Health Sector Humanitarian Response Strategy

Jordan 2014-2015

Health Sector Working Group

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1. Introduction

In early 2014, a Health Sector Strategic Advisory Group (SAG) for the Humanitarian Response was formed to further support the work of the Health Sector Working Group in Jordan. One of the SAG's main tasks[1] was developing the Health Sector Humanitarian Response Strategy, expanding upon the existing response strategy and objectives present in the *2014 Syria Regional Response Plan 6* (RRP6).

This document, which will be periodically updated, outlines the context of the humanitarian response in Jordan, particularly highlighting the Syrian refugee crisis and its implications on the national health system. Virtually all the data and figures in the strategy are related to Syrian refugees, as a large number of assessments have been carried out with this population in recent years. It is important to note, however, that the humanitarian response in Jordan also addresses refugees of nationalities other than Syrian, as well as the affected vulnerable Jordanian population. In addition to Syrian refugees, Jordan is also host to a significant Iraqi refugee population (nearly 30,000) and also to refugees of other nationalities (nearly 5,000), testament to the Kingdom's long history of providing safe haven to those fleeing strife in their homeland.

The numbers of Syrians who have sought refuge here (over 600,000 to date), and the resulting impact on the national infrastructure has required ongoing humanitarian support. As the crisis continues, there is a need to shift focus from short-term interventions to longer and more sustainable ones, expanding national capacity to respond to this, and future crises. During that transition, adequate health coverage must continue to be provided for all affected populations.

[1] Jordan Refugee Response. Health Sector Strategic Advisory Group for the Humanitarian Response Terms of Reference. July 2014. http://data.unhcr.org/syrianrefugees/download.php?id=6354

2. Context

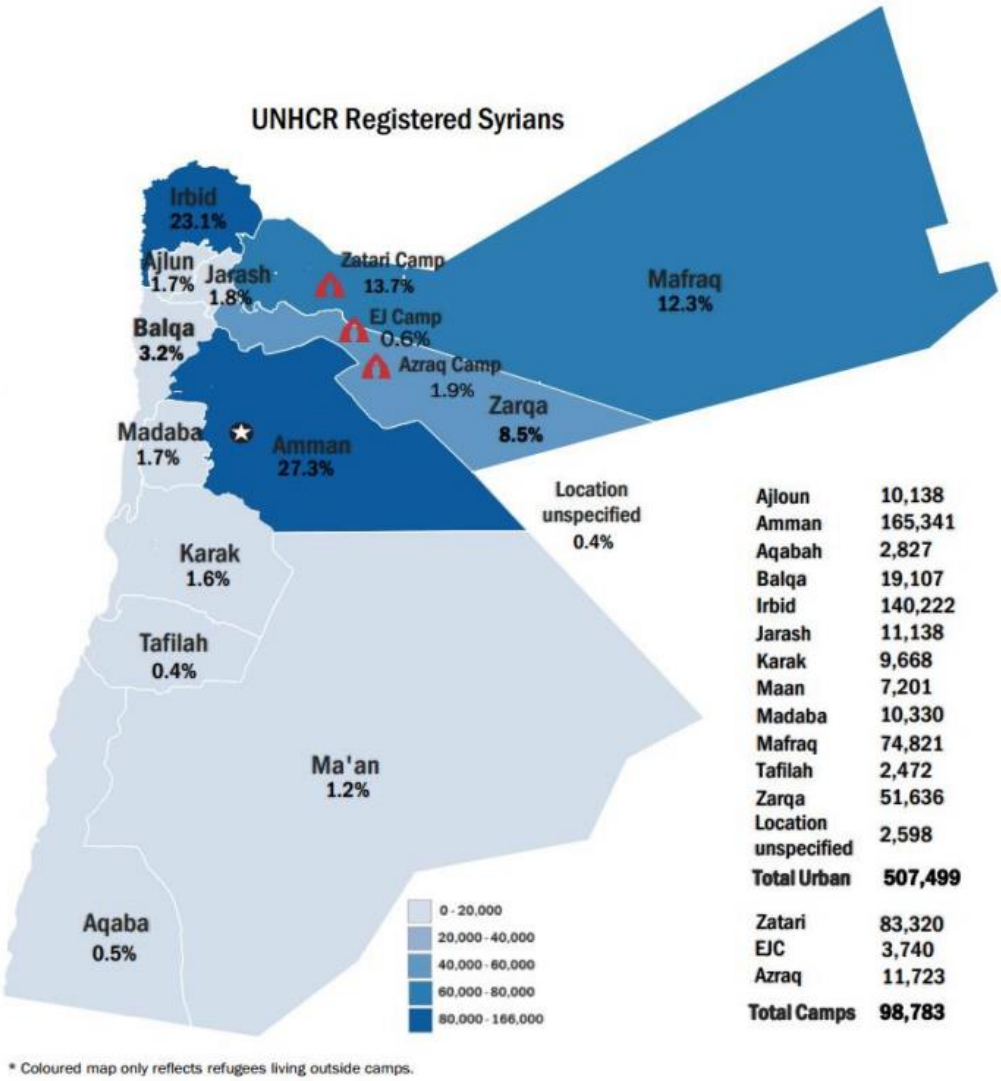
Syrian refugees registered with UNHCR

- **Urban areas: 507,499**
- **Camps: 98,783**

Source: UNHCR registration data – end July 2014

Within the overall coordination approach to the Syrian refugee response in Jordan, the Health Sector brings together different UN agencies, national and international NGOs, donors and government actors who are all working to support the continued provision of essential health services to Syrian refugee women, girls, boys and men.

With the Syrian crisis in its fourth year the evolving humanitarian context poses new demands on health systems in Jordan and consequently on the Health Sector. There is a need to strengthen planning and coordination even further to ensure an appropriate response. This includes strengthening national capacity to cope with the increased numbers requiring health services; improved collection and analysis of data and dissemination of information; emergency preparedness; and, crucially, improving the alignment of international responses with national structures and strengthening the link between the humanitarian and the development responses.



Ajloun	10,138
Amman	165,341
Aqabah	2,827
Balqa	19,107
Irbid	140,222
Jarash	11,138
Karak	9,668
Maan	7,201
Madaba	10,330
Mafraq	74,821
Tafilah	2,472
Zarqa	51,636
Location unspecified	2,598
Total Urban	**507,499**
Zatari	83,320
EJC	3,740
Azraq	11,723
Total Camps	**98,783**

**Source: UNHCR Registration data – end July 2014*

3. Overview of health needs and risks

The Syrian refugee health profile is that of a country in transition with a high burden of **non-communicable diseases** (NCDs); 21% of consultations in Zaatari in 2013 were for NCDs[2] (diabetes constituted 17%, hypertension 17 % and chronic respiratory diseases 14%). **Communicable diseases** also remain a public health concern with a measles outbreak in Jordan in 2013 and an ongoing polio outbreak in the region; there have been 137 cases of tuberculosis diagnosed amongst Syrians since March 2012 with four multidrug resistant cases; and increasing numbers of both imported leishmaniasis and hepatitis A cases in areas hosting large numbers of Syrians. The patchy immunization coverage especially of refugees outside of camps is of concern particularly in light of the polio outbreak with 36 confirmed cases in Syria and two confirmed cases in Iraq. The last virologically-confirmed polio case in Jordan was reported on 3 March 1992. There is a need to strengthen uptake of routine immunization (Jordan has 10 vaccines in its schedule) and support campaigns for both Syrian and Jordanian children to respond to the threat of polio.

Morbidity

21% of consultations in Zaatari in 2013 were for NCDs:

- **17% diabetes**
- **17% hypertension**

- **119 cases of TB since March 2012**

- **39.8% of ≥18 years have at least one chronic condition**

Crude and under five mortality rates based on Zaatari data in 2013 were within expected ranges and comparable to Jordan's rates. Crude mortality rate peaked in the first quarter at 0.37 per 1000 per month and declined to 0.21, 0.17, and 0.19 in the second, third and fourth quarter respectively. In the first quarter of 2014 this was stabilised at a crude mortality rate of 0.1 per 1,000 persons per month and the under 5 mortality rate was 0.3 per 1,000 persons per month. Neonatal mortality has improved from 26 per 1,000 live births in the camp in 2013 to 15.6 per 1000 in the first quarter of 2014. If sustained, these rates are now comparable with those of Jordan. Nevertheless, a neonatal and maternal care assessment[3] conducted in January 2014 in Zaatari and Mafraq demonstrated the need to refocus on appropriate and effective lower technology interventions such as kangaroo mother care, use of the partograph and early initiation of breast feeding as well as ensuring early management of both maternal and neonatal complications prior to referral. In 2013, 41% of under five deaths occurred in the neonatal period.

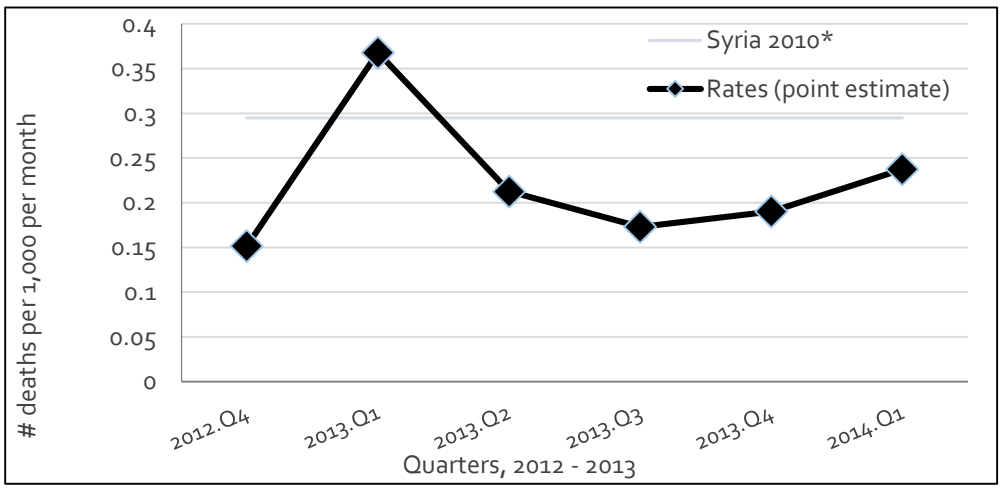


Figure 1 – Quarterly mortality rates, Zaatari, Jordan, 2012-2014

*Syria crude mortality rate for 2010. Source: World Bank.

Note: Indicated rates may underestimate true rates if either all deaths were not reported or estimated population of the camp is higher than true camp population. Rates indicated here are preliminary and may be revised.

[2] This does not include consultations for mental health and injuries.

[3] Ministry of Health, UNICEF, UNHCR, UNFPA, Maternal and New Born Health Services. Rapid Assessment Report Zaatari Camp and Mafraq Women and Children's Hospital. January 2014

***Figure 2**– Non-communicable diseases as reported from Zaatari camp, January – March 2014 (n=62,142)*

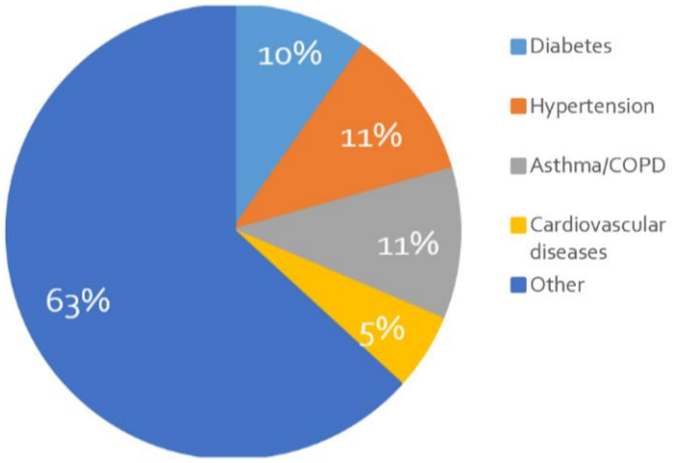
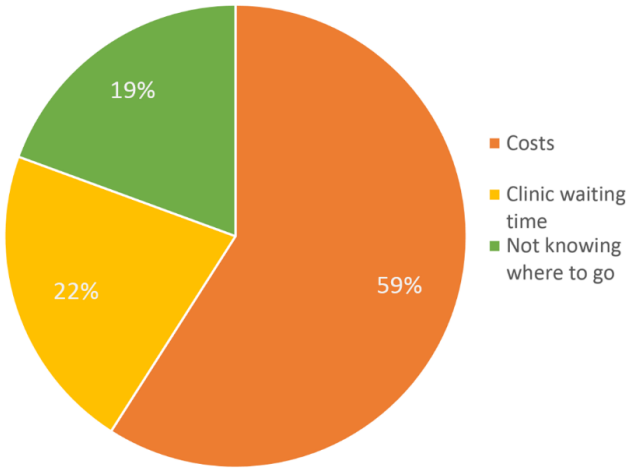


***Figure 3**– Reasons for not receiving care for chronic diseases*



NCD management is not always satisfactory, with inadequate monitoring, lack of a multidisciplinary approach and treatment interruptions. According to a survey conducted by UNHCR in February 2014[4] in non-camp refugees among household members who were ≥18 years, 39.8% were reported to have at least one chronic condition and 23.9% of household members with chronic diseases reported difficulty accessing medicine or other health services. The main reasons mentioned for inability to get care were costs (44.7%), long wait at the clinic (16.3%), and not knowing where to go (14.7%). During in-depth interviews with 51 NCD patients in another assessment,[5] the main barriers to care expressed were inability to get regular medications due to Ministry of Health (MoH) shortages and then the cost of needing to purchase these medications themselves. Not surprisingly 34 respondents stated that their condition had worsened since leaving Syria. The continuing challenges in adequately addressing NCDs have the potential to seriously impact both quality of life and life expectancy amongst refugees. MoH, WHO, UNHCR and other health stakeholders have established a task force to improve NCD management amongst Syrians.

Reproductive Health

- **100% of deliveries in Zaatari in first quarter of 2014 attended by a skilled attendant**
- **Amongst non-camp refugees 96.9% delivered in a health facility, of which 30.2% were in a private facility**
- **Deliveries in girls under 18 years old has increased from 5% in first quarter of 2013 to 11% in first quarter of 2014**

Reproductive health coverage has improved with 100% of deliveries in Zaatari in the first quarter of 2014 attended by a skilled attendant (compared to 92% on average throughout 2013). However, complete antenatal care coverage (at least four visits) and tetanus toxoid coverage both need improvement. The proportion of deliveries in girls under the age of 18 was 11% in the first quarter of 2014 which represents a significant increase compared to the average for 2013 of 5%. Girls under 18 are more likely to experience obstetric and neonatal complications. There is a need for Health Sector actors to link with Child Protection (CP) and strengthen interventions to reduce early marriage. UNFPA continues to support Jordan Health Aid Society (JHAS) in providing basic emergency obstetric services in Zaatari and has progressively increased the capacity and resources to meet demands. While UNFPA, MoH and other key partners have worked extensively to

[4] UNHCR and JHAS. Non-Camp Syrian Refugee Household Knowledge, Access and Uptake of Health Services Baseline Survey. February 2014.

[5] IMC. Health Access Assessment in Non-Camp Refugees in Jordan. December 2013- January 2014.

improve the clinical care for sexual assault survivors though development of guidelines, trainings, and distribution of post-rape kits, there is still a need to improve quality of service in this field. Notably progress has been made in terms of connecting health facilities to other services thanks to the CP and sexual and gender-based violence (SGBV) standard operating procedures. Messaging on SGBV is very sensitive and community and provider knowledge continues to be limited, however extensive efforts have been implemented at the inter-agency level to improve knowledge of SGBV response services.

According to the UNHCR survey in non-camp refugees among women and girls aged between 14 and 49 years, 16.6% were pregnant at least once in the past two years while in Jordan, and of those who had delivered in Jordan, 96.9% delivered in a health facility – 30.2% of those, in a private facility. A range of factors could explain the use of private facilities for deliveries including administrative barriers for registered refugees, lack of knowledge of available services, shortage of female doctors in the public sector and preference for private care. UNFPA with MoH and other stakeholders also supports reproductive health services through both mobile and static clinics in out-of-camp settings to enhance access for vulnerable and marginalized populations, such as in the Jordan Valley and southern governorates.

Injury remains a considerable burden. A Handicap International/HelpAge International assessment[6] reported that 8% of refugees in Jordan have a significant injury of which 90% were conflict-related. Men accounted for 72% of the injured persons with the highest proportion of injuries found amongst those aged 30 to 60 years. The impact of injuries on men of productive age increases household vulnerability. The capacity to address the health needs of war wounded has increased substantially, particularly emergency stabilization, acute surgery and rehabilitation (physical and psychosocial). However, there are still major gaps in medium to longer term post-operative/ convalescent care, home nursing, functional rehabilitation (assistive devices/prosthesis) and community-based rehabilitation.

Injuries

- **8% of refugees in Jordan have a significant injury (90% conflict-related)**
- **72% of injured are men**
- **22% of Syrian refugees in Jordan have an impairment**

Mental Health

- **9,178 consultations for mental health disorders in 2013**
- **10% epilepsy**
- **17% severe emotional disorder**
- **12% psychotic disorder**

The **disabled and elderly** are under-represented in UNHCR's registration database and more needs to be done to ensure that they have equitable access to the health services they need. According to the Handicap International/HelpAge International assessment, 22% of Syrian refugees in Jordan and Lebanon have an impairment. There are inadequate services for children with specific disabilities, e.g. cerebral palsy. More needs to be done to ensure that needs of the disabled and elderly populations are addressed to ensure their access to health care services. Disaggregated data in the *Regional Response Plan 6* is assisting with this.

Mental health problems remain a significant concern for refugees in Jordan. There were 9,178 consultations for mental health disorders in 2013 (10% for epilepsy/ seizures, 17% for severe emotional disorder and 12% for psychotic disorder). In general, there is an over-emphasis on trauma and less focus on delivering comprehensive, integrated services, and on supporting natural coping strategies and family/community resiliency. Furthermore, the geographic coverage of services needs to be widened. A comprehensive

[6] Handicap International/HelpAge International. Hidden victims of the Syrian crisis: disabled, injured and older refugees. 2014.

assessment[7] conducted in 2013 revealed an increased need for early detection and referrals, services to address concerns in children, and strengthening outreach, family and community-based activities that promote resiliency, skill building and adaptive coping strategies. More attention is needed for chronic mental health conditions, cognitive impairment, and pervasive developmental disorder.

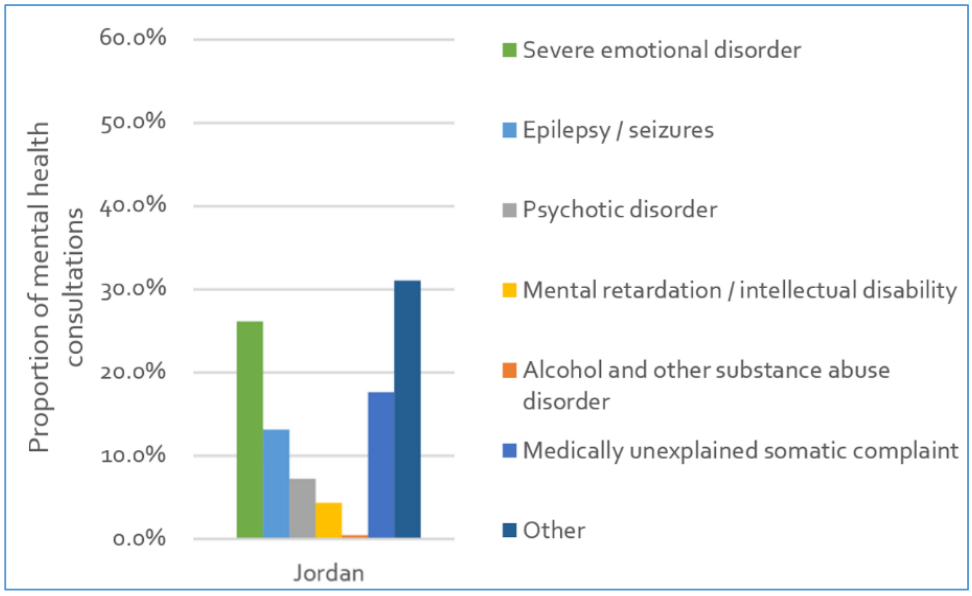


***Figure 4** – Mental health conditions in Jordan (Zaatari camp), January – March 2014*

The acute **malnutrition** prevalence among refugees is low with a global acute malnutrition level of 1.2% in children under five in Zaatari based on weight for height Z score and 0.8% in refugees out of camp.[8] Anaemia in children under five and women of reproductive age in Zaatari camp was high at 48.7% and 44.7% respectively. Lower but still concerning levels were found in the host community. There is a need to expand anaemia prevention and treatment initiatives and ensure access to other critical micronutrients. Infant and young child feeding (IYCF) practices were poor pre-conflict including early weaning, and inappropriate complementary feeding practices. Despite the low acute malnutrition levels new arrivals under five years old will continue to be screened with Mid-Upper Arm Circumference (MUAC) in light of the potential deterioration of food security and nutrition status inside Syria.

At primary health care level there is limited **access** for unregistered refugees, those with expired asylum seeker certificates and those with a Ministry of Interior Card that does not match their current place of residence. Restriction of movement for women and girls may limit their access to health services, while lack of female providers for reproductive health services though improved is also a barrier. Recent assessments by IMC[9] and PU-AMI[10] have also shown that refugees have trouble accessing health services if living in a governorate different from the one where they registered with the Ministry of Interior; for some, while healthcare is provided free of charge, transportation to and from health centres incurs a significant cost they cannot afford, and many find the distance to clinics a barrier in itself.

[7] WHO, IMC, MOH and EMPHNET. Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrian in Jordan. February 2014
[8] UNHCR/UNICEF/WFP/WHO/UNFPA/Medair. Nutrition Survey Preliminary Findings. April 2014.
[9] IMC, UNHCR, UNFPA. Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings Throughout Jordan, With Sub-Investigation on Non-Communicable Disease Management: A Qualitative Cross-Sectional Cluster Survey. March 2014.

[10] PU-AMI. Hashemite Kingdom of Jordan, Syrian Crisis: Health Needs Assessment. March 2014.

Refugees continue to cite lack of **information on health services** as a major problem. Although a UNHCR/JHAS survey demonstrated that 96% of registered refugees know that they have free access to governmental health services only 67% know that those who cannot access services can be assisted through UNHCR partner clinics.[11] Furthermore, an Oxfam study[12] demonstrated that 75% of respondents in Zaatari wanted more information on medical services while refugees in the host community want clarity on which medical procedures they are entitled to, which they must pay for and why, and how to request additional support if necessary. Women refugees in non-camp settings cited lack of knowledge about available services as a barrier much more frequently than men[13] highlighting the importance of diverse communication strategies to reach women.

Information Needs

- **75% respondents in Zaatari want more information on medical services**
- **67% refugees know they can be assisted through UNHCR partner clinics if they can't access government health services**

Secondary and tertiary care need a continued high level of funding to ensure access to essential care such as deliveries, caesarean sections, war injuries, congenital abnormalities including cardiac abnormalities and renal failure. Despite the high level of care available in Jordan, gaps in service delivery exist including long-term post-operative care – especially for injuries – and surgical management of certain complications such as pressure sores. Costly complex treatments such as certain types of cancer cannot be supported with available resources necessitating difficult choices relating to resource allocation. A Reproductive Health Assessment[14] identified access to delivery services for unregistered non-camp refugee women as problematic due to lack of awareness of available mechanisms to ensure coverage.

National Health Systems

- **9% of total patient visits were Syrian**
- **Hospitals in Irbid governorate:**
  - **16,687 consultations for Syrians in primary health care centres**
  - **763 inpatients**
  - **4,767 outpatients**

MoH's critical role in providing refugee health services needs to be recognized and supported. Facilities in areas hosting large numbers of refugees are often overburdened. The Health Facility Assessment[15] in the five northern and middle governorates of Irbid, Mafraq, Jerash, Ajloun and Zarqa demonstrated that over 9% of total patient visits were by Syrians. This manifests in shortages of medications – especially those for chronic diseases – and beds, overworked staff and short consultation times. This also fosters resentment amongst the Jordanian population. National capacity to provide inpatient management of acute malnutrition has not yet been developed. The health information system in urban settings needs to be integrated nationwide and to be able to routinely disaggregate Syrians and Jordanians in key areas.

[11] UNHCR and JHAS. Non-Camp Syrian Refugee Household Knowledge, Access and Uptake of Health Services Baseline Survey February 2014
[12] Oxfam. Refugee Perceptions Study - Zaatari Camp and Host Communities in Jordan. June 2014.
[13] IMC. Health Access Assessment in Non-Camp Refugees in Jordan. December 2013–January 2014.

[14] Boston University School of Public Health, UNHCR, UNFPA, CDC, Women's Refugee Commission. Reproductive Health Services for Syrian Refugees in Zaatari Refugee Camp and Irbid City, Jordan: An Evaluation of the Minimum Initial Service Package. 17–22 March 2013.

[15] MoH, WHO, UNHCR, UNICEF, UNFPA, Harvard/IAPS, JUST & MDM. Joint Rapid Health Facility Capacity & Utilization Assessment. July 2013.

At community level, coverage of **outreach and Syrian community involvement** in the promotion or provision of health services is insufficient. Syrian refugee providers remain outside of the mainstream coordination mechanisms. This undermines Syrian access and coverage of key services, community capacity building, self-reliance and the ability to withstand future adversity. There is a need for greater access of refugees to information and enhanced refugee participation and engagement in identification of health and disability related needs, provision of information and linkages with health and rehabilitation services.

While the main focus of the international and donor community in Jordan is on the large numbers of Syrian refugees, refugees of other nationalities also constitute a significant number of persons of concern, and care needs to be taken to ensure that they are also being provided with enough information on their rights to access health care, and are receiving assistance as appropriate from MoH, UN agencies and NGOs.

i. Health system performance

With a sustained number of Syrian refugees entering Jordan and the clearing of the registration backlog, demand on the public sector as well as NGO-supported clinics continues to grow. In March 2014, for example, there were 16,687 consultations for Syrians in primary health care centres, 763 inpatients and 4,767 outpatient visits in hospitals in Irbid governorate alone. Despite the difficulties, MoH has maintained its policy of free access to primary and secondary care in their facilities for registered Syrians living outside of camps. Most refugees therefore have the right to access MoH services. However this has caused a considerable burden on MoH facilities which cannot be sustained without significant additional support.

MoH immunization capacity was strengthened with in-kind support of cold chain equipment and vaccines provided by UNICEF, essential medicines supported by WHO and equipment supported by UNHCR. The MoH has also partnered with Medécins Sans Frontiers to open a trauma surgery facility in Ramtha Public Hospital for the management of injured Syrians crossing the border. In addition, MoH, with the support of WHO Jordan has begun creating weekly epidemiological bulletins that highlight the key communicable disease related issues that have arisen in Jordan in the previous week.

MoH with the support of UNFPA provides family planning methods for the affected population in Jordan. UNFPA has continued supporting MoH by providing pharmaceutical supplies and equipment including ambulances, ultrasounds, reproductive health kits, and autoclaves to assist in meeting the demands of the affected population.

ii. Target groups and areas

There are two main population groups of concern: refugees (Syrians – over 600,000 women, girls, boys and men registered with UNHCR; Iraqis – over 28,000 women, girls, boys and men registered with UNHCR; Sudanese, Somalis and others – over 4,000 women, girls, boys and men registered with UNHCR); and affected host community.

As of end July 2014, the geographical distribution of Syrian refugees per governorate is as follows: over 160,000 in Amman (27%), over 150,000 in Mafraq (26%, including over 80,000 in Zaatari camp); over 140,000 in Irbid (23%); and over 60,000 in Zarqa (10%, including over 11,000 in Azraq camp).

Other refugees registered with UNHCR

- **28,809 Iraqis**
- **4,417 other nationalities**

Source: UNHCR registration data – end June 2014

The geographic focus on northern governorates is important, but attention will also be given to the acute health sector challenges faced in a number of middle and southern zone governorates.[16]

Population group	Total Population
Camp refugees	150,000
Non-camp refugees	550,000
Other affected population	700,000[17]
Refugee children under five	133,000
Refugee women of reproductive age	161,000
Adolescents	126,000
Pregnant women and lactating women	35,000
Refugees with impairment and disabilities	154,000
Refugees with injuries	56,000

Table 1 – Estimated target populations based on end of 2014 projections

iii. Coordination

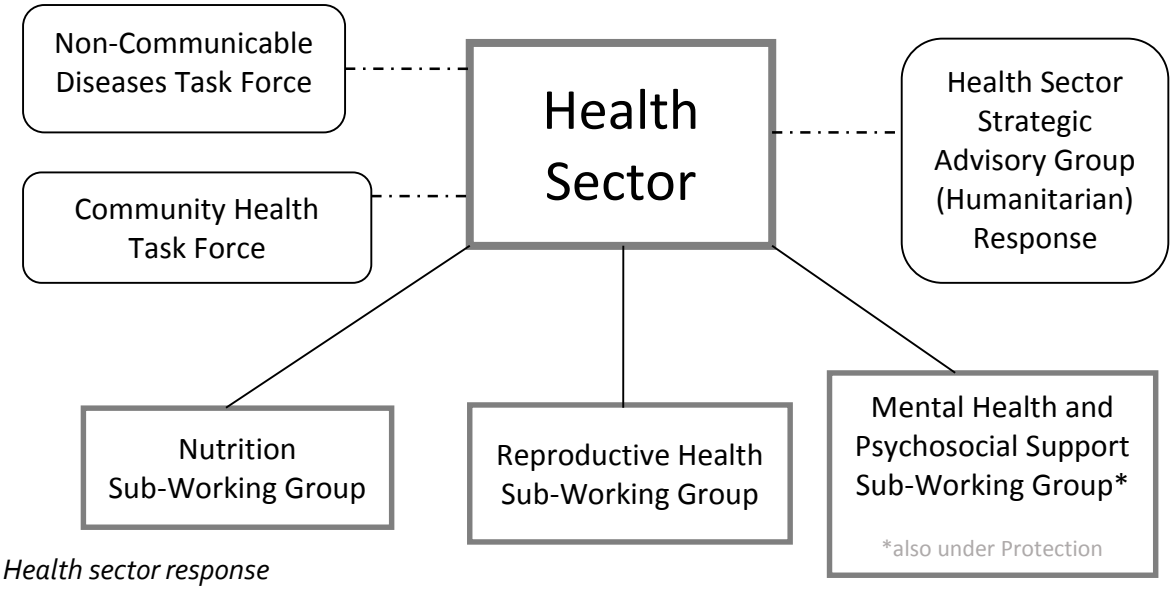


Figure 5 *– Health sector response*

Coordination is an essential part of the humanitarian response, with the aim of avoiding unnecessary duplication of service delivery and identifying gaps where services are most needed. Coordination platforms at national and field levels have been strengthened with increasing utilization of data and survey results to ensure gaps and emerging needs are addressed. In transitioning from humanitarian relief in the Syrian refugee context there is a need to link with the broader development initiatives in-country. This will entail stronger coordination both within and between the humanitarian and development sectors at all levels; health sector mapping of all development initiatives and the relationship between the humanitarian effort and development efforts, and elaboration of longer-term plans to strengthen gaps highlighted by the humanitarian situation.

[16] Such as Zarqa, Maadaba, Balqa, Maan, Karak and Tafilah.

[17] This total does not include the 3,850,000 individuals who will benefit from vaccinations.

In early 2014, a Strategic Advisory Group was created to provide technical and strategic support to and increase ownership and joint accountability within the Health Sector. Currently, the Health Sector is comprised of a main working group and two sub-working groups (Nutrition and Reproductive Health); a third sub-working group, Mental Health and Psycho-Social Support, falls under both the Protection and Health Sectors. In late 2013, a Community Health Task Force was also formed, to harmonize the approach to community health, including developing a Community Health strategy and reaching consensus on the definition and main tasks of Community Health Volunteers; in early 2014, a NCD Task Force was formed to support MoH in increasing the response capacity for NCDs, and for actors to share experiences and consolidate NCD interventions.

Gender focal points within the sector will assist in ensuring that the differential needs of women, girls, boys and men are considered throughout the response.

iv. Strategic Intersections

The Health Sector liaises with other sectors including Cash, water, sanitation and hygiene (WASH) and SGBV, to ensure consistency in programming and mutual assistance in meeting objectives. Emergency cash assistance can be used to meet health sector objectives by supporting transport to and from health services or covering some costs not able to be covered elsewhere. There are clear linkages between WASH services and health status. Gender-based violence requires a multi-sectoral response with health services being integral to the detection, prevention and response to GBV.

The Health Sector will take account of the different needs of women, girls, boys and men, recognize the potential barriers they may face in accessing services and ensure that women, girls boys and men can access health services equally. This will be assessed, integrated, monitored and evaluation throughout all stages of the response.

4. Goals

Reduce excess morbidity and mortality amongst Syrian refugees through initiatives which strengthen national health systems, build Syrian community capacity and continue to ensure host community access to health services.

5. Objectives

To support the continued provision of essential health services, major needs and priorities have been identified at community level, primary health care level, secondary and tertiary care and the national health system. In order to achieve the broader health sector goals, the Health Sector will frame its response in Jordan according to the following objectives.

1. **Improve equitable access, quality and coverage to comprehensive primary health care for Syrian refugee women, girls, boys and men in Jordan by end of 2014.**

   Expected outputs:

   i. Management of communicable diseases, including Expanded Program on Immunization (EPI) services in place.

ii. Management of common non-communicable diseases strengthened
iii. Comprehensive reproductive health services provided to Syrian refugees and affected Jordanian population
iv. Increased availability of safe and confidential GBV related medical services
v. Appropriate IYCF feeding practices promoted
vi. Improved access to mental health services at the primary health level

2. Improve equitable access, quality and coverage to essential secondary and tertiary health care for Syrian refugee women, girls, boys and men in Jordan by end of 2014.

Expected outputs:

i. Referral system for secondary and tertiary care supported
ii. Secondary mental health services provided
iii. Physical rehabilitation for persons with injuries and/or disabilities provided
iv. Access to emergency obstetric care provided
v. Facility based convalescent and longer term post-operative care provided for those with injuries and serious disabilities

3. Support the capacity of the national health care system to provide services to Syrian women, girls, boys and men and vulnerable Jordanians in the most affected governorates.

Expected outputs:

i. Access to primary and essential secondary and tertiary health care supported through equipment, financial support, medication and medical supplies especially essential chronic disease drugs
ii. Capacity building MoH services and staff as well as other national actors developed

4. Improve coverage of comprehensive health and rehabilitation services to Syrian refugees through integrated community level health and rehabilitation interventions by end of 2014.

Expected outputs:

i. Community health volunteer teams and referral system in place
ii. Community level nursing for those with injuries and serious disabilities provided
iii. Community management of acute malnutrition programs implemented and monitored
iv. Community level rehabilitation provided
v. Community level mental health services provided

5. Improve and monitor access of non-Syrian refugees to primary, secondary and tertiary health care services

Expected outputs:

i. Access to primary, secondary and tertiary health care services for Iraqi and other non-Syrian refugees is supported

6. Strategic Approaches

The response strategy will be throughout the refugee cycle from arrival to durable solutions and will consist of the following:

1. Respond to immediate health needs of new arrivals including those with injuries, NCDs, pregnant women and other specific needs.
2. Continue the provision and facilitation of access to comprehensive primary and essential secondary and tertiary health services both in and out of camps and strengthen the community health approach.
3. Strengthen the capacity of the national health system in most affected areas to respond to the current crisis, withstand future shocks and meet associated needs of the Jordanian population.

The response strategy in Zaatari and Azraq camps will be to ensure effective coordination to address gaps, including logistical and human resources support to MoH in order to strengthen their lead coordination role; continued monitoring of refugee health status, coverage and access especially for the most vulnerable; and promoting linkages with national health systems so that support will go to nearby MoH facilities where possible rather than creating high-level systems inside the camps.

In relation to SGBV, health care providers play an important role in receiving disclosure from survivors and provide critical clinical management and referral. This will be strengthened through training and improved monitoring in coordination with the Protection Sector, SGBV sub-sectors, Family Protection Department, and other relevant national institutions, including through the full implementation of the CP and SGBV standard operating procedures. Critical gaps outside the camps which are not able to be met by the MoH will be met through further supporting NGO clinics and support for referrals. Continued support to NGOs to relieve the burden on MoH facilities is needed until the MoH facilities are able to manage the increased workload. UNFPA and UNICEF will be supporting MoH to develop a complete Clinical Management of Rape Survivors protocol in line with internationally defined standards. A health information system has been introduced in UNHCR-supported NGO facilities in order to contribute to the available data on Syrians, including data disaggregated by gender and age. This in combination with the recently established GBV Information Management System, coordinated by UNHCR and UNFPA, will be able to provide increased information of trends and SGBV as well as gaps in service provision.

In both camp and non-camp populations two additional approaches will be developed. Firstly, a strategy to strengthen refugee participation and engagement in provision of information and selected health services (e.g. diarrhoea management with oral rehydration solution, behaviour change communication, MUAC screening, referral to primary health care centres), by training and supporting male and female community health volunteers, will be developed by agencies working in the Health Sector and resources sought for this. Secondly, vulnerability identification and scoring will be improved with the aim of better targeting and reaching those most vulnerable with essential services and assistance and monitoring of assistance against needs. This will build on a pilot project initiated in Zaatari in 2013 and expanded to other sectors.

In response to the polio outbreak in Syria the MoH, WHO, UNICEF and other actors in Jordan have developed a polio prevention and response strategy. This includes a total of three national immunization campaigns targeting all children under five including Syrians in camp and non-camp settings completed by March 2014, strengthening active and passive surveillance for acute flaccid paralysis cases, introducing environmental surveillance, establishing three walk-in cold rooms and enhancing social mobilization for immunization.

The Health Sector will continue, in a coordinated manner, to conduct assessments of needs and capacities (including refugee women, girls, boys and men), coverage and impact (gender disaggregated), as well as

ensure periodic monitoring and evaluation and the availability of the necessary information to inform strategic planning processes. In particular the observed gender differences in mental health consultations (more males than females), psychiatric admissions (more females than males) and injuries (more males than females) will be explored to determine if this represents a morbidity pattern or differential access.

For refugees in non-camp settings the national system will be supported through adequate human resources in areas most affected by Syrians, essential medicines, supplies, equipment and critical infrastructural improvements, and performance-based incentives for staff. Specific capacity gaps will be addressed though training and development of workplans with partners, such as inpatient management of acute malnutrition, clinical management of SGBV, integration of mental health into primary health care; or through staff secondment or human resources support, such as for chronic disease management and specialized trauma surgery.

Certain gaps are beyond the capacity of the Health Sector to address, including the MoH staffing freeze which limits their ability to respond to the increased workload, or major infrastructure gaps such as the new Zarqa Hospital. Furthermore, humanitarian funding channels often preclude general budgetary support to the MoH but require funds to be channelled through humanitarian partners and in-kind support.

7. Key Overarching Approaches

i. Use of inter-agency health and reproductive health kits (IAHK, RHK)

- The use of Inter-agency Health Kits is no longer required and agencies should be using procurement based on consumption and local morbidity patterns.
- RH kits can be used for emergency preparedness and response to critical gaps but only the Clinical Management of Sexual Violence kit is suitable for ongoing needs due to the very specific drugs provided.

ii. Comprehensive Reproductive Health programming

- As the crisis is in its fourth year the emphasis in reproductive health should be on comprehensive programming. The Minimum Initial Services Package (MISP) is only appropriate for new camp situations or preparedness measures for a large influx.

iii. Balance between Health Systems Strengthening and Services Delivery

- Focus on strengthening of existing national health systems whilst still ensuring services for refugees are maintained or strengthened
- The Syrian crisis can be used to strengthen key components of national responses in key areas e.g. GBV response, neonatal care, nutrition, mental health, NCD management and emergency preparedness.

iv. Support equitable and sustainable access to health services

- A country specific essential health package for Syrian refugees will be developed in order to establish a minimum agreed package for Syrians. The essential package will need to include:
  - Primary health care; Routine EPI
  - Curative health care for main causes of morbidity and mortality
  - Preventative health care for main causes of morbidity and mortality
  - Comprehensive reproductive health care with emphasis on identified priorities
  - Community health with emphasis on identified priorities
  - Disability related health services

- Nutrition
- Mental health
- Communication for development in priority areas

v. Essential medicines and drug donations

- Adhere to WHO's Interagency Guidelines: Guidelines for medicine donations - revised 2010. Third edition, 2011. (http://whqlibdoc.who.int/publications/2011/9789241501989_eng.pdf)

vi. Guiding documents

i. Technical Standards Applicable: UNHCR's Essential Medicines and Medical Supplies Policy and Guidance.
   a. 2011. (http://www.unhcr.org/4f707faf9.pdf)
   b. 2013. (http://www.unhcr.org/527baab09.pdf)

ii. Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas. 2011. UNHCR (http://www.refworld.org/docid/4e27d8622.html)

iii. UNHCR's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern. 2009. (http://www.unhcr.org/4b4c4fca9.html)

iv. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 2011. (http://www.sphereproject.org/handbook/)

v. UNHCR's Health Information System: http://www.unhcr.org/pages/49c3646ce0.html

vi. Core Commitments for Children in Emergencies, Health, UNICEF. (http://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/UNICEF/UNICEF1%20-%20Core%20commitments%20for%20children%20in%20emergencies.pdf)