KamdEl-louz and Arsaland and has plans to rehabilitate them (cleaning, chlorination and protection) in order to increase the water resources inside the settlements and local populations. Moreover, 27% of ITS households in Central and Western Bekaa are using the Bekaa Water Establishment network in one way or another<sup>5</sup>. These 27% represent a huge unexpected number that disrupts the normal functioning of the public network. As described previously, the public network is already facing challenges (quantity, quality, management) and it is unable to fulfil the entire host community needs. Likewise, the municipalities are taking care of more than 70% of the solid waste disposal resulting from the different ITS. The average disposal price is 15\$ per ton. Given that a municipality disposes of a minimum of eight tons per day, we can imagine the extra funds and resources required to meet the new needs.

All this highlights how the Syrian crisis has amplified existing challenges. Besides, water quality remains the major concern for Syrian refugees in the tented settlements. Most of the

households cannot afford bottled water, especially the large families. During the emergencies and the first days of establishing in Lebanon, households are obliged to use the existing water sources for drinking. To avoid diarrhoea and other water related diseases, ACF provided all the beneficiaries with ceramic water filters. The advantage of these filters is the ease of maintenance and the practical replacement of ceramic candles, which are available in the local market at affordable prices. The average life duration of the ceramic candles is one year if well maintained. Nevertheless, 28% of water filter users in Central and Western Bekaa confirmed they never maintained their filters due to lack of time and/or lack of knowledge; this is despite several awareness sessions conducted by ACF to familiarise the households with filter use and maintenance.

In addition to ceramic water filters distribution, ACF used to undertake bacteriological and chemical water analysis on different samples collected at household level, water point level and even from the public network. At the beginning of the intervention, it was easy to send all the water samples to be analysed in the few private laboratories in Bekaa but with the increasing number of ITS, the number of samples grew to the degree that the laboratories could no longer absorb them. Thus, ACF established its own in-house water analysis laboratory with a capacity of more than 80 water tests per day. ACF observations and field experience showed that most of the Syrian refugees have a minimum background level of hygiene practices. However, a survey found that 14% of households did not know the risks or diseases related to the consumption of unsafe water.

### The 'software' side of WaSH programming

The software component of ACF intervention represents an important part of the response to raise awareness concerning the rational use of water and the establishment of best hygiene practices. In each tented settlement, ACF estab-

lished a WaSH committee composed of five members, including at least two women. The role of the WaSH committee is to ensure good communication between the ACF field team and the beneficiaries inside the tented settlements, to inform ACF about newcomers and urgent needs in the settlement and to reiterate the hygiene practices and other messages among beneficiaries.

Furthermore, the entire WaSH component came to support the nutritional intervention by maintaining continuous access to safe water and hygienic sanitation at the nutrition child-friendly tents established by ACF in different tented settlements in Arsaal (see field article in this issue regarding the programme). Additionally, an ACF/UNICEF WaSH intervention is currently ongoing, to deliver access to WaSH facilities in NFE Schools (Non Formal Education Schools) located inside or nearby settlements for children between 5 and 12 years old. ACF provided the informal schools with necessary water storage, water filters, hand-washing points, hygiene kits, latrines and desludging services, in order to keep a hygienic environment and avoid water related diseases among more than 5,000 children in Bekaa.

### Linking relief, rehabilitation and development

ACF is convinced that supporting the host community in Lebanon is a part of the mid-term and long-term solution to the crisis. With the financial support of the European Commission (ECHO) and in collaboration with Bekaa Eater Establishment and the municipalities of Sarayin, Tamnin El Tahata and Torbol, ACF managed to identify four structural projects consisting of the construction and the equipping of two new deep boreholes, the rehabilitation of a 100m<sup>3</sup> water reservoir and the rehabilitation of an existing pumping station. These identified actions

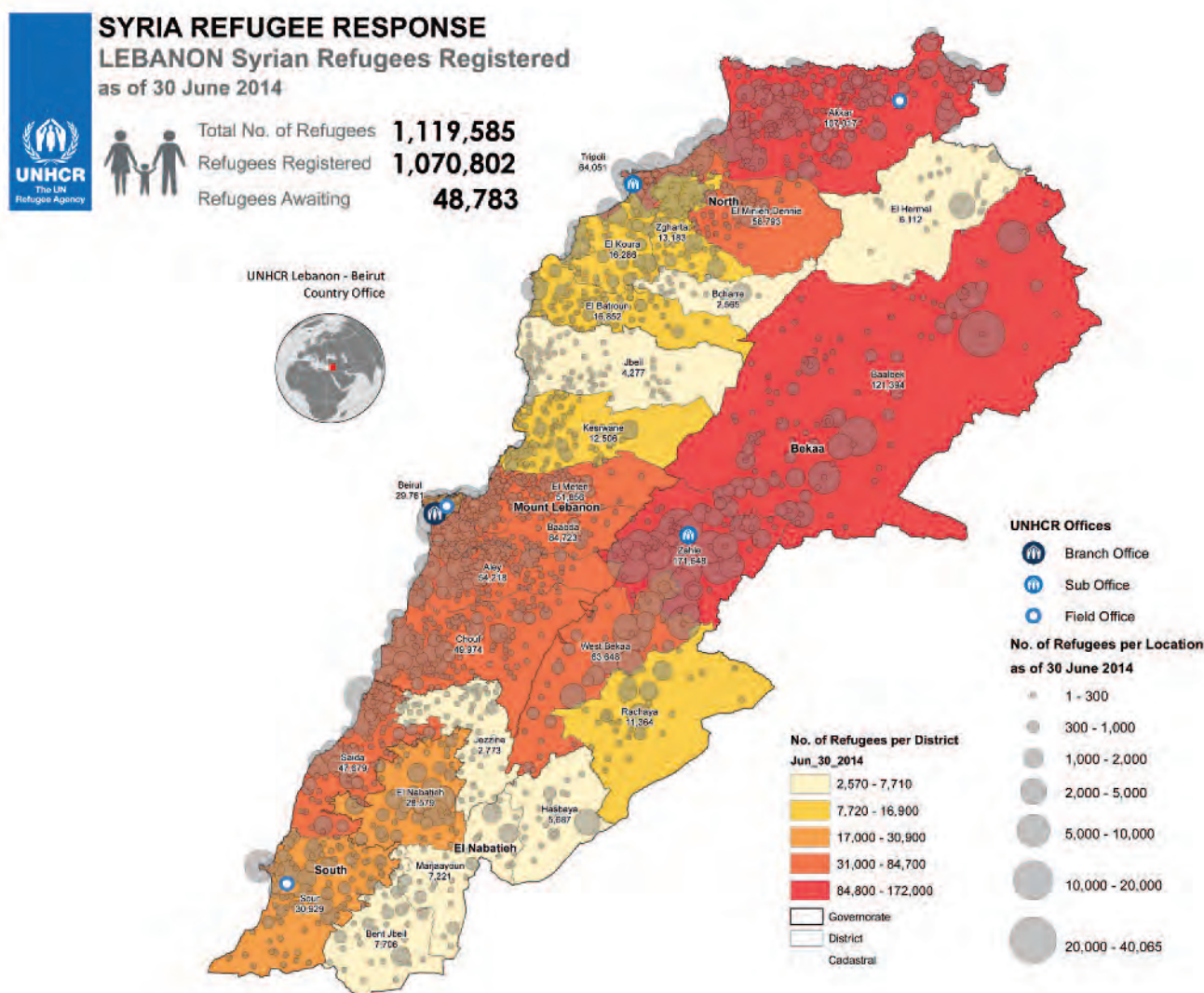
<sup>4</sup> ACF. (2014). Humanitarian WASH Response to the conflict affected population in Bekaa Valley. KAP Survey.ACF.

<sup>5</sup> See footnote 4



Latrine installation

Map 1: Concentration of Syrian refugees in Lebanon (June, 2014)



will increase the public network capacity and therefore, improve the water access to both Syrian refugees and the host community. Moreover, ACF executed a sewage network rehabilitation project that allowed the municipality of Ghazze to reduce the risk related to the non-functional sanitation network and allowed host community and three existing schools to connect to the new sewage line with a total number of 8,000 beneficiaries. While desludging services were the fastest and easiest solution to keep a hygienic environment inside the tented settlements, the high cost of this solution made it non-sustainable. Furthermore, the huge number of latrines and the limited capacity of the sewage network made the sludge disposal more complicated. The minimum cost of one latrine desludging service is about 15\$ and the total amount can amount to millions of dollars, knowing that for every 15 to 20 persons, there is at least one latrine that should be desludged every month. Latrine desludging is not an environmentally friendly solution. Indeed, a considerable amount of black water is thrown into the Litani River, which is Lebanon's largest river feeding an important part of Lebanese agricultural lands. ACF added a contractual ob-

ligation to incite desludging service providers to discard the collected black water into the dedicated treatment plants.

**Coordination saves lives**

In the midst of all the WaSH responses provided by the different international and national non-governmental organisations (NGO'), the need for coordination seems to be vital. Indeed, a few days after the beginning of the Syrian conflict, hundreds of local and international organisations started emergency response by providing water, sanitation, hygiene promotion, shelter, education and health services. In terms of WaSH activities, it was difficult for the different organisations to understand who was doing what and where. For instance, some water tanks were distributed in the same locations by different NGOs. Water trucking services were provided by different suppliers funded by different NGOs in the same settlement, which made the quality control of water very difficult. In term of non-food items distribution, such as hygiene kits and winterisation kits (e.g. blankets and stoves), double distributions encouraged the beneficiaries to sell items on the local market.

The WaSH sector, led by UNHCR and co-led by UNICEF, has a coordination role helping the organisations understand who is doing what and where and also organising the geographical targeting according to the needs. ACF was one of the international organisations involved in the water scarcity task force led by UNHCR and UNICEF and has already started to rehabilitate existing water points, repair some broken pipes and create new boreholes to increase the existing capacity. The WaSH sector coordination played an important role in the harmonisation of awareness messages between all the NGOs, which are mainly related to water saving, the best hygiene practices and health messages among beneficiaries. Moreover, the WaSH sector was involved in the water scarcity crisis and mobilised all the NGOs to work together in coordination with governmental institutions to assess the needs in the most vulnerable locations and to find both short term solutions and some longer term ones for both Syrian refugees and host communities.

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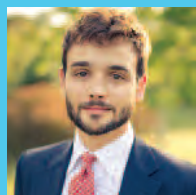
## Impact evaluation of a cash-transfer programme for Syrian refugees in Lebanon

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### Background

More Syrian refugees reside in Lebanon than in any other country in the region. As no refugee camps have been established in Lebanon, Syrian refugees live in over 1,000 villages and communities across the country and increasingly reside in informal settlements (ISs). The pace of the refugee flow has more than quadrupled since 2012. At the beginning of 2013, there were 130,799 Syrians registered with UNHCR in Lebanon; this has grown to more than 1.1 million registered refugees (September 2014). The magnitude of the crisis can only be understood relative to Lebanon's population of around 4.5 million people.

### The winterisation cash-transfer programme

Starting in November 2013, an inter-agency winterisation<sup>1</sup> programme began providing cash transfers to around 60% of all refugees from Syria (including Palestinians), Lebanese returnees, and some vulnerable Lebanese families. This article details the findings of a study<sup>2</sup> on the impacts of the winterisation cash transfer programme run by UNHCR and partners, from November 2013 to April 2014<sup>3</sup>. The programme gave \$575 USD via ATM cards to 87,700 registered Syrian refugees in Lebanon with the objective of keeping people warm and dry during cold winter months. The programme also provided heating fuel, tools for improving shelters and non-food items (NFI), such as blankets, children's clothing, and stoves. About 87,700 Syrian refugee families (in Lebanon) received cash intended for the purchase of heating supplies.<sup>4</sup>

Aid was given at high altitudes to target assistance for those living in the coldest areas during the winter months. Eligibility for the programme was determined by a geographic criterion (refugees residing above 500 metres altitude were eligible, while those living below were not<sup>5</sup>) as well as demographic criteria.<sup>6</sup> UNHCR used the demographic data to calculate a 'vulnerability score.' Only households with a vulnerability score above a cut-off were eligible for the programme. Each eligible household was notified via SMS that they were eligible to receive an ATM card at a distribution point. The head of household could pick up the card and receive a pin number. Beneficiaries were notified by SMS message when UNHCR and implementing and operational partners transferred cash to the ATM card. Eligible households could withdraw the money at any ATM. Anyone who had the card and pin could withdraw the money. Although UNHCR and the operational partners generally told beneficiaries that the cash assistance was intended for the purchase of heating supplies, there were no restrictions on beneficiary expenditure (though the message varied across operational partners). Therefore, beneficiaries could spend received cash as they wished.

At the same time as the cash transfer programme, WFP was running an e-voucher programme, allowing recipients to buy food at specific stores. Eligibility was based on the same demographic criteria as the winterisation programme, regardless of altitude. All survey respon-

<sup>1</sup> By 'winterisation' the humanitarian community means the process of assisting beneficiaries in staying warm, dry, and healthy during winter months.

<sup>2</sup> Winterisation cash. Aiding Syrian refugees in Jordan. From November 2013 to May 2014. IRC. August 2014.

<sup>3</sup> UNHCR operated more than half of the cash assistance. Operational partners included: ACTED, AMURT, AVSI, CARE, Caritas, CISP, DRC, Handicap International, Humedica, IOCC, IOM, Makhzoumi, MEDAIR, Mercy Corps, NRC, Oxfam, Save the Children, SHEILD, SIF, Solidar Suisse, and World Vision. Source: UNHCR's winterisation partner Coordination Map (December 2013).

<sup>4</sup> All aspects of the winterisation programme assisted about 96,700 vulnerable families of various targeted groups (Syrians, Palestinian Refugees from Syria, Lebanese returnees and vulnerable hosts). Around 87,700 received cash through ATM cards, checks or Liban post, while around 9,000 received fuel vouchers. In addition, 21,000 households received one-off in-kind winterisation assistance.

<sup>5</sup> Altitude was used to target those living in the coldest areas. 500 metres specifically was chosen, instead of 501 or 502, because it is an easy-to-remember multiple of 100. This further emphasises the as-if random nature of the altitude cutoff, which allows us to make inferences about the effect of aid

by comparing recipients to non-recipients with similar vulnerability scores.

<sup>6</sup> Additionally, families living in "inadequate shelter" were targeted regardless of altitude. The vast majority of informal settlements are located near the sea (low altitudes) or in the east (high altitudes). Since surveyed households were living between 450 and 550 metres, households living in inadequate shelter and informal settlements were rare in the sample. The demographic criteria calculated a vulnerability score based on a weighted sum of the number of: children ages 0-2y, children ages 3-4y, children ages 5-12y, children ages 13-15y, children ages 16-18y, able bodied adult males 18-59y, disabled individuals in household, adults 51-61y, adult dependents 61-70y, adult dependents 71+y, adult females 18-22y, adult males 18-22y, children at risk of not attending school. "Severe vulnerability" status was given to households (HH) that were elderly headed (HH size  $\geq 2$  and only one adult  $\geq 59y$ ); only one non-dependent adult in household (HH size  $\geq 2$  and only one 18-59 year old in household); families with two or more disabled in the family (HH size  $\geq 2$  and disabled in family  $\geq 2$ ); elderly household with one or more disabled adult (HH size  $\geq 2$  and disabled  $\geq 1$  and only 1 adult  $\geq 59y$ ); Unaccompanied/separated minor; child-headed household (HH size  $\geq 2$  and HH members are ages between 0 and 18y).



dents (both treatment and control groups) received the e-voucher. The monthly value of the food e-voucher was \$30USD per person.

## Beneficiary selection

Inter-agency funding could cover transfers for 87,700 households for the winterisation cash transfer programme. To define the altitude criterion, UNHCR used the highest point within each town as the altitude for all households within that town. The vulnerability score was calculated using biometric data available in UNHCR registration records.<sup>7</sup> The initial assignment to the programme was conducted using the geographic and demographic data for each household in the UNHCR databases, as of November 2013. For the purposes of this survey, a *household* was defined as a group of people who spend most nights under the same roof and share in financial activities like income and spending. For instance, two 'households' may live under the same roof if they operate independently of each other in financial matters.

## Research design

This study used a regression discontinuity design (RDD) that allowed quantification of the causal impacts of the cash transfer programme. The research measured the impacts of cash on numerous metrics of household well-being, negative coping strategies, and food and non-food consumption. It tested whether cash produces negative consequences such as local-level inflation or drawing more refugees to regions with assistance (a "pull factor"). And finally, it sought to estimate the multiplier effect of cash aid, i.e. for every dollar of cash assistance, how much would the Lebanese economy benefit.

In order to evaluate the programme's impact the study compares outcomes of cash beneficiaries residing slightly above 500 metres (i.e. less than 550 metres) (treatment group) to non-beneficiaries residing slightly below (above 450 metres) (control group). The same demographic criteria were used at all altitudes to calculate vulnerability. Therefore the study is comparing households that are similar in their vulnerability scores and only slightly different in altitude. Households did not know beforehand that there would be



an altitude eligibility cut-off. This suggests that, around the cut-off point, selection to treatment should not be related to background characteristics in expectation.

According to UNHCR refugee registration records, there were 827 households in the treatment group and 962 households in the control group, i.e. 1789 households in total within the window of analysis (450 metres to 550 metres altitude). This includes only households that had a vulnerability score above the eligibility cut-off.

Because of Lebanon's topography, the distribution of registered Syrian households living between 450 and 550 metres covers nearly the entire country, running from the north in Akkar to the south in Bint Jbeil. Figure 1 shows the location of all towns where survey respondents lived at the time when the winterisation programme began. In November 2013, when the programme began, survey respondents lived in 15 of Lebanon's 25 districts (*aqdia*).<sup>8</sup> Due to beneficiaries who moved between the beginning and end of the programme, interviews were conducted in all 25 districts.

UNHCR's demographic data was used to compare pre-treatment characteristics between the treatment and control groups. Among the demographic variables that were available, 21 of 24 variables were balanced.<sup>9</sup> Therefore, prior to the start of the programme, households in treatment and control group were very similar.

Thus, differences measured after the programme represents causal impacts of cash assistance. All other aid programmes were equally distributed between the two groups around the altitude cut-off.

The survey was translated and back-translated by separate parties, pre-tested in Halba, Akkar and later pilot-tested in Khirbat Daoud, Akkar and in Al Bourjein, Chouf. Enumerators were Lebanese local to the survey region. The Research Manager conducted three two-day training sessions with groups of enumerators, to enable more direct communication and understanding through smaller training groups.

## Data collection

The questionnaire consisted of 226 questions. The primary respondent in each household was the person mainly responsible for how the household spends its money. An interview took about one hour. A town-level stratified random sample of households was asked 81 additional questions on local prices and market characteristics.<sup>10</sup> A full description of the data collection methodology is available in an online appendix.<sup>11</sup> The study compared households living within 40 metres of either side of the 500-metres altitude cut-off due to a drop in sample size at smaller bandwidths. For simplicity, results only for one bandwidth are included here. Other technical publications will show robustness to bandwidth specification. The survey was administered in April and May 2014, beginning about five months after the start of the programme and one day after the programme's final cash transfer. The Research Manager spent more than 20 days in the field and sat in on more than 80 interviews.<sup>12</sup> Enumerators worked in pairs, with one conversing and reading and the second writing. Enumerators collected the data using anonymous paper-and-pencil interviewing. On average, survey teams conducted five interviews per day. Usually, other people were present in interviews including friends, family, and neighbours.

## Key findings

While the use of cash has increased significantly over the past decade,<sup>13</sup> there is little rigorous evidence of the impact of cash assistance programmes in refugee crisis. The research design

<sup>7</sup> Syrians need to be registered to be eligible for UN winterisation cash assistance, the program studied in this paper. Some NGOs run separate small-scale cash programmes that can include or explicitly target the unregistered.

<sup>8</sup> Chouf, El Meten, Aley, Kesrwan, El Nabatieh, Jbeil, Akkar, El Minieh-Dennie, El Koura, El Batroun, Bent Jbeil, Sour, Marjaayoun, Hasbaya, Jezzine.

<sup>9</sup> Balance means that differences are not statistically significant (all p-values are above 0.1). The number of residents of every age group was balanced between treatment and control groups. This reveals that households in treatment and control groups had, on average, the same demographic structure prior the start of the programme. The population of the towns where respondents lived was balanced. Education levels for

household members above 30 were also balanced. The Research Team subsetted on age because this was measured post-treatment, and we wanted to only consider people old enough that receiving cash would not have an effect on their education levels. The number of disabled and non-disabled individuals in households within age groups was also balanced, except for three categories. We found imbalance in "Males not disabled aged 51 - 59", "(both genders) Disabled aged 13 - 15", and "(both genders) Disabled aged 16 - 17". The differences are small in absolute terms.

<sup>10</sup> The town-level stratified sample selected up to four respondents in each village. If a village had four or fewer respondents from our full sample, then all households in that village were interviewed.

<sup>11</sup> Online appendix material at <http://www.danieltrmesterson.com/research>

<sup>12</sup> 1861 individuals met the selection criteria in November 2013 at the beginning of the program. By the time the researchers sought respondents for the survey in April 2014, 62 households were no longer present in UNHCR data. So when surveying began, there were 1789 households in the sample. Given 1361 complete interviews, the study had attrition rates of 24-26 percent depending on which calculation you use.

<sup>13</sup> Cash disbursements in humanitarian emergencies tripled between 2008 and 2012, peaking at \$262 million in 2010. Global Humanitarian Assistance Report 2013 <http://www.globalhumanitarianassistance.org/wp-content/uploads/2013/07/GHA-Report-2013.pdf>



International Rescue Committee

months increased spending on heating supplies. However, the value of the cash assistance was too low to meet the programme's objective of allowing all beneficiaries to keep warm constantly throughout the winter and beneficiaries only partially use it for this purpose. Almost half of beneficiaries reported that heating supplies were often not enough to keep warm. This is not because heating supplies were unavailable in the market, but because beneficiaries' income was so low that they were forced to use the cash assistance to satisfy other basic needs, in particular food. Households spent the majority of cash assistance on food and water despite receiving food vouchers from WFP.

Markets were able to provide sufficient quantities of the goods and services that beneficiaries demanded. The programme did not have a meaningful impact on prices. Across approximately 50 consumer goods, there was no meaningful trend toward higher prices in treatment communities. The programme had significant multiplier effects on the local economy. Each dollar of cash assistance spent by a beneficiary household generated \$2.13 USD of GDP for the Lebanese economy<sup>14</sup>. Also, the research shows that the grants were spent locally, meaning that local Lebanese economies benefit from the cash programme. The vast majority of beneficiaries (more than 80%) preferred cash assistance compared to in-kind assistance (e.g. food parcels).

The study confirmed the absence of a number of hypothetical negative consequences of cash assistance. For instance there was no evidence of beneficiaries spending cash assistance irresponsibly or meaningfully reducing labour supply. The research did not find that cash assistance exacerbated corruption and exploitation. There was no evidence that cash assistance is a pull factor for refugees to settle in communities where cash is distributed.

Indebtedness and asset depletion will likely continue without further assistance. The majority of households surveyed had no savings and were on average \$500 USD in debt. Cash assistance helped in a very marginal way to limit further indebtedness. But the amount of cash assistance given to date is modest in comparison to the costs of the minimum expenditure basket and previously incurred debts. Even with the cash assistance, household income remained insufficient to cover refugee's basic needs.

### Limitations

This study provides a number of key findings that are relevant to policy and practice in Lebanon, and beyond. But, there are a few limitations that should also be acknowledged.

First, the results in this study are only representative of refugee households living around 500 metres altitude. Great care has to be taken to extrapolate from the findings to higher altitudes, not to mention other countries and contexts. In higher altitudes, where average tem-

peratures can be several degrees colder, the impact of cash assistance on heating fuel purchases is likely to be stronger because the weather is colder. In lower altitudes, on the other hand, one would likely see even less spending on winter goods.

Second, this research demonstrates benefits of cash assistance and provides evidence against hypothetical negative impacts. The study does not, however, provide evidence of the positive effects of providing cash assistance in place of in-kind assistance. The comparison groups were control households that received food e-vouchers, versus treatment households that received food e-vouchers *and also* cash assistance.

Third, 85% of respondents were male. The results for intra-household tensions, therefore, need to be interpreted with caution, as women respondents may have answered this question differently. Any downward bias, however, will be present in both the treatment and control groups. The under-reporting will reduce the likelihood of identifying a true effect if it exists. But if one identifies a difference between the groups one could be confident that it is real and that the difference is *at least* as large as what the study would have found without measurement error.

Fourth, the study estimates the impacts of cash when \$575 was delivered per household over the course of five months. The findings suggest, but do not prove, what would happen with a different amount or timeframe. Specifically, the absence of evidence of market distortions from the recent programme suggests that Lebanon's market is able to adjust for increased demand. This suggests that Lebanon's economy could adjust to larger amounts of cash aid. The study's evidence on the multiplier effect suggests that Lebanon's economy would benefit even more from larger cash transfer amounts and/or broader targeting.

Finally, the research design allows confident statements that the cash transfer caused the difference in outcomes between the treatment and control group and about the scale of the difference. *How* the cash caused a difference in a particular outcome is a different – and very challenging – research question about causal mediators and causal pathways that could require a research project to study causal pathways for each outcome.

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is a key contribution to research on Syrian refugees in Lebanon, and more generally to research on the impacts of cash aid in a humanitarian crisis. This is the first study, to the researchers' knowledge, to rigorously compare refugees receiving cash to those not receiving cash, which makes it possible to quantify the causal impact of the assistance.

Cash assistance produces multiple positive social impacts within the household and in the community. Cash assistance increases school enrolment and reduces child labour. Findings from this research show that households receiving cash assistance were half as likely to send their children to work as households not receiving cash assistance. In the control group, about 33% of children were currently enrolled in school, compared to about 39% in the treatment group. This suggests that cash assistance increases access to education.

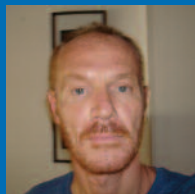
Cash assistance caused reductions in negative coping strategies. Households receiving cash assistance less frequently reduced the number of meals per day, reduced the portion of meal sizes and restricted consumption by adults for children to eat. Cash recipients were less likely to withdraw children from school. The programme also increased mutual support between beneficiaries and other community members, and decreased tensions within beneficiary households. The cash programme led to reduced tensions in beneficiary households and between refugees and the host community.

This study found that the cash assistance for beneficiaries at high altitude during winter

<sup>14</sup> Higher-round effects can be calculated by the formula:  $dY=C/(1-MPC)$ . That is, the total amount of additional Gross Domestic Product (dY) generated by one beneficiary household is calculated by dividing the amount of winterization cash that the beneficiary household spends (C) by one minus the marginal propensity to consume (MPC). The total amount of additional Gross Domestic Product (GDP) that each beneficiary households generates for the Lebanese economy is then given by  $dY=575/(1-0.53)=1223.40$  USD. The multiplier is  $M=1/(1-0.53)=2.13$ . See the full report for more details.

## Towards a 21st century humanitarian response model to the refugee crisis in the Lebanon

By Simon Little



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*This article represents the views of the author and is not an official DFID position. It was written in early summer 2014, before the sixth Regional Response Plan (RRP6) mid-year review.*

### Background

The humanitarian situation in Lebanon is changing. After two years of a resource-intensive response, delivered through multiple agencies and sectors, the anticipated reduction of humanitarian funding is likely to change the scope and shape of the response. As a result, it is unlikely that what was achieved in 2012 and 2013 (a comprehensive package of life-saving assistance delivered to an ever enlarging caseload of refugee and non-refugee beneficiaries) will be achievable in the future.

In the evolution of all crises, there are key moments when the humanitarian community has to make difficult decisions regarding the future maintenance and delivery of the response and for Lebanon, the mid-2014 review of the sixth Relief Response Plan (referred to as RRP6), represents such a time.

The dimensions of the crisis in Lebanon are staggering. The country hosts the highest per capita refugee population in the world and the RRP6 is set at \$1.7 billion for 2014. As of mid-2014, however, the appeal was just 17% funded (\$287 million secured). It is unlikely that the RRP6 will secure anywhere near the \$881 million secured against RRP5 in 2013, though refugee numbers are expected to continue to grow.

The need for continued humanitarian and/or stabilisation/development assistance can be largely negated through the provision of livelihoods/employment opportunities. However, there is no easy way to create employment in a politically fragile environment where the economy is hemorrhaging<sup>1</sup> and where the three primary employment sectors (agriculture, construction and services) are already heavily congested. Cash for work schemes delivered by humanitarian and non-humanitarian actors are providing value and utility to those that benefit but, collectively, the employment created amounts to tens of thousands of work days, rather than the millions required. In the absence of a massive multilaterally funded public works scheme ca-

pable of providing long-term employment to thousands of refugees and poor Lebanese, many households will continue to rely on the assistance provided by the humanitarian community.

### A model response or a challenging response model?

With greater numbers of refugees seeking sanctuary in Lebanon from mid to late 2012, the responsibility to lead and coordinate the humanitarian effort was debated between UNHCR and the UN Office for the Coordination of Humanitarian Affairs (OCHA). The former declared that a steadily increasing flow of refugees accorded it the lead coordinating role, whilst OCHA highlighted aspects of the Transformative Agenda, notably the Cluster System and reinforcing the role of the Humanitarian Coordinator. Although the swelling of refugee numbers strengthened UNHCR's claim, there were some within the humanitarian community who remained perplexed as to why a cluster system, far from perfect but refined over successive crises, was overlooked. Whilst UNHCR is certainly mandated to lead/coordinate refugee responses, introducing a sectoral response (though different from the cluster system largely in name only) caused confusion and delays amongst humanitarian actors more familiar with a cluster approach refined in recent crises. Nonetheless, structures and leadership is one thing but for those we seek to assist, what's delivered is always more important than who delivers it.

A scaled up response was predicated on the delivery of blanket food assistance, hygiene, baby kits etc., complemented by more selective transfers of education, health and shelter support. The mode of delivery drew heavily on experience and practice acquired in successive crises over the past three decades, reinforcing the traditional response hierarchy with UN agencies securing the lion's share of donor funds, and thereafter subcontracting the bulk of on the ground delivery to a range of international

non-governmental organisations (INGOs)/NGOs<sup>2</sup>. As a rule of thumb, the more partners involved in delivering an operation, the less optimal the arrangement, in part because of the duplicate costs associated with UN oversight and INGO delivery (e.g. two sets of premises, vehicles, personnel, HQ costs, etc). Operating costs can spiral further if the implementing INGO delivers through a national partner.

In terms of assistance delivered the response model applied in Lebanon is little different to that introduced elsewhere with a focus on the distribution of material lifesaving assistance. In applying a response model heavily influenced and shaped by practice in Africa, the humanitarian community may have failed to acknowledge the contextual differences of responding in middle income Lebanon, with well-established basic service delivery and a functioning private sector. Whether a model that is predominantly focused on disbursing vast quantities of material assistance was best suited to the specificities of the crisis in Lebanon – even during the peak period of refugee influx – is debatable<sup>3</sup>.

It is interesting to note that eight sectors were established under UNHCR stewardship pretty much in the mirror image of the cluster system. The aforementioned eight sectors are jointly coordinated by a UNHCR sector coordinator (with the exception of the food security

<sup>1</sup> The GoL/World Bank estimates that by end 2014, Lebanon will have sustained economic losses totalling \$7.5 billion due to the crisis in Syria.

<sup>2</sup> Valued at \$1.21 billion the appeal budgets of the three frontline UN agencies (UNHCR, UNICEF and WFP) collectively constitute 71% of RRP6. As well as supporting UN activities, donors such as DFID have provided bilateral support to INGOs.

<sup>3</sup> One of the top principal differences between responding in Lebanon and elsewhere are the costs associated in maintaining a response.

<sup>4</sup> These are: education, food security, health, non-food items (NFI), protection, shelter, social cohesion, and water, sanitation and hygiene (WASH). The protection sector has the following two subgroups: Child Protection in Emergencies (CPE) and Sexual and Gender Based Violence (SGBV).

sector) and a Government of Lebanon (GoL) representative<sup>4</sup>. Six of the sectors have three or more coordinating agencies with global cluster lead agencies, such as UNICEF for WASH, WHO for health, etc. joining a UNHCR and GoL representative. This might be viewed as a suboptimal arrangement with sectors coordinated by two UN P3/4's, whereas one might suffice<sup>5</sup> and may contribute to costly and potentially cumbersome coordination<sup>6</sup>.

Over the past couple of years, the humanitarian response in Lebanon has grown in direct proportionate to the needs that exist, and the resources available to respond to such needs. As a result, estimates suggest that 100 or so humanitarian/development agencies are currently present (though not all active) in Lebanon, employing upwards of 3,000 individuals, around 350 of whom are thought to be international staffers<sup>7</sup>. The collective cost of staffing this operation is conservatively estimated at \$00's of millions annually with an estimated 20% of overall project funding expatriated through personnel and other out of country costs. Furthermore, though RRP5 may have mobilised \$881 million in 2013, just 50-60% of this is thought to have been converted into assistance and/or services that reach the beneficiary end user with the balance likely to have been absorbed by a range of in and out of country administration/operating costs<sup>8</sup>.

So, the response model in Lebanon has been designed and structured to adhere to the prevailing model of cross-sectoral multi-partner engagement. In this, the UN oversees a response model implemented in large part by INGOs. National and international staff are employed at the centre, and field level, to coordinate and implement. From the outset of the crisis the role of the private sector has been limited as has the willingness and/or ability of GoL structures and services to engage. The response model in Lebanon has assumed a largely predictable form.

The current response model has probably grown beyond the means of donors to sustain it and whilst scaling up proved challenging, scaling back is probably more so with personnel and logistics tied to long-term contracts. Donors played a part in driving the response agenda as did the media and by extension the public. In today's overheated and overly competitive humanitarian sector, it would have been unusual, if not unconscionable, for any of the larger agencies, be they UN or INGOs, not to have sought a foothold in Lebanon, though very few of either type operated in middle income Lebanon pre-crisis. Typically, in the free for all that follows the onset of crises, those that vacillate are left behind and thus potentially bereft of funding<sup>9</sup>. With the exception of institutional outliers, such as ICRC and MSF, this is unacceptable to the extent that the contemporary humanitarian market demands action from all, even those with limited contextual experience.

### What distinguishes Lebanon and how should we do things differently?

At an operational level, there's little to distinguish the crisis in Lebanon – and the resulting need

for humanitarian assistance – with comparable crises in Africa or Asia. As such, it makes perfect sense that the response offers an integrated package of lifesaving assistance, delivered through experienced and proven partners employing tried and tested methods of delivery.

Most forecasters agree that humanitarian funding for Lebanon probably plateaued in 2013. The year 2014 will likely experience a steady reduction (perhaps 60% of that mobilised in 2013?) with a steeper decline in funding anticipated for 2015. Conversely, as funding reduces the number of vulnerable people, both refugees and non-refugees are expected to increase. So it really will be a case of looking to do more with considerably less! Compounding the challenge of dwindling resources is the fact that Lebanon is an extraordinarily expensive context in which to operate. The cost metrics of the response in Lebanon are enormous. Which other past or current response model is predicated on a household minimum expenditure basket (MEB) of \$607 per month with the survival basket costed at \$435 per month or \$5,220 per annum<sup>10</sup>? The costs simply don't bear comparison and yet, peculiarly, the response model employed in (for example) Kenya and Lebanon, and across the world, is effectively the same.

Because the cost of responding in Lebanon is so extraordinarily high, the international community can ill afford suboptimal response systems or delivery mechanisms. Against the backdrop of reducing humanitarian funds, it's imperative that the current response model is adjusted to be certain that agencies are truly delivering impact and value for money. In recognising the challenge and cost of continuing to operate in Lebanon two options are presented: the first, a reactive/inactive approach; the second, a proactive approach.

**The reactive/inactive approach.** As indicated previously, the RRP6 has secured less than one-fifth of the funding needed for the year at the time of writing. This is cause for concern, if not entirely unexpected. Few expect 2014 funding levels to equal those achieved in 2013. With fewer funds, the humanitarian community is less able to maintain levels of coverage and service provision. Cuts are inevitable and there

is a danger than the response simply loses steam and gradually peters out. The narrowing of sectoral focus will be accompanied by fewer and fewer target households receiving assistance. Equally, the gaze of donors, responders and the media may be turned by a future emergency with Lebanon, not inconceivably, being abandoned to a painful cycle of ever diminishing returns.

**The proactive approach** recognises the operational dilemma and looks to adjust in advance of its consequences. This is already taking place and the current Cash Transfer Programme offers a useful illustration. A recent review of the operational set up of cash programming in Lebanon suggested a number of refinements that, if introduced, could provide a leaner, more responsive and cost effective delivery model.

Cost saving measures might a reduction in the number of actors involved in transferring cash, unifying the coordination of cash transfer programming, attenuating the structure for transferring cash, utilising a single ATM cash transfer mechanism, etc.

Operational refinements only go so far as the scale of the crisis will outstrip available resources-the response model can be adapted until no further adaptation is possible. To make a real impact, the community needs to be bolder and more ruthless in introducing change. As a matter of urgency we need to review the optimality of the current structure, specifically the future requirement for 24 UN agencies and 100 INGOs<sup>11</sup>. We need to consider the appropriateness of maintaining the current sectoral structure and the various working groups and task teams therein. All these structures are populated with high cost international personnel. In addition, we should take the opportunity to review the value of a decentralised, resource intensive coordination system. In essence we need to determine whether the existing response structure enables us to deliver more with less? With the crisis in Lebanon unlikely to end anytime soon we need new humanitarian order to ensure that our future focus remains firmly on those we are here to serve, rather than shoring up institutional mandates or finances.

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<sup>5</sup> The annual cost of engaging a P4 UN officer in Lebanon is estimated at around USD 200,000+.

<sup>6</sup> By way of emphasising the suboptimal response model at play, it is worth highlighting the assessment of need. A recent DFID funded Multi Sector Needs Assessment reviewed 88 multi and single sector assessments conducted during 2013. The GoL, Red Cross Movement, Gulf actors and others outside the RRP6 probably conducted a further 30 or so assessments. All these assessments take time, cost money, duplicate effort and seek similar information that may serve to confuse beneficiaries.

<sup>7</sup> The number of national and international staff is not exact but estimates put those currently employed by humanitarian agencies in Lebanon as follows; the four main UN agencies (UNHCR, UNICEF, UNRWA and WFP) employ national and international staff in the following ratios: UNHCR 480:160; UNICEF 100:20; UNRWA and WFP 61:15. Bear in mind that UN agencies subcontract the bulk of implementation to INGOs. National/international staffing levels for the lead INGOs (DRC, IRC NRC, SCI) are as follows: DRC 550:50; IRC 300:26; NRC 353:23 and SCI. The total number of international personnel engaged in the response clearly runs to hundreds of posts with thousands of national staff engaged.

<sup>8</sup> The estimates presented are based on rudimentary calculations from individual funding proposals received over the past 18 months.

<sup>9</sup> At the start of 2013, 22 INGOs were included in RRP4. By the end of the year, this number had increased to 51 INGOs. The number of INGOs represented in RRP6 has grown yet further. The overall INGO/NGO community is thought to number in the order of 100 agencies. Twenty-four UN agencies are present in country (source: Inter-Agency Coordinator, Lebanon).

<sup>10</sup> In 2012 Lebanon's GDP per capita was \$9,705 or approx. 50% more than the estimated survival basket. Though the MEB was calculated to cost the minimum living expenses for refugees, the figure is comparable to the \$4 per day poverty line presented in the GoL's National Poverty Targeting Programme.

<sup>11</sup> The Red Cross Movement has its own parallel structure with the International Committee of the Red Cross (ICRC), the International Federation of the Red Cross and Red Crescent Societies (IFRC) and 18 partner National Red Cross Societies orbiting around the Lebanese Red Cross.

# The potential role of local academia in protracted crises – the example of the American University of Beirut



The American University of Beirut (AUB) is the country's leading institution of higher learning, and has been in existence for almost 150 years, offering a space for critical thinking, high-quality research, and study. AUB houses six faculties, with around 800 in the instructional faculty and a student body of about 8000 students.<sup>1</sup>

**By Amelia Reese Masterson, Hala Ghattas and Fouad M Fouad**

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As academics, our mission includes preparing competent professionals through high educational standards, conducting relevant and timely research, and translating knowledge into policy and practice through capacity building, advocacy and outreach. At the American University of Beirut (AUB), academics have done this throughout numerous refugee influxes, the Lebanese civil war, the 2006 war with Israel, and now the Syria crisis.

Academic activities have frequently been adjusted to the realities that surround us, including adaptations in course content to ensure that our students are able to think analytically and respond to the challenges arising out of contexts such as conflict or refugee crises. Our seminars and research often address and question the historical and socio-political underpinnings of the protracted emergencies we live in, assess and document their consequences, and evaluate the impact of interventions. Research in this setting is forced to either account for or focus on the effects of the crises we are witnessing. Students at AUB engage in volunteering and outreach activities, as do faculty members who may also be called upon to provide technical expertise in various forms.

Box 1 gives examples of some of the academic initiatives that have been instigated at AUB. These include capacity building initiatives for both students and local and regional humanitarian workers, research to better understand and describe the effects on diverse populations of both the emergencies and the humanitarian interventions or policies designed to mitigate these, and service and outreach initiatives.

Academia also provides a space for critique and dialogue – including self-critique in emer-

gency circumstances. As we attempt to assess and analyze the situation, we question the role of various actors in humanitarian efforts, as well as our own mandate and possible contribution in times of crises. Although the latter remains a subject of constant discussion, our potential value-added derives from our long-term in-country (and in-region) experience, our academic departments which provide education and training capacity, our research and policy centres that have ability to seek longer-term funding and maintain strong ties with local and regional stakeholders, and our technical expertise in a variety of specialties. AUB can therefore provide a long-term outlook (as opposed to short-term relief), in-depth analysis (as opposed to rapid assessment) and the possibility to build on this broader knowledge to inform programmatic and policy priorities and implementation.

### *Challenges faced by local academic institutions*

Operational research in emergencies is invaluable in building the evidence base for programming, both locally and globally, and in building upon a growing body of literature exploring this context. It is clear that AUB has the resources and capacity to play a critical role in developing such evidence. However, there are some limitations inherent to academic institutions that limit their ability to engage in research in crisis settings. Here we highlight several key challenges to such 'real-time' research, and lay out potential approaches for circumventing these obstacles, or even thinking beyond them.

A major challenge is rapidly shifting research priorities in crisis settings. Research priorities may be set by governments seeking to fill gaps in knowledge, by international agencies looking

to build programme-relevant knowledge, by donor agencies, or by academic institutions. These research agendas may not always be in harmony. This poses several difficulties for academic involvement, namely identifying suitable funding in a timely manner, maintaining flexibility to adapt to the changing situation on the ground, and identifying funding to meet both academic and local or global research priorities. There is growing interest among funding organisations and government agencies, as well as humanitarian organisations, in operational public health research in emergencies. However, funding for research in volatile areas is limited and therefore highly competitive and is often awarded to institutions with a global reputation coming from outside the region. These barriers could be overcome through research partnerships and collaborations amongst international and local institutions.

A second challenge pertains to the constraints to timely research inherent in academic institutions like AUB, including the time needed to obtain ethical approval before launching research with human subjects, pressure on faculty to publish in a timely manner to obtain promotion, and the constraints of an academic calendar including teaching responsibilities and committee duties. If the international community is willing to coordinate with faculty and students, these schedule and timing constraints can easily be overcome. For example, both faculty members and students at AUB have previously assisted international organisations in Lebanon in using previously-collected monitoring, evaluation, or assessment data to inform programming – either as part of a student's practicum requirements

<sup>1</sup> American University of Beirut  
<http://www.aub.edu.lb/main/about/Pages/index.aspx>

## Box 1

### Examples of academic activities

#### Teaching and training

- Individual courses or parts of courses exist, dealing with specific aspects of emergencies (e.g. reproductive health in conflict situations).
- Many existing technical courses integrate examples, case studies, and projects that address issues arising from the emergency. Examples include courses in epidemiology that have integrated modules on designing data structures for rapid surveys; another includes a case study on the Syria polio outbreak in a course on Migration and Health.
- Various departments use a community-based or service learning approach, where as part of regular course credit, or practicums, students are placed within NGOs, UN or governmental agencies to conduct assessment, data or policy analyses, health behaviour interventions, etc. In these cases, students learn from the “real-life context” but also act as an up-to-date technical resource for these agencies.
- Research projects and Master’s theses have often focused on research questions relating to refugees, war, and conflict, and social determinants of health in contexts of emergencies<sup>3,4</sup>.
- Short-courses have been designed and implemented by various departments to build local technical capacity and respond to the needs of local or regional agencies in training in humanitarian crises. Examples include a Public Health in Complex Emergencies course and the Nutrition in Emergencies (NiE) regional training initiative (see article by Ghattas et al in this edition of Field Exchange).

#### Service and outreach

- Many of our faculty members act as technical consultants or advisors for NGOs, UN and governmental agencies and hence have either a direct or indirect influence on policy and interventions.
- Students and faculty members often engage in volunteering activities as well as direct relief (e.g. health promotion in schools, mobile clinics in camps, providing language courses in informal refugee settlements, collection and distribution of non-food items).

#### Research

AUB has been involved in research and evidence-building in emergency settings throughout previous conflicts and refugee settings in Lebanon<sup>5,6,7,8,9</sup> and continues to play this important role in the current Syria crisis<sup>10</sup>. Examples of ongoing research include:

- Feasibility of innovative interventions to improve uptake of antenatal care
- Assessing the impact of the crisis on maternal and neonatal health outcomes
- Evaluation of cash versus e-(food) vouchers
- Exploring the effects of conflict on the health of very young adolescent Syrian refugees in the Bekaa

#### A space for critique, dialogue and advocacy

AUB provides a platform for political, historical, and philosophical critique of humanitarian action and a space for dialogue and advocacy through seminars, conferences, publication of opinion pieces, and hosting of stakeholder dialogues. Examples include:

- The Knowledge to Policy Centre at the Faculty of Health Sciences which held a policy dialogue entitled “Promoting access to basic health care services for Syrian refugees in Lebanon.”
- The Lancet Palestinian Health Alliance Meetings that have been organised jointly with the Institute of Community and Public Health at Birzeit University, which describe, analyse, and evaluate the health and health care of Palestinians, as well as documenting the impact of the conflict on health and informing evidence-based policy and practices.
- Various lectures and working group discussions have been held on humanitarianism including a lecture by Prof Didier Fassin on “The Politics and Ethics of Humanitarianism.”
- On the occasion of its 60th anniversary, the Faculty of Health Sciences at AUB is holding an international scientific conference on “Public Health in Contexts of Uncertainty” which aims to explore and reframe the role of public health professionals and academic institutions in contexts of uncertainty.

or as an expert consultancy in the case of faculty. It is also possible to accelerate the process of obtaining ethical approval if the research does not collect personal identifiers or uses existing, de-identified data. In fact, in light of the need for rapid ethical review in research pertaining to Syrian refugees, AUB’s Institutional Review Board (IRB) has streamlined the application process for research to be carried out in coordination with humanitarian agencies in emergency settings.

#### Moving forward

With the Syria crisis in its fourth year, and the number of refugees in need of assistance in Lebanon reaching 1,138,874<sup>2</sup> (as at August 2014) and still growing, local resources should not be overlooked. While the strain on Lebanese infrastructure, not least the healthcare system, is clear, public health research and capacity building experience, coupled with deep regional understanding, also become critical tools to address the challenges faced.

The countries surrounding Syria, which are now hosting 13% of the total Syrian population<sup>2</sup>, are facing a protracted refugee crisis and no longer a new emergency. This ongoing regional crisis, with waves of refugees over the past three years, will continue to have major geopolitical implications. In the case of Lebanon, there has been a large influx of people into a small country, resulting in serious pressure on the host population (not to mention the pressures faced by those displaced by the conflict). This movement has resulted in a demographic shift, and we can no longer think of the crisis as having mere short-term effects.

Such a protracted crisis, accompanied by changing demographic landscapes, requires a longer-term approach. The response must move from a short-term emergency relief mindset to one that is able to address not only the needs of Syrians, but also the longer-term needs of both refugees and vulnerable host populations affected. Technical capacity and in-depth local expertise are often disregarded in the heat of humanitarian response, or remembered at a late stage. AUB has much to contribute to the efforts of IN-NGOs, UN agencies, local NGOs, and the Lebanese Ministries in light of the health challenges the country is facing. AUB has the ability to add local context to international action and contextualise international interventions, hopefully serving as an example of how a local institution can meaningfully adapt and respond to a protracted crisis on its doorstep.

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<sup>2</sup> UNHCR Syria Regional Refugee Response Portal <http://data.unhcr.org/syrianrefugees/country.php?id=122>

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<sup>9</sup> Habib RR, Hojeij S, Elzein K, Chaaban J, Seyfert K. (2014) Associations between life conditions and multi-morbidity in marginalized populations: the case of Palestinian refugees. *European Journal of Public Health*, 24,727-33.

<sup>10</sup> Dewachi O, Skelton M, Nguyen VK, Fouad FM, Sitta GA, Maasri Z, Giacaman R. (2014) Changing therapeutic geographies of the Iraqi and Syrian wars. *Lancet*, 383, 449-57.



Syrian refugees in Lebanon

Sam Tarling, Caritas, Lebanon

## Insight into experiences of older Syrian refugees in Lebanon

### Summary of report<sup>1</sup>

*This summary was prepared by Isabelle Saadeh Feghali, Coordinator at the Caritas Lebanon Migrant Centre, Beirut, Lebanon.*



Caritas Lebanon Migrant Centre (CLMC) is pleased to share the results of this study on older persons among refugees coming from Syria. “Forgotten Voices” is an important opportunity to understand better the particular needs of older persons in the refugee population as well as to draw greater attention to this group which tends to be over-looked in many responses.

Older persons constitute an increasingly larger share of the world’s population, and refugees affected by both natural and man-made disasters. At the same time, their stage in life presents particular constraints, needs, and strengths of which the humanitarian community must take note. It is important that the humanitarian community create and implement age-appropriate, age-specific responses for older persons in a refugee crisis setting.

Adequate nutrition is essential to maintain health according to the World Health Organisation, this is especially needed by older people aged above 60 according to the World Health Organization who might have special needs and require specialized diets due to chronic diseases, e.g. low salt intake for high blood pressure. These dietary requirements must be taken into consideration when planning the nutritional intervention for older persons during emergencies. Many other factors must also be taken into

consideration such as the distribution method (avoiding long periods of standing, assistance needed to carry supplies), and the capacity to prepare and consume food available. Health, mental health, social circumstance, financial needs and the right to humanitarian assistance are all critical considerations.

Building on its expertise in this field, CLMC collaborated with Johns Hopkins University to create a study designed to understand better the plight of older refugees from Syria. Key findings are shared here with a particular focus on the nutrition component.

### Method

The study utilized a mixed-methods design with quantitative and qualitative components. The quantitative component used a survey questionnaire to record basic demographic information, displacement history, and care-giving for the older person, non-communicable diseases, disabilities, nutrition, mental health, and functional status. Because there are few data available on the older refugee population in Lebanon, the survey focused on collecting the information related to a broad range of issues affecting older refugees rather than focus on a particular issue in-depth. Information about each survey participant was also gathered from the CLMC and PALWHO databases of registered refugees to add additional data for analysis. Open-ended

interviews with older refugees, as well as humanitarian organisations providing aid to refugees in Lebanon, were added to provide a qualitative component to the study. Interviewing older refugees offered a valuable opportunity to explore issues in greater depth and to seek explanations for trends observed in the quantitative data. Meetings with the staff of humanitarian organizations were also arranged to learn about their experiences serving older refugees and ask if they had planned or implemented programs or assessments to address the specific needs of older refugees.

### Profile of study sample

Taking place in early 2013, the study sampled approximately 10% of the older refugees registered in its database. A total of 210 refugees were included. Overall, 167 older Syrian refugees and 43 older Palestinian refugees responded to this study; these sample sizes allowed measurement of population characteristics within an error margin of  $\pm 7.6\%$  for Syrian refugees and  $\pm 15\%$  for Palestinian refugees coming from Syria<sup>2</sup>. The average respondent age was 68 years old (range

<sup>1</sup> Forgotten voices. An insight into older persons among refugees from Syria in Lebanon. Caritas Lebanon.

<sup>2</sup> The calculation of margin of error assumes the most conservative prevalence rate of 50%, a survey response rate of 95%, a study design effect of 1.0, and a 95% confidence interval.



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60-96 years). Most of the older Syrian refugees live in houses (39%) followed by tents (26%), apartments (23%) public buildings (6%), unfinished structures (3%) or other dwellings (3%).

At the time of the study, 55% of the Syrian refugees had registered as refugees and 15% had applied but not yet registered. The remaining 30% had not yet registered – this was probably due to a number of factors including recent arrival, lack of awareness of registration process, and fear of sharing personal information with the authorities.

**Results**

The results of the study were surprising in that they highlighted an over-whelming need. Some key data include:

- Of respondents, 74% noted that they were dependent on humanitarian assistance to meet their basic needs.
- Nearly all older refugees – 96% of Syrians and 100% of Palestinians – reported they had a family member who would take care of them if they were sick or help them if they had an emergency.
- 79% identified financial cost as their primary difficulty in seeing a doctor when they need medical care.
- 66% described their overall health status as bad or very bad. Nearly all respondents listed at least one chronic illness, with 60% having hyper-tension, 47% having diabetes, and 30% having some form of heart disease. Most respondents had multiple chronic illnesses.
- Most respondents had a number of disabilities including 47% reporting difficulty in walking and 24% reporting vision loss. Approximately 10% of older refugees were physically unable to leave their homes and 4% were bedridden. Large numbers of older persons require mobility aids such as walking canes and eye glasses.
- 87% of respondents were unable to regularly afford medication they require regularly.
- Reducing meal sizes, skipping meals, and skipping fruits, vegetables, and meats were common among older persons. In fact, there was a tendency for older persons to eat less quantity or less quality food in

order to provide better meals to younger members of the family.

- High numbers of older persons reported mental health concerns. Nearly 61% of respondents reported feeling anxious, while significant proportions of older persons reported feelings of depression, loneliness, and feeling a burden to their families.

**Nutrition**

The survey conducted on the frequency of consuming certain types of food found that older Syrian refugees consumed meat on average of 1.4 days a week, while consuming dairy food, fruits and vegetables more frequently with an average of 3.1 and 3.2 respectively. Note, the survey was conducted in the winter of 2013, which may have affected food access. The study identified many factors associated with the frequency of eating from different food groups, especially the poor financial status of the refugees which is leading them to eat only bread for many days. Older Syrian refugees ate only bread 1.2 days per week, whereas older Palestinian refugees ate only bread 5.0 days per week. An age-related factor is also a significant influence, where older people in big households prefer to eat bread and keep the meat parcels for the young children. The frequency of eating certain food types was also related to refugee location - people living in tents in rural villages ate more fruits than bread, even while having poor financial status (tent settlements tend to be located near rural agricultural areas).

Older refugees reported a reduction in their food portion sizes for around 1.9 days a week, skipping a meal took place at an average of 1.5 days a week and not eating for around 0.5 days a week. Both Syrian and Palestinian older

refugees frequently skip meals and go entire days without eating or eating only bread.

**Discussion**

Despite these grim findings, CLMC found that older persons have a number of significant assets to bring to their families. Older persons tend to garner more respect and are able to be more effective negotiators with the host community. They also tend to have a positive effect on other members’ mental health and can provide assistance with child care and household chores. CLMC concentrated its recommendations in this study on activating those strengths for the benefit of both the older person as well as his/her household.

CLMC has also built on its history in working with the Palestinian refugees and tried to see if the lessons learned from that experience can be used in the Syrian context. CLMC used the same *Outreach Methods* which were mainly based on home visits which are critically important for health care. Furthermore CLMC included the *Care for Chronic Illness* in its health services. Moreover, CLMC used *Medical Cards* in order to keep all medical info with the refugees when needed. CLMC also introduced the *Life-Cycle Education* in order to increase the knowledge of its partners on how to treat older persons appropriately. In addition to that, CLMC trained caretakers who are mostly daughters or relatives in order to provide continuous support. Finally and in order not to isolate older persons who have minor mobility issues, CLMC introduced *Mobility Aids* in order to support those elderly people with walking canes, bed rails, etc.

For more information, contact: Isabelle Saadeh, email: isaade@clmc.org



Syrian refugees in Lebanon

Sam Tarling, Caritas, Lebanon



# Meeting cross-sectoral needs of Syrian refugees and host communities in Lebanon



By Leah Campbell

This summary is based on a longer written case study written by Leah Campbell for CaLP<sup>1</sup>. A video presenting the programme is also available<sup>2</sup>. If you would like more detail on the case study, particularly the context, decision to support host communities as well as refugees, protection impacts and monitoring strategy, please consult the longer case study.

## Introduction

In complex crises such as the Syrian conflict and resulting regional displacement, affected populations have an equally complex set of needs, which do not fit neatly into the current architecture of humanitarian response. Refugees who have fled their homes with few physical or social assets, require support which considers their needs holistically. The rise of cash-based responses in the humanitarian sector is in part due to the flexibility of this modality to meet a diversity of needs through one intervention. Nevertheless, many cash-based responses remain sector-specific, with organisations providing cash for rent or vouchers for specific food items.

Cross-sector cash programmes (also called multi-sector) address need across the boundaries of sectors and clusters. Providing cash which is intentionally cross-sectoral places decisions in the hands of affected households, who are empowered to make choices and prioritise needs.

## IRC's programme

Between February and October 2013, the International Rescue Committee (IRC) implemented an unconditional cross-sector cash programme in Akkar, north Lebanon. The programme provided monthly cash assistance for a time-limited period of 4-6 months to 700 Syrian refugee and 425 vulnerable Lebanese households. Heads of households, most of whom were women, received an ATM card which was reloaded monthly with \$200 USD. The objective of the programme was to improve living conditions and allow recipient households to meet basic needs, which were di-

verse and changing. It aimed to reduce negative coping strategies, particularly for women, and reduce social tensions between Syrian and Lebanese vulnerable households.

IRC undertook gender based violence (GBV) and livelihoods assessments in order to understand the needs and situation of the affected population, particularly the risks for women and girls and the income opportunities available. These assessments found that Syrian refugees and Lebanese host communities were under severe financial strain and relying increasingly on negative coping strategies. Rented accommodation was hard to find and the capacity of communities to host refugees was diminishing. The influx of refugees had a significant impact on the income and expenditure of both refugees and host communities. Daily wages were reduced by up to 60% and as a result, many families couldn't meet basic needs. Almost all were resorting to incurring debt to meet their expenses, alongside negative coping strategies, such as selling assets/in-kind assistance and sending children to work. Providing assistance to both vulnerable Syrian and Lebanese households can help to mitigate the tensions caused by these difficult economic circumstances by addressing the needs of both groups transparently, focusing on vulnerability rather than nationality

Establishing the value of the transfer was a challenge, and required consideration of needs across multiple sectors, differences between urban and peri-urban areas, and harmonisation

between multiple agencies providing similar, or sector-specific, cash assistance. The value of \$200 USD was based on minimum expenditure basket calculations led by the Cash Working Group in Lebanon. It is estimated to be equivalent to 40-50% of basic needs expenses for a family of six. This value was transferred to the programme's selected recipients through reloadable ATM cards, which were found to offer the least risk and highest flexibility of the options available. Less than 3-6% of programme participants had previous experience of using an ATM card. However, after a 1 hour training and practice session, 59-71% were able to use the card without assistance and almost all were able to use the card with the assistance of family or friends. The programme did find that ATM cards are not the most suitable option for the elderly and those with disabilities.

IRC identified potential affected vulnerable populations via referrals from a variety of sources and then conducted assessments exploring various vulnerability criteria, including dependency ratio, assets, food consumption and income-expenditure gap. Following interviews and observations to assess regular income and expenditure, food consumption and coping strategies, households were ranked and the most vulnerable selected as programme recipients.

<sup>1</sup> <http://www.cashlearning.org/resources/library/410-cross-sector-cash-assistance-for-syrian-refugees-and-host-communities-in-lebanon-an-irc-programme>

<sup>2</sup> <https://www.youtube.com/watch?v=F77jufrcQdk>



Renée Goulet

Those households were then invited to an information session to receive their ATM card and training. IRC operated a hotline to address questions and problems for card users, and acted as an intermediary between recipients and the card provider.

IRC's initial vulnerability criteria prioritised women-headed households, many of whom had little experience managing household budgets. Funds were always provided to the head of household. In an effort to extend the long-term impact of the programme, IRC piloted financial literacy training alongside the cross-sector cash programme. This training, delivered over six weeks, provided micro-level budgeting and debt management support in conjunction with IRC's Women's Protection and Empowerment team. Increasing women's self-reliance and capacity to maximise available resources is particularly important, and can mean reduced exposure to negative coping strategies and GBV.

Due to the growing need in Lebanon, IRC has expanded its cross-sector cash programme as well as other related programmes, including financial literacy. IRC is also expanding its livelihoods assistance programming and will offer conditional assistance in the form of cash for work and cash for training.

### Monitoring impact

IRC conducted post-distribution monitoring (PDM) through a survey with different recipients every 2-3 months. This survey looked at satisfaction with modality, ability to access funds, impact of the assistance on coping ability and security concerns. Price monitoring was also conducted at selected shops to monitor changes (over time and between Syrian and Lebanese shoppers) in market prices of a basket of frequently purchased items.

Measuring impact of cash assistance can be complex, particularly when multiple organisations are providing cash. When the programme is

cross-sector, it can be a challenge to see sector-specific impacts. IRC's PDM gives a general understanding of how the cash is being used and what potential impacts it is having. For example, the PDM surveys track the percentage of recipients reporting that their main expenditure of IRC cash assistance is food, rent, healthcare or debt repayment. Though these figures are general, they give a clear indication that needs are varied and IRC's single programme is able to support a diversity of vulnerable households. IRC also examined the percentage of recipients who report an increase in a variety of wellbeing indicators. For example, IRC PDM showed that, on average, 52.5% of recipients report they are "able to provide larger portions of food" to their family, and 72.5% report being able to "eat higher quality food" as a result of IRC's cross-sector cash support. These nutrition-related impacts are alongside other sector-specific impacts ("better health conditions", "improved shelter/accommodation") as well as cross-cutting impacts ("reduction in household debt").

### Challenges and lessons learned

Three key challenges faced during implementation of this programme were that of dependency, funds not being spent as expected, and inflexible coordination mechanisms. The risk of dependency is amplified when supporting needs in multiple sectors. IRC's cash assistance was designed to provide short-term support to vulnerable refugees and Lebanese households. Though recipients were informed about the nature and timeframe of the support so they could make informed decisions, need is high and humanitarian response in the region is underfunded. As for how funding is spent, the challenge of cross-sector programming is that the choice of how funds are to be spent lies with the affected household. This does not fit well within existing humanitarian funding and reporting mechanisms, which expect funds to be allocated to specific sectors and for decisions

about allocation to be made in advance. Programme monitoring relies on recipients being honest and accurate, which adds to the challenge. IRC built strong assessment and monitoring systems and trusted in these. Recognising the importance of coordination to ensure harmonisation and avoid duplication where possible, IRC sought to participate in coordination mechanisms. However the existing coordination structure does not appear flexible enough to accommodate a cross-sector programme effectively. IRC's first monitoring results showed that for most, food was the main expenditure. As a result, IRC participated in the Food Security Working Group. However, on further monitoring the amount spent on rent was higher than that for food and in most cases, households reported that they spent the funds in multiple sectors. As it is impractical to participate in every sector working group, and how funding is used by affected people changes month to month, it is unclear how actors such as IRC should participate in the coordination system in Lebanon.

Several lessons emerge from IRC's cross-sector cash programme in Lebanon. Firstly, the humanitarian system must be more flexible, and let go of the need to control how cash transfers are allocated by households. It needs to trust crises-affected people to make decisions for their own households. Secondly, it needs to find ways to adapt planning and coordination mechanisms to accommodate cross-sector programming, rather than attempting to force a square peg into a round hole. Thirdly, agencies should recognise that though cash can meet a variety of needs, not everything can or should be monetised. Additionally, ATM cards will not work for every household. Finally, IRC's programme highlighted the importance of working holistically and in partnership with colleagues. Specific lessons on working with local municipalities, banks and protection colleagues can be found in the full case study.

For more information on this case study, contact Leah Campbell [l.campbell@alnap.org](mailto:l.campbell@alnap.org)

### Recommended further reading

Adeso (2013). *Adeso workshop report: Multi Sectoral Cash Transfer. Nairobi*

*Afghanistan Cash and Voucher Working Group (2013) Cash transfer programming in complex emergencies: Technical Operational Guidelines for Afghanistan*

<http://afghanctp.org/Content/Media/Documents/Annex-15CashTransfersTechnicalOperationalGuidelines-Afganistan-309201352515963553325325.pdf>

CaLP (2011) *Making the Case For Cash: A field guide to advocacy for cash transfer programming* [http://www.cashlearning.org/downloads/resources/tools/CaLP\\_Making\\_the\\_case\\_for\\_Cash\\_v2-FINAL\\_screen.pdf](http://www.cashlearning.org/downloads/resources/tools/CaLP_Making_the_case_for_Cash_v2-FINAL_screen.pdf)

Midgley, T. & Eldebo, J. (2013). *World Vision. Advocacy Report. Under Pressure: The Impact of the Syrian Refugee Crisis on Host Communities in Lebanon*



7th NIE Regional Training Course, Lebanon, June 2014

## The impact of the NiE regional training initiative: the Lebanon experience 2010-2014

By Hala Ghattas (American University of Beirut), Linda Shaker Barbari (International Orthodox Christian Charities) & Omar Obeid (American University of Beirut).



Hala Ghattas is Assistant Research Professor and Associate Director of the Centre for Research on Population and Health at the American University of Beirut's Faculty of Health Sciences. In her previous role at the Department of Nutrition and Food Sciences, she co-organised the NiE regional training initiative.



Linda Shaker Barbari is Country Representative at International Orthodox Christian Charities (IOCC) Lebanon and nutrition focal point for IOCC.



Omar Obeid is Professor of Human Nutrition and Metabolism in the Department of Nutrition and Food Sciences at the American University of Beirut. He leads the NiE regional training initiative at AUB.

The Nutrition in Emergencies Regional Training Initiative (NIERTI)<sup>1</sup> was set up in 2009 as a two year USAID/OFDA funded initiative by the Emergency Nutrition Network (ENN), implemented by the UCL Institute for Global Health (IGH). The initiative has continued as a collaboration of academic institutions and agencies to provide high quality training in emergency nutrition in the regions most affected by humanitarian disasters. In the Middle East, NIERTI is implemented by the Department of Nutrition and Food Sciences of the American University of Beirut (AUB)<sup>2</sup>.

### Establishing NIERTI at AUB

In response to the recognised gap in technical capacity in nutrition in humanitarian emergencies,<sup>3,4</sup> the NIERTI project, initiated in 2009, aimed to develop professional short courses in emergency nutrition in the three regions of the world most commonly affected by humanitarian emergencies. Having faced varying humanitarian challenges over the last few decades, the Middle East region has some of the highest numbers of forcibly displaced persons worldwide.<sup>5</sup> The AUB has witnessed multiple conflicts and humanitarian crises on its doorstep.

The Department of Nutrition and Food Sciences was approached by IGH to collaborate on the initiative at the grant-writing stage, and when funding was received in 2009, began planning the first NIERTI Lebanon course. The core course content was based on the Global Nutrition Cluster (GNC) endorsed Harmonised Training Package (HTP) on nutrition in emergencies<sup>6</sup>. In establishing the first pilot course, AUB and IGH discussed the particularities of the region that would affect the content of the courses taught in Lebanon. The importance of full training on Infant and Young Child Feeding in Emergencies (IYCF-E) was discussed given the various violations of the Code on the International Marketing of Breastmilk Substitutes that had occurred during the humanitarian response to the 2006 Israel-Lebanon war.<sup>7</sup> The relatively low occurrence and potential risk of acute malnutrition in the region led to the shortening of the sessions on the management of moderate and severe acute malnutrition. We considered adding sessions on the nutritional

management of chronic diseases in emergencies given recent experience of high prevalence of chronic conditions, such as hypertension and diabetes, in Iraqi refugees in Jordan, Lebanon and Syria<sup>8</sup>. This topic was not added to the main NIERTI course due to timetable constraints but was discussed during the course with participants and added to the Arabic courses subsequently run by International Medical Corps (IMC) and IOCC (see later).

The pilot course ran in 2010 with 14 modules and was a shortened 6-day version of NIERTI (Table 1). It was largely attended by Lebanese participants who had been specifically targeted. The course was well evaluated and proved to have provided an opportunity for motivated individuals working in-country to meet and unify some of their objectives as regards NIE preparedness and IYCF-E (Box 1 highlights the personal experiences of Linda Shaker Barbari, now Country Director at IOCC, who attended the first course).

At the time, we had little idea of the potential value of this pilot course in building national capacity just in time for what is being termed the largest humanitarian crisis of our era.<sup>9</sup>

- 1 Nutrition in Emergencies Regional Training <http://www.nietraining.net/>
- 2 American University of Beirut. <http://www.aub.edu.lb/>
- 3 Adinolfi C, Bassiouni DS, Lauritzen HF et al. (2005) Humanitarian Response Review. New York and Geneva: UN
- 4 Gostelow L (2007). Capacity development for nutrition in emergencies: beginning to synthesise experiences and insights. NutritionWorks/IASC Global Nutrition Cluster.
- 5 United Nations Office of the High Commissioner for Refugees (2013) War's Human Cost, Global Trends Report 2013. <http://www.unhcr.org/5399a14f9.html>
- 6 IASC Global Nutrition Cluster's Harmonised Training Package [http://www.unscn.org/en/gnc\\_htp/](http://www.unscn.org/en/gnc_htp/) and <http://www.ennonline.net/resources/htpversion2>
- 7 Maclaine A and Corbett M (2006). Infant Feeding in Emergencies: Experiences from Indonesia and Lebanon. Field Exchange 29, December 2006. p2. [www.ennonline.net/fex/29/infantfeeding](http://www.ennonline.net/fex/29/infantfeeding)
- 8 Mateen F, Carone M, Al-Saedy H, Nyce S, Ghosn J, Mutuerandu T, Black RE. (2012). Medical conditions among Iraqi refugees in Jordan: data from the United Nations Refugee Assistance Information System. Bulletin of the World Health Organization; 90: 444-451.
- 9 UNHCR (2014) Syria Emergency Appeal <http://donate.unhcr.org/international/syria>
- 10 Perry A, Meeker J, Seal A. (2012). Experiences of the Nutrition in Emergencies Regional Training Initiative. Field Exchange 42, January 2012. p50. [www.ennonline.net/fex/42/experiences](http://www.ennonline.net/fex/42/experiences)

**Table 1: Length, participation and content of the NIERTI-Lebanon courses**

Year	2010	2012	2014
Number of days	6	12	9
Total number of participants	17	24	35
Number of Lebanese participants	13	10	25
Number of regional participants	3	3	7
Number of international participants	1	11	3
Modules covered	Introduction to NIE	Introduction to NIE	Introduction to NIE
	Causes of malnutrition	Causes of malnutrition	Causes of malnutrition
	Humanitarian system	Humanitarian system	Humanitarian system
	Humanitarian standards and M&E	Humanitarian standards and M&E	-
	-	Humanitarian funding	-
	Rapid assessments	Rapid assessments	Rapid assessments
	-	Surveillance and early warning	Surveillance and early warning
	Nutrition surveys	Nutrition surveys	Nutrition surveys
	Food assistance	Food assistance	Food assistance
	Micronutrient interventions	Micronutrient interventions	Micronutrient interventions
	Management of severe acute malnutrition	Management of severe acute malnutrition	Management of severe acute malnutrition
	Management of moderate acute malnutrition	Management of moderate acute malnutrition	Management of moderate acute malnutrition
	-	CMAM challenges and opportunities	-
	-	Food security and livelihoods	Food security and livelihoods
	Infant feeding in emergencies	Infant feeding in emergencies	Infant feeding in emergencies
	Emergency preparedness	Emergency preparedness	Emergency preparedness
	-	Nutrition survey exercise	-
	Emergency simulation	Emergency simulation	Emergency simulation
	Professional development	Professional development	-

**The dynamics of NIERTI in the response to ongoing crises in the region**

Planning for the second NIERTI course began in 2011, amidst news of the escalating conflict in Syria. We recognised both the need to support regional capacity through a full 11-day NIERTI course<sup>10</sup> targeting relatively senior national and international individual practitioners, and for training of local Arabic speaking health staff. The NIERTI 2010 had created momentum amongst motivated attendees, trainers and organisers of the course. Two of the participants managed to mobilise resources from their organisations (IOCC and World Vision Lebanon) to sponsor nine Lebanese participants to attend the full NIERTI 2012 course, including staff from the Ministry of Social Affairs, the Ministry of Agriculture, the Ministry of Economics, the Lebanese Red Cross and local NGOs. This proved a critical time when the country was beginning to host a few hundred thousand Syrian refugees. NIERTI 2012 was attended by 24 participants from 15 different nationalities.

NIE training however, still needed to trickle down to health care workers on the ground and in order to do so, the materials needed to be translated into Arabic and examples needed to be contextualised. IOCC took the lead on this and with technical assistance from AUB and IMC, two additional 5-day Arabic-language NIE courses derived from the NIERTI materials were held for a group of health care providers working on the ground in Syria (who travelled to Lebanon for the training) and for Lebanese primary

healthcare staff working with Syrian refugees. This was the basis and the start for many other training workshops implemented in Lebanon targeting health care providers and NGO staff. To-date, more than 250 health care providers have attended NIE and IYCF-E training in Arabic in Lebanon. The same trainers then travelled to Jordan where a similar 5-day NIE was held by IMC for providers of health care in the Zaatari camp<sup>11</sup>. For the latter, additional modules were developed in Arabic on Nutritional Management of Chronic Disease and Nutritional Needs of Pregnant and Lactating women.

The NIERTI proved to be invaluable in ensuring local preparedness to respond to the Syrian humanitarian crisis. It meant that organisations were ready to conduct nutritional assessment and develop nutrition programmes on the ground, as well as build the capacity of their staff in essential NIE concepts. A core group of individuals and organisations that had been part of the first Lebanon NIERTI (as participants, trainers and organisers) were focused on NIE, and ensured nutrition was discussed as part of the Health Working Group meetings now taking place as part of the Syria crisis response within Lebanon. Having learned from the 2006 experience, and due to the mobilisation of actors from ministries as part of NIERTI, this core group was quick to act on issuing a Joint Statement on Infant and Young Child Feeding in Emergencies (IYCF-E), which was endorsed by various governmental entities, NGOs and academic institutions. This enabled

the avoidance of mistakes previously encountered regarding infant feeding, such as the untargeted distribution of donated baby food, infant formula and bottles, as well as one-off infant formula samples to hospitals, municipalities and directly to internally displaced populations.

In 2014, AUB was approached by UNICEF to conduct further NIE training for the region. A 9-day adapted NIERTI was held for participants working in the Syria crisis response, and was sponsored by UNICEF.

**The future of NIERTI – Lebanon**

The course and the materials developed for NIERTI have proved to be adaptable to various training needs over the past few years. It has managed to address the needs of different audiences, in both English and Arabic, with varying level of detail and modules.

The model has proven to be cost-effective and sustainable as long as participation fees have been able to cover the costs of international trainers and experts able to continuously update materials. In Lebanon, sponsorship of participant fees by various agencies has ensured the ability of local staff to attend these courses. The modular format lends itself to further adaptability and could be integrated into the teaching programme at the AUB to ensure sustainability post-emergency, when agencies’ priorities as regards funding participants may shift.

One of the challenges that will need to be addressed as the NIERTI continues in its current form, is obtaining funding for a more comprehensive update of the materials; currently we rely on expert trainers to do this year-to-year. We also struggle with defining the optimal length of the training course and have to balance the need to ensure competence is achieved with the amount of time agencies are willing to let their staff attend training. We are therefore considering linking NIERTI with other courses that could be taken online or in person as pre-requisites; one such option is the Building a Better Response (BBR) initiative developed by IMC, Concern and the Harvard Humanitarian Initiative.<sup>12</sup> Others could involve online courses in basic concepts of nutrition.

Lebanon now finds itself with the highest concentration of refugees per capita worldwide. Although rates of acute malnutrition in Syrian refugees remain low, in a population where 75% of households are food insecure<sup>13</sup>, ensuring capacity for programmes that contribute to the continuous prevention of malnutrition will be essential, particularly in the context of the funding shortfall for the Syria response appeal<sup>14</sup>.

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<sup>11</sup> See also Abla C, 2014. Experiences on Nutrition in Emergencies Training for Syrian refugees response in Jordan. Field Exchange 48.

<sup>12</sup> Building a Better Response <http://www.buildingabetterresponse.org/>

<sup>13</sup> WFP(2014). Preliminary results of the Vulnerability Assessment for Syrian Refugees (VASyr).

<sup>14</sup> UNHCR <http://data.unhcr.org/syrianrefugees/regional.php>

## Box 1 The knock-on effects of the American University of Beirut NIERTI: a personal experience

By Linda Shaker Barbari

Having learned about the NIERTI workshop from a colleague at AUB, I decided to attend the first 6-day course in September 2010. I felt participating in the training would be ideal for me to contribute to emergency preparedness within my country, which has had its fair share of emergencies. I did not have many expectations, except that being a strong breastfeeding advocate, I was looking forward to hearing about infant and young child feeding in emergencies (IYCF-E). I funded myself to attend as my employer, IOCC, did not have the resources. A mother of two young children at the time, I juggled what was necessary to make it happen and funded myself to attend. The NIERTI gave me the “how” and the “what” needed to proceed my personal ambition; to help those most in need in the most difficult situations. During the last day of the training, we wrote our professional development plan. My plan included three objectives: to contribute to a National Emergency Nutrition Preparedness Plan, to improve infant and young child feeding (IYCF) practices in Lebanon, and to pursue research on IYCF-E. I’ve made progress on all three areas and have maintained a close engagement with the NIERTI and AUB through my career path.

Back in 2010, many of IOCC programmes were not related to nutrition but fresh from the NIERTI, together with colleagues, we devised a strategic plan that included NIE and IYCF-E. We started small; in 2011, IOCC partnered with World Vision Lebanon who was also starting work on maternal and child health. We incorporated NIE and IYCF-E workshops within existing activities targeting grassroots organisations, and contributed to the National Programme on IYCF<sup>15</sup>. I helped secure resources from IOCC to sponsor national participants in the 2012 NIERTI course (see main article). Many participants who attended the 2012 training continued to work on nutrition and two hold key positions within the nutrition programme at IOCC. I was also instrumental in securing funds and delivering on the adapted, translated NIERTI course in Lebanon and in delivering the subsequent NIE and IYCF-E workshops by IOCC and partners within Lebanon. The acute malnutrition and IYCF-E programme currently implemented by IOCC was the first nutrition programme to be implemented in Lebanon in response to the Syria crisis; it owes a lot to the NIERTI in setting the stage for IOCC’s nutrition programming. The third NIERTI course was conducted in June 2014 and included staff from different NGOs and UN agencies. IOCC shared its experience within the training including lessons learned, challenges, and future plans; incorporating such contextual experience is of great value.

I am currently pursuing my PhD at the University of Dundee in Scotland with a focus on IYCF-E policies. I am more determined than ever to advance with nutrition in emergencies and IYCF-E interventions, all thanks to a 6-day training course that I attended in 2010.

<sup>15</sup> Shaker-Barbari et al (2014). Institutionalising acute malnutrition treatment in Lebanon. Field Exchange 48 p17.



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