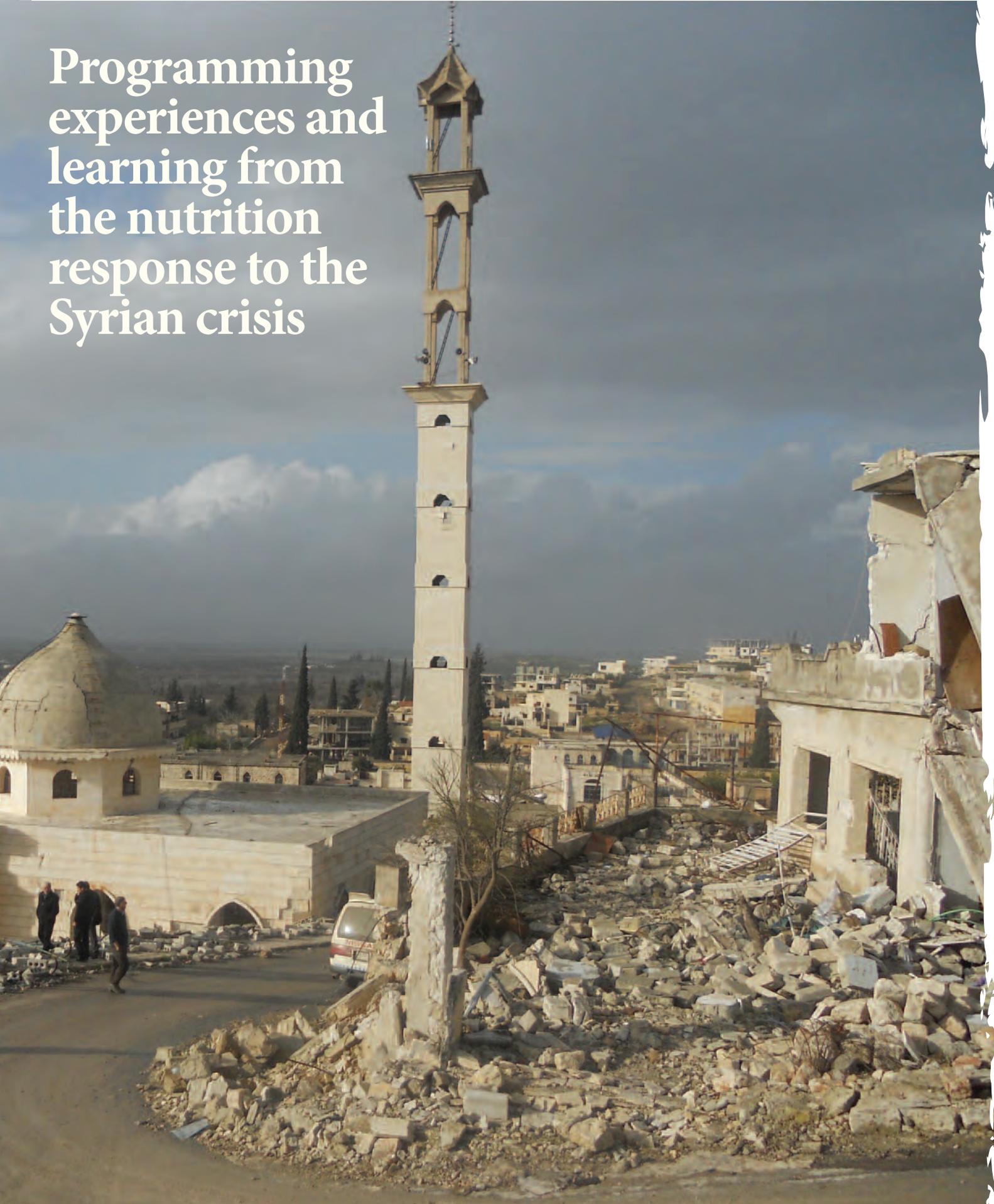


Field Exchange

Emergency Nutrition Network

Programming experiences and learning from the nutrition response to the Syrian crisis



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Ahmad Baroudi, SC Lebanon, 2013

Approximately two years after the outbreak of civil war in Syria in April 2011, the ENN decided to compile a special issue of Field Exchange on the humanitarian response to the crisis that unfolded. This decision was based on the fact that there was (and remain) a number of unique features of this ongoing regional emergency and it presented an important opportunity to capture programming experiences and learning. In particular, the massive and unprecedented scale of need amongst those displaced in Syria (there are now over 9 million displaced Syrians and it is the biggest refugee crisis faced by UNHCR in its 64 year history) combined with the generosity of host governments and the donor community (including many non-traditional donors) in meeting needs; the programming challenges of remote management in conflict affected Syria and of serving the needs of non-camp populations in refugee hosting countries (the vast majority of refugees are not in camps); the substantial impact of the refugee population on host populations, and the unprecedented scale of cash and voucher programmes being employed in the region. At the outset of compiling this special issue, it was not clear to the ENN what, if any, nutritional challenges were being faced. This only began to emerge as we engaged with key actors and undertook a number of country visits. The ENN views article that accompanies this editorial is an attempt to set out the nutrition challenges of this crisis and emerging issues as we see them.

The ENN began the process of compiling this special issue a year ago, conducting over 100 telephone interviews (at headquarters, regional and country level) with agencies working in the region (UN, INGOs, NGOs, donors and research groups) in order to obtain agency briefings, hear programming experiences and scope out potential areas of interest for field articles. At the outset, in September 2013, ENN met with staff in UNHCR, IFRC, ICRC and OCHA in Geneva who provided overviews of their respective agency responses in the region and helped identify key issues to highlight in the edition. Three ENN Technical Directors then visited the region in March/April 2014 to meet with 45 country offices in Jordan, Lebanon and southern Turkey, interviewing more than 60 staff involved in the response. Efforts to conduct a short trip to Damascus proved unsuccessful given the security situation. Field visits, facilitated by WFP, Save the Children Jordan, IOCC and UNHCR, were conducted to see programmes first hand. On return to the UK, the ENN team continued to work closely with authors to develop and finalise articles and met again with Geneva based agencies in July 2014, to share the essence of our observations now reflected in the ENN views piece (see page 2).

It is important to note that we reflect the experiences of the 'traditional' humanitarian com-

munity; it proved too challenging (this time) to capture experiences from the immense non-traditional¹ humanitarian community that has responded to this crisis, including several important non-traditional donors and a large number of faith-based organisations. Many of these organisations/institutions have not been part of the formal coordination structures established as a response to this emergency and this is one of the reasons why we found it difficult to engage with and capture the programming experiences of these entities. By all accounts, the humanitarian response of the Syrian community – at home and abroad – has been huge,

The outcome of these efforts is in effect a triple edition of Field Exchange comprising 35 field articles (plus four postscripts), nine views pieces, one research article, one evaluation, one news piece and three agency profiles. The unprecedented number of articles generated has meant that for practical and cost purposes, we have produced it in two forms: a full online edition and a smaller print edition that features a selection of programme-oriented articles informed by considerations of geographic spread, range of sectors and 'richness' of learning. The online edition will feature on the UNHCR Syria response interagency information sharing portal, the 'go to' online destination for programmers in the region².

A number of field articles have fallen by the wayside, largely as agencies came to view the material as 'too sensitive' for publication. Although disappointing, some of the authors have stated that the process of writing the article was useful for internal lesson learning even though the material cannot be disseminated more widely. There is also material in this special issue that has been written anonymously to protect the interest of agencies, as well as articles where the authors have purposively omitted or steered clear of information which could jeopardising future programming.

The fifty-four articles in this special issue provide a truly unique overview of programming experiences in the region, as well as insights into the institutional architecture and challenges involved in supporting programming. The field articles cover a wide range of programming experiences in Syria, Jordan, Lebanon, southern Turkey (both cross-border into Syria and refugee programming within Turkey) and Iraq. A number of articles describe programmes for scaling up the treatment of acute malnutrition and support for infant and young child feeding (IYCF) in Jordan and Lebanon. There are several articles on the food voucher programmes implemented by WFP in the region. Cash has largely replaced general food distributions in the regional response apart from in Syria itself. Cash has also been used to support access to other critical needs, such as health care, shelter and livelihoods, with these 'nutrition-sensitive' programmes imple-



mented by a variety of UN and INGOs. We have also broadened our horizons to feature articles from agencies specialising in water, sanitation and hygiene (WASH), shelter, and gender based violence related programming that touch on nutrition. Two articles were 'commissioned' by the ENN – one explores the legal basis for military involvement on humanitarian grounds in Syria, a pro bono piece of work by an international barrister, Natasha Harrington, enabled by A4ID³. The second article is an anthropological review of the nutrition-related social aspects of the refugee experience in Jordan, which involved a month of field work by two anthropologists and an ENN volunteer. There are also a number of cross-cutting features in articles, such as co-ordination mechanisms, information management and challenges of remote programme management in Syria. What all these articles have in common is that they provide a rich font for learning. The accompanying ENN views piece attempts to synthesise key themes emerging and lessons learned with respect to nutrition programming and response.

Throughout this process, we have been genuinely struck by the incredible engagement of humanitarian staff with us to candidly share and write their stories, typically in 'out of office' time in evenings, weekends and whilst on leave. The authors remained eminently patient with our nagging for final drafts. All the agencies were incredibly supportive of our country visits. We extend a huge thanks to all.

We hope you find this special publication of Field Exchange to be useful for your work and an enjoyable read. We welcome feedback including letters to the editors (contacts below).

Jeremy Shoham & Marie McGrath
(Field Exchange Editors) and
Carmel Dolan (Guest Editor)

¹ For want of a better term, non-traditional humanitarian actors are those operating outside the 'traditional' UN agencies and NGOs effort and includes Arab donors, local NGOs, Syrian diaspora

² <http://data.unhcr.org/syrianrefugees/regional.php>

³ <http://a4id.org/>

ENN's perspective on the nutrition response in the Syria crisis

By Carmel Dolan, Marie McGrath and Jeremy Shoham

Unless otherwise stated, referenced articles feature in Field Exchange 48.

While the ENN's role is first and foremost to capture programming experiences and lesson learning (and we hope we have done this successfully), it is perhaps inevitable that the ENN team would make observations and therefore formulate views about the response from a nutrition perspective. Given the sheer amount of content generated across a breadth of programming and contexts, our observations go beyond a typical editorial and we have taken the liberty to write this views piece. In it we share our perspective on what we have observed regarding programming experiences and the related institutional architecture and challenges involved in coordinating the response.

It is hoped that our reflections will contribute to collective learning and may help inform the ongoing response in Syria, as well as future programming in similar contexts. However, it should be stressed that this is not an evaluation or review by the ENN. Rather, this views piece is a convergence of perspectives amongst the ENN team who visited the region as we reflected on what we were hearing and reading, and as themes and patterns began to emerge. In order to bring coherence to our views, a guiding question we have posed has been 'how effective has the humanitarian sector been in addressing the nutrition needs of those affected by the Syria crisis?' We have largely considered this on a technical and programmatic level although perhaps inevitably issues that have underpinned and shaped the response, e.g. analytical capacity, leadership and coordination, have emerged as critical factors for consideration.

Overview

The Syria crisis has resulted in an unprecedented number of refugees and displaced people in need of food, health, shelter, protection and other basic services. The refugee hosting Governments of Jordan, Lebanon, Turkey, Egypt and Iraq¹ with the support of the traditional and non-traditional² humanitarian community, have been meeting these needs with an enormously impressive programme of support. At the time of writing (September 2014), these host Governments continue to support 3,030,653 million Syrian 'people of concern' (2,998, 118 registered refugees) at an estimated annual cost to these governments of over \$3.7 billion³. In

Lebanon and Jordan, the government policy is to facilitate integration of the Syrian refugee population into the host population or into informal tented settlements (ITS). In Turkey, the government's policy has seen 220,240 Syrians hosted in 17 camps, and 623,385 Syrians settled amongst the host community⁴. Within Syria, the humanitarian community is responding to the needs of the internally displaced either from the capital Damascus or through cross border operations implemented largely from southern Turkey and Jordan. The combination of displaced and refugee populations makes the Syria situation the largest crisis of its kind in living memory and the largest refugee crisis in UNHCR's 64 year history. Another feature of the crisis has been the transition from early blanket food aid distributions to a highly targeted, organised and unprecedented humanitarian cash and voucher programme, meeting food, health, shelter, livelihoods and non-food needs.

To date, the overall refugee response seems to have successfully averted a nutritional crisis in spite of the unprecedented scale of this emergency and the challenging context, including the dispersed nature of the population and difficulty of providing services to large non-camp as well as camp dwelling populations. Prevalence of acute malnutrition is low in Jordan and Lebanon and as implied by the lack of nutrition survey data from Turkey, is not considered an issue amongst the refugees hosted there. Due to access constraints, up to date, representative nutrition data from within Syria are not available and therefore, the picture in Syria is less clear. However, following a number of pilots, great efforts are underway to establish credible nutrition surveillance systems in key conflict affected governorates⁵. It is hoped that this initiative will rapidly fill the nutrition data gap in.

The nutrition sector's response: treatment of acute malnutrition and infant and young child feeding (IYCF)

The profile of collated nutrition articles in this edition of Field Exchange demonstrates that the nutrition sector identified and focused on two main programming areas: establishing capacity for the treatment of acute malnutrition in children (particularly in Lebanon and Jordan) and support for IYCF, in particular, breastfeeding support. Whilst nutrition activities in Syria also have heavy emphasis on acute malnutrition treatment and breastfeeding support, there is "equal importance" given to preventive measures in evolving programming, such as micronutrient supplementation⁶.

Treatment of the acute malnutrition

Pre crisis, the nutrition situation in Syria was defined as 'poor' with global acute malnutrition (GAM) prevalence reported at 9.3%, stunting at 23%⁷ and under-fives anaemia at 29.2%⁸. In late 2012, an initial nutrition survey of Syrian refugees in Lebanon and Jordan indicated a low prevalence of GAM: (4.4% in Lebanon; Jordan, 5.1% in the non-camp population and 5.8% in Za'atari camp). The continued influx of refugees, poor living conditions in the ITSs in Lebanon, low breastfeeding rates and the widespread use of infant formula in the host and refugee populations, combined with anecdotal reports of acute malnourished children, led to increasing concerns amongst the nutrition community about threats to nutritional status⁹. Furthermore, whilst the recorded prevalence were 'acceptable' in global terms, to national representatives, any cases of acute malnutrition were unacceptable in this context¹⁰. These factors prompted the decision by UNICEF and a number of non-governmental organisations (NGOs) to scale

¹ We focus on Lebanon, Jordan and Turkey given this is where we have documented experiences in this edition. We recognise that Iraq and Egypt have also hosted significant numbers of refugees.

² For want of a better term, non-traditional humanitarian actors are those operating outside the 'traditional' UN agencies and NGOs effort and includes Arab donors, local NGOs, Syrian diaspora and businesses.

³ 2014 funding appeal. Currently 44% funded (correct as of 18th September 2014). Accessed at <http://data.unhcr.org/syrianrefugees/regional.php#file:///C:/Users/Marie/Downloads/TurkeySyriaSitrep>

⁴ [file:///C:/Users/Marie/Downloads/TurkeySyriaSitrep](http://data.unhcr.org/syrianrefugees/regional.php#file:///C:/Users/Marie/Downloads/TurkeySyriaSitrep) 12.09.2014.pdf

⁵ Hala Khudari, Mahmoud Bozo and Elizabeth Hoff. *WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management*.

⁶ Hala Khudari, Mahmoud Bozo and Elizabeth Hoff. *WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management*.

⁷ Syria Family Health Survey (SFHS), 2009

⁸ Ministry of Health, Nutrition surveillance system report, Syria, 2011.

⁹ Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*.

¹⁰ ENN interviews in Jordan and Lebanon.



Refugee home north of Jordan

up treatment programmes in Lebanon (such as described by International Orthodox Christian Charities (IOCC)¹¹ and Relief International¹²) and in Jordan (such as implemented by Medair¹³, Jordan Health Aid Society (JHAS)¹⁴ and Save the Children Jordan¹⁵). As neither country had prior experience of implementing treatment programmes, considerable investment was made in building national capacity¹⁶ and in training initiatives¹⁷. These experiences are featured in a number of interesting articles, many that worked to integrate acute malnutrition treatment in the healthcare systems in Jordan and Lebanon. A similar scale up has not been seen in the Turkey Government led response.

A subsequent cross-sectional cluster survey in Lebanon in 2014 appeared initially to confirm the fears of an impending nutrition crisis, with the prevalence of GAM increasing from 4.4% to 5.9% in Lebanon and to just under 9% in the Bekka Valley where a substantial proportion of refugees resided. However, the anticipated case load from this prevalence estimate was not being seen in screening activities in Lebanon or Jordan¹⁸ or found in other assessments¹⁹. Furthermore, the few cases that were detected often had pre-existing co-morbidities²⁰. Increasing uncertainty about the reliability of the Lebanon survey data, led to UNICEF requesting CDC²¹ to carry out a re-analysis of the data in 2013. This revealed that there had been some data manipulation regarding height measures²² and resulted in a readjustment of GAM prevalence to just 2.2% (0.4% SAM). Doubts have also been cast about

the validity of the earlier Lebanon 2012 survey and Jordan 2012 nutrition survey²³, fuelled by the recent UNHCR survey in Jordan in 2014, which suggested a dramatic fall in GAM to 1.2% amongst non-camp and 0.8% in camp refugees²⁴.

It is certainly good news that the prevalence of acute malnutrition is so low in this population. However, the issues around the integrity of nutrition data raise the real prospect that the drive to scale up treatment of acute malnutrition was unnecessary in both Jordan and Lebanon or at the very least, that limited resources might have been used to better effect elsewhere. It is difficult to put a figure on the level of resources devoted to scaling up treatment programmes but these are likely to have been considerable. For example, in Lebanon, 30 primary health care (PHC) centres had been 'activated' to treat acute malnutrition²⁵, whilst further capacity is provided through mobile clinics²⁶ and extensive community screening looking for cases. Furthermore, the importation of therapeutic feeding products has undoubtedly been costly in both Lebanon and Jordan²⁷. It is interesting to note that whilst attention to GAM rates has defined a significant proportion of the Lebanon and Jordan nutrition response, this has not been the case in southern Turkey. We could find no reference to GAM in the refugee camps in Turkey, possibly because the Turkish Government and Turkish Red Cross (TRC) drives the shape and content of the response and the role of United Nation (UN) agencies and international NGOs is less influential.

In other aspects of the response (notably within Syria) there has been a lack of representative nutrition data to inform programming²⁸. Small-scale assessments, in Idleb, Ar Raqqa and Aleppo governorates in Northern Syria, described in an article by World Vision International²⁹, found low levels of GAM (MAM < 2.6% and SAM < 0.5%). Similarly, nutrition screening (mid upper arm circumference (MUAC) during a measles vaccination campaign) by MSF in Tal-Abyad District of Al-Raqqa governorate found a prevalence of 0.6% GAM³⁰. However Médecins sans Frontières (MSF) supported clinics were identifying a higher caseload than prevalence figures indicated, leading to the decision to provide treatment for acute malnutrition treatment. Of those subsequently admitted 45% (119 cases) were infants under 6 months – an age group traditionally excluded from surveys and nutritional surveillance. Surveys have not been conducted in the hardest to access locations so a more serious situation may exist in the besieged locations. However, WHO have been strengthening nutrition surveillance through health centres in Syria in a number of conflict-affected governorates since April 2014 so that nutrition data should become increasingly available in the coming months³¹.

Infant and Young Child Feeding (IYCF)

The second main focus of the nutrition response has been on IYCF. Whilst breastfeeding is culturally accepted and commonly practised amongst Syrians (most mothers initiate breastfeeding)³², exclusive breastfeeding rates are low, and breastfeeding falls off considerably by 1 and 2 years of age³³. Infant formula use is a recent and increasing form of infant feeding that is culturally accepted³⁴. This context indicates a need for both breastfeeding and artificial feeding support, and flags the need for particular attention to complementary feeding given the low continued breastfeeding rates. Our compilation of experiences suggests the nutrition sector has largely fallen short of meeting the wider IYCF needs of infants and children.

Our collation of articles reflects that the programming emphasis has been particularly on breastfeeding support in a bid to protect and ideally increase breastfeeding rates. This has

¹¹ Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

¹² Jamila Karimova and Jo Hammoud. *Relief International nutrition and health programme in Lebanon*

¹³ Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

¹⁴ Ruba Ahmad Abu-Taleb. *Experiences of emergency nutrition programming in Jordan*

¹⁵ Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*

¹⁶ James Kingori. *UNICEF experiences on nutrition in the Syria response*; Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*; Ruba Ahmad Abu-Taleb. *Experiences of emergency nutrition programming in Jordan*; Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

¹⁷ James Kingori. *UNICEF experiences on nutrition in the Syria response*; Hala Ghattas Linda Shaker Berbari & Omar Obeid. *The impact of the NiE regional training initiative: the Lebanon experience 2010-2014*; Caroline Abla. *Experiences on Nutrition in Emergencies Training for Syrian refugees response in Jordan*.

¹⁸ Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee*

children and women nutritional needs in Jordan; Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

¹⁹ WFP VASyR assessment in 2013 MUAC based assessment found a prevalence of 1% MAM and 0.4% SAM. Susana Moreno Romero. *WFP experiences of vulnerability assessment of Syrian refugees in Lebanon*.

²⁰ Foot Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*; Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*.

²¹ Centres for Disease Control and Prevention

²² Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*; personal communication.

²³ Personal communication. It is not possible to confirm these suspicions, as was possible with the Lebanon 2013 data.

²⁴ Bilukha O et al (2014). *Nutritional Status of Women and Child Refugees from Syria – Jordan*, April-May 2014. *MMWR/July 25, 2014/Vol. 63/No. 29*

²⁵ Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

²⁶ Jamila Karimova and Jo Hammoud. *Relief International nutrition and health programme in Lebanon*.

²⁷ Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*.

²⁸ Hala Khudari, Mahmoud Bozo and Elizabeth Hoff. *WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management*.

²⁹ Emma Littleedike and Claire Beck. *Experiences and challenges of programming in Northern Syria*.

³⁰ Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*.

³¹ Hala Khudari, Mahmoud Bozo and Elizabeth Hoff. *WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management*.

³² Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*.

³³ Susana Moreno Romero. *WFP experiences of vulnerability assessment of Syrian refugees in Lebanon*.

³⁴ Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*.

yielded some strong and necessary breastfeeding support programming in Lebanon³⁵ and Jordan³⁶ and is the focus of attention on IYCF support within Syria³⁷. However, there have been large gaps in attention and action on support to non-breastfed infants (or infants who are breastfed but heavily dependent on infant formula), especially to refugees in host communities³⁸ and in Syria. Support to non-breastfed infants has not been entirely absent – we feature articles on successful targeted programmes of support in Zaatari camp in Jordan (UNHCR/Save the Children Jordan) and in Lebanon (IOCC). But they are small scale and for the vast majority of Syrian infants dependent on infant formula, whether within Syria or in host countries, access to supply is unknown and by all accounts, either inaccessible or expensive in absolute terms or relative to other household needs³⁹.

Undoubtedly, addressing IYCF needs have been challenging in this response, particularly in Syria where access is limited and remote programme management the only means to deliver⁴⁰, and in host communities where refugees are scattered and difficult to identify and follow up.⁴¹ The region has a track record of misuse of infant formula in crisis times.⁴² An added complication is that standard IYCF indicators and programming options are heavily biased towards breastfeeding populations where infant formula use is the exception. Low breastfeeding rates identified in 2012 and 2013 assessments amongst Syrian refugees in Jordan and Lebanon created breastfeeding targets but no actions or advocacy around meeting the immediate nutritional needs of non-breastfed infants⁴³. The Joint Rpaid Assessment of Northern Syria (JRANS) 2012, the Syria Integrated Needs Assessment (SINA)⁴⁴ in Dec 2013 and GNC scoping mission in Syria⁴⁵, data from surveys in Lebanon and Jordan, and articles we feature by GOAL, MSF, Action Contre la Faim (ACF), IOCC, WHO, UNICEF and

Medair all noted need or demand for infant formula supplies and support. But for a few small scale exceptions (as outlined earlier), agencies were not willing to take it on, especially as they couldn't ensure targeting or guarantee water, sanitation and hygiene (WASH) conditions (as recommended by policy guidance), or go against agency policy positions not to supply infant formula⁴⁶. The consequences of poor coverage of support to formula dependent infants are not well documented – most infants are dispersed in host communities or within Syria. Some insight is provided in an article by ACF, where almost half of the infants aged 0- < 6 months admitted to ACFs acute malnutrition treatment programme in Lebanon had received infant formula, and breastfed admissions were not exclusively breastfed⁴⁷. In the same programme, 70% of admitted children aged 6-23 months were using infant formula on presentation. An article by MSF from northern Syria found that more than half of the admissions to their treatment programme were infants under six months of age; the lack of safe formula feeding (supplies and conditions) was a significant contributing factor (high cost, erratic supply, low availability) and despite much advocacy, there were no programmes to support formula dependent infants on discharge⁴⁸. This caseload was not picked up by surveillance or survey data as data on infants under 6 months were not included. This has been described as an information blind spot and is being challenged even in largely breastfeeding populations⁴⁹.

It appears that complementary feeding support in this emergency response also falls short. Featured articles describe limited access to fortified complementary foods for children in Zaatari camp in Jordan; a three month 'stop gap' supply was provided in 2013 by UNHCR⁵⁰ with only a sustained supply of SuperCereal Plus eventually established by WFP in February 2014⁵¹. It was

not well accepted by the community and significant follow up has been necessary to support its use⁵². No provision for complementary food for children living in the host community was made. Fortified complementary foods are not available in the Jordanian shops linked to the WFP voucher scheme, while fortified foods available in pharmacies are prohibitively expensive⁵³. The WFP VASYR assessments in Lebanon in 2012 and 2013 pointed to extremely low dietary diversity amongst children and highlight the micronutrient status risk amongst both children and adults⁵⁴ but no evidence of concerted action. In Lebanon, no one organisation was willing to undertake blanket distribution of micronutrient powders (MNPs) for children aged 6-59 months⁵⁵. The consequences of inadequate support to complementary feeding are now reflected in the high prevalence of anaemia in both countries; amongst Zaatari camp refugees in Jordan is now at 48.4%, a "problem of major public health significance" according to WHO criteria⁵⁶.

Questions are raised by a number of articles as to whether infant formula use has been overly 'policed' in this context. There were riots over access to infant formula in the early days of Zaatari camp in Jordan and subsequently, tensions around subjecting mothers to physical assessments to determine whether they could breastfeed or not⁵⁷. Infant formula is excluded from the voucher programmes documented in Syria⁵⁸ or in Jordan, only stocked in pharmacies and so not available through the WFP-supported food voucher schemes for non-camp refugees⁵⁹. Tensions around infant formula supply were also observed in the Turkish refugee camps during the ENN's field visit and are reflected in a number of case studies featured^{60,61}. Breastfeeding support programmes amongst refugees in Jordan have seen improvements in knowledge but not practice.⁶² Observations of a small anthropological study commissioned by the ENN also question⁶³

³⁵ Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

³⁶ Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*; Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

³⁷ Hala Khudari, Mahmoud Bozo and Elizabeth Hoff. *WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management*.

³⁸ Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee children and women nutritional needs in Jordan*.

³⁹ Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*; Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*; Hannah Reed. *GOAL's food and voucher assistance programme in Northern Syria*; Ann Burton. *Commentary on experiences of IYCF support in the Jordan response*.

⁴⁰ Hannah Reed. *GOAL's food and voucher assistance programme in Northern Syria*.

⁴¹ Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

⁴² Ali Maclaine and Mary Corbett (2006). *Infant Feeding in Emergencies: Experiences from Indonesia and Lebanon*. Field Exchange 29, December 2006. p2. www.enonline.net/fex/29/infantfeeding

⁴³ Inter-agency nutrition assessment Syrian refugees in Jordan. Host communities and Zaatari camp. Final report, January 2013.

⁴⁴ In the SINA, 23.5% of key informants reported a predominance of exclusive breastfeeding, 72.3% reported mixed feeding, and 3.4% exclusively used infant formula. The use of animal milk to feed infants under 6 months was also reported. Key informants called for infant formula as a key priority.

⁴⁵ Accessed via the GNC Global Coordinator.

⁴⁶ Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*; Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

⁴⁷ Juliette Seguin. *Challenges of IYCF and psychosocial support in Lebanon*.

⁴⁸ Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria*.

⁴⁹ Kerac et al (2010). *Prevalence of wasting among under 6-month-old infants in developing countries and implications of new case definitions using WHO growth standards: a secondary data analysis*. Arch Dis Child. Published Online First: 2 February 2011. Open access at: <http://adc.bmj.com/content/early/2011/02/01/adc.2010.191882.full>

⁵⁰ Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee children and women nutritional needs in Jordan*; Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*; Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*; Ruba Ahmad Abu-Taleb. *Experiences of emergency nutrition programming in Jordan*.

⁵¹ Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee children and women nutritional needs in Jordan*; Sura

Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*.

⁵² Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee children and women nutritional needs in Jordan*; Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

⁵³ Ann Burton. *Commentary on experiences of IYCF support in the Jordan response*.

⁵⁴ Henry Sebuliba and Farah El-Zubi. *Meeting Syrian refugee children and women nutritional needs in Jordan*.

⁵⁵ Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*.

⁵⁶ Bilukha O et al (2014). *Nutritional Status of Women and Child Refugees from Syria – Jordan, April-May 2014*. MMWR/July 25, 2014/Vol. 63/No. 29

⁵⁷ Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan*.

⁵⁸ Hannah Reed. *GOAL's food and voucher assistance programme in Northern Syria*.

⁵⁹ Ann Burton. *Commentary on experiences of IYCF support in the Jordan response*.

⁶⁰ Luigi Achilli and Raymond Aporthe. *The social life of nutrition among Syrian refugees in Jordan*.

⁶¹ Suzanne Mboya. *Artificial feeding in emergencies: experiences from the ongoing Syrian crisis*.

⁶² Gabriele Fänder and Megan Frega. *Responding to nutrition gaps in Jordan in the Syrian Refugee Crisis: Infant and Young Child Feeding education and malnutrition treatment*.

⁶³ Luigi Achilli and Raymond Aporthe. *The social life of nutrition among Syrian refugees in Jordan*.

the ambition and even appropriateness of the zeal and method of breastfeeding support, given the reality of the IYCF context. A postscript by Ann Burton asks whether the humanitarian sector is really ready to support 'informed decisions' by mothers to not breastfeed⁶⁴.

There is no question that there is a need for protection and support of breastfeeding in mixed fed populations. These contexts are particularly challenging, and Lebanon, as an example, has a long history of struggling with inappropriate infant formula marketing both by companies and medical personnel, and widespread Code violations in both normal and crisis times. Experiences around IYCF in the 2006 conflict⁶⁵ laid the groundwork for a Lebanese national programme focused on strengthening Code implementation⁶⁶. It is important that humanitarian crises and the associated response don't undermine national efforts to strengthen policy and programming around breastfeeding protection and support. A mother from Syria has the same right to support for breastfeeding as a mother in Sudan. But equally, a non-breastfed infant has the same right to humanitarian protection as a breastfed infant.

Many of the issues highlighted reflect a tension between the public health interest to support breastfeeding versus individual rights and realities.

The characteristics of the IYCF response indicate a lack of strong critical analysis of the IYCF situation, weak stewardship of the technical response and a lack of emergency preparedness by in country actors pre-crisis. Anticipating 'trouble ahead', attempts to secure funding for a regional IYCF expert in early 2013 were unsuccessful⁶⁷. These experiences challenge us to rethink our conception of what IYCF in emergencies entails and the IYCF programming models in the Middle Eastern context.⁶⁸ Indeed the characteristics of the IYCF Syria response may have exposed a fundamental flaw in how we frame IYCF in emergencies in policy guidance, which influences programming approaches. Defined as the protection and support of optimal IYCF⁶⁹, current guidance largely caters for artificial feeding in exceptional circumstances/as a last resort and is usually relative to breastfeeding. It could be that the IYCF development agenda has overly influenced IYCF emergency response, such that pragmatic compromises on global feeding targets in the immediate term are poorly catered for in challenging humanitarian contexts; we are loath to compromise our high standards. How to enable and see through informed choice by a mother is not well catered for. A reframing

of the objectives of IYCF-E support in humanitarian terms, rather than in purely optimal feeding terms, would allow us to accommodate, at least at a policy level, contexts where infant formula use is prevalent. This would be one important critical action to emerge from this leaning. It remains that whilst elements of existing IYCF policy guidance have fallen short, the global Sphere standards on IYCF (2011) clearly state that "actions must enable access and supply of breastmilk substitutes to infants who need it". Clearly, this standard has not – and continues not – to be met.

Applying an Afro-centric lens to a middle-eastern context

The ENN's view is that there has been an over emphasis on the treatment of acute malnutrition and on IYCF and that the nutrition sector has (to borrow a quote from a previous and infamous evaluation of the Great Lakes Emergency in 1996) to some extent, 'missed the point'. That's not to say nutrition community didn't respond in good faith to what was perceived to be an emerging nutrition crisis at the outset of the response, as described earlier. However the nutrition community appeared to adopt and stick with a largely Afrocentric lens to the nutrition problems in the region, i.e. the sector expects to see high mortality and increased GAM in an emergency or feels there is a need to demonstrate risk, with programmes put in place at the ready to treat. Whilst considerable IYCF emergency experiences also come from Asia, they draw heavily from predominantly breastfeeding populations. It may also be that acute malnutrition treatment and IYCF were the only 'nutrition' areas that donors would (eventually) fund; "selling nutrition to the wider humanitarian community was challenging without a glaring nutrition crisis (no severely emaciated children reported)"⁷⁰. Added to this, flawed/suspicious nutrition survey data in Lebanon and Jordan and the low breastfeeding rates helped paint the picture of a refugee population difficult without a "action on the brink of a nutritional crisis with the concomitant need to provide acute malnutrition treatment and promote breastfeeding at all costs.

Gaps in nutrition response

We feel that the momentum to scale up of treatment for acute malnutrition and promote breastfeeding may have distracted from undertaking a sector wide and thorough needs assessment of all the nutrition problems facing infants, children, mothers and other vulnerable groups (the elderly, the sick), including maternal and child anaemia (and possibly other micronutrient deficiencies), child stunting, overweight, and non-

communicable diseases (NCDs) – all of which were prevalent in the Syrian population pre-crisis and very likely to remain a problem or even increase risk as a result of the crisis. The combination of an Afrocentric response model and the perceived need to seek donor funding for the more typical emergency nutrition problems, raises the question as to whether the nutrition sector should have focussed its attention on additional areas of need and advocated to donors to expand their nutrition lens to reflect the wider range of nutrition problems faced in the region. Donors may also have had a hand in the lack of sectoral critical analysis of this situation, for example by requiring signs of raised GAM rates before investing in a dedicated nutrition working group in Turkey⁷¹ or failing to resource strong regional IYCF leadership. To put it another way, have there been significant gaps in the emergency nutrition assessments and responses?

Anaemia

The data on anaemia suggests that it should have attracted more of an analytical focus. Whilst anaemia was prevalent in the Syrian population pre-crisis, the first survey of anaemia prevalence amongst refugees in Lebanon and Jordan only took place in 2014, i.e. some 3 years after the crisis began. Prevalence of anaemia amongst camp refugees in Jordan was found to have deteriorated from pre-crisis levels to 48.4% in under five's, a problem defined by WHO as of 'major public health significance'⁷². It remains prevalent amongst refugees in the Jordanian host community at 26.1%⁷³ and in Lebanon at 21%⁷⁴. The increase in the prevalence of anaemia in Lebanon and continued moderate levels in Jordan in a context of low and possibly declining levels of wasting points to inadequate access to high quality foods rather than a lack of calories – especially amongst children 6 months of age and above. We have already highlighted major constraints regarding access to fortified foods for complementary feeding. The UNHCR guidance on anaemia indicates that in high anaemia contexts, a low quantity Lipid Nutrient Supplement (LNS) (for 6-24 month olds) or blanket micronutrient powders (MNP) (for 6-59 months olds) can be considered to reduce levels of anaemia in emergency contexts⁷⁵. We also know from recent work amongst other refugee populations that high levels of anaemia in refugee settings may indicate high levels of other micronutrient deficiency diseases.⁷⁶ Our articles describe how within Syria, WFP and UNICEF have been distributing micronutrient powders to prevent micronutrient deficiencies; in Jordan, there has been blanket supplementary feeding

⁶⁴ Ann Burton. *Commentary on experiences of IYCF support in the Jordan response*.

⁶⁵ Ali Maclaine and Mary Corbett (2006). *Infant Feeding in Emergencies: Experiences from Indonesia and Lebanon*. Field Exchange 29, December 2006. p2. www.enonline.net/fex/29/infantfeeding

⁶⁶ Linda Shaker Berbari, Dima Ousta and Farah Asfahani. *Institutionalising acute malnutrition treatment in Lebanon*.

⁶⁷ Personal communication from four sources.

⁶⁸ Suzanne Mboya. *Artificial feeding in emergencies: experiences from the ongoing Syrian crisis*.

⁶⁹ Operational Guidance on Infant and Young Child Feeding in

Emergencies, v2.1 (2007). <http://www.enonline.net/operationalguidanceiycfv2.1>

⁷⁰ James Kingori. *UNICEF experiences on nutrition in the Syria response*.

⁷¹ Anon. *Coordinating the response to the Syria Crisis: the southern Turkey cross border experience*.

⁷² Bilukha O et al (2014). *Nutritional Status of Women and Child Refugees from Syria – Jordan, April-May 2014*. MMWR/July 25, 2014/Vol. 63/No. 29

⁷³ Bilukha O et al (2014). *Nutritional Status of Women and Child Refugees from Syria – Jordan, April-May 2014*. MMWR/July 25, 2014/Vol. 63/No. 29

⁷⁴ Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*.

⁷⁵ UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations. UNHCR, 2011. <http://www.enonline.net/unhcrspecialnutritionalproducts>

⁷⁶ *Assessing micronutrient deficiencies in emergencies. Current practice and future directions*. Nutrition Information in Crisis Situations. UNSCN and for example: Woodruff BA et al (2006). *Anaemia, iron status and vitamin A deficiency among adolescent refugees in Kenya and Nepal*. Public Health Nutrition. Vol 9, Issue 1, p 26-34.

programmes (BSFPs) in Zaatari and Azraq camps but not to the host community; in Lebanon, MNPs distribution has been limited to PHCs after the child is seen by the paediatrician⁷⁷. On balance, this reflects limited action to monitor micronutrient deficiency disease prevalence or to implement programmes to address anaemia (and other micronutrient deficiencies).

Stunting

Furthermore, little attention has been paid to child stunting in terms of discerning the trends, underlying causes or identifying potential interventions. Mortality associated with severe stunting (<-3 SD height for age) is higher than that for moderate acute malnutrition at 5.5 times (MAM 3.3 times)⁷⁸. Given that there are contexts where severe stunting prevalence is higher than the prevalence of MAM (e.g. Zaatari camp Jordan (2014): moderate wasting 0.9%, severe stunting 2.9%; Lebanon (2013) 1.8% moderate wasting, 2.8% severe stunting), it would be justifiable for the humanitarian nutrition community to have highlighted stunting as a nutrition problem requiring further analysis and attention. Cautious interpretation of figures implies that stunting prevalence had in some instances, seemed to halve from 23% (2009) by the early stages of the crisis and then deteriorate over the response, most notably in Lebanon (from 12.2% (2012) to 17.3% (2013)). Child stunting has not featured in articles from the refugee hosting countries; an exception is a WFP article describing their cross line and cross border programming in Syria. Here, there has been the recent introduction of Nutributter® (a nutritional supplement) with a view to preventing childhood stunting amongst children aged 6-23 months. Distributions of the supplement started in May 2013 and fulfilled 71% of the plan for January 2014; over 17,240 children in Aleppo and Al-Hasakeh were assisted out of 24,249 children. As with anaemia, UNHCR has well developed guidelines and a menu of options for assessing and managing stunting in refugee populations which includes consideration of food supplementation products and a range of interventions spanning health, WASH and food security depending on the stunting prevalence. But the guidance appears not to have been put into practice.

It appears that emergency nutrition actors have not yet forged links with development actors to advocate for actions to address stunting and anaemia, which is a missed opportunity to ensure a 'continuum of care' in the context of child malnutrition. This is symptomatic of a much wider and global disconnect between the emergency and development sectors whereby efforts to address acute malnutrition are largely perceived as the domain of emergency nutrition response, and stunting and anaemia as the concern of development actors. However it remains that on the anaemia/stunting front, UNHCR has well developed guidance that includes wasting and stunting, along with wasting, as key nutrition indicators with associated programming interventions. A key question is therefore, what hampered putting this guidance into practice? Clearly, there are compelling reasons to identify and

overcome barriers and foster more integrated, holistic policy and programmes which protect and improve nutritional status.

Non-communicable diseases (NCDs)

Another significant 'gap area' or issue which the emergency nutrition community has not yet raised relates to the treatment and prevention of NCDs that have a nutritional aetiology/management aspect, e.g. diabetes, hypertension and heart disease. 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. A UNHCR survey in Lebanon in July 2014 found 14.6% of over 18 year olds had one chronic condition, with the prevalence highest amongst the oldest (46.6% in over 60 year olds).⁷⁹ The main reported chronic conditions of nutrition interest were hypertension (25.4%), diabetes (17.6%) and 'other' cardiovascular disease (19.7%). The NCD problem amongst older people is also reported in other articles we feature by Caritas, HelpAge International and Handicap International.⁸⁰ Treatment is difficult to access for many of those with these pre-existing conditions (the UNHCR survey found 56.1% were unable to get access to care), is costly for service providers and requires long term commitment to care. There is a risk that following a low fat/salt diet has not been possible given the limited cash transfer (CT) or food voucher transfer resources available to refugees and the displaced; the ENN is not aware of any analysis that has taken place of the suitability or cost of foods available in relation to NCDs. A question for the nutrition sector is whether there should have been closer engagement with agencies like WFP and the International Committee of the Red Cross (ICRC) implementing food voucher programmes to ensure that the diets needed to manage these conditions were available, promoted and affordable. If so, does the sector have adequate guidance material to inform such assessment and analysis? If this isn't the role of the emergency sector, what checks and balances are there for development actors to take on these considerations?

Added to this is the issue of overweight (18% prevalence overweight in U5's pre crisis⁸¹) which is a risk factor for NCDs. Mean weight-for-height z-scores in Zaatari and outside the camp in the 2014 survey were above the WHO standard population mean, indicating that Syrian refugee children in Jordan on average were slightly overweight rather than suffering from wasting⁸². As with the artificial divide which separates policies and programmes for wasting and stunting, it is

rare for overweight to be recognised and addressed in emergency programmes even where these are prevalent and the situation, as with Syria, is protracted. The (soon to be released) first Global Nutrition Report will highlight the fact that 'multiple burdens are the new normal' which raises a question for both the emergency and development nutrition communities as to how they can better assess and respond to the multiple needs of affected populations within their own programming and through engagement with each other...in other words, can our systems connect and embrace the 'new normal'?

Vulnerability criteria

A critical issue for the entire humanitarian sector in the Syria response has been how to develop vulnerability criteria to assist with targeting decisions. CTs and in-kind distributions were initially implemented as blanket distributions for refugee populations in the two main hosting nations (Lebanon, Jordan) and for most of the camp populations in southern Turkey. However, appreciation of a greater complexity to what constitutes vulnerability and the need to conserve scarce resources in light of under pledging by donors to various Regional Response Plans (RRP) has led to greater targeting of increasingly scarce resources⁸³. The pressure to target resources has meant development of vulnerability assessment tools such as the score cards used by UNHCR⁸⁴ and the rounds of Vulnerability Assessment of Syrian refugees (VASyRs) implemented by WFP⁸⁵; WFP's e-voucher programme in Lebanon targeted 70% of refugees following the 2013 VASyR. However, apart from MUAC measurements in the 2012 VASyR, there has been very little use of anthropometry to help define and understand vulnerability or more specifically, nutrition vulnerability. Nutrition surveys could theoretically have been used to greater effect to help define population strata in most need of nutritional support or indeed to endorse the targeting decisions taken, e.g. monitoring the nutrition of households excluded from CTs. Furthermore, nutrition indicators (including anaemia and stunting) could have been useful to help define households for inclusion in CT programmes. Finally, given the unprecedented scale and duration of the CTs being implemented in refugee hosting countries (particularly in Jordan, Lebanon and Turkey) it seems as if the opportunity to conduct robust research into the nutritional impact of these programmes has not been capitalised upon. This is unfortunate given the dearth of published data on this in a global context where humanitarian CT programming

⁷⁷ Najwa Rizkallah. *UNICEF experiences of the nutrition response in Lebanon*.

⁷⁸ Khara, T, & Dolan, C. (2014). Technical Briefing Paper: Associations between Wasting and Stunting, policy, programming and research implications. Emergency Nutrition Network (ENN) June 2014. Report available at: <http://www.enonline.net/waststuntreview2014>

⁷⁹ Frank Tyler. *Characteristics and challenges of the health sector response in Lebanon*.

⁸⁰ Report summary. *Insight into experiences of older Syrian refugees in Lebanon*; Lydia de Leeuw. *The situation of older refugees and refugees with disabilities, injuries, and chronic diseases in the Syria crisis*.

⁸¹ UNICEF State of the World's Children Report. 2014.

http://www.unicef.org/sowc2014/numbers/documents/english/SOWC2014_In%20Numbers_28%20Jan.pdf

⁸² Bilukha O et al (2014). *Nutritional Status of Women and Child Refugees from Syria – Jordan, April-May 2014*. MMWR/July 25, 2014/Vol. 63/No. 29

⁸³ Hisham Kighali, Lynette Larson and Kate Washington. *Aid effectiveness: determining vulnerability among Syrian refugees in Jordan*.

⁸⁴ Hisham Kighali, Lynette Larson and Kate Washington. *Aid effectiveness: determining vulnerability among Syrian refugees in Jordan*.

⁸⁵ Susana Moreno Romero. *WFP experiences of vulnerability assessment of Syrian refugees in Lebanon*.



Children inside an improvised shelter in Baalbek District, Bekaa Valley

is becoming more normalised. There is currently an enormous gap in understanding whether and how CTs either prevent or address under-nutrition (wasting, stunting and micronutrient deficiencies) in humanitarian contexts.

Cash programming

The scale and scope of CT programming in the Syria region has been unprecedented within a humanitarian programme context. A large component of the CT programming has effectively replaced in-kind food aid or general rations^{86,87,88}. Cash has also been used to support access to shelter, health care, heating supplies⁸⁹, and promotion of livelihoods⁹⁰. Much has been achieved and there has been enormous and invaluable lesson learning documented in this edition with regard to CT programming design and implementation^{91,92}. Indeed this was one reason why the ENN sought to compile a special issue on the Syria crisis response and to capture as much of this experience as possible. There are two stand-out issues around CT programming which the ENN believe may be emerging in the Syria response:

The first relates to availability of global resources for large scale CT programming in a humanitarian context. Many agencies (including donors) are openly admitting that the current level of CT programming is unsustainable and that substantial reductions and increased targeting will be necessary over the coming months, especially in light of RRP 6 failing to meet its budget pledging targets⁹³. A question that arises is whether the 'sector' can assume the same level of resource availability for CTs in humanitarian contexts as has been available for in-kind food aid in the past. To put it another way, are donor resources for in-kind distributions completely fungible or exchangeable with regard to cash provisions? This question seems all the more pertinent given trends that may be emerging with regard to in-kind food aid availability and provision. There are suggestions⁹⁴ that a number of factors related to trade (and trade agreements), climate change, and programming preferences, are in the process of coming together in a way that may reduce the reliability of in-kind food aid provision in the future with the implication that CTs may increasingly need to replace in-kind food aid in humanitarian contexts where conditions such as market functionality support their implementation. Given that the food aid system in the past has worked largely due to the mutual interests of multiple stakeholders (gov-

ernments, farmers, business interests, and humanitarians) can we assume that a different set of stakeholders involved in CT programming will be able to leverage the same political support and therefore level of resources and how will this be assessed? Could it also be that we are seeing in the Syria region the first test of this?

A second set of questions arises in relation to the institutional architecture around cash programming in humanitarian contexts. We raise these issues as they affect and are impeding programming. The Inter Agency Standing Committee (IASC) system does not have a 'Cash Cluster' in that cash is subsumed under a multiple of working groups (or indeed clusters) in any given emergency depending on the level of conditionality^{95,96}. The questions that might follow begin with who coordinates policy and practice and who is accountable for the overall coherence and convergence of cash programming in any given emergency. Going further, one could ask is there need for other technical agencies to support the type of conditional programming that WFP undertake, does the UN system need to re-configure the roles and responsibilities of the various technical agencies around CT programming and who defines these roles and responsibilities to ensure coherent programming (a related question is how are the UN agencies to be held accountable for CT programme performance). There is also a set of questions as to how the nutrition community fits into this architecture to ensure maximum nutrition impact of CTs. In the case of the Syria crisis, we have already highlighted the absence of nutrition assessment and analysis informing targeting and access to necessary foods, e.g. complementary foods for children, infant formula, low sugar and low salt, etc. Is there a need to develop minimum

standards (SPHERE) for cash programming in humanitarian contexts and should the nutrition sector be at the 'head table' in helping to define those standards? We would argue yes.

Nutrition coordination and leadership

The scale of the Syria crisis response has inevitably led to coordination challenges. The crisis has resulted in unprecedented numbers of internally displaced people in Syria and refugees being hosted in southern Turkey, Lebanon, Jordan and Northern Iraq. Whilst the main responsibility and financing for the refugee response has been by the host governments, UNHCR has been at the forefront of UN agencies with ultimate accountability for the wellbeing of refugees. A large number of national agencies (e.g. Turkish Red Crescent), international NGOs and other UN agencies supporting the governmental responses, all of whom require financing, information, coordination and technical leadership to assess and meet the needs of those affected. A number of articles in this edition give valuable insight into UN and international NGO coordination⁹⁷.

Within Syria, agencies are responding to the needs of the internally displaced through operations running out of the capital Damascus in coordination with the Assad Government. Aid is provided to government and non-government (so called cross-line programming) held areas of Syria⁹⁸. Fascinating insights into the these operations are shared in an article by WFP, which reflects on the rationale and experience of working with and through Government in an operation which has gradually negotiated and secured enough humanitarian space to help meet the food needs of 4.2 million largely displaced Syrians. Ironically, in the face of immense 'nutrition' achievement, as we go to press, WFP is on the brink of a dramatic scale down of its Syria operations in the face of a looming resource crisis. A second article by WHO describes their nutrition programme, closely coordinated with UNICEF and WFP, to rebuild nutrition surveillance, develop capacity to treat acute malnutrition, support breastfeeding, and prevent malnutrition through micronutrient distribution/Ready to Use Supplementary Food (RUSF) distribution in what remains a highly insecure and challenging operational environment. This edition also features a variety of 'cross border' programming largely from southern Turkey which supply aid to the displaced in the northern non-government

⁸⁶ Louisa Seferis. *DRC experiences of cash assistance to non-camp refugees in Lebanon and Turkey.*

⁸⁷ Kathleen Inglis and Jennifer Vargas. *Experiences of the e-Food card programme in the Turkish refugee camps.*

⁸⁸ Ekram Mustafa El-Huni. *WFP e-voucher programme in Lebanon.*

⁸⁹ Christian Lehmann and Daniel T. R. Masterson. *Impact evaluation of a cash-transfer programme for Syrian refugees in Lebanon.*

⁹⁰ Francesca Battistin. *IRC cash and livelihoods support programme in Lebanon;* Isabelle Pelly. *Designing an interagency multipurpose cash transfer programme in Lebanon.*

⁹¹ Isabelle Pelly. *Designing an inter-agency multipurpose cash transfer programme in Lebanon.*

⁹² Volker Schimmel. *UNHCR cash programming in emergencies – implementation and coordination experience during the Syrian refugee response in Jordan.*

⁹³ Simon Little. *Towards a 21st century humanitarian response model to the refugee crisis in the Lebanon.*

⁹⁴ Personal communication, Ed Clay.

⁹⁵ Isabelle Pelly. *Designing an inter-agency multipurpose cash transfer programme in Lebanon.*

⁹⁶ Leah Campbell. *Meeting cross-sectoral needs of Syrian refugees and host communities in Lebanon.*

⁹⁷ Key articles include: Alex Tyler and Jack Byrne. *UN and INGO experiences of coordination in Jordan;* Simon Little. *Towards a 21st century humanitarian response model to the refugee crisis in the Lebanon;* Profile: *Syria INGO Regional Forum (SIRF);* James Kingori. *UNICEF experiences on nutrition in the Syria response;* Anon. *Coordinating the response to the Syria Crisis: the southern Turkey cross border experience.*

⁹⁸ Rasmus Egdal. *WFP's emergency programme in Syria.*

⁹⁹ Hannah Reed. *GOALS food and voucher assistance programme in Northern Syria;* Anon. *Non-food cash voucher programme for IDPs in Northern Syria;* Emma Littleclike and Claire Beck. *Experiences and challenges of programming in Northern Syria;* By Kathleen Inglis and Jennifer Vargas. *Experiences of the e-Food card programme in the Turkish refugee camps;* Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam. *Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria.*

held areas of Syria⁹⁹. Coordination of cross line and cross border programme are characterised as complex, highly political, fast changing and, particularly in the context of the cross border programme, highly sensitive, resulting in tensions amongst the international agency actors.¹⁰⁰ As a marker of the sensitivities, it is noteworthy that a number of articles about cross-border programming that agencies committed to write for this special issue have been withdrawn at various drafting stages due to concerns about the potential impact of the article on their agency's activities. Despite all these challenges, the Syria response is hugely impressive in terms of the scale and level of programme innovation, the dedication of humanitarian staff working in this context, as well as the commitment and resourcing from the host and donor governments.

The IASC cluster mechanism has not been formally activated in the refugee hosting countries as UNHCR has overall responsibility for the refugee operation. Rather, sectoral working groups have been established covering food security, health, shelter, protection and education with UNHCR at the overall coordinating helm – pretty much in the mirror image of the cluster system^{101,102}. Within Syria, similar working groups exist to coordinate the response¹⁰³. Until very recently, nutrition working groups had not been established in any of the countries, possibly because the low levels of GAM were not seen by agencies (including donors¹⁰⁴) to justify the need for dedicated nutrition coordination. Nutrition coordination in southern Turkey, Jordan and Lebanon has, therefore, been absorbed into a small sub-group of the health working group. In Turkey, despite considerable efforts by some international NGOs and the Global Nutrition Cluster (GNC) to garner increased attention to nutrition, as a sector it occupies a very small space in the overall information exchange and coordination meetings¹⁰⁵. The Jordan nutrition sub-working group has been particularly active with infant formula control, access and management, arguably not a good use of coordination energies¹⁰⁶. A nutrition sub working group has recently formed in Lebanon¹⁰⁷. Coordination in the nutrition sector, in contrast to the other main sectors such as food security, health, and WASH has not had dedicated coordination staff. The GNC, recognising the need to get nutrition on a stronger footing and following a 1 week scoping mission in Sept 2013, deployed a cluster coordinator for southern Turkey for 3 months (Dec 2013 to Feb 2014)¹⁰⁸. This deployment met with a number of difficulties and did not lead to a longer-term nutrition coordination appointment.

With the benefit of overview of the different country responses and multiple agency pro-

gramming, the ENN has been surprised that a protracted Level 3 crisis should have had such marginalised nutrition coordination structures and focus. This may in part reflect the lack of a coherent sectoral overview, which could objectively clarify the nutrition situation for a wider audience to inform programme decision-making. Instead, nutrition has been limited to a focus on acute malnutrition treatment in the context of low levels of GAM and a sub-set of IYCF, namely breastfeeding protection and support. If we therefore accept that the nutrition community has not adapted its nutrition lens to reflect the range of nutrition needs that typify a Middle East emergency and has been almost entirely absent from the design and implementation of an unprecedentedly large scale social protection programme (cash and vouchers), a number of questions about coordination and leadership arise, which include:

- i) Should the nutrition sector have had dedicated working groups to enhance analysis and response and/or should nutrition have been more mainstreamed in the overall response by having representation (sub-working groups) in other working groups like cash and WASH? If so, how and by whom should this have been coordinated and who should have resourced this?
- ii) Should the Nutrition Cluster have remained active in southern Turkey's cross-border programme and also been activated to address the nutrition needs of refugee populations in Lebanon, Jordan, etc, to share the load with UNHCR?
- iii) Should the Nutrition Cluster have been activated to support the affected host community in refugee hosting countries?
- iv) What is the role of nutrition-related development actors to prepare for a crisis and to actively influence the international emergency effort in delivering a context specific and timely response?
- v) Where is the responsibility for a coherent and objective nutrition sector assessment and response overview without which there has arguably been a poorly analysed and partial response?

Implicit in these questions is a question about leadership and the ability to critically analyse what is being done in the name of nutrition. Many of the obvious shortfalls in the collective nutrition response to the Syria emergency speak to a lack of leadership. Was there a clear, objective lead agency for nutrition in this crisis to oversee the scope and quality of assessments, analysis, and interpretation and in turn, the shape and content of the nutrition related considerations across all related sectors? Arguably, had there been robust leadership and ownership, the nu-

trition sector may have avoided the dominant emphasis on the scale up of treatment for acute malnutrition whilst failing to address anaemia. There could have been a more objective and context-specific appraisal of the IYCF situation that needed (and still needs) a more critical analysis of the situation, some innovation and new types of programming to address needs. In terms of objective overview, it is interesting to see what the Syria Needs Assessment Project (SNAP) has brought to the humanitarian sector in terms of humanitarian data sharing and analysis¹⁰⁹; perhaps there are some lessons to be learned for the nutrition sector?

Accountability

One final thought relates to accountability within the nutrition sector. Given the missed opportunities in the nutrition response, how do we hold ourselves accountable and institutionalise learning to avoid making these mistakes again? The answer is a very difficult one as we still lack clarity around roles, responsibilities and leadership in the nutrition sector. At the very least, we think a sectoral evaluation following a large-scale emergency programme of this type would add real value to collective learning. Whilst there are many evaluations following each new emergency, these are either agency specific evaluations or on rare occasions, evaluations across the overall multi-sectoral response. The last sectoral evaluation for nutrition (and other sectors) following a multi-agency humanitarian response was in 1996 for the Great Lakes Emergency. Subsequent attempts at similar system-wide, collaborative evaluations (e.g. following 1998 Hurricane Mitch and the 1999 Kosovo crisis) did not bear fruit possibly due to lack of "effort and collective spirit"¹¹⁰. Without critically examining the overall coherence of our nutrition responses in emergencies, we risk repeating the same mistakes over and over again. Should there not be regular nutrition sector evaluations of emergency responses to ensure that we learn for the next time, do we have sufficient collective will to pull together on this, and if so, who should lead on this?

This Middle East emergency has, and continues to be, uniquely challenging in its scale and complexity. There has been an extraordinary response from a vast array of stakeholders across many sectors, and nutrition indicators suggest that a large-scale nutritional emergency has thankfully been largely averted. However, nutrition vulnerabilities remain poorly analysed and inadequately addressed and, indeed, such vulnerabilities may well worsen as the availability of resources for the Syria crisis rapidly decline. The nutrition community – both emergency and development – is needed as much now as in the height of the crisis. Let's hope we can rise to the challenge.

⁹⁹ Anon. *Coordinating the response to the Syria Crisis: the southern Turkey cross border experience.*

¹⁰⁰ Alex Tyler and Jack Byrne. *UN and INGO experiences of coordination in Jordan.*

¹⁰¹ Simon Little. *Towards a 21st century humanitarian response model to the refugee crisis in the Lebanon. Note these coordinating mechanisms may have changed since.*

¹⁰² Rasmus Egdal. *WFP's emergency programme in Syria.*

¹⁰⁴ Anon. *Coordinating the response to the Syria Crisis: the southern Turkey cross border experience.*

¹⁰⁵ Emma Littledike and Claire Beck. *Experiences and challenges of programming in Northern Syria; Personal communications.*

¹⁰⁶ Sura Alsamman. *Managing infant and young child feeding in refugee camps in Jordan; Ann Burton. Commentary on experiences of IYCF support in the Jordan response.*

¹⁰⁷ Najwa Rizkallah. *UNICEF experiences of the nutrition response*

in Lebanon

¹⁰⁸ Emma Littledike and Claire Beck. *Experiences and challenges of programming in Northern Syria.*

¹⁰⁹ Yves Kim Créac'h and Lynn Yoshikawa. *The Syria Needs Assessment Project.*

¹¹⁰ John Borton (2004). *The Joint Evaluation of Emergency Assistance to Rwanda.* HPN. Issue 26, March 2004.

Lebanon



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

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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 criteria¹, 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 IRC². 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

¹ 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.

² 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 2013³ 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.

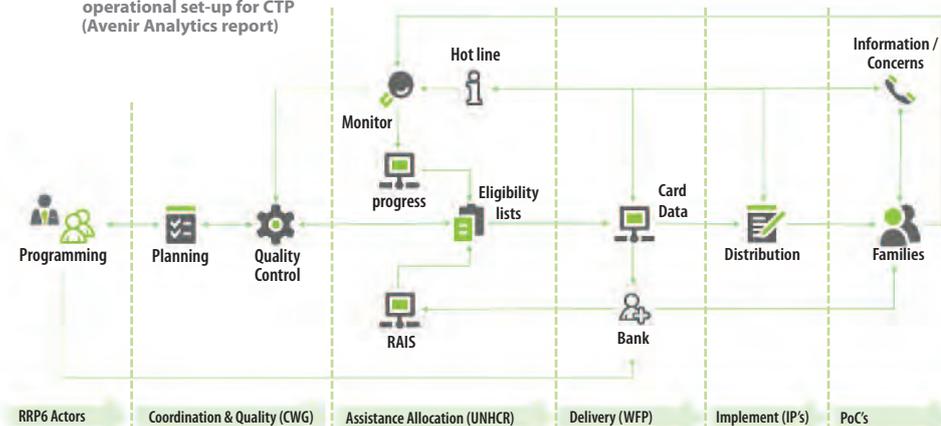
The experience of this winterisation cash programme, led to a desire and willingness to (a) further harmonize cash programme design including targeting, monitoring and delivery mechanisms and (b) transition to longer-term and scale-up of multipurpose cash assistance as a strategic shift within the response. 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.

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

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

³ 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 structure⁴ 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.⁵ 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
Transfer Value	\$175

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

⁵ 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 IRC⁶) 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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⁶ See article summarising the evaluation of the IRC programme in this edition of Field Exchange

Postscript

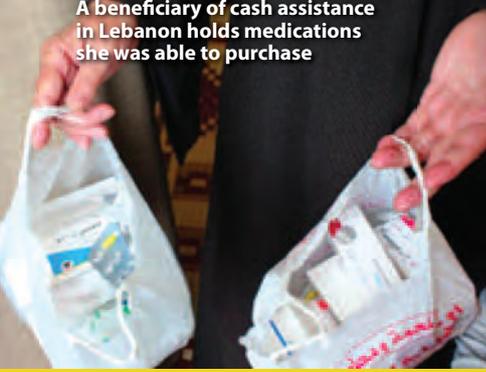
By UNHCR Lebanon and UNHCR Cash Section, Division of Programme Support and Management, Geneva

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 Lebanese¹ reside in the North.²

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.³

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 2013⁴, 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

¹ 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.

² 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.

³ 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.

⁴ 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 2013,⁵ 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.⁶

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.

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

⁶ 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 regulations⁷. 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.⁸
- 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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⁷ 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.

⁸ 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 localities¹ 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
- 2 Harmonised Training Package: 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 Haugsboe/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)². 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)³ 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 contracted⁴ 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 years⁵, 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 IOCC⁶.

Programme materials and supplies, including lipid-based Ready to Use Therapeutic Food (RUTF), Ready to Use Supplementary Food (RUSF)⁷ 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 malnutrition⁸. 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

⁶ 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.

⁷ Products are Plumpy'nut, Plumpy'sup and NRG5.

⁸ 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%⁹.

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

By Pressila Darjani and Linda Shaker Berbari



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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 nutrition¹. 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 childhood² and adult obesity, hypertension and high cholesterol³ in Lebanon are comparable to those in the United States. The prominent misconceptions, lack of proper supportive environment, and the heavy marketing of artificial feeding⁴ 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

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

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

³ WHO Lebanon Health Profile, 2008. www.who.int/gho/countries/lbn.pdf

⁴ 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 encouragement⁶.

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 endorsed⁵. 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

⁵ 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.

⁶ 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.

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Nutrition 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 strategy¹. 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 2013² (still under analysis) does not indicate an increase in the prevalence of acute malnutrition compared to the 2012 assessment results³. 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 Lebanon⁴. 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.

¹ WHO Regional Strategy on Nutrition (2010–2019) and Plan of Action

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

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

⁴ http://www.moph.gov.lb/Prevention/Surveillance/documents/N10_2014May26.pdf

⁵ 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 situations⁶

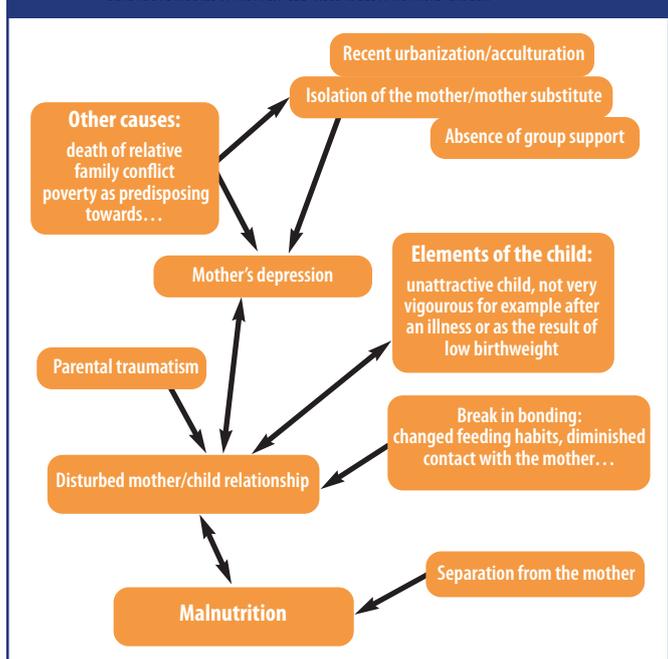


Figure 2: Percentage of exclusively breastfed and not exclusively breastfed children at programme admission according to caregiver declarations

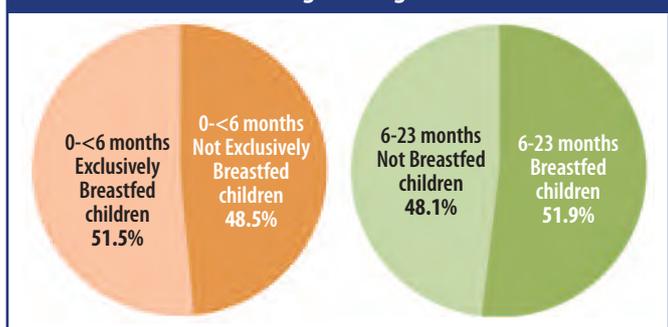
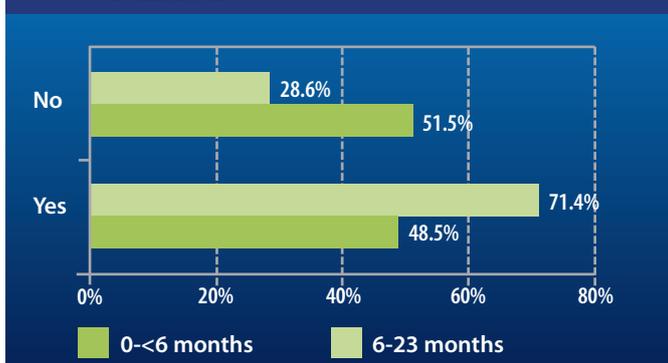


Figure 3: Percentage of children receiving or not infant formula at programme admission according to caregiver declarations



Project approach

ACF’s approach to prevent undernutrition is to combine nutrition and psychosocial support⁵. 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

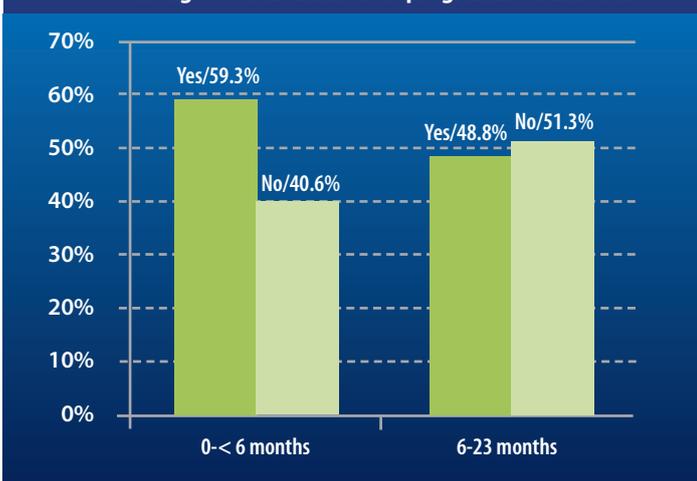
ACF has identified different practices hampering appropriate feeding and care for young children. Breastfeeding practices specifically as observed and assessed by the ACF field team are not optimal. Data collected from caregivers’ declaration at admission to the programme show that almost half of the 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.

⁶ 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



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 investigated⁷. 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

⁷ 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-5¹, 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 response² 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 facilities³ for referral of cases of acute malnutrition identified. CNP outreach activities include Mid-Upper Arm Circum-

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

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

³ 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.

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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
North							
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%
Total North Lebanon	55	267	322	234	72.7%	24	7.5%
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%
Total Bekaa/ Beirut/ Mount Lebanon	53	144	197	177	89.8%	0	0%
Total in RI localities	108	411	519	411	79.2%	24	4.6%

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.



Christina Bethke is currently the Health Coordinator for International Medical Corps in Lebanon.

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 pace. However, beginning in January 2013, the rate of influx increased sharply reaching nearly 50,000 new registrations on a monthly basis¹. 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 world². 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 individuals³.

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 settings⁴.

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.

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

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

³ <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>

⁴ 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 diarrhoea⁵.

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 components⁶:

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

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

⁶ 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%⁷. 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 insecurity⁸. 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

⁷ Preliminary results released by UNICEF during Bekaa Health Coordination Meeting, 28 August 2014

⁸ 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



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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 programmes 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 Lebanon¹. 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.

¹ 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 years². 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 UNHCR³ 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 IOCC⁴, 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 treatment⁵. 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%

² See article by AUB in this edition of Field Exchange (p67) and visit www.nietraining.net

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

⁴ See field article by IOCC in this edition of Field Exchange.

⁵ 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 (≥ -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 MAM⁶. 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

⁶ 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

By Ekram Mustafa El-Huni



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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 distributions¹, 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

¹ 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

WFP/Laure Chadraoui

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)².

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) criteria³, 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-

² 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

³ 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).¹ 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 report².

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

² <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.³ 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

³ 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 survey⁴. 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

⁴ 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 purposes⁵. 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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⁵ 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 Chapter¹. It also draws on findings from a subsequent health access and utilisation survey by UNHCR in July 2014².

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 stakeholders³.

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

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

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

³ 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 expensive⁴. 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 Lebanon⁵.

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).⁶ 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%)⁷. Deteriorating WASH conditions in informal settlements pose serious health risks for the spread of communicable diseases⁸. 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 infections⁹. The health needs among elderly Syrian refugees are particularly acute with limited access to care and medications¹⁰.

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)¹¹, 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)¹². In Lebanon, in line with rising population numbers, the incidence of

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

⁵ See footnote 4.

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

⁷ See footnote 2.

⁸ See footnote 1.

⁹ Health Information System 2013

¹⁰ 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.

¹¹ 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

¹² 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 high¹³.

A UNHCR survey in July 2014 found that 14.6% of households had at least one chronic condition amongst ≥ 18 years¹⁴. 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 2014¹⁵. 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 analysis¹⁶, 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%¹⁷.

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 Lebanon¹⁸ 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 refugees¹⁹. 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 response²⁰. 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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¹³ 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.

¹⁴ See footnote 2.

¹⁵ See footnote 2.

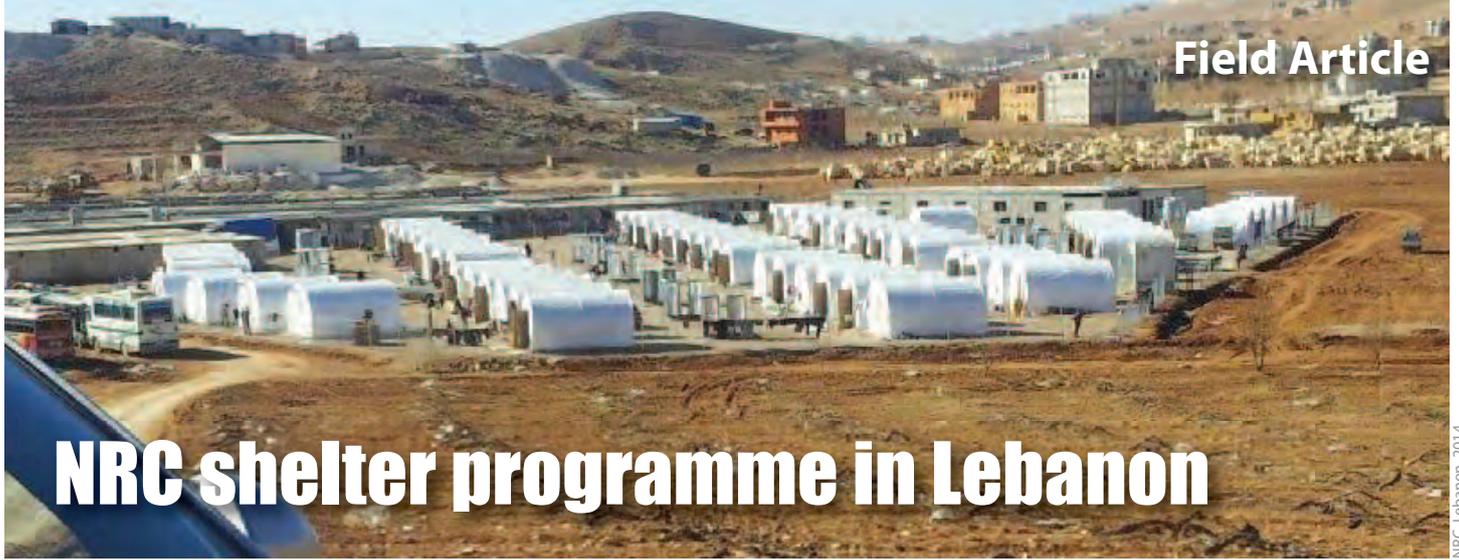
¹⁶ See footnote 4.

¹⁷ See footnote 4.

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

¹⁹ See footnote 4.

²⁰ See footnote 1.



NRC, Lebanon, 2014

NRC shelter programme in Lebanon

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)¹ 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 gatherings² 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.

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

² "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-being³. 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 refugees⁴, 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 Lebanon⁵ 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)

³ 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

⁴ 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.

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

⁶ 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'⁶.

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 Lebanon⁷, 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

⁷ 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

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.

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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.¹ 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.² 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.³ 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.⁴ 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.⁵ 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.^{6, 7, 8 & 9} 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.¹⁰

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.¹¹ 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.^{12,13} 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.¹⁴

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.¹⁵ 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.¹⁶ 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

¹ Syrian Refugees Registered in Lebanon (UNHCR, July 2014)

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

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

⁴ 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)

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

⁶ Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)

⁷ Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)

⁸ Household Database (SC Lebanon, 2014)

⁹ Mapping of Sub-standard Buildings (SC Lebanon, 2014)

¹⁰ Shelter Update (UNHCR, May 2014)

¹¹ Annual Average Meteorological data (American University of Beirut)

¹² Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)

¹³ Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)

¹⁴ 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).¹⁷ Rent typically accounts for a quarter of a refugee family's expenditure.¹⁸ 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).¹⁹ 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.²⁰ 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.^{21,22,23} 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.²⁴ 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 needs²⁵.
- 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-

¹⁵ Housing, Land and Property (HLP) Issues in Lebanon – Implications of the Syrian Refugee Crisis (UN-Habitat & UNHCR, August 2014)
¹⁶ 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)
¹⁷ A Precarious Existence; The Shelter Situation of Refugees from Syria in Neighbouring Countries (NRC, June 2014)
¹⁸ Vulnerability Assessment of Syrian Refugees (VASyR) in Lebanon (WFP, July 2014)
¹⁹ Inter-Agency Update on the Situation in Aarsal & Surrounding Areas (UNHCR, August 2014)

²⁰ Shelter Poll Survey on Syrian Refugees in Lebanon (UNHCR, March 2014)
²¹ Syrian Refugees Registered in Lebanon (UNHCR, July 2014)
²² Survey on the Livelihoods of Syrian Refugees in Lebanon (Oxfam, November 2013)
²³ Winterisation Cash Transfer Programme. Impact Evaluation Report (IRC, August 2014). See also article in this edition of Field Exchange.
²⁴ Equity in Humanitarian Action - Reaching the Most Vulnerable Localities in Lebanon (UNICEF and UNHCR, August 2014)
²⁵ 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 2015²⁶ 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.²⁷ 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.²⁸ 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.²⁹ 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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²⁶ RRP6 projections

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

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

²⁹ 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 ¹	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"> ✓ Relatively cheap and quick ✓ Doesn't require any formal approvals ✗ "Temporary" ✗ Only partially addresses core needs
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"> ✓ Relatively cheap and quick ✓ Doesn't require formal approvals ✗ "Temporary" ✗ Only partially addresses core needs
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"> ✓ Relatively cheap and quick ✓ Give major improvement in living conditions and is highly visible ✗ "Temporary" ✗ Only partially addresses core needs
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"> ✓ Relatively cheap and quick ✓ Doesn't require any formal approvals ✗ "Temporary" ✗ Only partially addresses core needs
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"> ✓ "Permanent" improvement in living conditions ✓ An investment in Lebanese infrastructure ✓ Secure tenure for the beneficiary family ✓ Rental reduction ✗ Relatively expensive and slower ✗ Required formal approval process

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

¹ 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 North¹. 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 Lebanese² 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 shortages³. 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-

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

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

³ World Bank. (2012). Lebanon Data. Récupéré sur World Bank Data: http://data.worldbank.org/country/lebanon#cp_gep

ments is 63 litres/per person/per day⁴ 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 another⁵. 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 100m³ water reservoir and the rehabilitation of an existing pumping station. These identified actions

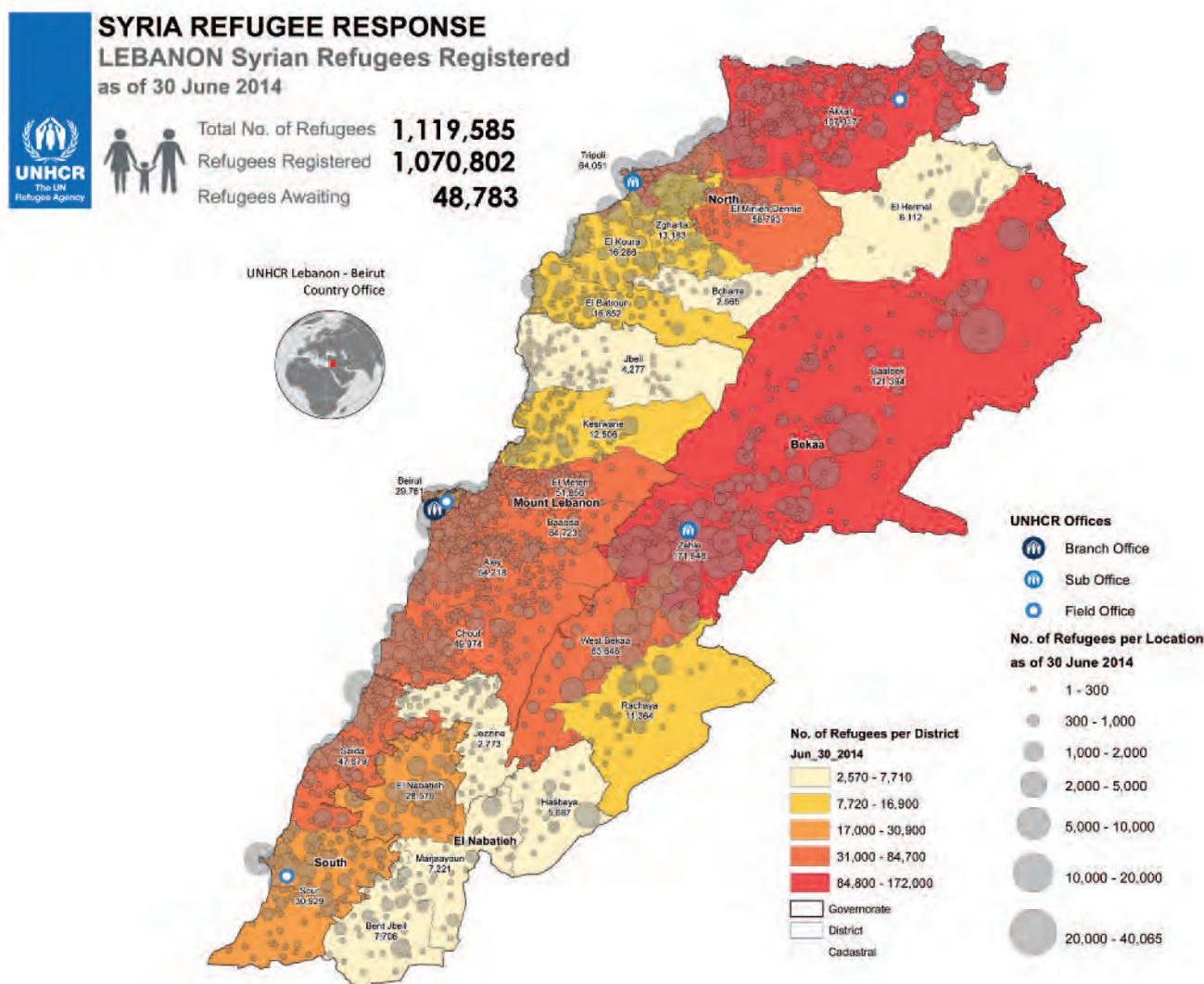
⁴ ACF. (2014). Humanitarian WASH Response to the conflict affected population in Bekaa Valley. KAP Survey.ACF.

⁵ 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 winterisation¹ 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 study² on the impacts of the winterisation cash transfer programme run by UNHCR and partners, from November 2013 to April 2014³. 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.⁴

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 not⁵) as well as demographic criteria.⁶ 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-

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

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

³ 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).

⁴ 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.

⁵ 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.

⁶ 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 ≥ 2 and only one adult $\geq 59y$); only one non-dependent adult in household (HH size ≥ 2 and only one 18-59 year old in household); families with two or more disabled in the family (HH size ≥ 2 and disabled in family ≥ 2); elderly household with one or more disabled adult (HH size ≥ 2 and disabled ≥ 1 and only 1 adult $\geq 59y$); Unaccompanied/separated minor; child-headed household (HH size ≥ 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.⁷ 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*).⁸ 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.⁹ 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.¹⁰ A full description of the data collection methodology is available in an online appendix.¹¹ 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.¹² 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,¹³ there is little rigorous evidence of the impact of cash assistance programmes in refugee crisis. The research design

⁷ 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.

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

⁹ 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.

¹⁰ 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.

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

¹² 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.

¹³ 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 economy¹⁴. 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

¹⁴ 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 haemorrhaging¹ 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)/NGOs². 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 debatable³.

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

¹ 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.

² 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.

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

⁴ 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) representative⁴. 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 suffice⁵ and may contribute to costly and potentially cumbersome coordination⁶.

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 staffers⁷. 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 costs⁸.

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 funding⁹. 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 annum¹⁰? 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 INGOs¹¹. 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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⁵ The annual cost of engaging a P4 UN officer in Lebanon is estimated at around USD 200,000+.

⁶ 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.

⁷ 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.

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

⁹ 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).

¹⁰ 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.

¹¹ 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.¹

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

¹ 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^{3,4}.
- 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^{5,6,7,8,9} and continues to play this important role in the current Syria crisis¹⁰. 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 1,138,874² (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 population², 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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² UNHCR Syria Regional Refugee Response Portal <http://data.unhcr.org/syrianrefugees/country.php?id=122>

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Syrian refugees in Lebanon

Sam Tarling, Caritas, Lebanon

Insight into experiences of older Syrian refugees in Lebanon

Summary of report¹

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 Syria². The average respondent age was 68 years old (range

¹ Forgotten voices. An insight into older persons among refugees from Syria in Lebanon. Caritas Lebanon.

² 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.



Syrian refugees in Lebanon

Caritas Lebanon

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.

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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 CaLP¹. A video presenting the programme is also available². 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.

¹ <http://www.cashlearning.org/resources/library/410-cross-sector-cash-assistance-for-syrian-refugees-and-host-communities-in-lebanon-an-irc-programme>

² <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

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

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)¹ 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)².

Establishing NIERTI at AUB

In response to the recognised gap in technical capacity in nutrition in humanitarian emergencies,^{3,4} 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.⁵ 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 emergencies⁶. 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.⁷ 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 Syria⁸. 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.⁹

- 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/ 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
- 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

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 course¹⁰ 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 camp¹¹. 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.¹² 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 insecure¹³, 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 appeal¹⁴.

For more information, contact: Hala Ghattas, email: hg15@aub.edu.lb

¹¹ See also Abla C, 2014. Experiences on Nutrition in Emergencies Training for Syrian refugees response in Jordan. Field Exchange 48.

¹² Building a Better Response <http://www.buildingabetterresponse.org/>

¹³ WFP(2014). Preliminary results of the Vulnerability Assessment for Syrian Refugees (VASyr).

¹⁴ 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 IYCF¹⁵. 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.

¹⁵ Shaker-Barbari et al (2014). Institutionalising acute malnutrition treatment in Lebanon. Field Exchange 48 p17.



7th NIE Regional Training Course, Lebanon, June 2014

Jordan



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

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WFP Jordan

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

By Edgar Luce



For the past two years, Edgar Luce has been working for WFP Jordan as a Programme Officer by monitoring operations, writing

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

Thanks to Henry Sebuliba, WFP for helping coordinate inputs, reviews and approvals in the article's development.

WFP assistance

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

Food distributions in Zaatari refugee camp

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

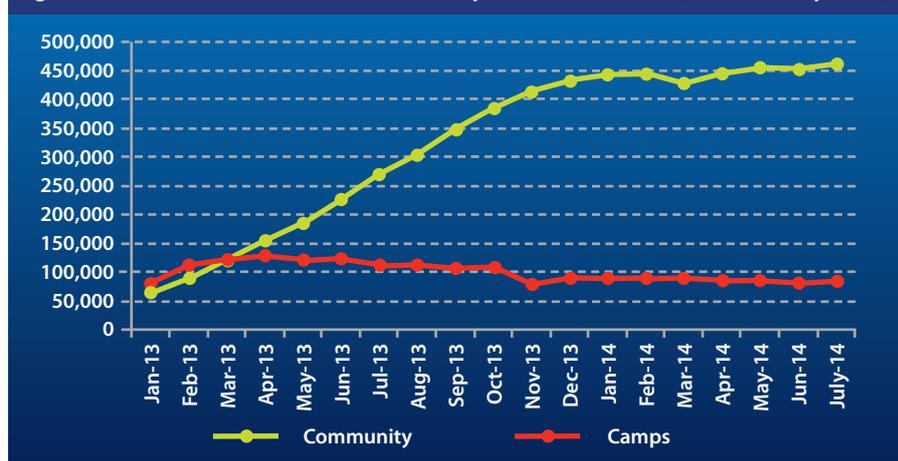
in August 2012 to 129,756 in April 2013). Thus, WFP transitioned to the distribution of dry rations in October 2012, once kitchens with cooking facilities were available for camp refugees to use. The rations, consisting of rice, lentils, bulgur wheat, pasta, oil, sugar and salt, were distributed from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

Paper voucher assistance

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

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

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



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

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

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

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

E-voucher programme

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

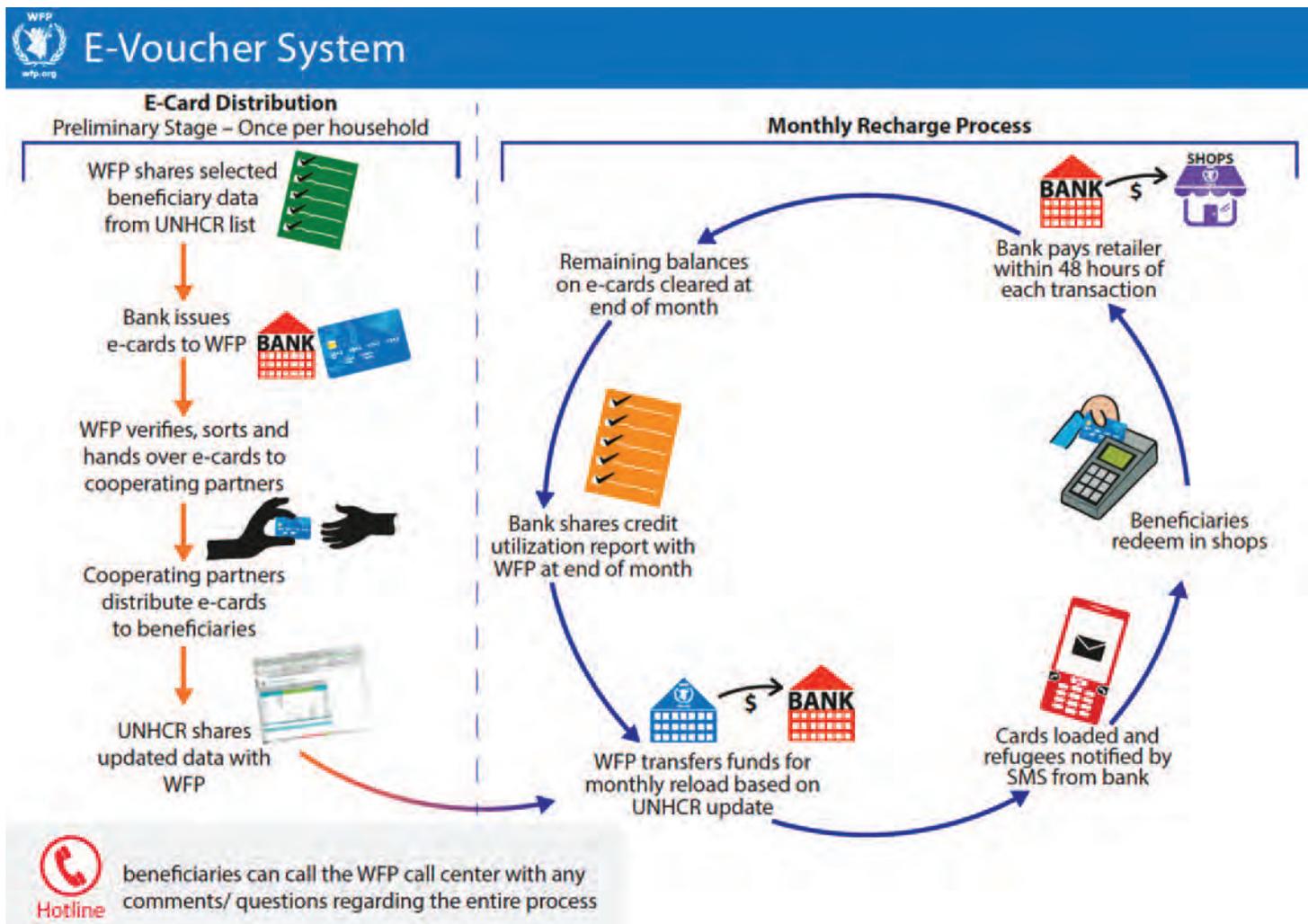
the host communities and started to pilot this approach in camps as well. E-vouchers allow the beneficiaries to spend their entitlements in multiple visits to the shops and are also more discreet and therefore less stigmatising. As the cards are recharged automatically through the partner bank, beneficiaries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

Key findings and lessons learned

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

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

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



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

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

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

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

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

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

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

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

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

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

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Rein Skullerud/WFP

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

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

WFP complementary food assistance in Zaatari Camp



WFP, Jordan, 2014

Meeting nutritional needs of Syrian refugee children and women in Jordan

By Henry Sebuliba and Farah El-Zubi



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Farah also supports coordination of the Food Security Sector in Jordan in addition to managing protection-related matters, and has former experience working with the World Health Organisation's Iraq Country Office for four years.

Background

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

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

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

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

Programme plan and implementation

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

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

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

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

Targeted Supplementary Feeding Programme (TSFP)

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

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

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

² Syrian Family Health Survey (2009)

³ MOH, Nutrition Surveillance System Report 2011

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

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



TSFP follow up in downtown Amman

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

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

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

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

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

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

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

Blanket age-appropriate food assistance

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

Decision-making regarding approach

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

Implementation challenges

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

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

Conclusion

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

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

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

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

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

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

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



By Volker Schimmel

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



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

How did we get here?

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

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

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

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

Cash-based interventions run by UNHCR in Jordan

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

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

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

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

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

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

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

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

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

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

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

Jared Kohler / UNHCR 2014



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

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

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

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

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

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

Coordinating cash assistance in a refugee response

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

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

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

Conclusion

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

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

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

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

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



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

Jared Kohler / UNHCR 2014

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

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



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Lynnette Larsen is a humanitarian information management specialist who has managed Humanitarian Information Centres in Kosovo, Iraq and Liberia and similar IM efforts in the 2005 Pakistan earthquake, 2008 Cyclone Nargis (Burma) and 2010 Haiti earthquake responses. She co-led implementation of the OCHA's IM capacity building strategy and developed an IM strategy within the Cluster approach.



Kate Washington is the lead facilitator for the Vulnerability Assessment Framework development with UNHCR. Previously, she worked for 5 years with CARE International in Jordan and has over 13 years

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Yara Romariz Maasri is an Associate Coordination Officer with UNHCR Jordan and has been supporting the Vulnerability Assessment Framework since November 2013. She previously worked in

refugee resettlement for over four years in Lebanon, Kenya and Cameroon, and was co-editor of the Fahamu Refugee Legal Aid Newsletter for three years. She holds a Master of Science in Forced Migration from the Refugee Studies Centre, University of Oxford.

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



Syrian children in their new housing unit in Irbid, Jordan

Georg Schaumberger/NRC

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

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

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

The project approach

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

Phase 1: Scoping and coordination:

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

Phase 2: Facilitation and design:

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

Phase 3: Lessons learned and recommendations:

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

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

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

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

Phase 1: Scoping and coordination

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

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



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

UNHCR/J. Kohler/February 2014

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

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

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

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

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

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

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

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

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

⁴ More specifically the weighting of scorecards was different.

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

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

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

The Saudi Relief Committee and Campaigns packed Ramadan food parcels daily and transported them to Zaatari camp.



WFP/Dina Elkassaby

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

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

Developing 'indicators' of vulnerability

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

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

Definition of vulnerability and framework outcomes

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

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

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

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

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

Progress to date

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

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

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

⁸ A software development phase when software features are complete.

WFP/Dina Elkassaby



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

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

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

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

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

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



WFP/Dina Elkassaby



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

UNHCR/J. Kohler/February 2014

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

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

Risks and safeguards

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

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

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

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

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

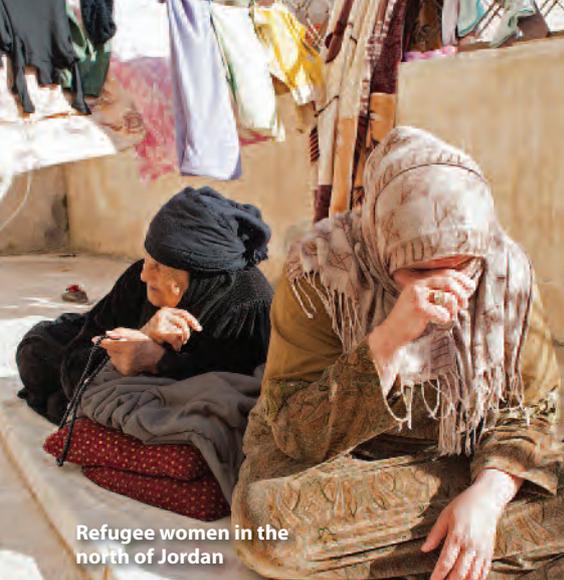
It is important to highlight that the VAF will not replace the need for sector-specific detailed needs assessments, but will assist in streamlining planning of such assessments and/or programmatic interventions by, for example, identifying geographical areas where a large number of cases with a sector-specific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

VAF validation plan and roll out

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

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

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Refugee women in the north of Jordan

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

By Gabriele Fänder and Megan Frega



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Background

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

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

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

Early IYCF assessment

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

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

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

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

IYCF programme

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

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

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

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

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

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

⁶ International Baby Food Action Network, 2011

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



Male focus group

Megan Freya/Medair, Jordan, 2013

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

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

Community networking

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

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

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

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

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

Programme coverage and impact

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

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

sampling frames involved:

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

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

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

Treatment of moderate acute malnutrition (MAM)

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

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

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

¹⁰ See profile of JHAS in this edition of Field Exchange

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

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

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

Acute malnutrition screening

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

Challenges

BMS donations and supplies

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

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

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

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

Expectations of aid

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

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

Discussion and recommendations

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

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

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

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

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

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

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

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

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

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



A group teaching session in the IYCF caravan

Managing infant and young child feeding in refugee camps in Jordan

Save the Children Jordan, 2013

By Sura Alsamman



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

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

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

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

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

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

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

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

Save the Children Jordan programme

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

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

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

Mother-baby friendly spaces

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

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

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

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

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

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

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

An individual teaching session



Save the Children Jordan, 2013

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

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

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

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

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

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

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

Community mobilisers

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

Box 1 Community mobiliser – success story

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

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

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

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

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

One of the IYCF caravans in Zaatari camp



Save the Children Jordan, 2013

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

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

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

The difficulties in managing infant formula

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

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

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

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

Box 1 Community mobiliser – success story

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

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

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

Infant formula is provided for infants until 12 months only.

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

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

Cup for bottle exchange in the IYCF caravan

Save the Children Jordan, 2013



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

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

Complementary feeding

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

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

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

Referral and management of acute malnutrition cases

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

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

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

Outside Zaatari camp

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

Discussion

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

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

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

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By Ann Burton, Senior Public Health Officer UNHCR Jordan

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

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

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

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

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

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

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

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

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

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

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

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

By Lydia de Leeuw



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Assisting the most vulnerable in the Syria crisis

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

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

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

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

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

Vulnerability assessment approach

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

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

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

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



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



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



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

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

Hidden victims of the Syria crisis

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

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

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

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

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

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

Humanitarian implications of the existing needs

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

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

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

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

Recommendations

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

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

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

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

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



Preparing for a Super Cereal Plus porridge demonstration

JHAS, Jordan, 2014

Experiences of emergency nutrition programming in Jordan

By Ruba Ahmad Abu-Taleb



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

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

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

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

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

Programming through partnership

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

¹ Source: data.unhcr.org, 2014

² Based on weight-for height (WFH)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Capacity development

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

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

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

Implementation of the nutrition programmes

Guidance development

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

The CMAM programme

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

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

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

Box 1 Mobile JHAS clinic services

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



Breastfeeding support in an urban clinic in Amman

JHAS, Jordan, 2014

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

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

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

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

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

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

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

Management of iron deficiency anaemia in pregnancy

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

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

Programme figures

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

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

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

Table 5: Guidelines for iron supplementation to pregnant women

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

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

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

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

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

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

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

Challenges and observations

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

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

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



An urban clinic in Amman

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

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

Lessons learned

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

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

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

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

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

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Teaching how to prepare Super Cereal Plus in an Amman clinic

⁷ Plumpy'nut

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

Marfaq-Zaatri

By Melanie Megevand, IRC



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

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

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

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

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

Nada, age 35, Jordan

Background

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

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

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

Impact of GBV on access to aid by women and girls

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

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

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

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

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

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

Domestic violence

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

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

Mona, age 21, Lebanon.

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

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

Farah, age 38, Jordan.

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

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

Haifa, age 41, Jordan.



Zaeemah, age 34, Jordan

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

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



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

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

Samira, Age 19, Turkey.

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

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

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

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

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

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

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

Early and forced marriages

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



Sabeen, age 15, Lebanon

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

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

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

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

Zain, age 18, Lebanon.

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

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

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

Haya, age 16, Syria

IRC Women's Protection and Empowerment programme

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



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

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

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

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

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



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

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

Cash assistance to mitigate risks

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

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

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

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

Conclusions

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

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



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

The social life of nutrition among Syrian refugees in Jordan

Sakiah Malkawi/WFP, Jordan, 2014



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

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

Method

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

Setting the scene

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

By Luigi Achilli and Raymond Apthorpe



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Raymond Apthorpe is an anthropologist specialising in applied humanitarian and development aid studies. He is currently the Vice President of Council of the Royal Anthropological Institute,

London. Currently Raymond is a Visiting Professor-elect, London School Economics and Political Science; and a professorial research associate at School of Oriental and African Studies, University of London. He undertook this work with ENN on a voluntary basis.

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

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

² It is important to note that UNHCR evidence shows

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

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

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

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

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

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

Box 1 e-voucher and the issue of registration

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

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

Box 2 What type of nutrition?

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

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

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

Box 3 Political economy

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

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

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

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

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

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

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

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

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

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

Box 4 Super Cereal Plus

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

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

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

Box 5 "Dangerous" food

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

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

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

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

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

Nutrition is already an inter-sector

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

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

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

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

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



Dina_EkKassaby/WFP, Jordan, 2014

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

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

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

Nutrition and humanitarian relief

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

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

Box 6 A special diet

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

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

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

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

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

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

Conclusion: The complex social relations of nutrition

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

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

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

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



UN and INGO experiences of coordination in Jordan

By Alex Tyler and Jack Byrne

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

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

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

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

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

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

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

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

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

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

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

³ For more information, see www.humanitarianinfo.org

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

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

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

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

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

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

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

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

From the INGO perspective

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

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

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

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

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

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

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

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

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

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

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

By Caroline Abla



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

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

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

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

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

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

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

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

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

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

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

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

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

Caroline Abla/IMC, Jordan, 2013

Participants in the NiE training in Jordan in 2012



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

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

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

Agency Profile

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



Interview by Tara Shoham, ENN volunteer



JHAS supported clinic in Amman

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

When was JHAS set up, by whom and why?

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

How does JHAS operate?

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

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

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

How is JHAS funded?

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

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

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

Does JHAS operate outside Jordan?

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

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

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

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

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

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

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

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

How would you describe the culture of the organisation?

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

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

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

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

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

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



Interview by Marie McGrath, Field Exchange Editor



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

When was JHCO founded and how did it come about?

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

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

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

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

What are your current areas of operation?

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

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

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

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

Which agencies have you worked with?

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

What other areas of humanitarian assistance are you involved with?

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

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

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

Do you provide assistance outside Jordan?

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

How are you funded?

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

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

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



Gabriele Fänder/Medair, Jordan, 2014

¹ International Fund for Agricultural Development

Syria



WFP beneficiary in damascus; WFP/Abeer Etefa

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SARC volunteers at a distribution centre in rural Damascus

Dima Elkassaby/WFP/Syria, 2013

WFP's emergency programme in Syria

By Rasmus Egendal and Adeyinka Badejo



Rasmus Egendal has more than 20 years of experience in international development and humanitarian aid assistance. Currently

he is serving as Deputy Regional Emergency Coordinator for WFP's Emergency Response in Syria and neighbouring countries.



Adeyinka Badejo joined WFP in 2001 and is currently Deputy Country Director for WFP in Syria. Previously, she served as a WFP

Programme Officer in Afghanistan, Zimbabwe, Sudan and in Rome and undertook field work in Pakistan, Palestine, Tanzania, Egypt, Cambodia, Nepal and Afghanistan.

The authors gratefully acknowledge the contributions of Sarah Gordon-Gibson, Regional Programme Manager, WFP Syria and neighboring countries; Lourdes Ibarra, Head of Programme, WFP Syria; Yasmine Lababidi, Nutrition Programme Assistant; and Nicoletta Grita, Reports Officer.

Overview

WFP has had a continued presence in Syria for almost 50 years, providing more than US\$500 million worth of food assistance into the country through development and emergency operations. Prior to the current conflict, WFP, together with its partner organisation the Syrian Arab Red Crescent (SARC), responded to emergency food needs following consecutive droughts, assisted in the implementation of school feeding programmes and provided assistance to Iraqi refugees seeking sanctuary in Syria. In October 2011, WFP launched an emergency operation to provide relief food assistance to affected families, in what was then a localised conflict. Initially targeting 50,000 beneficiaries, the operation was rapidly scaled up as the conflict spread over the following months. Over time, WFP modified the composition of the food basket, in response to changes in the availability and accessibility of individual commodities. A blanket supplementary feeding programme (BSFP) for young children was developed following concerns over declining nutritional indicators. Ready-to-eat food rations were provided for newly displaced families without access to alternative sources of food or cooking facilities.

In 2013, WFP gradually scaled up its response, reaching close to 3.4 million beneficiaries across all 14 Syrian governorates. WFP expanded its network of local non-governmental organisations (NGOs) beyond SARC to enhance its capacity and reach to meet rapidly growing needs. As of June 2014, a total of 27 partners support the delivery and distribution of WFP food assistance. These include SARC, 25 local NGOs, and one international NGO (the Aga Khan Foundation) working in Hama governorate. Through their long established presences and extensive local networks, WFP's partner organisations, local authorities and community leaders mobilised to help ensure and organise the safe delivery of assistance. Each partner has been selected to ensure their compatibility with WFP's mandate and with the principles of the UN Global Compact¹ and the WFP Code of Conduct.

Considerable efforts to strengthen local capacity have been made throughout 2013 including supplying crucial equipment and providing training on warehouse management, safe distribution practices, and programme monitoring. While allocation to partners varies on the basis of needs, capacity and access, on average approximately 55% of total food rations are allocated to SARC, while the remaining 45% are distributed by the NGO partners. SARC implements distributions through its branches and sub-branches, or through local charities in locations where it has no presence.

The number of WFP staff in country has gradually increased to over 200; the majority of these are national staff. WFP and local partners are currently implementing three main schemes – general food distribution, BSFPs for young children and ready-to-eat rations. The latter are distributed to newly displaced families with limited access to food or cooking facilities during the initial days of their displacement. In late 2014, two additional components were added: a school feeding programme to encourage regular attendance in school and distribution of food vouchers to promote dietary diversity for pregnant and breastfeeding mothers.

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¹ <https://www.unglobalcompact.org>

Box 1 WFP's targeting approach

WFP establishes the ration type in consultation with partners, according to nutrition considerations, local preferences and procurement capacity. The ration is then approved by the relevant government authorities. Targeting criteria are also established in consultation with partners, based on the following vulnerability criteria:

- Persons and households that have been displaced and have little or no income for food
- People located in or near areas subject to armed activities with little or no income for food
- Persons and households hosting a displaced family with little or no income for food
- Poor people in urban and rural areas affected by the multiple effects of the current events and who have little or no income for food.

Figure 1: WFP planned and reached general food distribution beneficiaries



WFP/Dalia Khamissy



Syrian refugees go shopping with e-vouchers

Needs assessment in November 2013

A WFP/FAO Joint Rapid Food Needs Assessment was conducted in November 2013 in Syria, in collaboration with the Ministry of Agriculture and Agrarian Reform and the Ministry of Social Affairs. It indicated that some 9.9 million people were estimated to be vulnerable to food insecurity and unable to purchase sufficient food to meet basic needs. Of these, some 6.3 million were estimated to be particularly exposed to the effects of conflict and displacement and in critical need of sustained food assistance. A severe reduction in agricultural production, combined with constraints in marketing available produce, as well as weakened import capacity to meet domestic demands, have increasingly limited food availability over time. Compounding the devastating effects of the conflict, exceptionally low levels of rainfall during the 2013/2014 winter season conditions impacted food production in 2014 and further exacerbated Syria's humanitarian crisis. Furthermore, inflation, high commodity prices and growing rates of unemployment significantly reduced household purchasing power. Foods and fuels have been severely hit by price inflation particularly in northern governorates. On the other hand, prices have actually dropped in some southern governorate areas. As available resources have been depleted over time and resilience

weakened, households have increasingly resorted to negative coping strategies including a reduction in both the quantity and quality of food consumed, a decrease in dietary variety, withdrawing children from school and selling assets.

General food distribution (GFD)

Targeting

WFP's GFD targets the most vulnerable households across all 14 governorates. WFP establish the target for each governorate on the basis of available needs assessment as well as consultation with partners (see Box 1). The assistance prioritises displaced households who have lost their main source of income, as well as poor communities hosting a large number of displaced families. Each household receives a food basket sufficient to feed a family of five for one month. The monthly family food basket consists of a variety of commodities such as rice, bulgur wheat, pasta, pulses, vegetable oil, sugar and salt. In 2014, the food basket was revised from 1680 kcals to provide up to 1,920 kcal per person per day. This increase was effected as WFP's programme monitoring findings suggested that families were increasingly less able to access additional food from alternative sources, mostly relying on the GFD. The quantity and composition of the basket has been subject to changes depending on commodity availability and pipeline status. Figure 1 presents the target and reached populations up to July 2014. In August 2014, food distributions reached over 4.1 million people, or 98% of the month's target.

Challenges

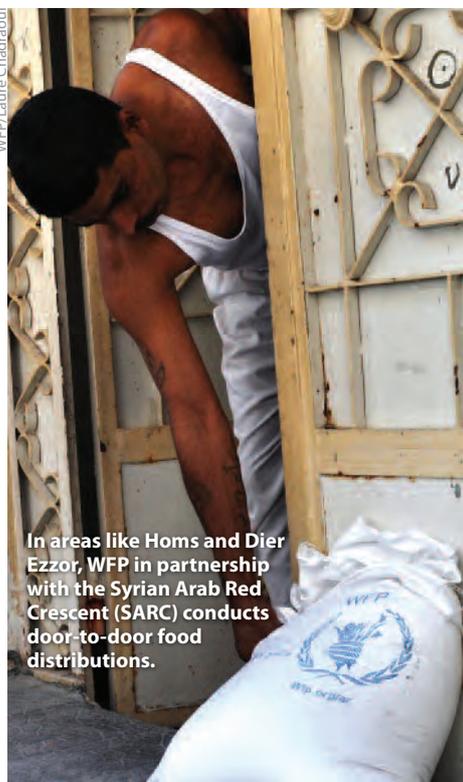
Distributions are conducted on a monthly basis in order to balance meeting the immediate food needs of beneficiaries with logistical challenges associated with such wide-scale activity across insecure areas. In 2013, widespread insecurity restricted access to many areas of the country, preventing the distribution of assistance at the planned scale. Particularly in the north, escalating infighting among multiple armed groups closed access routes and deadlocked assistance to Al-Hasakeh for most of the year, to rural Aleppo from August 2013 and eastern Aleppo city from September 2013. By November, the entire north-east was cut off as routes to Ar-Raqqa and Deir-ez-Zor were also blocked by continuous clashes. Haphazard access narrowed the scope of monitoring activities which could not be conducted

in Ar-Raqqa, Deir-ez-Zor and Quneitra for the entire year. Furthermore, shifting patterns of active conflict prevented WFP teams from visiting the same sites each month, obliging them to rotate distributions among locations as security conditions permitted. Access constraints continued into 2014 as the crisis became more protracted. WFP planned and 'reached' general food distribution beneficiaries are shown in Figure 1 (Jan – July 2014).

Food assistance to millions of civilians trapped in besieged locations, including an estimated 800,000 in Rural Damascus, remained sporadic despite unrelenting appeals for unhindered access. Al-Hasakeh is one of the hardest governorates to reach with humanitarian assistance. The continued closure of border crossings, active fighting in neighbouring governorates and radical armed groups blocking passage of trucks severely disrupted overland food deliveries since July 2013. As needs in the governorate continued to grow and food security of affected populations deteriorated, on three instances WFP was compelled to resort to costly but necessary emergency airlifts as the only means to deliver food to the targeted 227,170 civilians. The first airlifts were conducted in December 2013 when 6,025 food rations for 30,000 people were airlifted from Erbil to cover just 13% of the monthly requirements. Through the second round of airlifts, conducted between February and March 2014, WFP was able to deliver just over 16,000 rations out of a planned 32,500 to support 80,000 people in the governorate. These were suspended in mid-March after Turkish authorities granted the long awaited greenlight for the passage of 10,000 food rations into Al-Hasakeh through Nusaybeen on the Syria-Turkey border. However from April 2014, the governorate was once again cut-off from access. As a result, in July 2014, a third round of airlifts was implemented from Damascus. A total of 10,000 family food rations for 50,000 people and 3,000 ready-to-eat rations to support the immediate needs of newly displaced families were delivered. During January 2014, 17,500 people were assisted with 3,500 ready-to-eat rations in Homs and Rural Damascus.

Each monthly cycle is typically completed over the course of 45 days, due to access constraints and extended dispatch cycles. WFP has

WFP/Laure Chaïraoui



In areas like Homs and Dier Ezzor, WFP in partnership with the Syrian Arab Red Crescent (SARC) conducts door-to-door food distributions.



Syrian refugees go shopping with e-vouchers

continuously had to make adjustments to the ration due to funding and supply chain issues. This has resulted in reductions in ration size. There have been many constraints to providing a full ration including delays in procurement, inspection and quality issues that delay approval in country and insufficient pledges from donors. To date (September 2014), cash flow problems have been mitigated by the use of WFP's internal advance funding mechanism, which have allowed borrowing against future contributions. However inadequate funding commitments have become a severe constraint (see later).

In April 2013, WFP added wheat flour to the food basket in response to widespread wheat flour and bread shortages. Targeting 70% of WFP's planned beneficiaries, the flour is provided to households living in areas where the effects of the conflict have decreased availability and reduced milling and bakery capacities, to the extent that target beneficiaries are reliant upon WFP wheat flour distributions to meet their bread needs. For the beneficiaries that receive fortified wheat flour, the food basket provides approximately 80% of daily caloric requirements. The food basket satisfies approximately 52% of minimum daily caloric needs for those residing in areas not targeted by wheat flour distributions. In areas where home baking is common, wheat flour is distributed directly to beneficiaries, while in other locations, wheat flour is supplied to functioning bakeries through SARC and other partners. Governorates that do not receive wheat flour include Damascus, Tartous and Latakia due to availability of bakeries. Governorates that receive 100% of wheat flour include Rural Damascus, Hama, Idleb, Ar-Raqqa, Al-Hassakeh, Deir ez-Zor and Dar'a. All remaining recipient governorates receive 70% of wheat flour. Those that do not receive flour do not get any additional items.

Monitoring

WFP have common monitoring tools and platforms in the region, as well as dedicated monitoring staff, although monitoring has been weak in Syria (only 15% coverage for 2013) due to insecurity and access constraints. However, by

January 2014, WFP was able to augment its monitoring capacity by engaging third-party monitors who are able to access locations WFP staff cannot. This has led to an improvement of the monitoring coverage to 41% of distribution locations. WFP monitors all accessible distributions by examining the process of beneficiary verification and the performance of cooperating partners. Beneficiary satisfaction with the distribution procedures is also monitored. Both female and male beneficiaries are consulted in the process. Shop monitoring examines the redemption of vouchers, type of commodities purchased, prices charged as well as beneficiary and shopkeeper satisfaction with the overall process. Beneficiary monitoring examines household outcome indicators including food consumption scores, dietary diversity and the various coping mechanisms used.

Monitoring data allowed comparison of beneficiary and non-beneficiary households and findings indicated poorer dietary diversity of the latter – especially with regard to access to fruits, vegetables, meat and dairy products.

Prevention of acute malnutrition

In March 2013, a BSFP was initiated to provide nutrition support to young children, prioritising 240,000 children aged 6-59 months. In 2014, over 189,000 children at risk of malnutrition were provided with nutrition support, including those in hard-to reach areas in Hama and Rural Damascus for the first time in months. Two programme variations (using different products) have been employed in different governorates. Implemented in partnership with the Ministry of Health and UNICEF, one scheme provides monthly rations of Plumpy'Doz® (a nutritional supplement for children) to children aged 6-59 months living in internally displaced persons (IDP) collective shelters. Since September 2013, three NGOs in partnership with WFP extended the feeding programme beyond official IDP collective shelters to reach vulnerable children residing in host communities in Tartous, Homs and Hama. Under the second BSFP variant, the supplementary product Nutributter® for the prevention of micronutrient deficiencies is being distributed to children aged 6-23 months living in collective shelters and among host communities in the northern governorates of Syria.



WFP beneficiaries in Syria

Fuel distribution

In response to anticipated harsh winter conditions during 2013/14, WFP provided emergency fuel support to vulnerable families with limited access living in collective IDP shelters, in partnership with UNHCR. A total of 58 collective shelters in Homs, Hama and Damascus were supplied with 100,000 litres of fuel to cover heating requirements for four months while 10,000 heat-retention Wonder-bags® were distributed to families unable to cook WFP food rations. A total of 2,500 Wonder-Bags® (out of 4,100 dispatched), were distributed to families in rural Damascus, Damascus and Idleb while over 24,000 litres of fuel were supplied to the 58 targeted collective shelters.

Voucher scheme targeting pregnant and lactating (PLW) women

The October 2013 Humanitarian Needs Overview (HNO) estimated that 300,000 PLWs across the country were at risk of micronutrient deficiencies and required nutrition support, as well as improved awareness of appropriate feeding practices. In addition, WFP's monitoring findings illustrated that access to and consumption of fresh produce (such as fruits, vegetables and animal protein) by families, including PLW, was very limited, increasing their vulnerability. Hence, WFP introduced a targeted voucher-based nutrition programme to complement the GFD ration and improve dietary diversity for pregnant and lactating women. Launched in July 2014, the pilot is targeting initially 3,000 women in Homs and Latakia cities. Beneficiaries receive vouchers to the value of US\$23 to purchase fresh products, including vegetables, fruit, meat and dairy products, which are not part of the general food ration. It is planned to target up to 15,000 women as this programme is fully rolled out.

School feeding

An estimated 2.3 million children in Syria are no longer regularly attending school or have dropped out completely. As part of the UNICEF-led 'Lost Generation' strategy to improve access to learning and facilitate a return to normalcy, in 2014, WFP introduced a school feeding programme targeting some 350,000 children in four critically affected governorates, including Rural Damascus, Homs, Tartous and Aleppo. The first phase of the project was launched in July 2014,



Kindergarten student receives nutritional support

targeting schools in critical districts in Rural Damascus and Tartous. During the first phase, up to 100,000 elementary school children aged 6-12 years received daily rations of fortified date bars, conditional on attendance. The programme, which was initially implemented in summer schools, has been transferred to regular schools when classes resumed in September.

Inter-UN coordination

WFP has had a Memorandum of Understanding (MoU) with UNICEF in Syria, since January 2013, whereby both agencies have committed, through joint programming, to scale up nutrition interventions to address malnutrition, as well as to tackle micronutrient deficiencies and promote the population's nutrition status. Accordingly, WFP currently focuses on the prevention of acute malnutrition (using Plumpy'Doz), while UNICEF focuses on its treatment (using Plumpy'Sup and Plumpy'nut). In addition, both agencies collectively focus on the prevention of micronutrient deficiencies (using Nutributter and micronutrient powder). A key challenge for both organisations has been the lack of current nutrition data to guide programming, due to access constraints to certain areas. WFP's programme for PLW complements the support already provided by UNICEF, WHO and the United Nations Population Fund (UNFPA), in

the form of micronutrient supplementation and reproductive health services. Through the Nutrition Sector Working Group, led by UNICEF, nutrition assessments are conducted to update the nutrition situation as well as define nutrition strategies.

Logistics

Logistical needs inside Syria are continuously changing due to the fluidity of the security and access situation on the ground, and require a high degree of flexibility in planning. In this context, a complex chain of delivery underpins the implementation of these programmes.

WFP imports food into Syria through the primary supply corridors of Beirut and Tartous, while the use of Lattakia port was also increased during 2013. In addition, a fourth corridor through Jordan has been activated in July 2014 following the adoption of UN Security Council Resolution (UNSCR) 2165. WFP retains the capability to rapidly adjust its use of available corridors in response to changes in the operating environment. Accordingly, the expansion of additional corridors through Turkey is also under use, thanks to UNSCR 2165.

Upon arrival in Syria, food commodities are assembled in five storage and packaging facilities strategically located in Safita, Lattakia, Homs and Rural Damascus. To avoid assembling the food basket on-site under challenging security conditions, food is packaged prior to dispatch, thus mitigating the risks of losses and ensuring that each family receives the adequate food items. Each packaging facility produces up to 10,000 food rations every day, which are then dispatched by over 1,000 trucks each month to governorates allocated to each centre according to respective strategic advantages. Facilities in Safita, Lattakia and Homs offering a good staging point to cover the requirements of central and northern governorates, while facilities in Damascus serve the southern governorates. This allocation maximises the efficiency of food dispatches while reducing travel times, thus mitigating exposure of cargo to security threats.

Once packaged, the family food rations are dispatched to secondary storage points inside Syria and delivered to WFP partners on the basis of monthly allocation plans. In some cases, WFP purchases pre-packed rations which are transported by suppliers directly at the handover

points to partners inside Syria, without being processed through WFP facilities. Wheat flour milling is undertaken outside of the country, in Mersin and Beirut. Subsequently, bagged wheat flour is shipped respectively to Syrian ports or trucked to Damascus. For transport inside Syria, WFP utilises existing commercial transport settings, encouraging local capacities where possible. Previously working with one single transport partner, WFP contracted five additional transport companies in September 2013 to increase its delivery capacity and respond to the growing need for humanitarian assistance within the country. Each transporter is allocated specific areas on the basis of a previously established presence in certain parts of the country. This maximizes WFP's ability to deliver to all locations. For specific areas where surface access can be sporadic and the humanitarian situation particularly dire, contingencies for airlift of life-saving supplies are arranged.

Food distributions take place at final distribution points (FDPs) agreed upon with partners. Due to the instability of security conditions on the ground, the number of FDPs and their locations vary from month to month, as partners may no longer be able to perform distributions in previously accessible locations, or beneficiaries may be unable to reach planned distribution sites.

Activation of the Logistics Cluster

Following the recommendation of the UN Regional Emergency Coordinator for the Syria Emergency, the Logistics Cluster was activated in January 2013 to support overall logistics coordination and provide services to humanitarian actors responding to the emergency in Syria. The Logistics Cluster, led by WFP, fills logistics gaps in emergencies on behalf of the humanitarian community, whilst also providing a platform for coordination and sharing of key logistics information among partners. As such, it provides free-to-user services to its humanitarian partners, including dedicated warehousing space for inter-agency cargo, as well as transport services throughout Syria. In addition, the Cluster ensures support for inter-agency convoys to deliver assistance to the most vulnerable communities in otherwise inaccessible parts of the country. The Logistics Cluster offers also humanitarian flights to Qamishli, on a cost-sharing basis.

Furthermore, the Logistics Cluster has established a logistics coordination forum in Damascus, Beirut and Amman. Over 30 organisations (UN agencies, NGOs, INGOs, and donor agencies) regularly attend meetings where participants discuss logistics bottlenecks and develop common solutions for improved humanitarian response. In addition, the Cluster produces regular logistics information products including situation reports, maps, assessments, meeting minutes, snapshots and flash updates on the Syria Logistics Cluster webpage, and shares them via a Cluster mailing list. As of June 2014, a total of 17 organisations were benefiting from the Logistics Cluster services



A Syrian boy collects his family's monthly ration of rice, flour, pasta, beans, vegetable oil, sugar and yeast.

² <http://unscr.com/en/resolutions/2165>

for their operations inside Syria. As additional organisations are allowed to work in Syria, the number of service requests has been increasing. Accordingly the Cluster has been rapidly scaling up its operations, and continues to be ready to expand further if required.

In 2014, WFP logistics in close coordination with procurement and shipping units, updated the Concept of Operations for the Syria Operation's Supply Chain and put in place measures to mitigate pipeline breaks and ensure timely arrival of commodities in Syria. Arrangements with suppliers now ensure a readily available stock of food commodities for immediate purchase upon receipt of funds by WFP. Additionally, procurement will be conducted solely within the Mediterranean, significantly accelerating lead times for the arrival of food in the country.

Risks to staff safety continue to represent the greatest threat to sustaining WFP operations in the country. Should the security environment deteriorate further, WFP may be forced to reduce its footprint inside the country by deploying both national and international staff to work from alternative locations. Remote management plans have been developed, including the increasing use of WFP's Lebanon and Jordan offices if necessary.

Ongoing challenges and lessons learnt

WFP's ability to deliver and distribute adequate food is affected by access restrictions and shrinking humanitarian space. However, WFP continues to work with the UN Country Team and partners to maintain a presence on the ground, implement activities and continuously advocate for unhindered humanitarian access.

WFP, and hopefully the Syrian population, have benefited from a clear WFP operational strategy at the outset. Recognising the political nature of the crisis and that high levels of inse-



WFP working with the Syrian Arab Red Crescent (SARC) Packaging Food Before Distribution

curity were going to prevent WFP from operating as normal, the decision was taken early on to adopt a pragmatic and opportunistic approach. WFP began its Syria emergency operation in 2011 and was the first organisation to launch an emergency operation without the full approval of the Syrian government, gradually building on its programming base to expand the humanitarian space through engagement and negotiation. This has been a slow process requiring persistence. Although at first and for many months it was only possible to work through SARC, WFP were gradually allowed to engage with more local NGOs and were not shut down as a result. WFP did not control the modus operandi but found that they could expand humanitarian space in a way that was acceptable and met needs of millions of people, including other organisations working on behalf of the conflict affected population. WFP has worked through numerous local partners since they have better access to most of the governorates. This has been a very positive development and has effectively changed the landscape of civil society in Syria by investing in building up capacity of national agencies.

While working in Syria, WFP have had to tread carefully with regard to the cross-border programme from southern Turkey as this expanded with an increasing number of agencies basing themselves in Gaziantep and Antakya in southern Turkey. With mounting criticism of the UN's lack of engagement in the cross-border programme, WFP began engaging with INGOs involved in cross-border work in early 2013 and sent a number of staff to liaise with the NGOs and ACU in order to focus on information management and nurture mutual understanding. This was followed by the deployment of a Global Food Security Cluster lead to work with NGOs doing cross-border work and to improve collaboration. This was a slow consensus and trust building exercise leading to the establishment of systems for sharing information about programming from southern Turkey and Damascus.

In May 2014, additional measures to improve operational coordination and joint planning were taken. This involved constructing a joint forward looking plan that indicated where there were operational overlaps and engaging in discussions with partners about how to decide on 'who does what, where'. Another meeting was held in July 2014 where an action plan was agreed for cross-border programming from

Turkey, Jordan and programming from Damascus, looking at the whole of Syria. A key challenge for all stakeholders is how to determine numbers in need.

Adoption of UNSCR 2165 on 14th July has had a positive impact in enabling WFP use the most direct route to reach cut-off communities. All WFP programming, including cross-border and cross-line, is now managed from Damascus. There are no WFP cross-border operations managed from Turkey or Jordan. This position has been taken in order not to undermine the mandate under UNSCR 2165. This has made programming harder in one sense as there are complex discussions and negotiations with the Syrian Government but WFP is gradually overcoming challenges related to fragmented and uncoordinated responses. While information about INGO programming is treated confidentially, any WFP cross-border programming from Turkey is planned from Damascus and the government is informed accordingly through the office of the Humanitarian Coordinator. An unexpected consequence of the UNSCR 2165 has been an increased readiness of the Government of Syria to facilitate cross-line convoys, a welcome development for WFP. This may partly reflect the battle for hearts and minds as the threat of ISIS appears to have increased.

Against the backdrop of these positive humanitarian and political 'sea-changes' is a looming resource crisis affecting WFP, who will effectively be running out of money for this and other programmes in the region in late 2014, resulting in dramatic scaling back of programming. This could not be happening at a worse time as winter approaches. The irony is that in August 2014, WFP managed to reach almost 4.1 million Syrians in Syria, the highest number since the emergency response began in 2011. In October, WFP hopes to still reach 4.25 million Syrians in country but will provide a food basket with a 40% reduction of the planned caloric requirement. WFP will do everything it can to advocate and strengthen resource mobilisation efforts in order to avoid a reduction of WFP assistance.

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Food For Syrian Refugees In Jordan

WFP/Faten AL-HINDI

³ <http://www.theguardian.com/global-development/2014/sep/18/world-food-programme-cut-aid-syria>



Syrian refugee and her child

Purvis/PUNFICK

WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management

By Hala Khudari, Mahmoud Bozo and Elizabeth Hoff



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We wish to express our sincere appreciation for the support and input from WHO's information management team and field staff for their feedback, commitment and responsiveness to build up the information provided. Special thanks go to Dr. Ayoub Al-Jawaldeh, Nutrition Regional Advisor, for his invaluable technical support and guidance, in addition to the publication office at the Eastern Mediterranean Regional Office.

Three years into a brutal crisis, the protracted conflict in Syria has had an immensely negative impact on essential living conditions of the Syrian population. Access to basic services and commodities such as food, livelihoods, safe drinking water, sanitation, education, shelter and health care has been compromised. This in turn has increased the populations' vulnerability to poverty, violence, food and nutrition insecurity, and disease. The volatile nature of the crisis has created unpredictable and unstable living conditions for the population. The ongoing conflict has caused forced displacement, socioeconomic limitations, insecurity and a lack of access to basic services. Coupled with recurrent droughts, the conflict has significantly affected food security and livelihoods and thus, has adversely impacted nutritional status, especially in children under 5 years; an already vulnerable population. More specifically, chronic poor dietary diversity, inadequate/improper infant, young child and maternal feeding practices, as well as geographical and gender inequalities have heightened the risk of malnutrition in children under five years.

According to the Syrian Family Health Survey (2009), conducted prior to the crisis, the nutritional situation of children under five years of age was poor, with an estimated 23% of them being stunted, 9.3% wasted and 10.3% underweight. Exclusive breastfeeding rates stood at 42.6% while the proportion of newborns introduced to breastfeeding within the first hour was 42.2%. Micronutrient deficiencies were also recorded in pre-crisis Syria in 2011, presenting a risk for sub-optimal growth among children; for example, anaemia prevalence among 0-59 month old children was 29.2%, while there was an 8.7% Vitamin A deficiency rate³ and 12.9% iodine deficiency prevalence⁴. Neonatal mortality rates, infant mortality rates and under-five mortality rates stood at 12.9/1000, 17.9/1000 and 1.4/1000 respectively⁵.

Coordinating response

The confluence of factors and lack of solid data on the nutritional status alerted the humanitarian community to the possibility that cases of malnutrition in Syria were going undetected. This prompted interna-

tional organisations and national counterparts to address the prevention, detection and treatment of emerging malnutrition cases. With the establishment of the Nutrition Sector Working Group headed by UNICEF and the Ministry of Health (MOH) in the second quarter of 2013, which emerged as a result of expanded nutrition activities and increased nutrition partners in the field, the response to malnutrition has gradually been strengthened. This has been realised through the involvement of key UN agencies including the World Health Organisation (WHO), UNICEF and the World Food Programme (WFP) and key national authorities and implementing partners including the MOH, Ministry of Higher Education (MOHE), as well as international and national non-governmental organisations (NGOs) such as International Medical Corps, Action Against Hunger (ACF) and the Syrian Arab Red Crescent (SARC). These stakeholders have scaled up their response by adopting a holistic strategic approach that covers i) preventative micronutrient supplementation; ii) screening for and referral of malnutrition cases; and iii) outpatient and inpatient treatment of acute malnutrition. WHO's response has focused on strengthening screening of children under five years for malnutrition and hospitalised care of complicated cases of severe acute malnutrition (SAM).

Scaling up WHO nutrition activities

Revitalising the Nutrition Surveillance System

Prior to the conflict, in 2009, a national nutrition surveillance system was established to report on acute and chronic malnutrition of children under 5 years visiting health facilities for their routine immunisation. The system extended to providing parents with information and a service to monitor child growth. However, with the conflict driven damage to the health system and the consequential shortage in nutrition personnel, the national nutrition surveillance

¹ WHO/MOH, Syrian Family Health Survey, Syria, 2009.

² Ministry of Health, Nutrition surveillance system report, Syria, 2011.

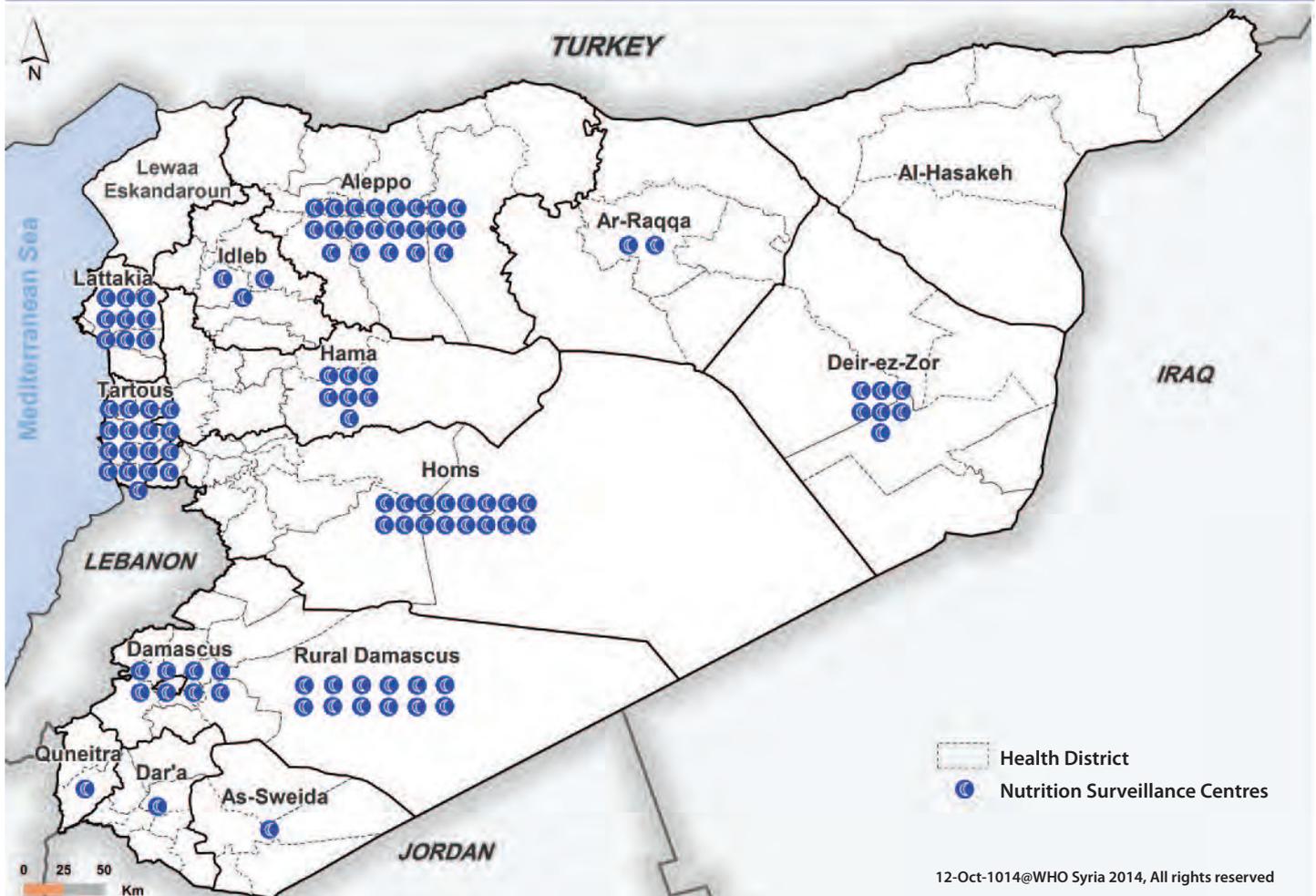
³ Ministry of Health, Vitamin A deficiency Study, MOH, 1998

⁴ Ministry of Health, Study on Iodine deficiency prevalence in Syria, MOH, 2006.

⁵ See footnote 1

Map 1

Syrian Arab Republic: Revitalised Nutrition Surveillance Centres



system has suffered from a reduction in the quality of nutrition service provision and deterioration in reporting and monitoring. With an expected increased number of acute malnutrition cases, and a scarcity of nutrition services, there was a concern that malnutrition cases were going undetected.

In order to understand the impact on overall nutrition related morbidity and mortality, detection and reporting on cases would need to be improved. In order to enhance the detection of malnourished children and fill the information gap, WHO is collaborating with the MOH and other partners to improve and strengthen the Nutrition Surveillance System. Between April and July 2014, twelve health centres from 12 governorates were selected to pilot a modified surveillance system. This modification encompassed revised reporting and monitoring tools and providing trained human resources. The pilot governorates were selected using two criteria: (i) conflict-impacted areas (Daraa, Homs, Aleppo, Rural Damascus, Idlib, Quneitra and Deir-ez-zor) and (ii) densely populated areas with high numbers of Internally Displaced Persons (IDPs) (Damascus, Tartous, Latakia, Hama and Sweida). Coverage rates of nutrition surveillance, capacity of human resources, avail-

ability of physical space, and equipment needs were also assessed and evaluated within the pilot timeframe. Aside from the pilot centres, nutrition surveillance was also started up again in the highly conflict-affected governorate of Ar-Raqqa, through the coordinated efforts of WHO field staff.

Numerous constraints were reported by the pilot nutrition surveillance centres. The lack of human resources, space, equipment and telecommunication-reporting utilities were cited as challenges by a number of Governorates. These obstacles were especially evident in the case of Deir-ez-Zor, where the single health provider present was only able to take mid-upper arm circumference (MUAC) measurements of 300 U5 children per month.

One aim of the pilot was to test the effectiveness of the capacity building trainings conducted on anthropometric measurement techniques including weight, height and MUAC and the reporting system. This included assessment of the tools and flow of data and adequacy of referrals and standardised management following community based management of acute malnutrition (CMAM) and WHO 2013 protocols. The findings of the pilot have demonstrated what changes

need to be effected for the next phase of the nutrition surveillance strengthening which aims to expand to 10 health centres within each governorate including enhancing capacity, provision of supplies and equipment and reporting templates and tools. The expansion began in mid-July when a team of health workers from 20 centres in Damascus and Rural Damascus were trained. By mid-October, 105 surveillance centres were following the improved surveillance system (see Map 1).

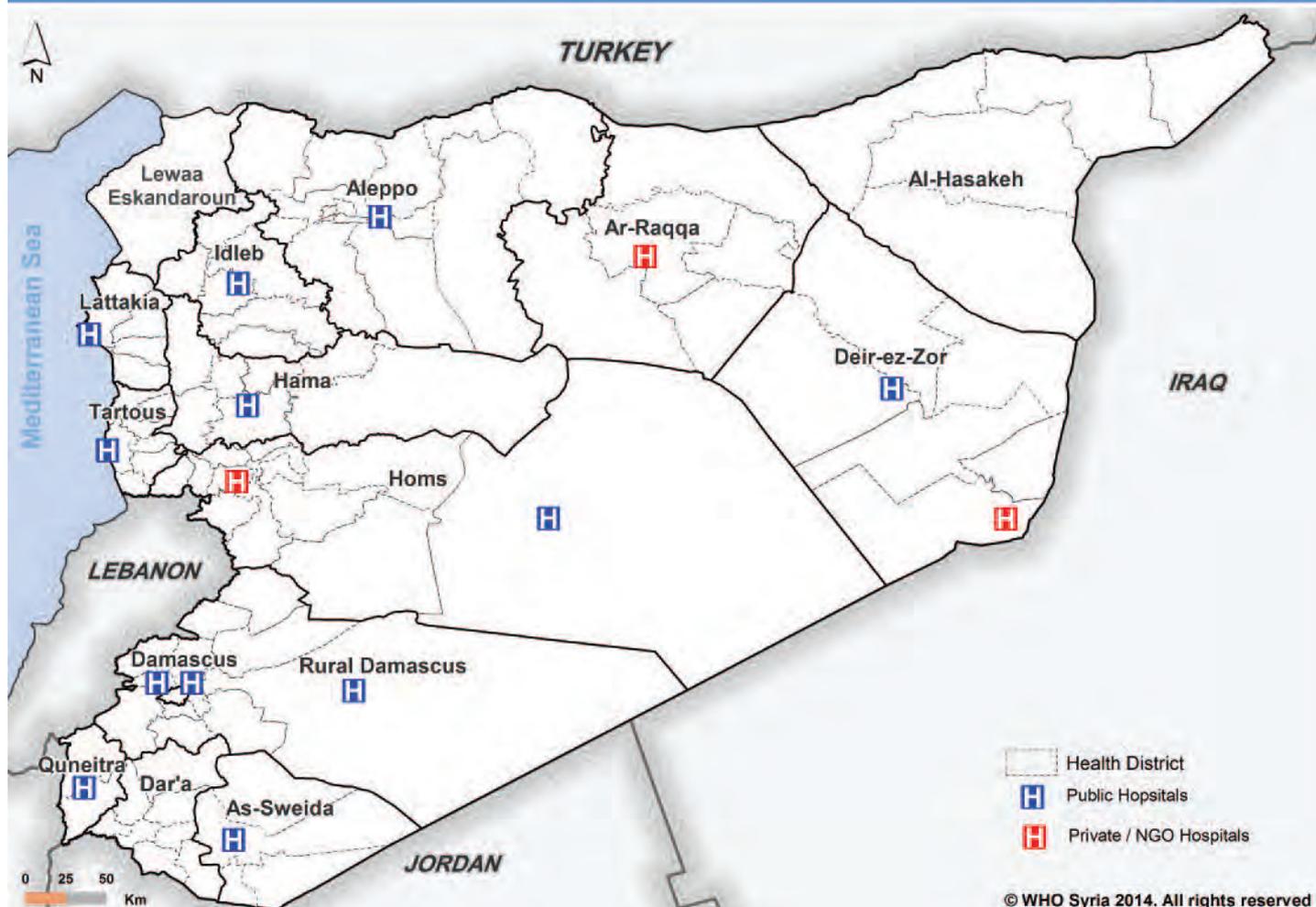
By the end of 2014, it is anticipated that more than 115 health centres will be integrated into national surveillance system. In 2015, a number of NGOs will be integrated into the programme in order to reach more children in affected and hard-to reach areas. The regular and accurate flow of information through monthly paper-based published reports shared with WHO and centrally with the MOH by main nutrition offices at the directorates of health in the governorates. Reports include cases of malnutrition in children under five years across the country that will be analysed and utilized to monitor prevalence and trends, and more importantly early detection of cases and referral for treatment.

Map 2

Syrian Arab Republic: Stabilisation Centres



World Health Organisation



A step towards success: active surveillance in Aleppo Governorate

The surveillance system in the northern Governorate of Aleppo has set a high standard and many ways been exemplary. As one of the main population centres in Syria, Aleppo city was once considered the industrial heart of the country. It is surrounded by large rural areas that have been severely affected by violent conflict for over 2 years. Huge population displacement, food shortages and economic losses are some of the many hardships Aleppo Governorate inhabitants have faced, making families and especially their children more susceptible to malnutrition. With a very active surveillance team, screening for malnutrition was optimised not only through screening cases entering facilities but also via mobile teams visiting shelters for the internally displaced in the city and conducting referrals for cases in need of treatment.

Since the start of 2014, the surveillance in Aleppo has consistently reported on cases from four health centres in four health districts in the governorate of Aleppo (the numbers available so far are limited to specific locations in the governorate, are not statistically representative and therefore not included here). In the month of August, 12 facilities have been activated in

urban and rural areas of Aleppo. These facilities are expected to screen an approximate 4000 children per month. In locations experiencing intermittent violence like north Aleppo, due to the security situation, some health centres stop reporting when the security situation is dire. This varies the total number of centres reporting from month to another with a typical difference of 1-2 centres.

Referral of detected cases and hospital care of complicated cases of severe acute malnutrition (SAM)

The implementation of the pilot phase of the modified Nutrition Surveillance System led to an increase in the detection of cases of malnutrition requiring treatment and confirmed morbidity and mortality due to nutrition related disease. Data collection and analysis on SAM is still ongoing; the full report will be out by early 2015. This increase highlighted the importance of establishing a solid referral system for specialised treatment to reduce associated mortality and morbidity.

Since January 2014, WHO has supported the establishment of Stabilisation Centres (SC) for the management of SAM in hospitals across the country in line with WHO's SAM Manage-

ment Protocol, updated in 2009 and 2013. So as to not create parallel systems within hospitals, these centres have been integrated within paediatric departments at the main public hospitals. Support to these SCs has been extended in three main areas, (i) building the capacity of the health workforce, critical for effective SAM management and treatment (ii) filling gaps in medicines, medical supplies and equipment for treatment of complicated SAM, e.g. anthropometric equipment, antibiotics, minerals, vitamins and F100, F75 formulas and (iii) providing technical support for treatment protocols and reporting. To date, over 350 health professionals from MOH, MOHE and private hospitals in Damascus, Rural Damascus, Homs (including Homs city and Tadmor), Hama, Aleppo, Idlib, Lattakia, Deir-ez-zor, and Quneitra have been trained on the WHO SAM Management Protocol adopting best practice techniques and food safety measures⁶. Additionally, systemised reporting through a developed hospital reporting template, has been initiated in collaboration with MOH.

As of August 2014, SCs in hospitals were established in nine governorates with MOH and

⁶ World Health Organisation, Training course on the management of severe malnutrition, WHO/NHD/02.4, 2009



Baby girl admitted to WHO supported SC who was successfully treated and discharged 12 days later

local NGOs. Centres within the public hospitals are available in Damascus (2), Aleppo (1), Hama (1), Lattakia (1), Qutaifeh in Rural Damascus (1), Homs (1-Tadmor), Quneitera (1), Sweida (1), Deir-ez-Zor and Idlib (1) (see Map 2). Eight of these centres have received SAM cases in Damascus, Aleppo, Lattakia, Idlib, Deir-ez-Zor, Sweida and Hama. In cities where public health facilities have been significantly damaged such as Homs, Deir-ez-Zor (Boukamal), Dara'a and Ar-Raqqa, cases are referred to private or NGO hospitals.

Reports from Damascus, Homs, Dara'a, Aleppo, Latakia, Hama and Deir-ez-Zor have been received on complicated cases of SAM requiring urgent medical attention. In the case of Hama, over a period of three months (April-July), 42 cases of complicated SAM were admitted in comparison to six cases admitted between January and March before the establishment of the SC. Further expansion of SCs to all governorates is planned with the aim to situate at least one centre per governorate to manage the caseload of SAM cases requiring hospitalised care. Future centres will be located in hospitals in Deir-ez-Zor (Deir-ez-Zor city), Dara'a, Tartous, Sweida, Qamishli, and Hassakeh.

Mainstreaming Infant and Young children feeding promotion

Infant and young child feeding (IYCF) and breastfeeding promotion has been prioritized and mainstreamed within most nutrition support activities. In Syria before the crisis, the rate of six-month exclusive breastfeeding had been consistently low (approximately 43%). Without the proper support of health staff and community based initiatives, lactating mothers have been struggling during the crisis with initiating breastfeeding. In many cases, due to displacement and overcrowded living conditions compounded by conflict-related distress, mothers lose confidence in the quantity and quality of their breastmilk, stopping breastfeeding all together and resorting to other practices. During an obser-

vatational mission in early 2013, doctors and midwives reported an increasing number of women who wished to breastfeed their infants, mainly because they could not afford infant formula. Due to the short stay in health facilities following delivery, help with initiation of breastfeeding had been insufficient. Also during 2013, WHO received numerous requests from NGOs supporting populations in need including the displaced to provide breast-milk substitutes like infant formula. These requests were not supported as they counteract WHO/UNICEF global guidance to promote exclusive breastfeeding; instead, WHO focused on promoting optimal IYCF practices. Requests for infant formula over 2014 significantly decreased.

A capacity building and programme-strengthening project was identified as an essential element to promote breastfeeding at the health facility and community level with the aim of raising awareness among lactating mothers in both displacement shelters and host communities. Since early 2014, WHO has conducted five trainings for more than 190 doctors and health workers from Aleppo, Damascus, Rural Damascus, Quneitera, Sweida, Homs, Derezzor, Hama, Latakia, Hassakeh, Tartous and Daraa in cooperation with the MOH-primary health care department. Trainings covered the importance of breastmilk, its constituents, techniques on initiation of breastfeeding and its benefits for both child and mothers.

Breastfeeding promotion has been streamlined across all WHO nutrition activities. It has been included in all training courses conducted on nutrition surveillance allowing surveillance health workers to conduct breastfeeding consultations for concerned visiting mothers. Data collection on breastfeeding rates will also be included through the nutrition surveillance system in the upcoming months, providing information for analysis of trends and further investigations on causal factors of the changes to breastfeeding rates. As yet, no assessment has been conducted to investigate any links between breastfeeding status and acute malnutrition.

Preventative micronutrient supplementation

Equally important to strengthening treatment capacity, preventative measures against micronutrient deficiencies have also been scaled up by nutrition working group partners through blanket distribution of ready-to-use supplementary foods (RUSF). WHO has also contributed to this initiative through the distribution of micronutrients for children and mothers during immunisation campaigns and in health facilities. In 2014, up to 900,000 children and 7500 adults were provided with micronutrient supplementation.

The way forward

During the second half of 2014, WHO will be further enhancing its nutrition activities across

four main areas:

1) Further strengthening of the nutrition surveillance system will be achieved through conducting decentralised trainings on nutrition surveillance to expand the re-activation of nutrition surveillance in 10 health centres in Latakia, Tartous, Idlib, Hama, Dara'a and Homs. Efforts will also be made to improve data entry, collection and reporting through strengthened operational capacity and procedures at the nutrition surveillance centres.

2) Distribution of supplies to SCs to improve and enhance treatment of admitted SAM cases. In order to expand geographical coverage, WHO is drawing on NGO and private sector capacities across the country. NGOs operating hospitals will be trained and supported with in-kind donations to also be able to treat detected complicated SAM cases.

3) Mainstreamed IYCF activities through extensive trainings for health workers in the health centres providing nutrition surveillance, allowing them to deliver key messages to mothers on the importance of breastfeeding and complementary feeding. Furthermore, two courses of training of trainers will be implemented to decentralise IYCF trainings across the country, contributing to raising the awareness of mothers visiting health centres or hospitals, or residing in displacement shelters or the host community.

4) Strengthened coordination with the Nutrition Working Group partners will be crucial in enhancing a coordinated referral process from surveillance centres, outpatient and inpatient treatment centres. Nutrition sector partners including MOH and SARC predominantly supported by UNICEF have worked to establish Outpatient Therapeutic Programmes (OTPs) in health centres to include the follow up and management of both SAM and MAM (moderate acute malnutrition) cases. Additionally, preventative nutrition services and blanket supplementation has been supported by WFP. These efforts have been strongly coordinated and continue to be through regular Nutrition sector meetings and bilateral meetings with UN sister agencies to bridge programmes and fill in gaps working towards a holistic CMAM approach.

WHO in coordination with nutrition sector partners has scaled up its nutrition response to help alleviate nutrition insecurity from a health perspective, aiming to provide quality nutrition services at health facilities to prevent, detect and treat cases of malnutrition and related mortality and morbidity. Efforts continue to obtain a clearer picture of the prevalence of malnutrition across the country. Halting the increase of malnutrition prevalence during the protracted Syrian crisis is crucial for children's health, well-being and physical and cognitive development.

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Experiences and challenges of programming in Northern Syria



Measuring height during the WVI supported anthropometric assessment

Anon, Northern Syria

By Emma Littledike and Claire Beck



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Claire Beck is the Global Emergency Health, Nutrition and WASH Team Leader for World Vision International.

World Vision International (WVI) set up offices in southern Turkey in May 2013 and began work in Jarabulus and Manbij, Aleppo governorate in response to the escalating violence in Syria and reports of large scale internal displacement. This article describes their experiences in supporting nutrition and related primary healthcare programming to internally displaced persons (IDPs) between May 2013 and April 2014.

Current IDP situation (May 2014)

The total number of IDPs in Jarabulus is currently estimated at 22,875 and the total catchment population is approximately 68,000. The total number of IDPs in Manbij is estimated at 115,518 with an estimated catchment population of over 1 million. In Jarabulus, the camps are managed by an independent Syrian individual with strong relationships in the community. Informal camps have been established in collective community spaces such as schools and unfinished buildings. There are a greater number of informal camps in Manbij than Jarabulus. Organised and established camps in Manbij are managed by other INGOs. The majority of IDPs at the camps are from Homs, Hama and within Aleppo governorates.

Early needs assessment

At the time of initial assessment by WVI, only background nutrition data from Syria was available. Pre-crisis, Syria had a high global acute malnutrition (GAM) prevalence of 9.3%, stunting (23%) and underweight (10.3%). Micronutrient deficiencies in children 0-59 months were also prevalent: 29.2% anaemia, 8.7% Vitamin A deficiency and 12.9% iodine deficiency¹ Pre-crisis infant and young child feeding (IYCF) practices

were poor. National figures show a low initiation of breastfeeding within the first hour of birth (42.2%) and low exclusive breastfeeding amongst infants < 6 months (42.6%) (national survey, 2009)². The percentage of children under 2 years who are not breast-fed is estimated at 10% (2009)³. According to national data from 2006, the timely complementary feeding rate for children 6-9 months was 36.5% and the proportion of children 6-11 months who received the recommended minimum number of complementary foods per day was 20.8%⁴.

In May 2013, an observational rapid area assessment was conducted by WVI in Jarabulus District, Aleppo governorate, Northern Syria to determine the need for and nature of health and nutrition interventions. The assessment team was made up of members of WVI's Global Rapid Response Team. The target population for the assessment comprised internally displaced persons (IDPs) living both in one camp and amongst the host community (four additional camps were later established to meet the needs of the increased number of IDPs arriving). The priority needs voiced by the IDP and host community during the rapid assessment in Jarabulus, Aleppo governorate were access to health services food, shelter and improved water, sanitation and hygiene (WASH) facilities for the camp residents and town inhabitants. Access to breast milk substitutes was also reported as a major issue.

Programme response

Primary health service support

WVI's immediate priority was to establish support to primary health care services. Health services were limited, consisting of a number of private doctors and a Qatari Red Crescent Field Hospital.

The Syrian Arab Red Crescent clinic had not functioned for a while. IDPs could not afford to visit the private doctors and the camp management was unable to cover the cost of medicines for the residents. In conjunction with the local leadership, including the health committee, a small primary health care centre (PHC) was established in June 2013 next to the main camp in the area. A paediatrician, midwife and two nurses were hired to provide services, while a community mobiliser was hired to conduct health and nutrition assessments, to provide psychosocial support to women and to counsel on optimal IYCF in all the collective centres. An English and Arabic speaking coordinator linked expatriate and Syrian staff. All staff were qualified within the Syrian health system and selected with support from the local council and the health committee, who approved all appointees. Initially, expatriate staff visited the projects biweekly for ongoing training and support, but once the border was closed to expatriates in July 2013, all support, supervision and training was done either remotely through phone or skype access, or at the nearest border crossing on a bi-monthly basis. Few Syrian staff could cross the border to meet with management staff as this was time consuming and had to be well planned due to the busy work schedules in the field and the need to keep services running. Lack of identification documents was also an issue.

¹ Revised Syria Humanitarian Assistance Response Plan (SHARP), Syrian Arab Republic, January- December 2013

² Syrian Family Health Survey, 2009

³ Figure estimated from area graphs in Trends in Infant Feeding Patterns, January 2009

⁴ Multiple Indicator Cluster Survey, Syrian Arab Republic, 2006

Building IYCF and SAM treatment capacity

Supports to IYCF and SAM treatment capacity were also provided. A planned IYCF training for all health and water, sanitation and hygiene (WASH) staff was postponed due to insecurity in the field. Instead, two doctors crossed the border for accelerated two day training. They were equipped with training materials and technical guidelines in Arabic language, and equipment to replicate it back in Syria during the afternoons when the clinic was closed. In practice, they could only deliver part of the training due to clinical demands. Guidance on the treatment of severe acute malnutrition (SAM) was also provided through technical resources and discussion. This proved sufficient for the paediatrician to begin treating acutely malnourished children who came to the clinic, rather than referring them for treatment at the hospital, which was 45 minutes travel by road and not always secure. F75 and F100 were made using locally available ingredients as commercial product was not available (see later for issues around supplies). Until then, the few children that presented at the clinic with SAM had complications and were referred to the hospital for medical treatment where no nutrition support was provided.

The initial rapid assessment was observational; it was not possible to collect data on feeding practices. Informed by background (national) data, all health staff were sensitized to the importance of exclusive breastfeeding. However the demand for BMS was high from the IDP and vulnerable host community. There was no BMS programme at the time although infant formula was available to purchase locally (see later under 'challenges'). As a result of consultation with the governing group, WVI adapted the organisation's Women, Adolescent and Young Child Space (WAYCS) model and instead of having separate dedicated spaces for women and children, an alternative more culturally appropriate approach was decided upon which was to set up WAYCS within clinic facilities. Staff began to hold small meetings for women in one of the clinic rooms to support them in breastfeeding and complementary feeding. It meant, however, that it was harder to include husbands and wider family in these sessions. To help overcome this, staff made tent-to-tent visits and collection centre visits to all pregnant and lactating women to provide support and education.

Further nutrition assessments

When WVI programmes began in June 2013, there were no current nutrition data available. By August 2013, two rapid mid upper arm circumference (MUAC) assessments had been conducted by two INGOs among children in Idleb and Ar Raqqa governorates in northern Syria. Both found low prevalence rates of SAM (<0.4%) and moderate acute malnutrition (MAM) (<2.4%). Both assessments had limitations. The larger rapid assessment in Ar Raqqa⁵ was conducted alongside a measles

vaccination campaign making it difficult to ensure quality data collection and the majority of children measured were <12 months. The rapid assessment in Idleb on 4,230 children did not provide enough information on the sampling methodology and household selection to determine how representative it was.

Given these limitations and the report of 30 cases of severe and moderate acute malnutrition to clinics between June and December 2013, WVI undertook an anthropometric survey amongst IDPs in Jarabulus district, Aleppo governorate on 20th – 24th December 2013. Both weight-for-height z score (WHZ) and MUAC were assessed. Given the operational constraints, training on anthropometric assessment was compromised and relied on guidance documents, video links and a survey leader (paediatrician) with research experience in nutrition and anthropometric assessment. The assessment was carried out during a difficult time (snow and conflict) and the methodology had to be adapted to survey accessible areas. The prevalence of acute malnutrition was again found to be low: 2.6% global acute malnutrition (GAM), 0.5% SAM and 8.1% underweight (low weight for age). Prevalence of stunting was 22% (7.7% severe). A photograph of each child's measurement was taken and examined for accuracy; the main limitation was an inaccurate adjustment for clothing weight (see images).

In September 2013, a joint scoping mission was carried out by the Global Nutrition Cluster (GNC) Rapid Response Team (RRT) consultant in Northern Syria to assess the nutrition situation.

Scaling up services: small scale needs, large scale challenges

Case management of SAM

Whilst the prevalence of SAM was low, there was a need for small-scale treatment capacity. Existing capacity was weak given lack of training and low exposure of staff to WHO treatment protocols. The majority of in-patient facilities did not follow WHO protocols and used intravenous fluid as one of the main treatment methods for children with SAM and complications. Exceptions were specialised children's hospitals in Aleppo and Damascus that are part of the Syrian Ministry of Health (MoH) and which follow WHO treatment protocols. In Syria, there was no commercially produced F100 or F75 available so locally prepared F75/F100 was used instead. An example of case management of a SAM case is given in Box 1.

In general, community based management of acute malnutrition is being explored but there is no community health worker network in existence so cases are being managed by a select few INGOs at their supported inpatient and outpatient facilities across the country. WVI is the only external (INGO) health

⁵ The actual number of children measured is not confirmed.

Severe acutely malnourished child on admission at PHC in Aleppo governorate



Anon, Northern Syria

Box 1 Treatment of a case of SAM

An infant presented to the clinic with acute watery diarrhoea having already received treatment with antibiotics and oral rehydration salts (ORS) from a private physician. The child had a history of chronic diarrhoea and had been formula fed since birth (never breastfed). The child had a WHZ <-3 and MUAC 11cm at 9.5 months of age. The infant showed signs of marasmus and dehydration. He had a fast pulse and dry hair. His weight on presentation was 5.5kg (a weight recorded at the private clinic was 6kg).

The staff began treatment by stopping the course of antibiotics, given the lack of evidence for the infection diagnosed. For the first two days, ReSoMAL solution was provided (5ml/kg = 30ml every half an hour). This was prepared as 5% Dextrose, 1.8g of sodium chloride and 1.5g of potassium chloride in one litre of water. F100 was also given and it was prepared as: 80g powdered full fat milk, 45g olive oil, 50g cane sugar, 1g potassium chloride, 0.5g magnesium citrate, 2mg copper acetate and 20mg of zinc acetate dissolved in 1 litre of boiling water and set to cool. The F100 was given to the child in 60ml doses every 2 hours. Vitamin A was also given for 2 days. The clinic staff reported that they cannot prepare F75 as there is no skimmed milk.

On the fourth day they gave the child Bactrim syrup and on the 8th day, gave iron. The child recovered and then maintained his pre-hydration weight (6kg) during this stabilisation period.

During the following 10 days, the quantity of F100 was increased and under supervision, he proceeded to gain weight at a rate of 15g/kg/day (90g/day). For another 20 days, the child was managed at home with increased F100; his father was capable of preparing F100. The child's weight increased to 8kg and MUAC increased to 12.5cm. He was discharged on lactose free milk until one year of age and then transferred to full fat milk (reconstituted NIDO). The child now drinks full cream milk, one boiled egg, and fruit daily. He returns to the clinic for regular weigh in.

Source: INGO worker

Severe acutely malnourished child after 3 weeks treatment



Anon, Northern Syria

Ingredients for making F100

Anon, Northern Syria



provider in our operational areas in Northern Syria.

Due to cultural norms and medical hierarchy, it is also proving difficult for humanitarian agencies to support in-patient facilities to improve the treatment of SAM with training and support. Designated in-patient referral facilities need to be identified in each governorate and there is a requirement for training events inside Syria to be delivered by a highly qualified consultant. Many health personnel that are both employed by the regime, working independently or for an INGO are unable to cross the border into Turkey without a passport. Travel to Aleppo to acquire a passport carries substantial safety risk. The need was therefore identified for a strong distance learning training package comprised of narrated videos in Arabic that could be stored on USBs and disseminated in-country. Whilst this is inferior to practical 'on the job' training at in-patient facilities, it is perhaps the only way to improve treatment, particularly in areas with poor access such as Deir ez zor and Homs.

Of note, we have seen a higher caseload of malnutrition cases in the past two months. There have been around 30 cases of malnutrition (24 moderately malnourished and six severely malnourished) identified at the clinics.

Therapeutic food supplies

Establishing a supply of therapeutic and supplementary feeding products has been problematic. Our agency could find no local equivalents of RUTF in Turkey and acquiring therapeutic feeding products from reputable suppliers has been difficult. The customs cost to import products is excessive. For example, an RUTF order worth \$650 carried a customs clearance cost of \$5000 on top of a \$1500 shipment cost. Increasing the order quantity did not improve the cost efficiency. Our agency managed to find a supplier who helped to secure customs clearance free of charge as a one-off gesture of support. However supplies had to be shipped straight into Syria (since the agency was not registered in Turkey and so goods could not be stored in-country). Thus it was not possible to share the supplies with other Turkey-based INGOs and Syrian NGOs as planned. Border closures further prevented staff sending supplies back to Turkey to share with other agencies. Importing and storing products in Turkey requires agencies to be registered as organisations undertaking medical activities. A number of agencies are not yet registered, despite their efforts, due to the length

of time required to submit and get feedback from applications.

Access to health care: the role of the private sector

In Manbij city, Aleppo governorate, there are 289 doctors working privately providing high quality care. IDPs are not able to pay the commercial prices for treatment at private clinics. Many primary and secondary clinic health care staff provide free consultations or a negotiated lower payment rate but given financial and time constraints, they are only able to see a small number of patients per day. WVI has recently embarked on a 1 year pilot of a small-scale health care voucher system using the private sector to provide quality services to IDPs who had little or no household income (April 2014 – 31st March 2015).

The pilot targets children under 5 years in select areas of Manbij. They will receive a voucher entitling them to one consultation at any private clinic and medicine from a pharmacy over the 12 month project period. At WVI's primary healthcare facilities in Jarabulus and Manbij, children under 5 years have the highest proportion of respiratory tract infections, gastrointestinal diseases and acute malnutrition. They are also the most vulnerable group to acquire diseases with outbreak potential such as acute jaundice syndrome, acute watery diarrhoea, polio and measles.

The caregiver presents the voucher to an accredited primary or secondary healthcare provider that they select, along with the eligible child's IDP registration card. After the consultation, the provider then submits a claim to the agency to obtain reimbursement for the services provided with all required paperwork, including detailed patient records. If the healthcare provider issues a prescription, the caregiver can obtain medicine from an accredited pharmacist by presenting it along with the voucher and the eligible child's IDP registration card.

Healthcare providers will receive an induction on the voucher system detailing the beneficiary age group eligible to receive treatment, records required for verification and how they can claim. Additionally, a number of vouchers will be issued from the agency's PHCs in Manbij to patients in need of quality secondary healthcare treatment from specialist doctors.

A demand-side financing scheme such as this is expected to reduce financial barriers to access and therefore should improve utilisation of health facilities by IDPs. Since the voucher scheme allows the caregiver to choose the providers, this should encourage quality health care services through increased competition in the market. Targeting children under 5 years should also reduce the possibility of voucher selling and misuse. By design, revenue earned by a health facility from IDPs is directly proportional to the number seen. Therefore, this scheme should enhance the quality and quantity of targeted private healthcare services. WVI will monitor quality of consultations randomly

to ensure clinics signed up to the scheme are providing adequate services.

BMS supplies and support

As reflected in the early needs assessment, the demand for BMS was high from the community; a reflection of its common use. Uncontrolled and untargeted distributions of BMS remain common, however determining the extent to which this is happening is extremely difficult, especially given the response is managed remotely. Some actions have been taken at coordination level to try and minimise risks (see postscript).

The need for support with safe artificial feeding was identified as particularly important in areas receiving large supplies of BMS. Information, Education and Communication (IEC) materials (posters and flyers) were provided to all agencies on how to prepare formula safely. There was one observational report of infant formula being distributed into cups from a large tank / container and handed out so in addition to the IEC, the working group also identified the need for safe feeding kits to be distributed.

Infant formula availability in the markets in Syria has been very sporadic and prices are higher than before the conflict. It is not affordable for IDPs and vulnerable host communities. Prices range from \$7-10 for 1kg in Jarabulus and Manbij when it is available. A small amount is available in pharmacies but it is not enough to meet the needs of the communities. It is also available in some markets. Currently (May 2014) there is almost none available. WVI has not procured infant formula as the programming focus was on breastfeeding support and procurement and transport of medicines and supplies from Turkey has been a huge challenge.



Medical examination at a primary health centre in Aleppo governorate

Anon, Northern Syria



MUAC measurement during the WVI supported anthropometric assessment

Anon, Northern Syria

tems, beneficiary feedback mechanisms were also important to ensure quality of service provision. Putting these standardized systems into place in each project early was essential to gain an indepth understanding and provide a greater level of support.

Remote management calls for strong and consistent communication via telephone daily at designated times, and regular trainings (in Turkey, online and in Syria). Given access to programmes was not feasible, the building of health worker managerial skills became as integral as health technical guidance, particularly for Health Coordinators in each location. Provision of training about humanitarian standards and regulations was also critical given all health staff had no prior experience of working on a humanitarian programme. Creativity was critical to ensure staff received quality training given the difficulties with border closure and lack of passports. Training delivery was through a variety of methods including Webex, training of trainers, videos and contracting Syrian consultants. Trainings are often conducted in a large community space and videoed for the benefit of new staff who may join in the future.

Effective contingency planning was another important lesson learned, given conflict and escalations in fighting have led to hibernation (temporary suspensions of activities) and border closures. These factors have complicated both movement of staff into and out of Syria and distribution of medical and therapeutic food supplies. The temporary cessation of clinic activities had a huge impact on the population as there are no other health providers. We learned that detailed contingency planning is essential. Supplies need to be pre-positioned and stored appropriately and staff need to have completed security training and be thoroughly briefed on security standard operating procedures.

Given the difficulties with procurement for unregistered agencies and transportation of supplies amidst border closure, early hire of a medical procurement specialist is essential to support supply chain establishment and management. The hiring of pharmacists within Syria to dispense medicines to patients and manage and plan stock from an early stage was also es-

sential. Our INGO has procured drugs from Turkey and within Syria. Sourcing drugs from within Syria can be a challenge for staff since not all pharmacies have the amount in stock that is required, forcing them to visit many times and buy piecemeal. Research also needs to be conducted evaluating the quality of medicines and supplies available for purchase inside Syria. WVI has developed an assessment tool to gain more information about production, regulation and gauge the opinion of Syrian pharmacists and health staff about the quality of medicines. Procurement and distribution of essential primary health care medicines across the border has posed significant challenges. Supplies have had to be sent out with biscuit shipments and once across the border, transporting them within areas affected by conflict to the project sites has been extremely difficult.

A thorough understanding of the situation in terms of health staff and facilities existing in the areas and resources available is very important. Establishing an ambulance was a real challenge given there were no equipped suitable vehicles for use. A large van, which had been badly damaged and abandoned in the conflict, was donated by local authorities and refurbishing and fixing the vehicle was a major effort. Procurement of specialist ambulance equipment from Turkey was also extremely time consuming and problematic. Both of these factors led to a time delay in the establishment of ambulance services which was not anticipated at the beginning of the programme. Gaining knowledge of the health care system generated the idea for voucher provision instead of the establishment of more clinics which may not be sustainable. It was deemed more effective for a larger number of doctors to remain in their private clinics and benefit from supplementary pay to treat IDPs than for a smaller number to give up their work for a position at a WVI clinic which may not be able to run sustainably. An indepth assessment of the capacity of all private clinics and pharmacists is currently being conducted.

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⁶ <https://www.khanacademy.org/>

Innovations

Remote training delivery

There have been many challenges in delivering training, such as lack of Arabic speaking trainers available in Turkey, border closures preventing travel, and limitations on the number of participants at venues. A training of trainers relies upon staff prioritising delivering training in-country which may not be feasible depending on the area, workload and available resources. This led WVI to develop a distance learning package in the style of Khan Academy videos⁶. Also, WVI has worked with a regional GNC/UNICEF IYCF consultant to produce a harmonised translated IYCF training package using training materials from many NGO nutrition actors working in the region. A series of videos on all nutrition topics, particularly IYCF-E and nutrition in emergencies, will be produced on USBs for distribution to all NGOs and passed onto Syrian health staff. Pre- and post-training tests are also being developed and added to the USBs so that agencies can check and verify that the staff have watched the videos and understood the content. Given the high turnover of medical staff in many areas, this also ensures that training new staff is not an additional burden.

Discussion

Remote management led to the development of robust data collection mechanisms which were set up in the early stages of the programme in September. A Health Information Management System (HMIS) was developed to monitor consultations for all morbidities including malnutrition. The HMIS automatically calculates incidence, prevalence and case fatality rates per geographic area. Data can be cross checked with patient records. Data entry is simple for field staff and data collation is automatic. There is a need for a standardised database system which can be used by all INGOs and Syrian NGOs and patient ID cards. Given the difficulties with ensuring a consistent supply of medicines, establishing a strong pharmacy system is also integral to provide inventory reports and determine needs ahead of time. The HMIS and pharmacy system combined enabled us to produce an annual forecast of pharmaceutical products required per clinic on a monthly basis, taking seasonal fluctuations in morbidities into consideration. In addition to data management sys-



Clinic staff outside one of the primary health centres in Jarabulus

Anon, Northern Syria

Postscript

Stop-gapping nutrition coordination for the Syria response

By Emma Littledike

This is a personal account of the experiences of Emma acting to stop-gap nutrition coordination around the cross border operations into Syria from Turkey.

The Global Nutrition Cluster (GNC) seconded a Rapid Response Team (RRT) Nutrition consultant to the Syria response for a three month period (13 Dec 2103-13 Feb 2014) to provide technical, strategic and coordination support to the Northern Syria Nutrition Sector response. On her departure, I was appointed as interim Nutrition Cluster Coordinator for a two month period to stop gap the lack of data and information on the nutrition situation. This appointment was on a voluntary basis, in addition to a busy full time job managing three large health and nutrition programmes for World Vision International (WVI).

In this role I have led weekly meetings and tried to build an evidence base for the nutrition situation. A key task in my role as coordinator was to evaluate critically existing data on the nutrition situation (e.g. review three anthropometric assessment surveys in Aleppo, Arraqa and Idleb (see earlier article)) and emerging from this, to advocate for and help support securing more nutrition information, especially in areas where accessibility, food security and humanitarian assistance were poor. During my tenure, a lead partner and survey methodology (SMART) was eventually agreed for a representative SMART nutrition survey in each governorate and a purposive sample in sub-districts that were more likely to have malnutrition¹. The survey is now underway in Idlib (May 2014) and other governorates will be surveyed post Ramadan.

There is a need to improve nutrition surveillance through clinics, community spaces and community workers. This is particularly important in areas where there is very little humanitarian support and for areas dependent on food assistance that can be affected by hibernation (when agencies have to suspend activities due to conflict) and border closure. Camps also need to screen new arrivals that may have travelled from highly food insecure areas. Many health actors do not record malnutrition in their health monitoring systems and few cases of malnutrition are reported amongst health partners (this may be due to low caseload and/or low awareness at management or field level). A Mid Upper Arm Circumference (MUAC) screening package with guidance materials and a training video is in development to help address this. The aim is to disseminate the screening kit to all actors and all community stakeholders and to offer online support to practice measurements via WebEx or Skype video. The cascade training of trainer's model is not far reaching enough in this context. Provision of a screening package such as this, whilst not ideal, could be a partial solution to the problem of poor access. Referral facilities also need to be identified and incorporated into the screen-

ing package and they in turn, require training in the treatment of severely malnourished cases. There is also a need to incorporate data collection on underlying causes of malnutrition into all multi-sector rapid surveys to gather more information on camp and host community needs. A multi-sector assessment is currently in planning (May 2014).

A major coordination challenge has been around the management of breastmilk substitutes (BMS), including around untargeted distributions to the population. To try and gain more information, in my coordination role, I advocated for inclusion of questions about BMS distribution in all general rapid surveys being conducted. A BMS distribution indicator was subsequently included in the Response Plan. Awareness amongst actors of the Operational Guidance on infant and young child feeding in emergencies (IYCF-E)² and the International Code of Marketing of Breast-Milk Substitutes³ was improved through handouts and making resources available on the google drive established for the working nutrition sub-group.

Sourcing therapeutic food supplies has been problematic (see earlier article which reflects the issues well under 'challenges').

Nutrition coordination in itself has been challenging in this context. Nutrition is not considered a sufficiently important issue to be a stand-alone sector as there is no evidence of acute malnutrition. This has led to the formation of a nutrition sub-group in the health working group. However participation and engagement of agencies in the nutrition sub-group has been minimal. There are very few nutrition experts in-country and only six agencies implementing nutrition activities. Many structured sessions had to be postponed because of poor attendance. All agencies were regularly sent agendas, meeting presentations and technical guidance documents to ensure they were supported with adequate resources.

The focus of coordination on nutrition has been on assessments, management of acute malnutrition and on IYCF. The degree of scale up needed for these nutrition interventions is unclear due to lack of current data on acute malnutrition prevalence and IYCF practices. While there are cases of SAM reported, the number of reporting facilities and catchment populations is unknown. We suspect there may be high levels of SAM cases in specific pockets of the country with poor access to food distribution and humanitarian support.

Additional significant nutrition problems are stunting and micronutrient deficiencies which have received little programming attention. There is a

need to build a solid evidence base and to focus on prevention activities in the immediate future. Syrian agencies have much greater access and need greater technical support from international NGOs to programme according to the needs they are witnessing in their areas of operation. In the immediate term, more nutritionists are anticipated to arrive to contribute expertise to the nutrition working group that may encourage participation.

My coordination time would have benefited greatly from more support with obtaining supplies such as ready to use therapeutic food (RUTF), safe feeding kits (for infants using BMS) and anthropometric equipment. Given the nature of the Syria response, the usual support of UNICEF with regard to supplies was not available. More support in securing Arabic speaking trainers would also have helped enable trainings. It is questionable whether a working group lead can be effective without good resource provision.

My coordination role has now ended and nutrition is incorporated into the health working group. There are advantages to this, as it allows nutrition issues to be discussed repeatedly with a larger group of actors for which it should be a concern. Integration into the health working group has led to increased attention and nutrition now comprises a substantial part of the new annual response plan. By July 2015, primary health facilities will improve screening and referral through standardised nutrition service packages. Treatment of acute malnutrition according to WHO protocols will be improved at designated health facilities. Access to support on IYCF practices will be improved through the training of focal points. Children and pregnant and lactating women will access micronutrients from targeted supplementary or fortified foods, supplements or multiple-micronutrient preparations. Encouraging the mainstreaming of nutrition activities into other sectors will also be very important. I continue to play an active nutrition role supporting with updates, discussion points and technical support to agencies on a voluntary basis.

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¹ A specialist agency developed a database ranking areas by likelihood of higher prevalence of acute malnutrition using food security and health data from the Syrian Integrated Needs Assessment (SINA)

² An international policy guidance endorsed by the World Health Assembly. Available at: <http://www.enonline.net/resources/6>

³ Access the full Code at: <http://ibfan.org/the-full-code>

Non-food cash voucher programme for IDPs in Northern Syria

By an international NGO

Written April 2014

The war in Syria is now in its third year and having displaced over four million Syrians internally - with over 2 million fleeing their country to Jordan, Lebanon, Iraq and Turkey - there is no end in sight. In Northern Syria, over 200,000 Syrians are living in internally displaced population (IDP) camps, namely Atmeh, Qah, Karameh, Aqqrabat, Bab-Al- Hawa and Al-Salhah, while 35,000 people are living in non-camp settings in villages.¹

Provision of assistance to such a large number of displaced people in camps with inadequate infrastructure is a challenge to humanitarian organisations. Most of the emergency response involves in-kind distributions of food and non-food items. These interventions have been effective in saving lives and preventing a further deterioration in the humanitarian situation. However, the approach has several drawbacks, including the fact that it is a huge logistical burden and time consuming activity - from procurement to stocking and transporting commodities to distribution. This is made all the more difficult in conflict affected areas. Also, it disempowers the affected population as it does not provide them with the ability to decide what commodities they want or prefer. With the aim of mitigating these problems, a pilot voucher programme was designed and implemented by an international non-governmental organisation (INGO) in one of the IDP camps.

Overview of voucher programme

This involved voucher distribution and the arrangement of two market days at which to spend the vouchers. The programme was implemented over one month. The programme was informed by a needs assessment and market assessment (1 week) by the INGO, followed by vendors' selection and beneficiary registration before implementation.

The needs assessment involved four focus group discussions (FGD) to understand the IDPs' need for non-food items. The FGDs were conducted with men, women, young boys and young girls. They indicated that the top three priorities were hygiene items, clothing, and kitchen items. The preference was for Syrian made items that met their social and cultural values, such as scarves, long skirts, specific shampoos and detergents. Based on the identified needs, market prices were collected for the major items and maximum prices were agreed with the vendors that would apply for the two market days. This was undertaken to protect the value of the vouchers that was based on the findings of the market assessment. Findings from the market and price assessments were shared with both vendors and beneficiaries. The

arrangement was governed by a signed memorandum of understanding with the INGO office to keep the price as agreed or constant. An exception was if vendors wished to sell at a lower rate (while maintaining quality) to attract buyers, they were free to do so. Beneficiaries had also the right to negotiate on price in order to buy more items. Either way, better deals could be made for the same quality of product. The agreements also included clauses on the respect of humanitarian principles and using an agreed upon stable exchange rate of Syrian Pound (SP) to United States Dollar (USD). Field monitoring and support was undertaken by the field staff.

Vendors were identified from nearby Syrian cities and their capacity to meet the identified needs was assessed. Twelve vendors were selected to participate in the market day to create enough competition to lower the prices, however only seven were able to participate. The five vendors who did not participate pulled out at the last minute; no reasons were given but may have been due to security issues or lack of sufficient stock.

Implementation

A total of 420 IDP households benefited from the pilot programme in the camp. Each household was provided with 12 vouchers, worth 12,000 SP (69 USD). The vouchers had denominations of 3,000, 1,500, 600 and 300 SP, to provide more flexibility in shopping for smaller or bigger items.

Two market days were selected and agreed on with the beneficiaries and vendors. The vendors trucked their goods to the camps on the agreed dates and the camp leaders were responsible for securing a space for the market place and for crowd control. The INGO staff monitored all activities during both market days and provided guidance when needed. At the end of the first market day, the vendors packed their remaining items and carried them back to their

home towns. With a better understanding of what the IDPs wanted to buy, the vendors increased the amount and the diversity of the items they brought to the second market day.

Feedback

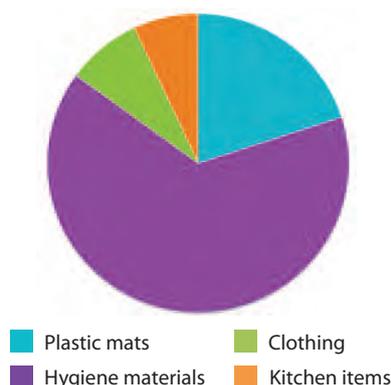
A rapid post distribution survey was conducted which found that all 420 households had spent 100% of their vouchers. The top three purchased commodities were hygiene materials, plastic mats, and clothing (see Figure 1). Beneficiaries indicated that they were highly satisfied with the programme and commented that it was the first time in two years that they were able to do their own shopping. They were pleased to regain their ability to make their own decisions about what to purchase for their families. However they commented that the price of goods had risen sharply over the past years due to loss of SP value. Some of the beneficiaries observed that prices were three times higher compared to what they used to pay in their hometowns a couple of years ago. Overall, the pilot programme was appreciated by the beneficiaries because it gave them the opportunity to choose goods depending on their needs, the goods were from Syria, the suppliers were Syrian, and the response time between the need assessment and the market days was very short. There was no security problem and no complaints were registered from the beneficiaries or the vendors. To date (May 2014), the programme has not been repeated but the team is preparing to scale up the voucher system to other camps.

Conclusions

The voucher programme was a speedy response to the camp IDPs and the best way to address their basic needs. Satisfaction among the beneficiaries was very high mainly due to a high level of participation (involving the beneficiaries) during the needs assessment, the market assessment and consultations at various levels. Also, use of local suppliers (Syrian) who are known by the community and part of the same culture helped to supply materials that fit to the context and cultural values of the IDPs. The voucher system has proven to be applicable in an IDP camp setting. It was implemented quickly in an emergency context to address basic needs of the IDPs, and carried lower risks due to the requirement for less logistic activities and low visibility of the approach.

Above all, the voucher approach empowers beneficiaries and respects their dignity as it gives them the right to choose how they meet their needs, which is fundamental principle of the humanitarian charter.

Figure 1: NFI voucher spending in Syrian IDP camp



¹ Turkey and Syrian refugees: the limits of hospitality. <http://www.brookings.edu/research/reports/2013/11/14-syria-turkey-refugees-ferris-kirisci-federici>

Crowds gather as an aid delivery arrives at a GOAL office in Idlib Governorate, Northern Syria



Davy Adams/GOAL, Northern Syria, 2013

GOAL's food and voucher assistance programme in Northern Syria

By Hannah Reed



Hannah Reed is the former Assistant Country Director for Programmes in GOAL's Syria Programme. She has over 10 years of

experience in the humanitarian and development sector, working in Bolivia and the Fairtrade Foundation, before joining GOAL in 2011. Since joining GOAL, Hannah has worked in the field and support offices in GOAL's Sudan, Haiti and Syria programmes.

With thanks to Hatty Barthorp, GOAL's Global Nutrition Advisor, and Alison Gardner, Nutrition Consultant, for their technical support.

Context

GOAL's response to the Syria crisis began in November 2012. To date, it has provided vital food and non-food aid to over 300,000 beneficiaries through both direct distributions and voucher programming in Idlib and Hama Governorates, Northern Syria, in addition to increasing access to water for over 200,000 people in northern Idlib.

GOAL Syria currently receives funds from four donors (OFDA, FFP, UKAID and ECHO¹). Under OFDA, GOAL implements voucher-based and in-kind Non-Food Items (NFIs) and winterisation support. FFP funding provides Family Food Rations (FFR) and support to bakeries with wheat flour alongside a voucher-based system for the most vulnerable households to access bread. A UKAID grant focuses on improved access to safe water, hygiene and sanitation and improved food security through a mixed-resource transfer model combining dry food distributions with Fresh Food Vouchers (FFV). Finally, Irish Aid and ECHO support unrestricted vouchers and cash for work to increase access to food and NFIs in areas with safe access to functional markets.

At the time of writing (May 2014), GOAL's food assistance programme is reaching upwards of 240,000 direct beneficiaries each month. Monthly unrestricted (food and NFI) vouchers are targeting 5,790 people, expanding to a total 13,200 direct beneficiaries each month from June 2014, while voucher-based assistance to meet winterisation needs reached over 72,000 people during winter 2013/14. Funding has also been secured to expand voucher-based assistance to increase access to inputs required for the protection and recovery of livelihoods and to include food production.

GOAL's Food Security programme implementation and design has been informed by

various assessments and studies completed over the past six months. These include a Food Basket Assessment (August 2013), Emergency Market Mapping and Analysis (EMMA) studies on markets for wheat flour and vegetables (January 2014) and dry yeast, rice and lentil (May 2014), a Food Security Baseline (December 2013) and Multi-sector Needs Assessment (January 2014). Design and implementation also continue to be informed by ongoing Post Distribution Monitoring (PDM) of all programme activities.

Programming context, including challenges due to access and security

The protracted conflict has resulted in urgent, humanitarian needs across Syria. The United Nations (UN) estimates that the conflict has displaced at least 6.5 million people within Syria, with a further 2.5 million refugees in neighbouring countries². A combination of direct and indirect factors has led to in excess of 9.3 million people classified as in need of humanitarian assistance. With reference to aid required per sector, the Syria Integrated Needs Assessment (SINA) found the highest number of people in need across the sub-districts surveyed were in need of food assistance, with an estimated 5.5 million people food insecure in assessed areas of northern Syria, including 4.9 million in moderate need and 590,600 in acute or severe need³.

Resulting in displacement, reduced access to livelihoods and market disruption, in addition to the direct loss of life and damage to infrastructure, the protracted conflict continues to

¹ US Office for Disaster Assistance; US Food for Peace; UK Aid Department for International Development (UK), European Commission Humanitarian Office

² UNOCHA Syrian Humanitarian Bulletin Issue 44, 27 February – 12 March 2014

³ Syria Integrated Needs Assessment, December 2013

Figure 1: Sources of food accessed by respondents

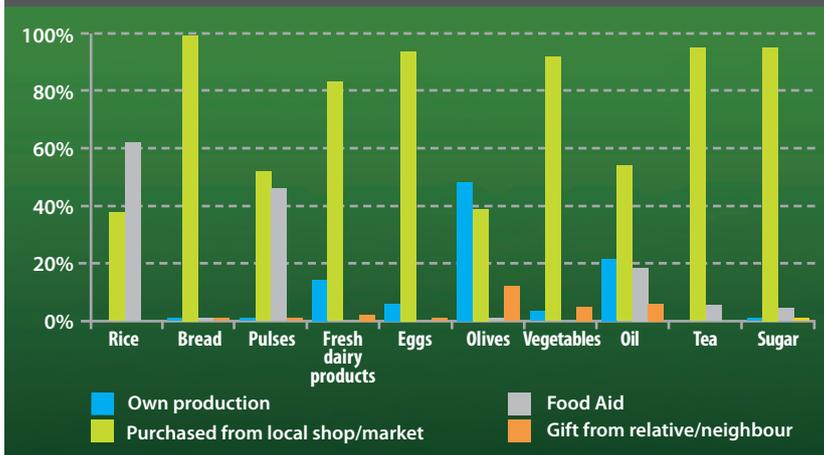
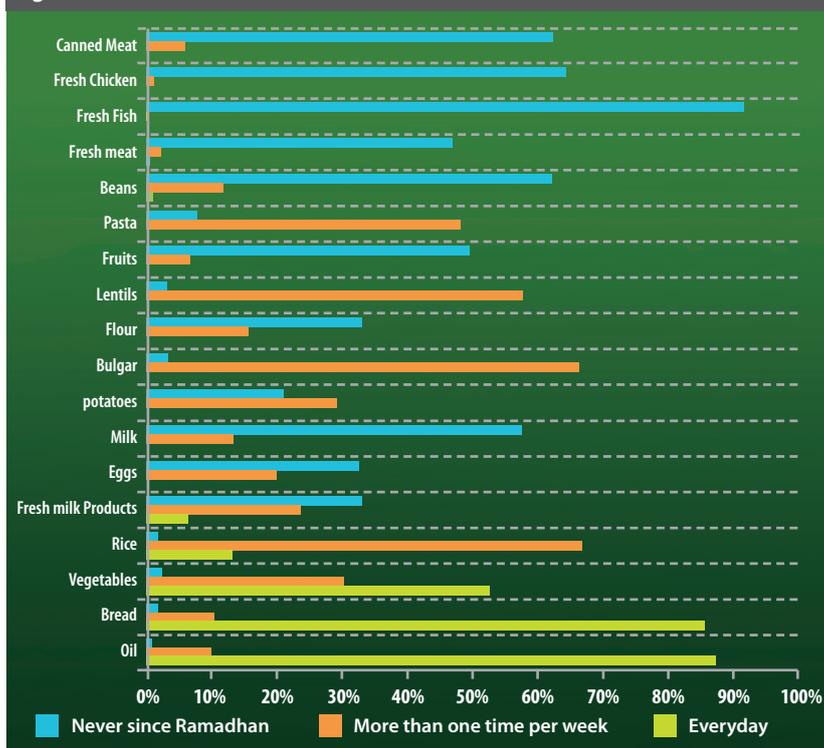


Figure 2: Current intake of common food items



impact negatively on the ability of affected populations to meet basic food and other needs without assistance. Increased reliance on coping strategies reduces household resiliency and results in increased immediate and sustained humanitarian need.

In tandem, the operational and security context continues to present challenges to the impartial and safe delivery of humanitarian aid. An increasingly fractured opposition force and changes in power dynamics requires continual operational adjustments to ensure aid can pass freely through check-points held by different and continually changing factions. Highly fluid changes within the opposition movement are accompanied by an increasing trend of Government military action in opposition-held areas of northern Syria, resulting in continued population displacement and a highly insecure opera-

tional environment for aid agencies. Deterioration in security in areas of Syria close to the border with Turkey, have also resulted in periodic and often prolonged border closures (notably in January 2014) which in turn prevent and/or delay cross-border delivery of aid to conflict-affected populations in Syria.

Assessments which informed the food kit design

The designs of GOAL's Family Food Ration (FFR) and complementary fresh food vouchers⁴ for distribution from Autumn 2013 up to early Summer 2014, were informed by GOAL's Food Basket Assessment⁵ (and supporting assessment of fresh food availability on local markets) completed in August 2013. The survey objectives were to obtain information on diet quantity, diet diversity, feed frequency, food availability, nutritional deficiencies

and access to produce an evidence base and recommendations for the contents of GOAL's FFR, and to reassess the profile of GOAL beneficiaries, including household size and composition of the household.

Key survey findings were:

- Percentage of households with at least one household (HH) member with specialised nutritional requirements: children aged 5 years and younger (66%⁶), elderly (15%), Pregnant and Lactating Women (PLW) (30%), and members with chronic illness or disability (27%).
- Average monthly income per HH is SYP 7,279 (\$29) while average monthly expenditure on food per HH was reported as SYP 9,265 (\$37).
- Ratio of HH member contributing to income to dependent HH members = 1:4

Figure 1 shows that the primary source of all food groups was purchase from local markets. The average monthly food expenditure reported exceeds average monthly income, suggesting a high risk of food insecurity in the absence of assistance to access food, and a need to rebuild livelihoods to increase income levels.

To assess current dietary diversity, respondents were also asked how often they consumed food items from a specified list of foods common in Syria (see Figure 2). Ramadan was 3 weeks before the household survey⁷. The results (Figure 2) reveal very low levels of dietary diversity with the population heavily reliant on bread and vegetables. The main additional foods consumed (eaten more than once a week) were other cereals, such as rice, bulgur and pasta, as well as lentils. Results of the assessment in terms of the % Recommended Daily Allowance (RDA) for kilocalories and micro- and macro-nutrients showed that households were able to meet an average of 900 kilocalories per person per day without assistance. The % RDA met without assistance was high for vitamin A (91%) and Vitamin C (92%) and low for protein (49%), fat (41%), iron (24%) and iodine (15%).

Design of different food kits and resulting operational difficulties

In response to these findings, GOAL designed two types of food ration. The FFR included tahini, raisins, fava beans and chick peas for distribution in areas without functioning markets, and therefore not receiving vouchers to access fresh food. In areas with safe access to functioning markets, a dual-transfer food assistance package was distributed that included both a dry food ration and vouchers to access food (see Figure 3 for nutrient composition including % RDA).

⁴ Fresh Food vouchers were distributed with dry food rations over this period, and only in areas where local markets will sustain a voucher-based approach
⁵ A household survey was conducted in August 2013, using convenience sampling of 607 randomly selected households in GOAL's operational areas. The sample covered 82% beneficiaries (of non-food aid) and 18% non-beneficiaries and a mix of rural and urban areas. Data were then triangulated through in-depth interviews in the same districts. The 'NutVal' tool was used for analysis of nutrient composition, while secondary data from FSLWG and OCHA, WFP documents were also referenced. In terms of limitations, some areas were inaccessible to the data collection team due to security constraints while challenges were also experienced with regards to respondents' ability to recall daily food intake.
⁶ Of which the average households sampled had 0.46 household members aged two years and younger, and 0.90 household members aged between three and five years.
⁷ Possible answers were: never since Ramadhan, more than once per week, and everyday

Figure 3: GOAL mixed modality Food Assistance package: % RDA met by dry food ration and fresh food vouchers

Food items	Energy	Protein	Fat	Calcium	Iron	Iodine	Vit. A	Thiamine	Riboflavin	Niacin	Vit. C
Current consumption (kcal)	900	26	19	220	6	25	557	1	0	13	30
Dry rations (kcal)	1212	38	31	94	11	251	26	1	0	15	4
Fresh foods (kcal)	184	11	7	139	1	20	591	0	0	5	20
Total	2296	75	57	454	19	295	1173	1	1	32	55
Required ration (adjusted for winterisation) (kcal)	2400	53	46	430	26	161	613	1	2	16	32
% of requirements supplied by current consumption	37%	49%	41%	51%	24%	15%	91%	60%	24%	80%	94%
% of requirements supplied by dry rations	51%	71%	69%	22%	44%	155%	4%	74%	20%	95%	13%
% of requirements supplied by fresh foods	8%	21%	15%	32%	5%	12%	96%	19%	15%	29%	62%
% of total requirements met	96%	141%	124%	105%	73%	183%	191%	152%	59%	204%	169%

Table 1: Trends in Household Food Consumption Score (FCS)

	Average			Male headed households			Female headed households		
	Oct-13	Dec-13	Jan-14	Oct-13	Dec-13	Jan-14	Oct-13	Dec-13	Jan-14
% households scored 'acceptable'	43%	22%	15%	40%	23%	15%	58%	43%	18%
% households scored 'borderline'	50%	47%	42%	56%	48%	45%	40%	43%	0%
% households scored 'poor'	7%	31%	43%	4%	28%	40%	2%	14%	82%

All food assistance was designed to meet a target of 2,400 kcal p/d adjusted from the Sphere standard (2,100 kcal p/p/d) by an additional 300 kcal p/d in order to meet increased calorific requirements during the winter period. For areas targeted by direct distribution of dry food rations only, GOAL designed two types of food kit – a full FFR and a reduced FFR. The latter was provided where targeted beneficiaries were also receiving a daily bread ration (457 kcal per person per day (pppd) via bread vouchers) under complementary GOAL programming; in this instance, the FFR contained reduced quantities of pasta, rice and bulgur wheat. For both FFR types, full and half kits were also provided, designed to ensure the RDA pppd was met and allocated according to household size.

In practice, disruption to border crossings resulted in frequent delivery of only one type of food ration. This disrupted distribution as it was necessary to wait for delivery of contingents of all food ration specifications to cross the border. Otherwise, distributing food kits to all registered households in any given village at different times had the potential to create security issues.

Modified food assistance modality

Given the unreliability of border crossings, the design of food kits has been greatly simplified for the next round of food security programming with one type of half kit only. Households will receive between one and three half kits each month depending on household size. A repeat of the Food Basket Assessment is planned for early June 2014 to inform the final specifications of the FFR. This will focus specifically on the % RDA currently met by targeted groups without assistance, and will ensure the RDA per person per day is met in terms of calorific and nutrient requirements. It is expected that the % meeting the RDA without assistance will have declined since August 2013, due to:

- Continued trend of price increases in food items

- Reduced purchasing power as conflict affected households deplete remaining savings, and
- Disruption to livelihood activities pre-conflict and the corresponding decrease in income generation capacity for much of the population.

GOAL's assessments in 2014 demonstrate a trend of decreasing food security within populations without access to regular food assistance. Table 1 shows average Household Food Consumption Scores (FCS) for populations surveyed in GOAL's operational areas during October 2013, December 2013 and January 2014.

Table 1 demonstrates progressive deterioration in household food security across targeted areas, with a striking increase in the number of female headed households ranked with a 'poor' FCS (82%) in January 2014 when compared to male headed households surveyed at the same time and in the same areas (40%). A sharp decline can also be seen in January 2014 figures when compared to the % of female headed households ranked with poor FCS in October (2%) and December 2013 (14%).

Food security is undermined by the type of income source, with the majority of households surveyed currently relying on irregular jobs (44%), the sale of personal assets (29%), assistance received from relatives (17%) and previous savings (7%)⁸. This represents a worrying trend as there are only a finite number of assets that may be sold or savings that may be utilised. On average, irregular jobs only generated USD \$65 / 9,724 Syrian Pounds (SYP) in the month prior to the survey, compared to the sale of personal assets (the highest source of income reported) which generated an average of USD \$415.5 / SYP 62,018 over the same period.

Correspondingly, the average monthly expenditure on food alone across the sample was USD \$81/SYP 12,105 significantly higher than the average income generated by irregular jobs,

which represents the most common source of income referenced. Households also reported that most of their income was not generated by jobs or livelihoods but by the use of coping strategies; 22% of the income source was through the sale of personal assets, whereas a further 22% was credit – strategies which are not sustainable⁹. Sixty eight per cent of households surveyed also reported outstanding debt, with 72% of these reporting that credit obtained had been used to purchase food. Other coping strategies identified to meet food needs include relying on less preferred or less expensive food (62%), taking on credit (29%), limiting portion sizes (25%), borrowing food (19%), and taking children from education to work (17%) or sending children or other family members to live with relatives (15%)¹⁰.

Recent surveys, reinforced by Emergency Market Mapping & Analysis (EMMA) studies on critical markets for tomatoes, potatoes, rice and lentils, reinforced the trend that food remains available in areas with functioning markets (see Figure 4). However, food remains inaccessible to many households in these areas due to reduced livelihood options and the widening gap between household expenditure and income.

Change of GOAL direction to include voucher programming

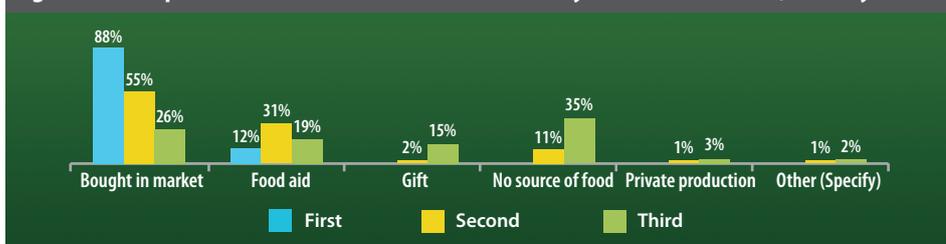
Given that access as opposed to availability represents the critical barrier to households meeting basic food needs without assistance, GOAL will expand the current FFV modality to include vouchers for both dry and fresh food in the next phase of food security programming. This recognises increased flexibility afforded by a market-based approach in areas with functional markets and when compared to direct distributions alone, reducing reliance on border crossings and the transportation of food rations when re-

⁸ Needs Assessment in northern Idlib, January 2014, GOAL.

⁹ See footnote 8

¹⁰ See footnote 8

Figure 4: Principal source of food* for households surveyed in northern Idlib, January 2014



*Respondents could give up to three sources of food ranked in order of importance as principale source of food.

lying only on direct distributions. This approach also recognises beneficiary preference for vouchers. A dual resource transfer approach also provides maximum operational flexibility, with the option to increase or decrease the ration of assistance provided via vouchers and via direct distributions in response to changes in market systems or in the security context.

This approach has been informed by GOAL's understanding of market systems developed through EMMA on critical markets for dry and fresh food, and by experience to date with fresh food vouchers and in addition to ongoing unrestricted and NFI voucher programming. Food assistance will be delivered through monthly food voucher distributions in areas which will sustain a market-based approach, and through dry food rations in areas without safe access to functioning markets.

The use of vouchers – when market systems permit – also seeks to 'do no harm' both to local markets and to livelihoods, by avoiding the potentially negative impact of large volumes of imported food goods being distributed in areas where markets continue to function¹¹.

GOAL welcomes the formation of a Cash Based Response Technical Working Group (Cash TWG) for actors implementing the cross-border response in northern Syria. GOAL is participating actively on the working group and has recently presented GOAL's voucher process (outlined below) in response to requests from other members. The Cash TWG has been formed to support lesson learning and exchange of best practice with reference to cash and voucher based programming in northern Syria and to improve coordination. With a market-based approach to assistance, it is critical that actors coordinate to ensure a 'Do No Harm' approach is applied to local markets. This will mitigate against the risk of 'flooding'/crashing local markets should there be a significant and uncoordinated increase in voucher-based programming by other actors, reliant on the same markets, within the same timeframes.

Details of the voucher programme design

Food vouchers will build on GOAL's established voucher modality, taking the form of printed, cash-based vouchers distributed on a monthly basis and exchangeable for food items only at selected and registered traders.

Following an assessment by GOAL field staff of trader's stock and capacity to restock and to

gauge willingness to engage with the conditions of GOAL's voucher scheme, traders sign a contract with GOAL to participate in the voucher scheme. This includes a commitment on the part of the trader only to redeem agreed items for GOAL vouchers exchanged by beneficiaries, namely dry and fresh foods for food security interventions (see Box 1 for decision making regarding vouchers related to infant feeding)¹². Punitive measures are in place and communicated to traders regarding infractions to the stated terms of the contract. This includes temporary moving to permanent exclusion from the voucher scheme if substantial evidence exists that vouchers have been exchanged for items outside the scope agreed by GOAL with traders and stipulated on the vouchers, in addition to other breaches of the contract signed.

Food vouchers are eligible for one month and redeemed for food by beneficiaries in a range of registered shops. Lists of shops participating and the prices charged for key food goods are distributed to beneficiaries with vouchers. Participating shops are also required to display the agreed price list in their outlets to reduce the risk of voucher beneficiaries being punitively charged for goods purchased with vouchers. Prices for food goods exchanged with vouchers are set in line with average market prices for these goods, and are not intended to be 'cheaper' than the same good purchased in the same markets by non-beneficiaries and using cash. GOAL vouchers continue to incorporate a series of security features¹³, while a rigorous system of checks ensure only the selected families receive and redeem the vouchers; that the vouchers are used for NFIs only; that the traders cannot increase prices arbitrarily and that any

complaints are quickly relayed to GOAL for investigation¹⁴.

Shopkeepers redeem vouchers with GOAL staff on a weekly basis and are reimbursed for the value of food items exchanged for vouchers. There are currently over 200 outlets registered with GOAL's voucher scheme offering a wider range of food and NFIs. GOAL is currently providing fresh food assistance to upwards of 10,000 households each month via a voucher-based modality. Initial assessments and demand from traders not currently registered demonstrate that scope exists to expand further the food voucher scheme under the proposed modification.

Both breastfeeding and use of breastmilk substitutes (BMS) – typically infant formula – is common in the population. In the January 2014 Needs Assessment, in nine sub-districts (Armanaz, Badama, Darkosh, Harim, Janudiyeh, Kafr Takharim, Maaret Tamsrin, Qourqeen, and Salqin) of Idlib Governorate, 25% of respondents reported infants 0-5m were being fed milk (regular, tinned, powdered or fresh animal milk), a further 17% of infants 0-5m were being fed infant formula and 41% reported other foods/liquids. Three-quarters (75%) of respondents also reported breastfeeding their infant. Various difficulties with breastfeeding were reported, such as too stressed to breastfeed (13%) and inadequate maternal food intake (29%).

Access to breastfeeding support and to BMS supplies for mothers is very limited in our target population. An international non-governmental organisation (INGO) is running an IYCF programme in just five of the 134 villages that GOAL currently operates in, though this may be expanding which may bring more opportunities

¹¹ The EMMA on rice and lentil critical markets completed in May 2014 by GOAL suggested that large-scale influxes of these food types via aid agency distributions may be impacting local markets systems for these commodities

¹² Note that shopkeepers include a strict ban on the exchange of vouchers for alcohol, cigarettes, infant formula and powdered milk. GOAL programme and M&E staff will continue closely to monitor shopping periods to ensure contractual requirements are met, and including that NFIs are not exchanged for food vouchers. The ban on exchange of vouchers for infant formula and powdered milk is in line with GOAL's policy of safeguarding children and the international Operational Guidelines for Infant Feeding in Emergencies (2007) which state that "infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues" See Box 1 for more considerations around infant formula/powdered milk exclusion from the voucher scheme.

¹³ There are two serial numbers, one is random and one is computer generated and therefore unpredictable. Each

voucher has a hologram which is GOAL-specific, patented and only produced in one factory in Turkey. There is a different colour for each batch of vouchers. Watermarks are incorporated into the design, which are very difficult to forge and there is also a complex pattern on the surface and exact measurements of the font. Replication of vouchers is therefore extremely difficult.

¹⁴ This system includes: price setting with participating shopkeepers prior to each round of distributions with price lists then displayed in participating outlets; the use of 'shopkeeper books' to register beneficiary names, ID numbers and voucher numbers against the items these are exchanged against; careful selection of shopkeepers against established accessibility and stock level criteria followed by signatures of contracts agreeing to abide by the terms and conditions of GOAL's voucher scheme; and clearly defined shopping and voucher redemption periods to guarantee close monitoring by both programmes staff and GOAL's M&E team to ensure guidelines are adhered to and to reduce the risk of unauthorised duplication or use of GOAL vouchers.

Box: 1 Decision making around exclusion of infant formula and milk powder from the voucher scheme and food distribution

Both breastfeeding and use of breastmilk substitutes (BMS) – typically infant formula – is common in the population. In the January 2014 Needs Assessment, in nine sub-districts (Armanaz, Badama, Darkosh, Harim, Janudiyeh, Kafr Takharim, Maaret Tamsrin, Qourqeen, and Salqin) of Idlib Governorate, 25% of respondents reported infants 0-5m were being fed milk (regular, tinned, powdered or fresh animal milk), a further 17% of infants 0-5m were being fed infant formula and 41% reported other foods/liquids. Three-quarters (75%) of respondents also reported breast feeding their infant. Various difficulties with breastfeeding were reported, such as too stressed to breastfeed (13%) and inadequate maternal food intake (29%).

Access to breastfeeding support and to BMS supplies for mothers is very limited in our target population. An international non-governmental organisation (INGO) is running an IYCF programme in just five of the 134 villages that GOAL currently operates in, though this may be expanding which may bring more opportunities to collaborate. Infant formula is expensive; the price of infant formula has risen significantly through the crisis. Untargeted distribution of

infant formula (ready-to-use and powdered products) is happening in the northern governorates (source: GNC scoping mission, Sept 2013); one INGO is collaborating with a number of these to minimise risks.

On balance, it was decided that GOALs vouchers and dry rations should not include a BMS as we do not have the capacity or relevant partnerships established to ensure appropriate targeting and also provide the requisite level of support/guidance to mothers. The hygiene-sanitation conditions are poor and access to safe water is a problem. Households still have a certain level of income from various sources, whereby GOAL FSL project is trying to protect assets and the 'income generation pot', by providing access to as replete a diet as possible. We excluded BMS to reduce the risk of families choosing BMS or other powdered milks over breastfeeding. Those who are dependent on BMS still have the potential to buy from local markets, as a greater proportion of their personal income would be available to spend on 'essential items', given the food/ vouchers provided by GOAL. In January 2014, the predominant expenditure for all households remained food, followed by health, water then fuel.

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Lessons learnt on voucher programming so far and vision for future.

To date, GOALs experience with voucher-based programming demonstrates that this is an appropriate and effective modality to increase access to basic needs for populations in northern Syria with safe access to functional markets. PDM demonstrates that targeted distribution of vouchers affords greater flexibility to beneficiaries than direct distributions (which is of particular relevance to address the needs of women and children) whilst simultaneously strengthening local markets, as evidenced by positive feedback from market actors. A recent survey of shopkeepers participating in GOALs voucher scheme found that 100% reported that they would like to sign future agreements with GOAL. In addition, a recent rapid assessment found that 88% of key informants surveyed who were aware of GOALs voucher system believe it has a positive impact on the market, while 71% of shopkeepers interviewed who were familiar with the system stated that they would be very interested in participating. An average of 93% of beneficiaries stated that the frequency of vouchers was appropriate to their needs, while 81.5% of beneficiaries responded that they were satisfied with the range of shops available to them.¹⁵

GOAL will therefore continue to increase access to food and other basic needs through a voucher-based modality, as the preferred option in areas with safe access to functional markets. This will be supported by continued direct distributions of food assistance when security or market capacity does not permit a market-based approach. Through continued emphasis on robust monitoring of the impact of assistance on food security, and on market impact of modalities employed, GOAL will scale up the use of vouchers in preference to direct distributions.

For more information, contact: Vicki Aken, Country Director, GOAL Syria, email: vaken@goal.ie



Families receiving food assistance from GOAL

¹⁵ PDM Irish Aid Vouchers Rounds 1 and 2



Small market in a town located in Idlib area, Syria

Brigitte breuillac/MSF-Syria, 2013

Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria

By Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam



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Saskia van der Kam is the nutrition expert of MSF in Amsterdam.

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Pre-war food and nutrition situation

Al-Raqqa governorate is in the North of Syria and has Al-Raqqa city as its capital. The governorate is divided into the three districts of Tal-Abyad, Al-Tawrah and Al-Raqqa. Tal-Abyad district was estimated to have around 200,000 inhabitants, of which around 40,000 were internally displaced populations (IDPs) (March 2013). There are no official collective centres or camps in Tal Abyad district. The IDPs live with host families or in empty buildings or makeshift accommodation with limited protection from weather conditions.

Pre-war, before March 2011, the main economic activity in Al-Raqqa governorate was agriculture, with the Euphrates as an important source of water for irrigation^{2,3}. In combination with imports from neighbouring countries, food availability generally met the needs of the growing population. With fixed price policies from the government, staple food was accessible for all. The agricultural sector was hit hard by the water crisis that peaked in 2008, which increased unemployment and reduced local food production. The event coincided with external economic factors and neo-liberalisation policies driving up prices of food, fertilisers and energy. These developments caused many Al-Raqqa farmers to move from their lands to the southern cities, in the hope of finding a job^{4,5,6}.

Undernutrition was a problem in pre-war Syria, reflected in 9.7% of children under five years underweight for their age, 2.3% wasted⁷ and 29% stunted⁸. Underweight and wasting were reported to be more prevalent in Al-Raqqa governorate, with the 6-11 months age group mostly affected⁹. In Al-Raqqa governorate, there were no specific protocols or programmes in place for the treatment of moderate and severe acute malnutrition. Since the outbreak of the conflict, agricultural production has been further hampered by insecurity limiting access to fields and markets, as well as the high price of fuel¹⁰. Moreover, the region experienced damage to its irrigation canals (10%)¹¹. Shortages of food, due to limited production as well as import problems, have been regularly reported and the prices of bread and other food have significantly increased¹².

¹ Hoetjes, M. The impact of armed conflict on health in Al-Raqqa governorate, Syria. KIT/Royal Tropical Institute: August 2014

² Masri A (2006) Country Pasture/Forage Resource Profiles. Rome.

³ Goodbody S, del Re F, Sanogo I, Segura BP (2013) FAO/WFP crop and food security assessment mission to the Syrian Arab Republic. Damascus.

⁴ Nasser, R; Mehchy, Z; Ismail AK (2013) Socioeconomic roots and impact of the Syrian crisis. Damascus.

⁵ International Crisis Group (2011) Popular protest in North Africa and the Middle East (IV): the Syrian people's slow motion revolution. Brussels/Damascus.

⁶ Rifat H, Ismail KA, Nawar AH (2010) Syrian Arab Republic Third National MDGs Progress Report.

Damascus.

⁷ Wasted defined as acute malnourished with weight-for-height <-2 z score. This includes moderate (MAM) and severe acute malnutrition (SAM).

⁸ Stunting defined as Height-for-Age <-2 z score

⁹ UNICEF (2008) Syrian Arab Republic Multi Indicator Cluster Survey: 2006. Geneva, Switzerland

¹⁰ The wheat production of 2013 showed a decline of 40% compared to the trend of the previous 10 years and the livestock sector in Syria has significantly reduced. Source: See footnote 2.

¹¹ See footnote 2.

¹² Hoetjes M (2014) The impact of armed conflict on health in Al-Raqqa governorate, Syria

Table 1: MUAC screening during vaccination campaign, May, 2013, Tal Abyad district, Syria

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	38	180	1,161	33,618	34,997
%	0.1%	0.5%	3.3%	96.1%	100%

Table 2: MUAC screening in mobile clinics, 3rd August - 21st September, 2013

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	3	2	29	637	671
%	0.4%	0.3%	4.3%	94.9%	100%

Table 3: MUAC screening in inpatient clinics, 1st July -15th September, 2013

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	16	8	22	383	429
%	3.7%	1.9%	5.1%	89.3%	100.0%

MSF operations in Northern Syria

Médecins Sans Frontières Operational Centre Amsterdam (MSF OCA) has been working in Northern Syria, Al-RAqqah governorate, Tal-Abyad district, since February, 2013. Medical programmes include inpatient paediatrics, as well as general outpatient services for adults and children. Services also include antenatal care, postnatal care, sexual and gender based violence care, family planning, as well as routine immunisation. The mental health programme includes individual and group counselling sessions, psycho-educational sessions and outpatient psychiatric care. The nutrition programme includes inpatient therapeutic feeding and ambulatory therapeutic feeding care. Expanded Programme of Immunisation (EPI) support has been provided to outlying villages. Donations of emergency medicines and medical supplies to other facilities in the surrounding area are also provided.

Until May 2014, the expatriate team included two Medical Doctors, two Nurses, a Mental Health Officer, a WASH (Water, Sanitation and Hygiene) officer, a Project Coordinator and a Logistician. To this date, 78 Syrian national staff were working with MSF, either directly or through a partnership with the national hospital in both medical and non-medical positions. When MSF OCA first began working in Northern Syria, the expatriate staff were able to live and work alongside the national staff. In January, 2014, with significant changes in the leadership of the area, a major security incident and closure of the border crossing from Turkey into Syria, MSF withdrew expatriate staff from Syria and

switched to a remote management style of working. National Staff were then supported by expatriate staff in Turkey via phone, email and skype. With regards to the nutrition programme, this meant that with each admission, the Syrian medical doctor would call the expat medical doctor responsible and discuss the patient's condition and treatment plan. These patients were followed up by the expat daily, via phone calls with the on duty physician. Trainings for national staff doctors and nurses were conducted via emailed power point and skype, and proved to be successful even with this unusual method of management. In May 2014, MSF closed the programme completely (see discussion for more details).

Nutrition situation 2013

In March 2013, an exploratory mission by MSF found no cases of acute malnutrition. Two months later, in May 2013, a mid-upper arm circumference (MUAC) screening was included as part of a measles vaccination campaign (including children from 9 months old to five years). This was undertaken to update information on the nutritional status of the IDP community given their situation (displacement, lack of income), a recent measles outbreak and anecdotal reports that that mothers had difficulties finding appropriate food (infant formula) for their children.

The MUAC screening found a 0.6% prevalence of global acute malnutrition (GAM). Thirty eight cases (0.1%) of severe acute malnutrition (SAM) were identified amongst 34,997 children screened (see Table 1). The vast majority of the identified cases were children younger than 1

year of age. The highest numbers and percentages of malnourished were found in the Central area, with the majority in Tal Abyad town. In the city, the malnourished cases were clustered. Percentages of children with a MUAC <125mm ranged from 0-10% per area in the city. The most common explanation for malnourished children with no underlying medical issues was that caregivers had no money to purchase infant formula. Seven medical cases were children with "a hole in the heart" (a congenital heart defect). MUAC screening by mobile clinics was also used as a way of monitoring the trend in the population. This showed no increase in malnutrition (see Table 2). MUAC screening from July to September 2013 of children attending the inpatient clinic did not show an alarming number of malnourished (Table 3).

Despite the low number of malnourished cases identified in the vaccination campaign, an increasing number of malnourished cases were attending in the mobile clinics in between April and May 2013. This triggered the opening of an Ambulatory Therapeutic Feeding programme (ATFP) at the end of May 2013, followed by an Intensive Therapeutic Feeding Centre (ITFC, inpatient facility) at the beginning of July 2013. Since the start of the programme, the number of admissions has increased slightly week by week. In order to have a better picture of the factors affecting the nutritional status amongst the Tal-Abyad population, MSF undertook a small qualitative survey among the most vulnerable populations in the Tal-Abyad region of Syria in August 2013.

Qualitative survey

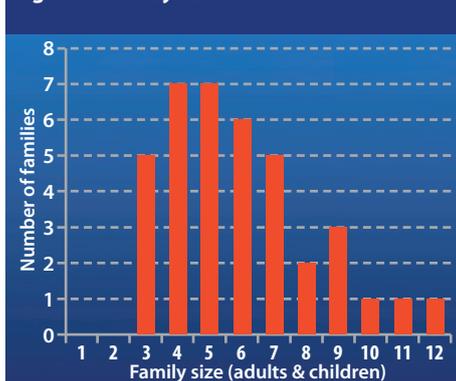
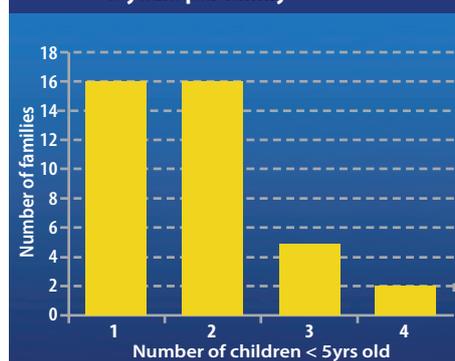
The surveyed population was IDPs living in schools in the Tal Abyad region¹³. A total of 39 persons were interviewed, all women, about their living circumstances and food security. The data were collected using a questionnaire administered by MSF staff working with the mobile clinics. The data covered a period between mid-August and mid-September 2013.

Family composition

Figure 1 shows the family size amongst those surveyed. The average family size was 5.9 with 79% (n=30) having 3-7 family members. The majority of the families (84% (n=32)) had one or two children aged 5 years or under (see Figure 2). Twenty two families (58%) had one or more children younger than 12 months (one family had two children under this age).

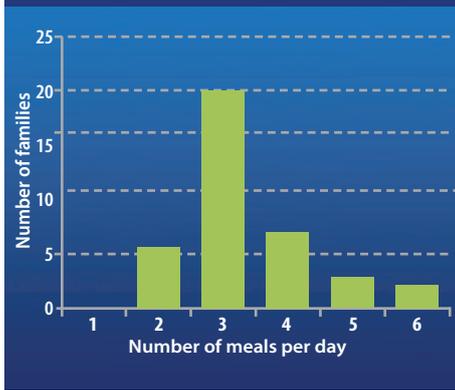
Availability and access to food

All but one interviewed woman (n=38/39) reported that a wide range of food was still accessible at local markets. However, for some of the women (n=9), access to markets was not easy since they live 10-15 km away. Public transportation is expensive (100 Syrian Pounds); most walk long distances to reach the market, sometimes arriving too late to find the items

Figure 1: Family size**Figure 2: Number of children younger than 5 years per family**

¹³ Matasci-Phelippeau L (2013). Nutrition status of IDP population in Tal Abyad district

Figure 3: Meal frequency



they need as the market starts early in the morning. Culturally, men are supposed to do the shopping. Only women with 'special circumstances' (widows, divorced) are 'allowed' to go out shopping. Married women should not leave the house regularly. Those interviewed reported the major problem affecting people's nutrition is that prices continue to rise and there is a lack of money due to unemployment (see Table 4). This has a direct influence both on the quantity and quality of food that can be purchased.

Almost 100% of the respondents reported having received at least one donation of food and non-food items (NFI) from different actors (Turkish Red Crescent (TRC), Qatari Red Crescent (QRC), Saudi Arabia, local court, private donations). Most of them, however, stressed that donations occur sporadically and they need regular donations. Mothers spontaneously expressed fears for their children, in particular lack of fresh milk, since this item is never included in food donations. Infant formula milk is generally available but the prices are very high; mothers simply cannot afford it. The only item that was received on a regular basis by IDPs living in some of the schools was free bread, donated by different armed groups. IDPs living in one of the schools reported receiving free rice regularly.

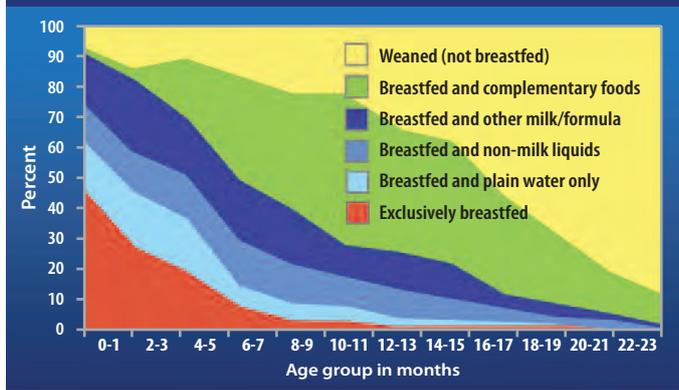
Meal frequency

Before the war, Syrians used to have three meals per day (breakfast, lunch and dinner). The survey investigated the number of meals IDPs are currently eating each day. As Figure 3 shows, 52% of the women interviewed (n=20/38) reported that their families are having the usual number of meals, 16% are having only two meals (n=6/38) and one third of the families are eating more than three meals (n=12/38) per day. In response to the question "do you often feel hungry?" almost 75% (n=29/39) of those interviewed replied "yes". Unfortunately, meal

Table 4: Average price increase between pre-war and August 2013

Food	Average price increase %
Bread	+ 233 %
Oil	+ 294 %
Flour	+ 424 %
Milk	+ 424 %
Rice	+ 639 %

Figure 4: Breastfeeding practice, Syria 2006 (UNICEF)



Source: MICS

quantity could not be ascertained. However, since three-quarters of respondents reported often feeling hungry, it can be inferred that those who are still having three meals (or more) are actually eating smaller quantities of food.

Diet diversification

In Syria, all the family usually eats together, unless there are guests or in the case of a special event, when women and children eat separately. The diet pre-crisis was varied and mainly composed of grains (bread, rice, bulgur, etc.), vegetables (soup, salads, etc.), beans (chick peas in hummus and falafel, lentil soup, etc.), dairy products (yoghurt, milk, cheese) meat and eggs. The survey revealed that people's current daily diet is generally composed of grains (bread, spaghetti, rarely rice) and vegetables (73% of adults, 63% of children). Only two people reported eating dairy products (milk, yoghurt). Meat and eggs are scarce and not consumed but beans and lentils are part of the diet. For some IDPs, the variety of food is even more limited; seven people reported that adults are only eating grains, with five people saying that the same is true for their children. In some cases, adults are favouring their children (n=6/33), by giving them the available vegetables and/or milk. In a small number of cases (4/33) the opposite is true, and parents report eating more vegetables than their children.

Infant nutrition and breastfeeding practices

"And mothers should breastfeed their children two complete years for those who want the breastfeeding to be complete"
(Qu'ran, 2nd verse, Al Bqarah, 233:37)

Breastfeeding is a practice accepted and even promoted by the holy Qu'ran. In fact, in "Islamic instruction, mothers are entitled a monthly payment from their husbands to breastfeed their children¹⁴". Breastfeeding was also used sometimes as a social regulator; if a mother breastfed another baby in addition to her own baby, they would become "brothers of milk". Marriage would therefore be forbidden between the two children in later life in a culture where intra-familial marriages are still common. Also, according to custom, the parents of a woman who has been breastfed can ask for a larger dowry than if she was not breastfed.

However, according to national staff, using formula milk became the new "fashion" in pre-war Syria. There are several possible 'cultural' reasons for this: people started to think that formula milk was better than mother's milk, some (urban) women started to have concerns about preserving the beauty of their breast and men who refused formula milk for their wives felt they might be perceived as mean. All these factors have meant that duration of breastfeeding has been decreasing and that some mothers have not breastfed at all. Furthermore, Syrian mothers also believe that babies benefit from water, water and sugar, a local type of "sheep clear butter", or tea in addition to breastmilk. Exclusive breastfeeding was and is still far from being a generalised practice. These findings are supported by a UNICEF survey which showed that less than half of infants were exclusively breastfed at birth in 2006; in Al-Raqqa, the exclusive breastfeeding rates was estimated even lower, only 26.5%¹⁵.

In the past decade, many efforts were made by the Ministry of Health (MoH), in collaboration with UNICEF, to provide breastfeeding education and promote exclusive breastfeeding for the first 6 months. According to data collected by UNICEF, from 2007 to 2011, 43% of women exclusively breastfeed during the first 6 months, and 25% continued partial breastfeeding until their baby was 2 years old. According to the data collected in the MSF survey, 68% (n=26/38) of the women interviewed reported that they were currently breastfeeding. Among them, 20 had babies aged < 12 months and four of them reported exclusively breastfeeding. When asked if infant formula was available, only three mothers replied affirmatively. For the majority of women, infant formula had become too expensive.

Health and sanitation

Lack of access to good quality water was the second most common complaint amongst respondents after lack of access to food. The surveyed IDPs got their water supply from three different sources: city water (tap), water trucking, and wells (See Figure 5). Out of the 39 people interviewed, 49% (n=19) complained about water quality, mainly saying that it is "bad", "dirty" or "salty". Only one respondent complained that there was "not enough" water. Despite this, only 3/39 stated that they were boiling water.



Ambulance in front of an advanced medical post supported by MSF in Idlib area, Syria

Lack of fuel was a main reason for this. The third most common complaint (7 people mentioned it) was poor hygiene due to overcrowding. Hygiene supplies were included in donations but again, this happened too sporadically.

These findings support observations during the assessments in the IDP collective centres in June/July 2013 where the MSF team concluded that the IDPs living there suffer from skin diseases, such as scabies, lice and ringworm. Furthermore, 80% of the IDPs interviewed reported suffering from diarrhoea, due to bad hygiene and water quality. Following the findings of the June/July 2013 assessment, MSF launched a water and sanitation intervention in the most affected schools and started up mobile clinics targeting the collective centres.

Nutrition programme

Doctors and nurses in Syria have not been trained on how to diagnose and treat malnutrition and protocols and guidelines were not in place to support the medical practitioners, as malnutrition was not common. This gap in medical care was one of the reasons for MSF to intervene given the cases of malnutrition identified in the MUAC screening. MSF began by integrating Ambulatory Therapeutic Feeding Centre (ATFC) services into outpatient clinic activities at the beginning of June 2013. MSF also supported an

ITFC in the paediatric ward in Tal Abyad hospital from July 2013. Out of an estimated under 5 population of 30,000 in Tal Abyad, the team expected 10-15 admissions per month for complicated SAM (0.5%).

Between July 2013 and April 2014, malnutrition was the principal reason for 5.3% of all admissions in the in-patient paediatric ward. In the same period, SAM was the main cause of mortality (21%) in the ward, followed by respiratory tract infection (RTI) and accidental intoxication (drinking petrol, cleaning solutions) (both 10.5%). All deaths due to malnutrition occurred amongst infants under 6 months. This does show an important trend compared with the mortality profile before the conflict, when malnutrition did not appear in the under-five's mortality profile.

All patients under 5 years, presenting to either the paediatric inpatient facility or the outpatient facility, are screened for malnutrition. Children whose MUAC is below 135 mm are assessed using weight-for-height z score (WHZ). All children are also assessed for oedema. Any child with WHZ <math><-3</math> or oedema is admitted. Patients are admitted to the inpatient ward (which is within the paediatric inpatient facility in the national hospital) and a caregiver is present from admission to discharge. Usually

this caregiver is the mother, although sometimes an alternative female family member is designated to stay. MSF ITFC nutritional guidelines are followed, which include the use of F-100, F-75 and Ready to use Therapeutic Food (Plumpy'nut) as needed. In the ATFC, patients are seen and assessed by the nutrition nurse in the outpatient department on a weekly or bimonthly basis, depending on the condition of the patient.

To date, the majority (75%) of cases have been direct admissions to the inpatient feeding programme. Between July and December 2013, 70 children were admitted to the ITFC of which 36% (n=25) were younger than 6 months. From January to April 2014, 49 patients were admitted to the ITFC of which 59% were younger than 6 months. This indicates that the malnutrition was a larger problem in Tal Abyad district than could have been expected based on surveillance data, which does not include this age-group. According to the ITFC medical staff, the majority of the children included in the programme were infants <math>< 12\text{ months}</math>. The team identified a number of contributing factors to malnutrition in these infants: a low rate of exclusive breastfeeding, significant use of infant formula in recent years, escalating prices and decreased availability of infant formula and inappropriate feeding (e.g. use of animal milk) when infant formula unavailable.

MSF market surveys showed a tremendous increase in prices of infant formula, from a pre-conflict price per can of 300SYP to 1500SYP in September 2013 and 1700SYP in February, 2014; more than a 500% increase.

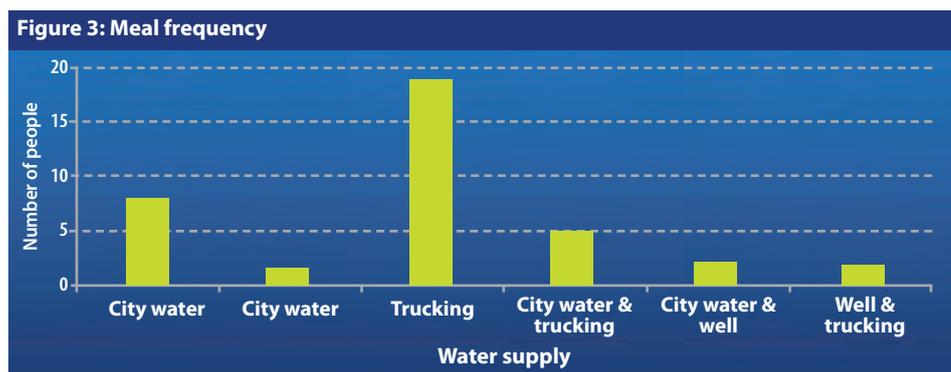
Programming challenges

At the outset, there was some resistance from the doctors and nurses to follow the MSF nutrition protocols. As these staff members had limited or no experience with malnutrition, there was a belief that the patient was sick due to other reasons, and therefore only needed interventions such as intravenous fluids and antibiotics. But with training, we were able to change this to a certain extent.

All issues related to breastfeeding and relactation were a challenge, in particular:

- Given the culture of using infant formula, knowledge of breastfeeding among staff and patients was very low. Some mothers had not breastfed at all or had stopped two or three months ago, although their children were still under the age of 6 months. In this age group, the options for therapeutic feeding include breastmilk, therapeutic milk and infant formula. Relactation is a difficult process, even with experienced health professionals providing advice and support, and mothers who are committed to the process. As exclusive breastfeeding was not a common practice amongst most women and the staff, there was limited drive to persist with relactation.

- When these children reached their target weights and were ready for discharge, the problem presented that many of the mothers had not yet



achieved exclusive breastfeeding and therefore would need to resort to giving infant formula. In ATFP where children are followed up after having been treated in the inpatient ward, MSF only provides breastfeeding advice and support, and does not give a supply of infant formula following the general international policy. This left many families in the difficult position of again trying to acquire infant formula, as no other local or international non-governmental organisation in the area was providing this to patients. The motivation to come to the ATFC for follow up was low as nothing other than advice was provided.

- Occasionally infant formula was supplied through the ATFC, but the team saw this as an exception. If mothers thought that they could receive formula milk, it would have undermined all the hard work that was done in the ITFC to motivate mothers to stimulate and restart breastfeeding. Moreover, the fear was that MSF would be overrun by mothers requesting infant formula.
- The time that expats were on-the ground was not sufficient to train staff fully on breastfeeding promotion, and remote support to breastfeeding was a challenge as locally there was virtually no experienced person on the ground. Predominantly male staff were unable to give breastfeeding support, as only female staff are able to discuss and assist patients with breastfeeding. Most of the female staff had never breastfed before. Also midwives had minimal experience teaching patients about breastfeeding.
- Although many breastfeeding videos were available, as well as pamphlets/books, due to cultural considerations, these materials were deemed too sensitive to use with patients in the programme although some were useful to train the national staff. A training plan was developed with the help of an experienced Save the Children staff but the security situation prevented implementation.

The supply of therapeutic foods and items was problematic. It was difficult for agencies to access international supplies of these foods and agencies were unable to procure comparable nutritional supplies locally. There was a rupture in the supply of F100 milk in January, 2014 so that MSF was required to purchase infant formula locally as an interim measure to use in therapeutic feeding programmes.

Finally, the defaulter rate of the therapeutic feeding programme was high (30% to 50% of the exits) both for the inpatient and outpatient programmes. Some of the reasons for default are not unusual for a feeding programme; these included the fact that some of the patients were IDPs, and their families were moving to another location and that sometimes the caregiver was unable to stay with the patient in the hospital, due to other responsibilities at home. However, what was reported most commonly with regards to patient default was that the parents did not understand or value the care being provided to their children. Due to a lack of understanding of malnutrition, there was distrust that therapeutic milk would be sufficient to support these patients. Also, once patients under 6 months were transferred from the ITFC to the ATFC and no longer were being given therapeutic milk or infant formula, mothers questioned the need to come weekly for weight and physical assessment.

Discussion

Despite difficulties in active case finding and screening, the number of acutely malnourished was higher than expected. The initial assessment and the surveillance did not indicate the importance of malnutrition in the Syrian IDP and host community. This can be partly explained by the large proportion of infants younger than 6 months amongst admissions, as these generally are excluded from screening and community assessment.

Reasons for acute malnutrition in infants appear to be a low rate of breastfeeding, lack of clean water, lack of resources to buy infant formula milk and physical exhaustion of the mother. Treatment of malnourished infants works in the short term, but after discharge from the inpatient ward, a dilemma arises. MSF did not supply infant formula for use at home, but the families would face the same difficulties with feeding their babies as an alternative referral or support system was lacking. MSF actively lobbied other agencies for such support but none was forthcoming. Overall MSF recognised the importance of breastfeeding in these circumstances and organised breastfeeding promotion and individual support as much as possible given the challenging circumstances.

Despite concerns about the general food security, this did not manifest itself in the nutritional state of older children or the general population. However, it was quite visible in very young age groups, who need high quality foods, including a source of milk or other foods of animal origin.

As food security and dietary diversity is low and there are no signs of improvement, MSF

considered blanket selective feeding for all children, as well as improving hospital food and lobbying for more food aid and humanitarian support. However two major constraints hampered implementation of these activities. Tal-Abyad is situated in a rebel controlled area in the north of Syria. This meant denial of regular cross-line support through UN coordinated food aid or nutritional support as this needed government permission. Importation of foods by MSF was not straightforward either. Furthermore, a significant security event involving MSF staff meant that expatriate staff were physically withdrawn from Syria in February 2014; this meant that new programme elements, like the roll out of breastfeeding promotion and support, could not be properly implemented.

Conclusions and recommendations

The Syrian context is relatively new for MSF, therefore we would like to share some lessons learned. In the immediate term, to address the needs and challenges we have identified, we consider that:

There is an urgent need for unrestricted access to people in need throughout Syria and unhindered cross border activities.

- Nutrition assessment and surveillance systems should include infants younger than 6 months, and be alert to potential changes in the under one year age group.
- There is an urgent need to supply infant formula to babies whose mothers have not been breastfeeding and therefore have a limited or lack of milk supply, and who are unable to afford or find infant formula for their babies.
- Medical professionals should be trained on breastfeeding to help educate pregnant women and to provide skilled support to establish breastfeeding and overcome difficulties. There is a need to explore the use of medications to assist women in increasing their milk supply. Strengthened individual support should be complemented by a breastfeeding community awareness campaign focusing on the need to breastfeed exclusively for the first 6 months of age, targeting not only mothers but their families and the community.
- Management of acute malnutrition (likely requiring training), vaccination and targeting the top three illnesses should be integrated into normal paediatric health care structures.
- Blanket selective feeding programmes providing high quality foods to young children and PLW and better quality general food distributions could prevent further deterioration of the nutritional status.

The MSF programme in Tal Abyad has been closed since May 2014; leaving very few agencies addressing malnutrition in Northern Syria. There is an urgent need for others to secure access and step up their nutrition support activities in Northern Syria.

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MUAC measurement in an infant

Anon, Northern Syria, 2014

Coordinating the response to the Syria crisis: the southern Turkey cross border experience

This views piece was developed by the ENN based on eight key informant interviews with donors, UN agencies and INGOs carried out during an ENN visit to southern Turkey in early April 2014, subsequent follow-up by email and meetings with OCHA Geneva and the Global Nutrition Cluster in June 2014. All contributors have seen various drafts but requested to be anonymous.

Note that this views piece reflects the experiences up to April 2014 (with some updates related to UN Resolutions). Other developments in the coordination mechanisms may have taken place since this time.

Background

The onset of the conflict in Syria, which resulted in the establishment of government and opposition controlled areas (the latter are predominantly in northern Syria), has meant that to date (April 2014), the humanitarian response has largely been administered through two separate and uncoordinated programming approaches¹. Firstly, humanitarian agencies based in the Syrian capital Damascus, work through the consent of the Syrian Government and with the Syrian Arab Red Crescent (SARC). Secondly, agencies administering services into northern Syria do so largely through programming planned and coordinated from southern Turkey. This is referred to as the cross border programme² and was initiated in the early months of the crisis by a number of diaspora Syrian based agencies and international non-governmental organisations (INGOs) with support from a small number of humanitarian donors. The coordination experience from the cross-border programme has highlighted a number of lessons learnt and challenges for the humanitarian sector. Coordination and planning for nutrition programming, in particular, appears to have been a casualty of some of these challenges. This is the main focus of this views piece.

Coordination in the absence of a cluster mechanism

Within Syria, the Damascus based UN agencies opted for sectoral coordination with UN cluster lead agencies working with a government co-lead. For nutrition, UNICEF as the cluster lead agency has been 'double hatting' providing technical input, as well as a crucial coordination role. In the opposition controlled areas of Syria however, there has not been any official UN coordination presence. In southern Turkey, the national and INGOs involved in the cross border programme established a coordination mechanism known as the NGO Forum, which shared information as best it could between operational agencies (largely INGOs). A joint rapid assessment mission into northern Syria (JRAM) carried out in January 2013 was an NGO Forum led initiative. The formation of the Assistance Co-ordination Unit (ACU)³ in November 2012

brought another prominent player in cross-border programming and it was hoped that this structure would take on operational coordination. However, a number of internal challenges prevented ACU from taking on this role. In addition, OCHA arrived in southern Turkey in February 2013 with a mandate to promote coordination of information management and needs assessments of the cross border programme. This engagement led gradually to the establishment of IASC⁴-like coordination mechanisms. The efficacy of this mechanism was challenged by the lack of cluster activation in Syria at that time, the constraints faced by UN agencies for their direct involvement in a response that was clearly opposed by the Syrian Government, as well as a lack of buy-in by INGOs to coordination by a UN agency (OCHA) that was not itself operational in the cross-border programme. Despite these challenges, there was an increased call for more coordination, in particular between programming from Syria and programming across the southern borders of Turkey into northern Syria.

To date (April 2014), UN agencies present in southern Turkey have largely (with some exceptions and to varying degrees) had to operate an information 'firewall' system between their cross border coordination work and their operations based in Damascus. There were two main reasons for this. The first was the risk of the Syrian Government finding out about UN cross-border activities from southern Turkey, which could jeopardise their work in Government controlled areas of Syria, i.e. the Syrian Government may place restrictions on UN agencies working both sides of the divide or even stop their activities altogether. The second was the potential risk to programming activities and staff involved in the cross-border programme if information was shared with Damascus based programming staff and government counterparts⁵.

The UN therefore effectively adopted an 'indirect support' modus operandi for southern Turkey. OCHA in coordination with global cluster lead UN agencies, INGOs and donors, set up working groups for each sector. Most of

these working groups were co-chaired between INGOs and UN agencies or cluster representatives (without cluster activation) and the majority of them had dedicated coordinators, funded by donors, to chair and steer the group's work. The working groups replaced the NGO Forum and provided a far more effective space for technical coordination within sectors – especially around information sharing and certain elements of operational coordination. The membership of the working groups was extended to cover a wider range of partners, including Turkish and Syrian NGOs which fed into a broader coordination architecture, including an inter-sector working group, as well as a strategic, decision-making body with key representatives of the humanitarian community to provide overall leadership for the response.

However, major challenges remain due to the absence of an official mandate for stronger UN operational involvement⁶. As a result, UN agencies provide support and guidance on humanitarian standards, training and planning of humanitarian programmes in support of NGO operations. WFP, in particular, has managed to use its regional hub in the capital of Jordan, Amman, as a forum for information sharing, thus overcoming to some extent the firewalling constraint⁷. According to many stakeholders in-

¹ See later for updates in this regard with respect to UN Resolution 2165.

² At the time of writing, programming across other borders, such as from Iraq and Jordan, existed but at much smaller scale and are not covered in this views piece.

³ Created in November under the initial leadership of Suhair al-Atassi, a vice president of the National Coalition for Syrian Revolutionary and Opposition Forces

⁴ Inter Agency Standing Committee

⁵ Some INGOs have also adopted a similar approach, i.e. basing themselves in Damascus and not implementing cross-border programming.

⁶ This situation has changed since the adoption of Resolution 2165, later in this article and footnote 9.

⁷ Subsequent and further actions by WFP to coordinate and align cross border and cross line operations following Resolution 2165 are shared in an article in this 48th edition of Field Exchange. Of particular note, all WFP operations in Syria, whether cross border or cross line, are now planned from Damascus.

interviewed during the course of the ENN visit, this has resulted in better 'gap' analysis by WFP, its implementing partners and the food security sector in general. The lack of operational involvement of the UN in southern Turkey for the cross border programme has meant that implementing agencies do not have access to financing mechanisms such as the Emergency Response Fund (ERF) or stocks of non-food items (NFI) and medicines. Furthermore, the absence of the cluster mechanism has also meant that there is no agency identified in the role as provider of last resort – a key feature of the IASC cluster mechanism and important to ensure accountability to both beneficiaries and to donors.

There are ongoing tensions for many agencies working on cross-border programming who believe that OCHA and the UN agencies could have operated more effectively. One view is that OCHA interpreted its role as one of reporting information rather than coordinating the meaningful assessment and analysis of information and the mapping of key gaps to ensure more equitable access to food and non-food assistance. An opposite view from within the UN family is that the refusal of many INGOs to share information with the UN has made it impossible to do meaningful assessments and analysis. Whilst NGOs have been advocating for better coordination, there have been sensitivities and dynamics with OCHA that have continued to constrain strengthened coordination. To some degree, personality clashes have been a part of this problem yet other sectors, notably education, food security and child protection have done well, highlighting that sectoral coordination with concomitant donor support can lead to enhanced coordination even in the most challenging situations. This, however, has not been the experience thus far with the nutrition sector.

The firewalled information between the cross-border programme in southern Turkey and the Syria programme has meant that southern Turkey based INGOs have had little information about programming being coordinated and implemented from the Damascus side, while agencies in Damascus do not know what is being planned and implemented cross border⁸. As a result, there have been examples of duplication of aid where the so called cross-line programme into northern Syria has been implemented in areas where NGOs operating from southern Turkey have already worked. In addition, there are also concerns that areas exist where both the cross-line and cross border programme have not reached areas in need.

The passing of UN Resolution 2139 in February 2014 raised expectations about greater freedom to share information amongst all stakeholders, as well as opening up more border crossing points from southern Turkey. However development in this regard needed the subsequent Resolution 2165⁹ – considered a "breakthrough in efforts to get aid to Syrians in need"¹⁰ – with the first UN convoy which crossed into Syria from Turkey through the Bab al-Salam border crossing on 24th July 2014. Food, shelter materials,

household items and water and sanitation supplies for approximately 26,000 people in Aleppo and Idleb Governorates were transported. The Syrian authorities were notified and more convoys anticipated. Nonetheless, at the time of interviewing (April 2014) there was still considerable mistrust between INGOs working in southern Turkey and the UN agencies. Although INGOs and donors understood why the UN agencies have operated in the way they have, there is constructive criticism about how they could have combined the maintenance of their 'safe' position in Damascus whilst working more effectively with agencies in southern Turkey. This has been referred to as the 'anonymisation of the response' and links to a widespread view that the UN agencies could have reached out more to INGOs, found better ways to share information (perhaps using the WFP regional hub model) and also connected more fully with Syrian NGOs working cross border. Syrian agencies are increasingly becoming involved in the working groups but this greater engagement has been a slow process. There is also a strong view amongst the donors and INGOs interviewed that as the UN is non-operational, their legitimacy for coordination is intrinsically diminished and that the UN should have been clearer from the start about what they could, or could not do. INGOs and donors have therefore been lobbying to have an INGO co-chair on the inter-sectoral working group in order to strengthen operational coordination. However, OCHA have been unable to grant this request as this arrangement would not be in line with IASC guidelines.

Nutrition sector coordination and leadership

Many actors working in southern Turkey are of the view that there has been an absence of leadership around nutrition programming and coordination. This has meant that there has been a lack of thorough sectoral analysis of the main nutrition problems faced within Syria and amongst the refugees. Added to this has been the limitation of the global benchmark for defining a nutrition emergency, which requires high or increasing levels of GAM for funding to be activated. In essence, donors wanted to see a higher GAM before agreeing to a dedicated nutrition working group and programme of funding. Whilst there are examples of low GAM and nutrition cluster activation in emergencies such as Haiti and the Philippines, the donor focus in the Syrian crisis has been largely confined to other sectors such as WASH (water, sanitation and hygiene) and child protection. There is no doubt that the Syrian crisis has lacked a well-articulated and coherent analysis of nutrition risk and needs and this has constrained the level of attention to the sector.

Between September 12th and 20th 2013, the GNC undertook a scoping mission to "assess the nutrition context and potential nutrition information-sharing mechanisms within the humanitarian response for northern Syria". It was undertaken by a two person team – one member of the GNC Rapid Response Team (RRT) and a nutritionist seconded from an

INGO. It was prompted by a lack of information and data about 'nutrition in emergencies' programming in northern Syria and by concerns regarding lack of understanding regarding infant and young child feeding (IYCF) in this context. It identified that coordination on nutrition needed to be enhanced, with particular emphasis on IYCF. Suggestions were made regarding potential coordination structures and systems. Subsequently, from mid December 2013 to mid-Feb 2014, a GNC RRT member (hosted by an INGO) was deployed "to provide coordination, technical and information management support" on nutrition to the cross-border Turkey based operation. Whilst inroads in raising the profile and engagement on nutrition between agencies was reported,¹¹ the profile of nutrition remained hugely constrained and was essentially short lived given the short term nature of the deployment. The mission placed considerable emphasis on IYCF (particularly breastfeeding support) as a priority issue for response and the need for a nutrition survey to establish whether acute malnutrition was a problem. Many stakeholders disagreed with these recommendations and also felt that the three month period should have resulted in more robust nutrition data and analysis to inform programming.

The absence of nutrition data in northern Syria has been a constant anxiety for implementing agencies that are aware of high levels of food insecurity and lack of access to health care and clean water for many internally displaced people and in the besieged areas. A nutrition sub-group has recently been set up as part of the health working group for the cross-border programme and is working to provide the analysis and programming recommendations needed for the nutrition sector. However, there are very few agencies involved directly in nutrition programming and added to this, the absence of a UN agency presence in the nutrition sub group has reduced the level of authority typically needed to influence donor financing allocations and their response.

A question is raised as to how, in a 'level 3' emergency, which is in its fourth year, there is not a standalone nutrition sector working group in southern Turkey with a lead agency providing credible assessment and analysis of the overall nutrition situation. There is also a related question as to why the GNC was not enabled to sustain a presence in southern Turkey in order to provide coordination for nutrition analysis and operational planning for the cross border programme.

⁸ See footnote 7

⁹ Resolution 2165, unanimously adopted by Council members on 14 July, authorised the United Nations and our partners to use routes across four additional border crossings with Turkey, Jordan and Iraq. The resolution also authorised the establishment of a monitoring mechanism to confirm the humanitarian nature of supplies brought through those crossings points. Available at: <http://unscr.com/en/resolutions/2165>

¹⁰ Under-secretary-general for humanitarian affairs/emergency relief coordinator Valerie Amos, executive director of the WFP Ertharin Cousin and Executive Director of UNICEF Anthony Lake, Statement on Security Council Resolution 2165 on humanitarian access in Syria.

¹¹ GNC End of Mission Report (Feb, 2014)

Turkey



Nesrine fled from Eastern Ghouta to a collective shelter for internally displaced families; WFP/Dina Elkassaby

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DRC experiences of cash assistance to non-camp refugees in Turkey and Lebanon

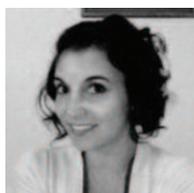
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Enda Modclair / DRC, 2014



DRC/IMPR Community Centre in Urfa province, Turkey

By Louisa Seferis



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on livelihoods, cash and emergency programming in Syria, Lebanon, Turkey and Iraq. Prior to 2011, she worked for four years in Africa on conflict and displacement through

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The author would like to thank the DRC teams for their continued work with Syrians across the region, in particular the DRC Turkey and DRC Lebanon teams for their dedication to beneficiary-focused, evidence-based programming. Thank you also to DFID for its

innovative approach to funding DRC in Turkey, and to ECHO and UNHCR for their regional partnerships with DRC on the Syrian crisis.

The abstract was submitted for the ENN Technical Meeting on nutrition at Oxford (7-9 October 2014), and DRC presented the concept during the marketplace presentations. The box on benefits and risks of cash transfer programming was also published in a DRC Evaluation and Learning Brief.

Cash programming has been used on an unprecedented scale in the Syrian crisis, largely due to the urbanised nature of the Syrian refugee caseload in affected countries and the well-developed markets and banking systems. This article outlines the main contexts in which urban Syrian refugees find themselves and their specific vulnerabilities, especially with regards to access to labour markets, credit and assistance. Unusually, we have found a need to understand and respond to the psychosocial needs of men, given how the crisis has undermined their provider role in the family. Until now, the humanitarian response has failed to address this issue adequately. The article will also review, from the Danish Refugee Council (DRC)'s perspective, how humanitarian programming for non-camp refugees in Lebanon and Turkey has evolved in order more holistically to meet refugees' changing needs in the face of protracted displacement, incorporating more traditional humanitarian responses with innovative and large-scale cash programming. Finally, the article will explore DRC's experiences and share observations around conditional versus unconditional cash.

Programming context

Since the beginning of the Syrian crisis in 2011, Syria's neighbouring countries have dealt with

the refugee influx in various ways – building numerous and well-equipped camps in Turkey, providing blanket assistance to all registered refugees in Lebanon, and establishing massive camps and processing centres at the Syrian border in Jordan. Regardless of the initial approach, by 2012, Syria's neighbours all hosted a significant number of non-camp refugees, many of whom settled in urban areas in the hopes of accessing income opportunities. In 2014, Syrians outside of camps constitute the majority of Syrian refugees in the Middle East.¹

DRC has been present in the Middle East, and in particular in Syria and Lebanon, since 2007. While programmes in Syria focused on mainly Iraqi and Somali refugees in urban areas, in Lebanon, DRC started a small programme to support Palestinian youth vis-à-vis livelihoods and self-reliance. The onset of the Syrian crisis shifted DRC Lebanon's focus to provide emergency assistance to Syrian refugees, later expanding the intervention to a holistic approach involving protection, community services and livelihood initiatives. DRC began its operations in Turkey in early 2013, modelling its response after successful interventions in Lebanon and elsewhere that concentrated on non-camp refugee populations. Given the scale of needs and the urban displacement context, DRC considered cash transfers a

relevant and cost-efficient way to provide assistance. In late 2013, DRC Lebanon embarked on a large-scale unconditional cash assistance programme to support families during the winter,² and in 2014, DRC Turkey initiated cash assistance through a DFID two-year grant aimed at providing assistance to vulnerable families and transitioning to livelihoods support in 2015 (project on-going).

The situation in Turkey

Turkey is the host country with the largest network of camps for Syrian refugees (civilians and combatants). While the number of refugees within camps in Turkey peaked by the end of March 2014 at just over 224,000 people, according to UNHCR, the number of non-camp refugees has steadily increased to over 564,000 by mid June 2014 – a 61.1% increase since the end of 2013. The majority of non-camp refugees live in southern Turkey in provinces along the border, with the largest concentrations in Gaziantep, Sanliurfa, Hatay and Kilis provinces. There are over 166,262 non-camp refugees in Gaziantep,

¹ <http://data.unhcr.org/syrianrefugees/regional.php>

² For more information, please see http://www.cashlearning.org/resources/library/417-unconditional-cash-assistance-via-e-transfer-implementation-lessonslearned?keywords=danish+refugee+council&country=all§or=all&modality=all&language=all&payment_method=all&document_type=all&searched=1&x=58&y=15.

³ UNHCR SitRep, 7 July 2014

108,349 in Sanliurfa, 134,275 in Hatay, and 45,200 in Kilis³. There are probably more non-camp refugees in these provinces who have not registered with AFAD (Disaster and Emergency Management Presidency of Turkey) and are therefore not reported by UNHCR. The majority of non-camp Syrian refugees in Turkey live in urban or peri-urban areas, renting and sharing accommodation with an average of 1-4 other families and surviving through temporary employment (mainly daily/monthly labour) and minimal assistance. Since May 2014, DRC Turkey has assessed 2,100 Syrian families in Hatay province, southern Turkey. Their main concerns, challenges, income and rental costs are shared in Box 1.

The majority of households assessed (75%) share all expenses between the households and individuals sharing a dwelling, which includes food and heating.

Box 1

Assessment results of 2,100 Syrian families in Hatay province, southern Turkey

Refugees' main concerns and challenges (households could report more than one concern):

- 86% reported a lack of job or self-employment opportunities
- 66% reported they had an insufficient food supply
- 60% faced discrimination by the host community
- 77% reported difficult access to humanitarian assistance

Income per month:

- 16% of households assessed earn 800 TL or more (approx. 400 USD)
- 34% earn between 500 and 800 TL (approx. 250-400 USD)
- 22% between 300 and 500 TL (150-250 USD)
- 9% earn between 100 and 300 TL (50-150 USD)
- 1% earn between 1 and 100 TL (up to 50 USD)
- 18% reported zero income

70% of households reporting a monthly income said the main source of income was labour.

10% indicated that their main source of income was selling assets and/or using savings.

Rent:

- 43% pay rent between 100-300 TL (50-250 USD)
- 41.5% between 300-500 TL (150-250 USD)
- 11% pay rent of 500 TL or more (250 USD)
- 1.5% pay up to 100 TL (50 USD), and 3% do not pay rent (hosted by other families)

Number of people per dwelling:

- 45% of households live in dwellings with 6-10 people
- 34% of households live with 1-5 people
- 21% live with over 10 people in a dwelling

The majority of households assessed (75%) share all expenses between the households and individuals sharing a dwelling, which includes food and heating.

In Turkey, refugees outside of camps face integration challenges such as language barriers⁴ and very few social ties, resulting in higher tensions with local communities and difficulty finding employment. Syrians in Turkey have very few opportunities to access credit with shops, and landlords generally demand rent/utility payments every month without exception or flexibility. Syrian men who do manage to find temporary jobs (daily, weekly, or sometimes monthly) often complain that they are not paid at the end of the work, and they cannot pursue any legal recourse because they have no right to work in Turkey.⁵ They say the Turkish employer will just find another Syrian to replace him, and generally not pay him either. Refugees say that working more in Syria means improving your quality of life; "in Turkey, working more means just trying to survive."

Syrian Kurds are the notable exception, as they can integrate into Kurdish areas of southern Turkey (e.g. Urfa Province) and enjoy better access to social networks and community support. This is also consistent with findings from DRC's livelihood programming in the Kurdish regions of Iraq, where Syrian Kurds who receive business grants have a high success rate due to their social networks and therefore access to credit, resources, connections and a customer base.

The situation in Lebanon

Lebanon hosts the largest number of Syrian refugees in the region, both in terms of absolute numbers (over 1,138,000 refugees) and as the greatest proportion of its population (over one-fifth of the total population currently in Lebanon is now Syrian).⁶ Given the initial small number of refugees and significant humanitarian presence, agencies provided assistance to all registered refugees (with some organisations focusing on the smaller number of unregistered refugees). Between 2012 and 2013, the refugee population grew exponentially and the humanitarian community struggled to maintain the same level of assistance. At the same time, the government did not change its 'no camp' policy, which meant refugees sought shelter through any means possible – renting with other families, inhabiting unfinished buildings, living in informal tented settlements, etc. Hosting "fatigue" and reduction in humanitarian assistance compounded refugees' difficult situations; since the end of 2013, the humanitarian community has drastically reduced its assistance, from providing cash and in-kind assistance to 70% of registered refugees to now planning cash assistance to 5-10% of refugees.

Finally, the cost of living in Lebanon is also extremely high and meeting basic needs is difficult, especially for Syrians used to the same standard of living for much less. The cost of living in Syria remains significantly lower than in Lebanon. Despite inflation within Syria due to the conflict, many basic goods (food/non-food) are still subsidised by the Syrian government or produced locally – albeit in a much more limited capacity than before the conflict. Moreover, the devaluation of the Syrian pound offsets

the increased prices in the black market, which is still cheaper than Lebanese markets.

Lebanon v Turkey context

In both Lebanon and Turkey, Syrians face challenges to generate stable income, which in turn affects their ability to meet basic needs as assistance wanes. Oversaturated labour markets, particularly for unskilled workers, either mean that there are fewer job opportunities or the jobs available put Syrian refugees in competition with the host community labour force. Syrians, generally willing to work for less pay than the host community, often crowd out local labour. This is particularly true for sectors such as construction, agricultural work, daily or temporary work and the service industry. For example, restaurants in some parts of southern Turkey often now employ young Syrian boys, starting from around 10 years old, to clear tables, wash dishes and translate for Arabic-speaking customers.

While many programme elements are similar between Turkey and Lebanon because non-camp refugees in both countries face similar challenges (lack of employment, high cost of living, especially rent/food, etc.), there are also marked differences. In Lebanon, there are no camps so all refugees are essentially 'non-camp.' The ties that existed between Syria and Lebanon prior to the conflict have eased refugees' integration – notably the language and exchange of goods and services (approximately 500,000 Syrians worked in Lebanon prior to the conflict, many of them seasonally). Syrians in Lebanon also have access to credit in local shops to buy foods and goods, or with landlords to delay rent payment when families have no income. However, the existing ties and similarities between Syria and Lebanon have also given rise to tensions based on communities' affiliations, many of which are exacerbated by humanitarian assistance to Syrians only. Syrians were perceived to receive huge amounts of assistance, while the Lebanese received nothing, and Syrians were "stealing" jobs from local communities because they were willing to work for much less. In Turkey, the social ties between refugees and local communities are minimal (Kurds being the exception), which means Syrians faced integration issues from the beginning. They also have limited to no access to credit, so they rely more on assistance, income and selling assets to make ends meet per month – landlords and shop owners rarely give refugees a 'grace period' to pay bills.

The psychological effects of the Syrian crisis

The majority of humanitarian protection and social responses concentrate on services to

⁴ In Hatay Province, 66% of Syrian families assessed by DRC reported that the language barrier was a main problem they faced in Turkey.

⁵ In order to apply for a work permit, Syrians must have residency papers – these are difficult to obtain in general, and the most vulnerable families do not have valid passports (required for the residency application). In 2014, Turkish authorities may loosen restrictions on applying for work permits through bylaws (exemptions for certain sectors/occupations or geographic areas).

⁶ Source: UNHCR, 2014. <http://data.unhcr.org/syrianrefugees/country.php?id=122>

women and children, who are perceived as the most marginalised groups. However, in this crisis, men also need support. The psychological impact of the crisis on Syrian men across the region is quite specific, as many feel that they cannot assume their traditional role as breadwinners and providers to the family. “Just give me a job, let me work. The rest, I can take care of myself.” DRC staff observed many physical disputes and instances of domestic violence, not just with project beneficiaries, but also in everyday life. With the prioritisation of services provision to women and children, there is little space for men to socialise outside of the house in settings where they feel comfortable sharing their stories. In DRC’s community centres in Turkey, which serve mainly non-camp Syrian refugees, there was a marked difference when activities and facilities were designed taking into account both men and women’s interests (including mixed-gender activities). In particular, DRC introduced story-telling activities for adult men, as staff found this group to be the ones struggling the most to deal with trauma and displacement. Men expressed gratitude in having the space to come together outside of the pressure of everyday life to find a job or act in a certain way.

Use of cash assistance by urban refugees

Syrian refugees outside of camps live in urban environments and engage with markets every day. Countries such as Lebanon and Turkey, particularly in the urban areas, enjoy relatively free and generally informal markets – businesses can start (and close) easily, and there are few regulations on small and ad-hoc enterprises such as grocers, coffee shops, barbers, etc. Moreover, refugees need cash to meet basic needs, which across the region they identify as mainly food, shelter, and health (education, hygiene items, etc. are generally less prioritised). In these areas, cash programming makes sense. However, many humanitarian agencies prefer either to give items in kind or provide conditional assistance (e.g. cash for training) or restricted through vouchers (paper or electronic), such as food vouchers. Many agencies are concerned that refugees will not spend the cash as organisations intend. This is because there is still a perception that in-kind or restricted cash will better meet needs, because “we don’t know what they will buy with cash.” This is despite extensive research worldwide on displaced populations and the use of cash in humanitarian assistance, demonstrating that the vast majority of recipients do spend responsibly.⁷ Research shows that the amount of cash or voucher transfers, proportional to a family’s estimated minimum expenditures, determines how much food the family can purchase, which is “obviously critical to the effectiveness of the transfer in improving consumption (amount of food able to be purchased, dietary diversity, negative coping mechanisms, etc.)^{8,9}” Anticipated expenditure is an aspect of household consumption that is not considered in most assessments or evaluations – it is already quite difficult for refugee households to estimate their actual expenditures. The main response we hear

about planning expenditures is that there is no planning – when an emergency comes up (usually medical), refugees will borrow money or drastically reduce other expenditures (delay rent payment, eat only basics or rely on family/friends for food, etc.).

Refugees across the region have reported household priorities and the fact that they cannot meet all of their basic necessities.⁹ Although needs vary in each refugee context and for different groups, the majority of Syrian refugees cite their main needs as food and shelter. Thus far, agencies in Turkey have not had a precise understanding of the minimum expenditure basket (MEB) of a Syrian family. Indeed, transfer values appear extremely low compared to prices of food. The Turkish non-governmental organisation (NGO) Support to Life estimates that a family of six people needs about 470 TL (approx. 235 USD) per month to eat a balanced diet, including fresh food. Most agencies are providing around 25% of this in food assistance via e-cards that must be redeemed in specific shops, whose prices are generally fair but often above bazaar or street vendor prices, particularly for fresh food.

DRC therefore has shifted much of its in-kind direct assistance for refugees to cash modalities and in particular, unconditional cash. DRC considered unconditional cash the best option given the vulnerability of families eligible for monthly assistance (as compared to all households assessed), and their necessity for flexibility and choice to meet needs monthly. The monthly cash assistance will not be able to cover 100% of a family’s monthly needs, so maximising purchasing power is essential. Moreover, establishing and maintaining conditional or restricted cash assistance programmes is extremely labour-intensive and counter-productive in such flexible and developed urban markets – artificially restricting markets (by selecting and only working with certain vendors) can encourage discrimination against voucher holders, including potentially influencing price inflation. Instead, DRC prefers to emphasise the beneficiary selection process, in order to identify and assist the most vulnerable families, and to focus on the monitoring process to track how the money is spent and its impact on households’ situations.

Impact of coping on food diversity, quantity and quality

In any displacement situation where refugees do not have access to reliable income or sufficient assistance, families will restrict the quantity, quality and diversity of food consumption. Syrian refugees are no exception. However, prior to the crisis, even poor Syrian families enjoyed varied and plentiful diets, due to the low cost of living in Syria – largely because of the vast array of locally produced goods and subsidised staple foods (flour, milk, even fuel and cooking gas). This means that any change in food consumption will be experienced more dramatically and is a stark reminder of their displacement. DRC assessments show that Syrian refugees almost immediately sacrificed food quality to meet basic needs. In addition to this, families assessed in Hatay Province in Turkey adopted a number of coping strategies, in order to meet food needs (see Table 1).

Anecdotal evidence and monitoring data suggest that Syrian refugees in the Middle East are restricting dietary diversity due to high prices, even when receiving electronic vouchers for food.¹⁰ They are mainly purchasing and consuming cereals/grains, pulses, oil, and limited quantities of cheese, while they forgo meat and other dairy products such as milk. It is unclear if this will have a lasting negative impact on health and nutrition, since refugees do manage occasionally to buy small quantities of fresh foods and protein; it is also unclear how humanitarian assistance could address dietary di-

⁷ Sarah Bailey 2013

⁸ Sarah Bailey, 2013

⁹ In Lebanon, qualitative (focus group discussions) and quantitative (household surveys by phone) in 2014 indicate that refugees’ main needs are food, shelter and healthcare. In Turkey, focus group discussions revealed the main needs as food and shelter; refugees have very little access to credit/debt sources, and therefore have limited time to accumulate enough money to buy food and meet rent/utility obligations.

¹⁰ Source: Household monitoring visits with non-camp refugees in Turkey and Lebanon, 2014.

¹¹ See Longley et al, 2012. As summarised by Bailey (2013): “The use of the transfer changes according to changing needs, seasonality, livelihoods and the objective of the programme. In this case, the first transfer had the highest proportion spent on food, and transfers towards the end of the intervention were more geared toward supporting recovery.”

Table 1: Coping strategies to meet food needs adopted by Syrian refugees, Hatay province, Turkey (2,100 households)

Coping mechanism (Families could list more than one)	% of total
Consumed less preferred or less expensive foods	84%
Reduced the number of meals per day	73%
Reduced spending on non-food items	72%
Limited portion size	49%
Spent savings on food	30%
Restricted adult consumption (so children could eat)	16%
Purchased food on credit or borrowed money to buy food	16%
Had school aged children working	13%
Asked for food (including begging)	12%
Skipped entire days without eating	4%
Not applicable	5%

Box 2

Considering cash: benefits and risks

Benefits

Dignity: Cash recipients do not queue visibly to receive assistance, the content of which is determined by external actors in the “best interest” of beneficiaries.

Empowerment: In any conflict or displacement context, vulnerable families have to prioritise certain needs over others, regardless of the levels of assistance they receive. With cash, families can choose directly which needs to prioritise; even with conditional cash (e.g. food vouchers), recipients can select what is most important to them. Cash can also improve certain members’ decision making within the household in a positive manner.

Cost efficiency: Cash reduces operational costs and provides more “cash in hand” to beneficiaries (although it is important to note that this is not always the case). Because recipients meet self-identified needs, there is generally a lower rate of aid diversion or sale.

Multiplier effects: Cash transfer programming can directly benefit local markets more than providing in-kind assistance, and can revitalise/strengthen local economies as well as benefit host communities.

Improved monitoring and evaluation:

Strong cash programming emphasizes monitoring and evaluation as the core activity to determine how cash is spent and its impact on households, markets and communities. Cash programmes can therefore provide more comprehensive feedback on people’s needs, vulnerabilities and coping strategies, in addition to the humanitarian impact on local contexts and communities.

Risks

Markets: If improperly assessed beforehand, some cash modalities can negatively affect markets by causing inflation or supply shortages.

People (households, individuals): Cash can exacerbate existing household tensions or negatively impact dynamics between household members (e.g. the head of household chooses not to spend money on food for the children). In extreme cases, cash given to a woman could increase her exposure to domestic violence, for example. In addition, cash programmes without end points/exit strategies and complementary assistance (counselling, training, etc.) run the risk of creating dependency rather than meet needs; although this is also the case for in-kind assistance programmes, it is especially concerning for cash because the assistance is another form of income and families can become reliant on it (like remittances or other external support).

Community dynamics: Depending on how beneficiaries are selected and existing community dynamics, cash can worsen relations between recipient and non-recipient groups (although the same can be argued for in-kind assistance). This is especially pertinent between refugee and host communities, particularly in countries where governments may not have the means to provide social safety nets / cash assistance to its economically vulnerable citizens.

versity concerns, given the fact that delivering fresh food in-kind is not feasible. One suggestion is to increase the cash transfer value provided to each family, but given evidence from other contexts and the huge needs, many households have gone so long without assistance that given additional cash, they might prioritise other expenditures such as rent, health, education, etc.

Moreover, evidence from other contexts demonstrates that consumption patterns change over time¹¹ and also with regards to the type of shocks, i.e. families required to move may prioritise shelter over food, while household level shocks, as when someone falls ill, may require expenditure on health care. Therefore, while refugees will nearly always spend a large portion of cash assistance on food, further research is needed to understand to what extent they are sacrificing dietary diversity, quality or quantity of food consumption to meet other equally pressing and basic needs.

Discussion

Most of DRC’s direct assistance to refugees has followed the general trend of humanitarian aid in the region – starting as in-kind support (food parcels and non-food items) and gradually moving towards cash-based responses, such as food vouchers or conditional cash for rent. The acceptance of unconditional cash, both by host governments and the international humanitarian community, only came about in full force by mid-2013. This shift to cash is part of DRC’s overall strategy to respond as holistically as possible to Syrian refugees’ needs outside of camps, with a dual protection and livelihoods approach. The need to create safe spaces, such as community centres, where refugees and host communities can access information and services and socialise is essential. At the same time, vulnerable individuals and families want support to meet self-defined needs, to decrease dependence on hu-

manitarian assistance, and plan for the future. The first step is to assist directly those most in need, which DRC believes is often done most efficiently through cash, as well as move towards more sustainable support such as skills development, job placement and facilitating business development, when feasible. It is much more difficult to influence or support sustainable livelihood solutions for refugees in urban contexts where labour market or supply trends have a greater effect on people’s ability to earn a reliable income; moreover, many vulnerable refugee households may not be able or willing to generate income. Cash is therefore a key tool in providing direct assistance to vulnerable families to meet self-identified needs and provide temporary income to alleviate economic vulnerability. The question remains how to transition from cash to more sustainable support in urban environments.

Cash allows families to meet self-identified priorities, as well as giving choice and dignity. There are both benefits and risks to this programming approach (see Box 2). Conditional cash, which seems to offer a more straightforward transition from traditional sector-based humanitarian responses, has drawbacks in terms of stigma, discrimination by vendors, and pricing issues (taxation and artificial control of market dynamics). At the same time, unconditional cash raises concerns about agencies’ loss of control / diversion of assistance, compromising nutrition, and creating dependency. There has been a lack of technical nutrition rigour in informing cash programming design and evaluation and implications of this on urban refugees in the Syria crisis response. This will require renewed focus in future responses.

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The Danish Refugee Council distributes food, hygiene kits, baby kits, blankets and cooking sets to refugees from Syria

Danish Refugee Council

Experiences of the e-Food card programme in the Turkish refugee camps



WFP/Jane Howard, Hatay Region, Turkey, 2013

By Kathleen Inglis and Jennifer Vargas



Kathleen Inglis currently works with the WFP as the Programme Communications Officer. She has worked in humanitarian aid in various capacities from communications to logistics and information management in protracted emergencies including Sudan, Ethiopia, Afghanistan, Pakistan and DRC.



Jennifer Vargas currently works with the WFP in Turkey as the Information Management/ Reports Officer. She has studied the region and refugee crises extensively and this marks her first foray into the humanitarian community.

Overview

The Government of Turkey has generally maintained an open-border policy with Syria since the first Syrian refugees began crossing the border in April 2011. Three years later, Turkey hosts more than 900,000 Syrian ‘guests’ - 220,000 live in 22 camps and approximately 700,000 in urban centres. These estimates are considered conservative as registration continues and by the end of 2014, the Government expects the total number of Syrians refugees will reach 1.5 million. Prominent news sources, such as the New York Times, Reuters-Huffington Post, have expressed concerns about the livelihood of Syrians residing outside of camps; food security, shelter and education were among the most basic unmet necessities mentioned. Thus far, provision of food assistance to off camp populations is limited to small scale interventions within non-governmental organisations’ (NGOs) area of operations. In the coming months, WFP plans to offer technical assistance to the Government to conduct a needs assessment and

develop an appropriate modality for the sustainable provision of food assistance to most vulnerable populations outside of camps.

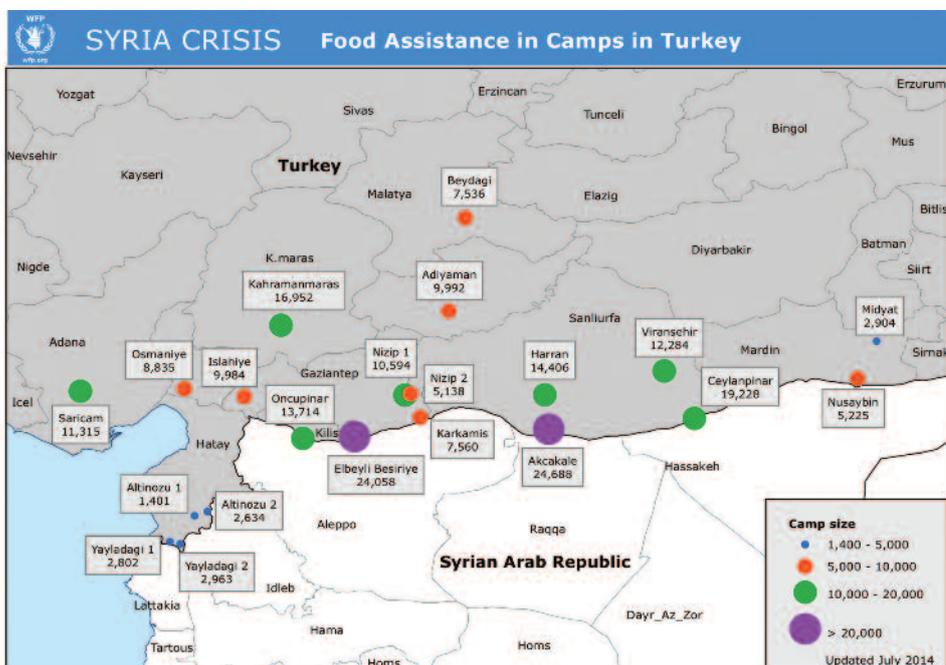
The international community has often lauded the Turkish Government for its generous response to the crisis. The Government of Turkey estimates that its provision of aid has surpassed US\$3.5 billion, while the international community has thus far provided some US\$150 million in assistance for Syrian refugees in Turkey. The camps, moreover, have received considerable recognition for the quality of shelter and service provision for the refugees. The Prime Ministry’s Disaster and Emergency Management Presidency (AFAD) is responsible for the management of all camps across ten governorates. The World Food Programme (WFP), in partnership with the Turkish Red Crescent (TRC, known as KIZILAY), has worked extensively with AFAD to provide food assistance to all civilian camp populations.

Electronic food card programme: how it works

The WFP/KIZILAY Electronic Food (e-Food) Card Programme was officially launched in October 2012 to provide food assistance to 12,000 beneficiaries in Kilis camp. The programme was envisioned as an efficient and innovative way of supporting families in camps to purchase diverse and nutritious food items of their own choosing with an e-card. The total amount of assistance for the household is electronically loaded onto the e-Food Card in two separate instalments per month. At the end of the month, the balance remaining on the card, if any, is cleared and returned to the WFP/KIZILAY e-Food Card Programme account. An updated list of family members still residing in the camp is provided by AFAD on a monthly basis and the amount uploaded to the card for the month is adjusted accordingly. To use the card, the persons undertaking the shopping must present their camp ID card at participating markets and the container or tent number/family number must match that printed on the e-Food Card. The e-Food Card only works in the terminals of shops selected by WFP, KIZILAY and the Government; this allows for oversight and monitoring, ensuring that sufficient quantities of various nutritious and fresh food products are available for purchase by households at competitive market prices. The entitlement can be redeemed in camp shops or shops located in nearby urban centres. All shops are under contract with KIZILAY and monitored to ensure compliance with programme regulations and highest standards of quality.

Moving from in-kind food assistance to a market-based approach

Prior to the introduction of the WFP/KIZILAY e-Food Card Programme, the government authorities were the sole entities responsible for providing food assistance and the modality varied from camp to camp. In the last week of July 2012 (when WFP and AFAD conducted the initial voucher feasibility assessment), half



First home-cooked meal since arriving in Turkey: Nazari household

On the first day of launching the e-Food Card Programme in Nizip II camp in April, 2013, WFP staff spoke with the Nazari household to learn what the family's first fresh cooked meal would be since fleeing their home in Syria several months before. The father was preparing a Syrian dish, "Sinyat Khidhar", made from fresh eggplant, tomatoes and onions with a mix of spices to serve to his mother, his wife (who had recently given birth in the camp) and their three young children. He told WFP staff, "I enjoy making the food for my family with my own

hands. The children can taste the things we used to eat in our homeland thanks to the e-Food Card Programme." Families enjoy the social norms of shopping and cooking for themselves and the camp managers have reported less food waste compared to the days of hot meal provision, as well as less stress for camp staff and the beneficiary families. The e-Food Card has also encouraged gardening and establishment of bread-baking facilities where infrastructure and resources permit.



WFP and TRC looking to contract more shops outside the camps to foster greater market competition

of the registered population (43,679) received daily cooked meals and the other half received parcels of dry food every two weeks and fresh food on a weekly basis. The composition of meals and food parcels was highly diversified and often exceeded the internationally agreed standards on daily dietary intake of 2,100 kilocalories, which is sufficient to meet the nutritional needs of disaster affected populations. As an example, the daily caloric content of cooked meals in one of the camps in Hatay ranged between 3,000 and 5,000 kilocalories per person per day and the content of dry and fresh food parcels ranged between 26 to 45 items. Likewise, the cost of assistance greatly differed across the camps, with the monthly cost for cooked meals ranging from US\$147 to US\$170 per person. These figures reflect the generous and first-rate response by the Government and local authorities, while at the same time raise questions regarding the sustainability of the services provided. At the time, it was expected that Syrians would return to their respective homes within a reasonable period of time. More than three years after the onset of the crisis that shows no signs of abating, demands, duration and scale of programming have increased, as well as the need for innovative and effective responses.

By April 2012, as the crisis continued to worsen and unanticipated numbers of Syrians kept crossing over the border, the Government of Turkey agreed to a 'burden-sharing' proposal with the international community. In August 2012, at the behest of the Turkish Government, WFP met with AFAD to discuss the possibility of providing complementary food assistance using voucher-based transfers, an approach recommended by WFP's voucher feasibility study. This proposal was well received by the government and was included in the United Nations Regional Response Plan. In consultation with AFAD, the Deputy Directorate General for International Political Organisations within the Ministry of Foreign Affairs and KIZILAY, it was agreed to implement a gradual strategy to transition from in-kind food assistance to a market-based approach with the provision of vouchers.

Finding the best solution based on context

Within the context of Turkey, that of a middle-income, emerging market economy with strong national capacity and pre-existing emergency-

response mechanisms, the role of international organisations shifted from solely providing humanitarian assistance (monetary or otherwise) to providing innovative programming that works in conjunction with existing national resources and capabilities. The launch of the WFP/KIZILAY e-Food Card Programme in Turkey was the first instance of an electronic voucher system being used at the outset of an emergency response. Simply put, it was the right tool, at the right time, in the right place and was only possible because of existing infrastructure and context:

- Interactions between international organisations, non-governmental organisations (NGOs), and the Government of Turkey were more synergistic than would normally take place in less developed nations; the government supported and facilitated the programme and transition process.
- AFAD-established and managed camps and provided beneficiaries with cooking facilities, electricity and commercial food markets located within the camps.
- The agriculture and the commercial food-sector in Turkey is strong: the country is among the world's leading producers of agricultural products and Turkey has been self-sufficient in food production since the 1980s.
- The electronic banking system in-country is established and robust.
- The use of vouchers both as a national welfare and safety-net mechanisms for vulnerable Turkish populations, and by commercial entities providing meals for employees, existed in Turkey prior to the Syrian crisis.
- KIZILAY's 150 years of experience in emergency response offered WFP a reputable and highly capable partner with a field presence in all of the camps. (KIZILAY is the largest humanitarian organisation in Turkey and is part of the International Red Cross and Red Crescent Movement. The organisation was founded under the Ottoman Empire on 11 June, 1868).
- Donors recognised the added value of the tri-partite partnership between WFP, KIZILAY and AFAD, which enabled significant contributions to be channelled through a UN agency to ease the burden of the Syrian crisis response on the Turkish Government and people.

The comparative advantage of the WFP/KIZILAY programme rests in the level of expertise both WFP offers in e-voucher programming and KIZILAY offers in emergency response, in Turkey and abroad. WFP's vast experience with cash and voucher programmes (C&V) and food security ensures that standard operating procedures were established at the onset of the Syrian response in Turkey, which facilitated programme transparency, beneficiary participation and donor confidence. KIZILAY had a wealth of experience in emergency and development work at home and abroad.

For instance, KIZILAY had developed its electronic card in mid-2012 for a pilot programme to assist social vulnerable groups in Turkey, which made it the tool of choice. It was further adapted and used in the e-food Card Programme, thereby greatly reducing lead time required for establishing agreements with financial institutions and designing and testing the practical functioning of a market based welfare system.

Merits of the market based approach

The programme has proven highly successful in terms of beneficiary satisfaction, effective use of limited resources and investment in the local economy. Over 90 percent of interviewed beneficiaries prefer the e-Food Card to hot meal provision. With regard to efficiency, the programme allows for over 70 percent savings when compared to the provision of hot meals, also eliminating food waste that inevitably occurs at distributions. The programme directly impacts local communities as beneficiaries use the entirety of their food entitlement at shops that are owned, managed and supplied by local retailers. AFAD was responsible for the establishment of commercial markets located inside camps. However, in the Hatay region where camps are located close to urban centres, WFP and KIZILAY identified, assessed and contracted existing commercial food markets located outside of camps to participate in the programme. The e-Food Card Programme served as a model for WFP's rollout of electronic vouchers in Jordan and Lebanon and for the AFAD card which is operational in all camps in Turkey.

Step by step expansion

By July 2013, the programme had rapidly expanded to cover 115,000 beneficiaries living in camps in ten provinces. At this stage, owing to WFP funding constraints, expansion plans were

This family bakery began baking Arabic flat bread to cater to the taste of the Syrian refugees, and they now also deliver to the camps.

Photo: WFP/Jane Howard



arrested and the programme capped to serving only fourteen of the 22 existing camps. Each beneficiary received 80 Turkish liras per month (approximately US\$40) loaded onto their family's e-Food Card that could be used in participating markets. AFAD continued to deliver food assistance in the eight remaining camps not covered by WFP and KIZILAY, either through provision of hot meals or in late 2013, through the newly launched AFAD E-Card programme – based on the WFP/KIZILAY programme model – that was also being utilised in some camps.

In response to the primary challenge of inadequate funding which constrained programme expansion throughout 2013, the Government of Turkey proposed to WFP a cost-sharing arrangement for the provision of the food ration for Syrians in all camps. Here, the WFP/KIZILAY contribution to food assistance would reduce from 80 to 60 Turkish liras (US\$30) and AFAD would supplement this with an amount of 20 Turkish liras (US\$10) per beneficiary per month onto the AFAD e-Card for food purchases and 5TL for non-food items also complemented by in-kind donations. By June, 2014, this tripartite arrangement has been implemented in all 21 camps where the Government requested WFP assistance, accounting for food security to over 217,000 beneficiaries in 45,000 households, who shop at a total of 58 shops. The monthly transfer

Emmanuel Safari – staff profile

WFP is the largest humanitarian agency in the world and as such, draws personnel and expertise from all corners of the globe. The first Cash & Voucher (C&V) programme officer sent to Gaziantep in south-eastern Turkey is a tall man from Rwanda named Emmanuel Safari. Emmanuel has extensive experience with the implementation of C&V programming in many countries including in Rwanda, Haiti, Egypt, Tunisia, Lebanon and Mali. Inquisitive residents of Gaziantep constantly stopped this unusual and friendly visitor to exchange a few words with him and, when bold, to request a photo with him! Safari's first impressions of the government assistance to its Syrian guests were about how much was being done and the incredible hospitality and generosity of the Turkish people.

to beneficiaries is US\$6.6 million which is directly spent in markets and, therefore, directly invested into the local economy.

Monitoring and evaluation activities

WFP has a robust monitoring and evaluation (M&E) and reporting programme in place; field monitoring staff (FMS) work in coordination with KIZILAY field staff to ensure markets have a wide variety of quality products for sale at market-value prices in hygienic and secure locations. Monitoring tools include: a post distribution monitoring questionnaire (PDM) to be applied at the household level, an onsite monitoring checklist (OSM) to be filled by monitors when visiting participating shops, and a beneficiary contact monitoring questionnaire (BCM) applied to beneficiaries coming out of these shops. Additionally, Price Market Monitoring (PMM) is conducted on a monthly basis in the contracted shops where e-Food Card Programme beneficiaries redeem their e-vouchers, as well as in non-participating city shops.

WFP monitoring findings indicate that the majority of programme beneficiaries have been living in camps for a relatively long period: 51 percent arrived over a year ago, another 42 percent arrived 7 to 12 months ago, and recent arrivals (less than 6 months) only represent 7 percent of the total in-camp population. The average size of a household is six members. Beneficiary heads of households in Turkey are, in 90 percent of cases, married and ten percent are single or widowed. Thirty-five percent of households are headed by females while only seven percent of households are headed by the elderly. Most of the interviewed families have children under five years of age and interviews revealed that for every working-age person who has the physical possibility of generating income, there are two dependents, which demonstrates a high level of socio-economic vulnerability.

Despite the constant monitoring activities of WFP and KIZILAY, and in almost all camps by market monitoring committees, high prices in contracted shops continue to pose challenges. WFP and KIZILAY monitors continue to advocate with all stakeholders for fair market prices in all participating markets. Rampant drought has been one contributing factor to price in-

creases. Turkey has been dealing with a drought that began at the end of 2013 and is causing major difficulties for agricultural producers. The drought, in conjunction with high temperatures, has severely decreased the yield of various nuts, fruits, vegetables and grains. The wheat harvest has decreased by at least 21 percent from 2013 and Turkey will be required to import wheat to meet demand. Economists predict that the drought will continue to raise the prices of food and keep affecting consumers throughout 2014. The drought has decreased water reserves and affected energy production, thus increasing the price of electricity throughout the country as well. Other compounding factors include fluctuations in the value of the Turkish lira, decreased food supply as well as the creation of monopolies in camps with very few participating shops. As a response to the monopoly issue in particular, WFP and KIZILAY with the encouragement of AFAD are now actively looking to contract more shops outside the camps to foster greater market competition and to encourage the provision of high quality commodities and services at lower prices to beneficiaries. Beneficiaries generally attain high levels of dietary diversity; they can purchase basic items for the nutritious diet established in the food basket. The high cost of infant formula, however, has been a continuing challenge, compounded by the fact that a large majority of mothers do not breastfeed past six months.

Sustainability of operation – funding and shortfalls

Looking forward, the mid-year review of the Regional Response Plan 6 (July- December 2014) stipulates that around 250,000-300,000 people will need food assistance in the next six months and WFP will require US\$58 million. Currently, WFP Turkey reaches 225,000 people per month and requires US\$8 million to do so; the operation faces a pipeline break approximately every six weeks. WFP is funded entirely by voluntary contributions and remains vigilant and engaged with donors in order to secure the funds.

Emmanuel Safari – staff profile

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A day in the life of a WFP field monitor working in the Syrian refugee camps in south-eastern Turkey

By Afaf Shasha



Afaf Shasha is Field Monitor Assistant at the World Food Programme (WFP). She holds an MA from the Department of International Relations at Bilkent University, Turkey. She has a strong continuing interest in human rights and conflict resolution and an equally strong desire to see progress towards a sustainable global peace.



Women doing their own shopping using WFP/TRC electronic food vouchers

WFP/Salah Malikawi

As a WFP field monitor, my job is to assess the food security situation in the camps for Syrian refugees specifically in the Hatay region. We need to know if they are getting the food they need and if their children are receiving the appropriate nutrition and how we can improve their access to food. That requires me to spend many hours in these camps mixing with refugees in their tents, which greatly contrasts to what I have done in my previous jobs. For years, I worked in a luxurious office with a multinational company but today as I stand in the camps, with displaced people forced out of their homes and living in tents waiting to hear of any news from home, I cannot help but draw comparisons between the two lives. In contrast to business meetings in fancy conference rooms in comfortable surroundings, I am now in the field inside the refugee camps, working with the most vulnerable displaced people and I do feel that I have lived two lives, which represent two different realities that are difficult to imagine existing in the same era of history.

At the camps, officially designated in Turkey as “guest tent cities,” the first scene is the crowd of children, who make up almost half of the camp’s population, playing on the ground, looking after their younger siblings or just out of their classes and running to us to practice the new Turkish words they have learnt. I speak with newly arrived 12-year old twins, Hasan & Hussain, one tall with fair skin and the other short with darker skin. They are sitting in their tent with their parents, eating oil and zaatar for breakfast. A 10-year old girl with beautiful grey eyes, Razan, wants to become an architect so she can build her own house. She does not enjoy living in tents and she is an orphan. I have also spoken with several 18 year old young

men who ran away from Syria, fleeing military service so they could continue their education.

Many of the girls and women, from under the age of 18 to over 40, are pregnant. Some of the mothers have a dozen or more children and even in their mid-thirties, some are grandmothers. Of course, health care and nutrition are their main needs.

Chatting with women carrying their babies while shopping, I check on how they breastfeed and how many times the baby receives milk per day. Some women mention how keen they are on breastfeeding at least until the sixth month. Others say that due to the stress and lack of sufficient food, they lack breastmilk and totally depend on infant formula and complain of its prohibitively high price.

The most gratifying scene, in my opinion, is seeing women doing their own shopping using WFP/TRC electronic food vouchers. WFP often uses vouchers to provide assistance in all camps in Turkey. It provides people with more choice and they can buy fresh food such as fruit, vegetables and milk that are not normally included in conventional food rations.

Vouchers also inject money into the local economies of host countries and help refugees develop financial awareness and planning. It encourages better management of the food budget.

Some of my tasks such as monitoring the families after they have received and redeemed their food vouchers are not easy. It requires special effort with the people who may not feel relaxed or confident enough to answer questionnaires because some of the refugees feel that any candid response could have negative impacts on the assistance that they receive. We, as field monitors, have to explain the purpose of providing

feedback on food availability in the market and if the family members are receiving the nutritious food that their bodies need.

The most challenging question that we ask Syrian refugees is what is the list of the foods they ate in the previous week, but the answers are crucial data for WFP evaluations of the nutritional status in the camp.

When asking them if they are eating differently from what they used to eat in Syria, the ‘guests’ often mention that can rarely eat their favorite foods. The vast majority – if not all – are very satisfied with the e-food card which allows them to buy the type of food of their own choosing. While grateful, beneficiaries do not like the provision of hot meals (used at the beginning of the crisis), since the food, did not for the most part, suit their taste. Bread is important in their diet. Large extended families with many adults consume lots of bread and as this item is not so cheap, it can be hard to meet their demands but the families are thankful to whoever supports them.

Refugees in many cases are just happy to chat with an Arabic speaker to share their feelings and worries; some get very homesick, while others seem to have adapted to camp life. Every number that makes up the statistics on Syrian refugees is actually a life story for a WFP monitor, for someone whom we might meet and talk to on a daily basis. As WFP field monitors, our role is to check on how balanced their diet and nutrition consumption is, while at the contracted market, we inspect the prices, and the proper quality, variety and validity of sold items to ensure equal accessibility for all the Syrian beneficiaries.

Being a displaced person is painful but we do the best we can to make life more comfortable for Turkey’s Syrian ‘guests’.

Iraq



Marco Frattini/WFP, Iraq, 2013

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Syrians in Iraq: Refugee response within a major humanitarian and political crisis

WFP/Abeer Etefa

By Lynn Yoshikawa



Lynn Yoshikawa is an analyst with the Syria Needs Analysis Project (SNAP) based in Amman, Jordan. She has worked

in the humanitarian sector for over 10 years in Afghanistan, Southeast Asia, the Middle East and in headquarters, primarily focused on policy research.

About the Syria Needs Analysis Project (SNAP): ACAPS and MapAction established SNAP in January 2013, a project aimed at supporting the humanitarian response in Syria and neighbouring countries by providing an independent analysis of the humanitarian situation of those affected by the Syrian crisis. ACAPS (Assessment Capacities Project, www.acaps.org) is dedicated to improving assessments of humanitarian needs in complex emergencies and crisis through the provision of context-specific information and analysis. MapAction (www.mapaction.org) is an international NGO whose mission is to assist responders to humanitarian emergencies by providing mapped information and other information management services that enable rapid situational assessment and decision making.

This article was completed in early October 2014.

With about 215,000 Syrian refugees¹ or less than 7% of the total registered number of Syrian refugees in the region, Iraq hosts the smallest number of Syrian refugees. Iraq has generally welcomed these refugees in ethnic solidarity to the semi-autonomous Kurdistan Region of Iraq (KR-I), where the vast majority of Syrians reside. Partly as a result of this as well as due to the unique complexities of operating in the KR-I, the international response to the Iraq refugee influx has been somewhat neglected compared to other neighbouring countries in the region. However, the June offensive by the Islamic State (formerly known as the Islamic State of Iraq and the Levant, ISIL) and various Iraqi groups have put the war-torn country back into the spotlight and re-ignited sectarian violence, as well as fears across the region. As the latest wave of conflict and displacement in Iraq takes its toll, – threatening to break Iraq apart and further fuel the conflict in Syria – the humanitarian response will be further challenged by deepening insecurity, uneasy acceptance of aid agencies by parties to the conflict and complex geopolitical interests.

Since the Syria Needs Analysis Project (SNAP) began remotely analysing the Syrian refugee situation in Iraq, as well as other host countries in the region, in January 2013, a lack of information and shared assessments on the unfolding situation was evident (for more on SNAP's work, (see page 156). Despite the relatively low number of NGOs operating in the area, the humanitarian situation appeared largely under control, with the authorities of the KR-I taking the lead and investing an estimated USD 120 million² in the construction of camps and the provision of water and other services. While Syrian refugees, who were largely of Kurdish origin, were initially welcomed by the local population in 2012, the KR-I authorities be-

came increasingly concerned with the impact on its security and booming economy, and closed the border in May 2013.³ In central Iraq, where the situation was more volatile, the border crossings had been closed in 2012, but about 9,000 Syrians,⁴ primarily from Deir-ez-Zor governorate, had fled to Iraq and were hosted in a camp and urban areas around the border town of Al-Qa'im. Due to its remote location and insecurity, only a handful of agencies worked in the area and since the Islamic State takeover in June, access has been virtually impossible.

As the conflict escalated in 2013, particularly in Aleppo and Damascus where a number of Kurdish communities reside as well as between Kurdish and opposition armed groups in eastern Syria in mid-2013, IDPs began to congregate on the Iraq-Syria border. As humanitarian conditions deteriorated, the KR-I authorities opened the border in late August, leading to an influx of 60,000 Syrians in one month. The KR-I and aid agencies were overwhelmed by the influx but managed to stabilise the population and establish new camps. In the subsequent weeks and months, the border crossings were again closed and dozens of new international aid agencies also arrived in the KR-I to help with the response. While new funding was made available for the refugee influx, aid levels levelled off in early 2014 even though the refugee population had swelled nearly threefold in the past year. Although some NGOs considered longer-term pro-

¹ UNHCR Refugee Response Portal, accessed 8 October 2014.

² Amnesty International, 3 January 2014. <http://livewire.amnesty.org/2014/01/03/life-getting-harder-for-syrian-refugees-in-iraqi-kurdistan/>

³ UNHCR, 16 December 2013. <http://www.unhcr.org/syriarrp6/docs/syria-rrp6-iraq-response-plan.pdf#B>

⁴ UNHCR Refugee Response Portal, accessed 13 July 2014. <http://data.unhcr.org/syrianrefugees/settlement.php?id=178&country=103®ion=85>

gramming for refugees,⁵ there was little traction among local authorities for this type of programming, leading to a number of aid agencies deciding to scale down either due to the lack of funds or other implementation challenges.

SNAP missions to Iraq found the operational environment in the KR-I to be much more complex than hitherto understood. While the environment in the KR-I is relatively 'unrestricted' and secure, compared to non-Kurdish areas of Iraq and other host countries, the context poses additional challenges not experienced in other countries. First and foremost, while all neighbouring countries have influenced and been influenced by the Syrian conflict, Iraq's internal divisions and regional allies bring an additional layer of geopolitical interests resulting from the deepening split between Sunni and Shia populations since the 2003 US-led invasion, the increasing autonomy of the KR-I from the central Iraq government, and Turkey and Iran's interests with the KR-I in relation to their respective Kurdish populations. In relation to Syria, the situation is further complicated by the fact that Kurdish areas in eastern Syria are administered by a Kurdish political party, which has a historically intense rivalry with the dominant political party currently in power in the KR-I.

Secondly, while the KR-I appears to be one cohesive entity and is often treated as such by the aid community, the reality is that its governance and administration structures are highly de-centralised and each governorate has its own set of policies regarding Syrian refugees. For example, Dohuk governorate, which hosts the lion's share of Syrian refugees within Iraq, has been issuing residency permits to both camp-based and urban refugees, while Erbil and Sulaymaniyah governorates have generally adopted a more restrictive position towards Syrians, and had largely stopped providing residency permits to urban refugees since in early 2013 in a bid to persuade them to move to camps. In addition to providing legal status to rent homes, residency permits also allow the holder to work legally, hence, they are sought after by refugees, both in and outside of camps. Since mid-2014, UNHCR succeeded in all three KR-I governorate to agree to a common policy on residence permits and fast tracking permits for Syrian registered with UNHCR, although some minor administrative issues persist.

Despite its oil wealth and semi-autonomous status, the KR-I remains dependent on Baghdad to access revenues from oil resources. This arrangement is further complicated by various political disputes regarding the sharing of oil wealth and territories claimed by both Baghdad and the KR-I. Despite these long-standing disputes, Iraq's political leadership has also been politically dependent on the Kurds in order to form a coalition government. In late 2013, KR-I made a deal to export some of its oil out through Turkey, a move Baghdad claimed was illegal, as revenues did not go through the central government. As a result, Baghdad cut off budget payments to the KR-I in March, leading to

delayed salary payments of many civil servants.⁶ The KR-I's budget crisis also affected the government's ability to maintain the camps, which it had established and maintained, with teachers and health workers reporting significant delays in the payment of salaries. New camp facilities, such as schools, had been built but were unable to start classes due to lack of KR-I financing to hire teachers.⁷

The KR-I authorities have expressed their wish for Syrian refugees to reside in one of the eight established camps. As a result, the needs of urban refugees have been neglected and little comprehensive information on their status was known until a recent needs assessment was undertaken by REACH. According to UNHCR registration figures, just over 40% of Syrian refugees are residing in camps in KR-I. In the largest Syrian refugee camp, Domiz, food aid was being distributed for over 75,000 people in March, however, verification efforts have revealed that more than 20,000 beneficiaries were actually residing outside the camp and have now been taken off of beneficiary lists.⁸ To date, UN agencies have primarily targeting refugees residing in camps with little official UN assistance going to urban refugees. In late 2013, local authorities in Erbil instructed aid agencies not to provide non-food items, cash or shelter assistance to Syrian refugees outside of the camps, even during the winter.⁹ Similarly, Dohuk authorities did not currently permit NGOs to provide cash assistance or gender-based violence programming for non-camp refugees. While there has been some room for manoeuvre for aid agencies to negotiate with local authorities, the restrictions have largely discouraged UN agencies from significant expansion of aid activities into urban areas.

The fall of Mosul to the Islamic State and armed Sunni groups in June, followed by offensives on a number of towns in northern Iraq and along the Syrian border has led to a massive humanitarian crisis and dramatic consequences for the whole region. The conflict led to the displacement of over 1.25 million people between June and October, according to IOM,¹⁰ with some Iraqis even fleeing across the border to Syria and thousands more to Turkey and Jordan. Minorities, particularly, Yazidis and Christians, have been severely persecuted and subjected to summary executions, siege tactics, and gender-based violence. Millions more have been affected by violence and shortages of food, water and fuel. Most IDPs originated and fled within the northern governorates of Ninewa and Salah Al-Din, but over 700,000 reportedly entered the KR-I and thousands more to disputed territories which are now largely under Kurdish control. The IDP influx to the KR-I has overwhelmed the limited and generally weak public services available, diverted attention from the Syrian refugee response, and heightened tensions. These factors have contributed to at least 10,000 refugees returning to Syria in recent months, despite increasing insecurity and limited access to aid in areas of return. This latest displacement comes on top of the Syrian refugee influx; over half a million displaced from Anbar

governorate this year, about one million IDPs and returning refugees and about 100,000 stateless people. While there are common drivers of conflict fuelling one another in both Syria and Iraq, Iraq's humanitarian crisis presents a formidable challenge in its own right and should not be conceived of as simply an 'appendage' to the current Syrian crisis.

To date, the international humanitarian community has gained limited acceptance by the Islamic State, both in Syria and in Iraq, and when access has been established, aid agencies are subject to strict conditions. Western donors are concerned that aid could be diverted to groups labelled as terrorists and counterterrorism-related restrictions may further impede humanitarian access to those in need. The legacy of remote management of humanitarian operations in Iraq (which began in the 1990s) persists and will continue to hamper an expanded presence of humanitarian organisations, as well as their ability to monitor needs and account for aid. While Saudi Arabia contributed USD 500 million to UN agencies for the Iraq crisis,¹¹ thereby addressing ongoing concerns about lack of funding from western donors, attention and funding will inevitably decline, and the Iraqi government must take responsibility for the protection and well-being of its people. In the past efforts to ensure that these responsibilities are transferred to, and undertaken by, Iraqi authorities failed as witnessed in the post-Saddam Hussein era.

SNAP's aim has been to build a common situational awareness of the humanitarian situation in Iraq to inform decision makers. However, the unfolding crises in Iraq have made this task infinitely more complex. The response and co-ordination architecture has become fragmented between those responding to the IDP crisis through the cluster system and those operating in through UNHCR's refugee response coordination mechanisms. Donors also mirror the fragmentation with different funding mechanisms for refugees and those affected by Iraq's internal crisis. With over one million Iraqis displaced this year alone, it will be increasingly difficult to maintain and work through these bureaucratic and institutional divisions and prioritise funding according to the assessed humanitarian needs. The process of mainstreaming the response and coordination remains unclear, but SNAP established a presence in Erbil in August to support decision makers with independent analysis of this highly complex crisis in order to inform the difficult decisions which lie ahead.

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⁵ NGO interviews, Erbil, 5-9 May 2014

⁶ Wall Street Journal, 23 May 2014. <http://online.wsj.com/>

⁷ UNHCR, 6 May 2014. http://reliefweb.int/sites/reliefweb.int/files/resources/UNHCR-Iraq_Syrian_Update_1-15_Apr_14_2.pdf UNHCR, 13 April 2014.

<http://data.unhcr.org/syrianrefugees/download.php?id=5256>

⁸ World Food Programme, 24 March 2014. <http://reliefweb.int>

⁹ NGO interviews, 5-9 May 2014.

¹⁰ Displacement Tracking Matrix, IOM, 3 October 2014.

¹¹ New York Times, 1 July 2014.

Regional



Syrian refugees in Jordan; UNHCR/J. Kohler/February 2014

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International legal consequences of the conflict in Syria



A young girl and her mother in Idlib Governorate

UNICEF/NYHQ2013-06989/Diffident

By Natasha Harrington



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A. Introduction

The term “humanitarian catastrophe” has particularly profound meaning in relation to the situation in Syria. After three years of civil war, over 150,000 people are estimated to have been killed and more than 2.5 million Syrians (over 10% of the population) have fled to neighbouring countries. In addition, at least 9.3 million Syrians inside Syria are in need of humanitarian assistance, over 6.5 million of whom are internally displaced.²

The existence of a “humanitarian catastrophe” is a trigger point for action under certain doctrines of international law. For example, the Responsibility to Protect (or R2P) doctrine recognises an obligation on the international community to prevent and react to humanitarian catastrophes. Certain international lawyers and States, including the UK, also argue that under international law it is permissible to take exceptional measures, including military intervention in a State, in order to avert a humanitarian catastrophe (hereafter referred to as “humanitarian military intervention”).³

This article examines the legal consequences of the humanitarian crisis in Syria. It addresses:

- the serious breaches of international humanitarian law and international human rights law committed by the parties to the conflict (Section B)

- the responsibility of the international community to react to the crisis in Syria, and in particular, the “Responsibility to Protect” (Section C), and
- the scope, under international law, for intervention in Syria by third States without UN Security Council authorization (Section D).

B. Breaches of International Law during the Conflict in Syria

Documenting all of the violations of international law carried out during the Syrian conflict would be an immense task, one that perhaps only the International Criminal Court (ICC) or a specialist tribunal could attempt (see below). Therefore, this section highlights just some of the most grievous violations of the rules of international law carried out by the parties to the conflict in Syria.

Applicable Legal Rules

The rules of international humanitarian law apply to the conflict in Syria because it is a non-international armed conflict: an intense conflict between a government and a number of well-organised rebel groups. In addition to international humanitarian law, international human rights law continues to apply in Syria.⁴ For example, Syria is a party to the International Convention on Civil and Political Rights (the ICCPR) and the Convention Against Torture.

Violations of International Law by the Parties to the Conflict in Syria

- Protection of civilians and distinction:* the parties to the conflict must not attack civilians, and must always distinguish between civilians and combatants and civilian objects and military targets. The

¹ Advocates for International Development (A4ID) is a charity that helps the legal sector to meet its global corporate social responsibility to bring about world development. It provides a pro bono broker and legal education services to connect legal expertise with development agencies worldwide in need of legal expertise.

² Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 22 May 2014, UN Doc. S/2014/365, para. 17.

³ See Response to Questions from the House of Commons Foreign Affairs Committee, Humanitarian Intervention and the Responsibility to Protect, 14 January 2014. Available at: <http://justsecurity.org/wp-content/uploads/2014/01/Letter->

[from-UK-Foreign-Commonwealth-Office-to-the-House-of-Commons-Foreign-Affairs-Committee-on-Humanitarian-Intervention-and-the-Responsibility-to-Protect.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284847/20140114_Humanitarian-Intervention-and-the-Responsibility-to-Protect.pdf) (last accessed on 23 May 2014).

⁴ The International Court of Justice considered the relationship between international humanitarian law and international human rights law in *Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory*, Advisory Opinion, I.C.J. Reports 2004, p. 136, at p. 178, para. 106. The UN Security Council called on both the Syrian authorities and armed groups to cease all violations of human rights in Security Council Resolution 2139, para. 2.

parties to the conflict must not undertake “indiscriminate attacks”, which by their nature strike civilians and military objectives without distinction.

This rule has been repeatedly violated by both sides to the conflict. In particular, the use by government forces of barrel bombs in civilian areas violates the rule of distinction. In May 2014, the UN Secretary-General reported that:

*“Indiscriminate aerial strikes and shelling by Government forces resulted in deaths, injuries and large-scale displacement of civilians, while armed opposition groups also continued indiscriminate shelling and the use of car bombs in populated civilian areas.”*⁵

- (2) *Torture and inhuman treatment*: the use of torture is absolutely prohibited, and cannot be justified by a state of emergency or war.⁶

An Independent International Commission of Inquiry for Syria (the Commission of Inquiry), set up by the UN Human Rights Council, has found evidence of the widespread use of torture, as well as incidents of starvation and sexual violence, in government detention facilities.⁷ Recently, certain rebel groups such as the Islamic State of Iraq and al-Sham⁸ (ISIS) are reported to have increased their use of torture against civilians.⁹

- (3) *Prohibition against the use of starvation of the civilian population as a method of warfare: the use of starvation against the civilian population is absolutely prohibited*. This means that, for example, during a siege civilians must be able to leave, and food and humanitarian supplies must be allowed access to, the besieged area. The Commission of Inquiry has noted reports of starvation in areas besieged by the Syrian authorities, such as Yarmouk.¹⁰ Human rights groups have accused the Syrian government of using starvation as a weapon of war.¹¹

- (4) *Prohibition against the use of chemical and biological weapons: the use of chemical and biological weapons in armed conflict is*

also strictly forbidden under international law. However, a chemical weapons attack on 21 August 2013 reportedly killed hundreds of people. A recent UN report on the situation in Syria also contained information about the use of toxic gas.¹²

- (5) *Protection of humanitarian relief personnel and medical personnel and facilities: the parties to the conflict must protect and respect humanitarian relief and medical personnel. Medical facilities must be protected and must not be attacked.*
- (6) In September 2013, a group of doctors published an open letter in *The Lancet* in which they cited “*systematic assaults on medical professionals, facilities and patients...making it nearly impossible for civilians to receive essential medical services*”.¹³ Some health facilities have been repeatedly attacked, and over 460 healthcare workers have reportedly been killed in Syria.¹⁴ UN staff and medical professionals have also been abducted or detained by the Syrian authorities and rebel groups.¹⁵
- (7) *Access to Humanitarian Relief: rapid and unimpeded access to humanitarian relief for all civilians in need, without distinction, must be ensured by the parties to the conflict.*

Both the Syrian government and rebel forces frequently interrupt access to humanitarian relief, particularly basic medical equipment.¹⁶ For example, a report by the UN Secretary-General states that:

*“Medical supplies including life-saving medicines and vaccines, and equipment for the wounded and the sick are commodities privileged through the Geneva Conventions. Denying these is arbitrary and unjustified, and a clear violation of international humanitarian law. Yet, medicines are routinely denied to those who need them, including tens of thousands of women, children and elderly. The Security Council must take action to deal with these flagrant violations of the basic principles of international law.”*¹⁷

Security Council Resolution 2139, adopted on 22 February 2014, demanded unhindered humanitarian access in Syria “across conflict lines and across borders”. Its preamble states that the arbitrary denial of humanitarian access may constitute a violation of international humanitarian law. However, the Syrian government refuses to authorise cross-border deliveries of aid through border crossing points that it does not control¹⁸, including crossing points identified as “vital” to reach over one million people in areas that are otherwise impossible to reach.¹⁹

In an open letter to the UN Secretary-General, a group of legal experts argued that if consent for relief operations is arbitrarily withheld by the Syrian authorities, then such operations may be carried out lawfully without consent.²⁰ However, the UN has not accepted this advice. It has maintained that the consent of the Syrian government is necessary for humanitarian operations, unless the UN Security Council specifically authorises such operations under Chapter VII of the UN Charter.²¹

In a recent report, the UN Secretary-General called on the Syrian government to allow cross-border aid deliveries and said that by withholding its consent, the Syrian government “*is failing in its responsibility to look after its own people*”²², invoking the language of Responsibility to Protect. Recently, it has been reported that UN diplomats are discussing a Security Council resolution that would authorise cross-border aid and threaten sanctions if the Syrian government fails to comply.²³ In the meantime, however, aid organisations that engage in unauthorised cross-border activities risk expulsion or even attack by the Syrian government.²⁴

Summary

The scale of the violations of international law committed in Syria is such that the Commission of Inquiry describes evidence “*indicating a massive number of war crimes and crimes against humanity suffered by the victims of this conflict*”.²⁵ War crimes are grave breaches of international humanitarian law, and crimes against humanity are acts such as murder, torture and sexual vio-

⁵ Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 22 May 2014, UN Doc. S/2014/365, para. 3.

⁶ Common Article 3 to the Geneva Conventions 1949; Articles 7 and 14(2) (non-derogation) of the ICCPR; and Article 2(2) of the Convention Against Torture 1984.

⁷ Independent International Commission of Inquiry on the Syrian Arab Republic, Oral Update, 18 March 2014, pp. 3-4.

⁸ Also known as the Islamic State of Iraq and Syria or the Islamic State of Iraq and the Levant.

⁹ Independent International Commission of Inquiry on the Syrian Arab Republic, Oral Update, 16 June 2014, pp. 6-7.

¹⁰ Independent International Commission of Inquiry on the Syrian Arab Republic, Oral Update, 16 June 2014, pp. 8-9; also referring to attacks on food distribution points by both government and rebel forces.

¹¹ <http://www.amnesty.org/en/news/syria-yarmouk-under-siege-horror-story-war-crimes-starvation-and-death-2014-03-10> (last accessed on 19 June 2014).

¹² Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 22 May 2014, UN Doc. S/2014/365, para. 12.

¹³ Open Letter: Let us Treat Patients in Syria, *The Lancet*, 16 September 2013; <http://www.thelancet.com/journals/lancet/>

article/PIIS0140-6736(13)61938-8/fulltext (last accessed on 26 May 2014).

¹⁴ Physicians for Human Rights calculates that Syrian government forces are responsible for 90% of 150 reported attacks on hospitals. <http://physiciansforhumanrights.org/press/press-releases/new-map-shows-government-forces-deliberately-attacking-syrias-medical-system.html> (last accessed on 26 May 2014).

¹⁵ Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 23 April 2014, para. 42. <http://www.msf.org/article/five-msf-staff-held-syria-released> (last accessed on 19 June 2014).

¹⁶ The International Independent Commission of Inquiry on Syria cites removal of essential medical and surgical supplies from aid convoys, resulting in scarcity of the most basic medical necessities such as syringes, bandages and gloves. Oral Update, 16 June 2014, p. 7, para. 46 and p. 8, para. 51.

¹⁷ Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 23 April 2014, para. 52.

¹⁸ Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 23 April 2014, para. 35.

¹⁹ Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 22 May 2014, UN Doc. S/2014/365, para. 31. If the fighting continues, there is

a risk that border-crossings with Turkey could be permanently closed, compromising the delivery of aid to approximately 9.5 million people. Syria Needs Analysis Project, Potential cross-border assistance from Turkey to Syria, April 2014. Available at: http://reliefweb.int/sites/reliefweb.int/files/resources/potential_cross_border_assistance_from_turkey_to_syria_0.pdf (last accessed on 23 May 2014).

²⁰ Open letter to the UN Secretary General, Emergency Relief Coordinator, the heads of UNICEF, WFP, UNRWA, WHO, and UNHCR, and UN Member States, 28 April 2014. Available at: <http://www.ibanet.org/Article/Detail.aspx?ArticleId=73b714fb-cb63-4ae7-bbaf-76947ab8cac6> (last accessed on 23 May 2014).

²¹ Under Chapter VII, measures to enforce decisions of the UN Security Council may be adopted.

²² Report of the Secretary-General on the Implementation of Security Council Resolution 2139 (2014), 22 May 2014, UN Doc. S/2014/365, para. 51.

²³ http://www.nytimes.com/2014/05/24/world/middleeast/un-chief-urges-aid-deliveries-to-syria-without-its-consent.html?_r=0 (last accessed on 20 June 2014).²⁴ Ibid.

²⁵ Independent International Commission of Inquiry on the Syrian Arab Republic, Oral Update, 16 June 2014, p. 2, para. 4.

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lence committed as part of a widespread and systematic attack against a civilian population.

These offences could be tried by the ICC. However, because Syria is not a member of the Court's statute, the ICC has no jurisdiction unless the situation in Syria is referred to it by the UN Security Council. A draft Security Council resolution referring the situation in Syria to the ICC was vetoed by Russia and China on 22 May 2014.²⁶

Therefore, there is a risk that war crimes and crimes against humanity will continue to be committed with impunity in Syria. In light of the gravity of the situation, we turn to examine the responsibility of the international community to respond to the crisis in Syria.

C. Responsibility of the International Community to Respond to the Situation in Syria

The R2P doctrine was developed by an International Commission on Intervention and State Sovereignty (ICISS) following the failure of the international community to prevent humanitarian catastrophes in Rwanda in 1994 and Srebrenica in 1995. R2P operates at two levels. First, the State itself is primarily responsible for protecting its own people. Second, if the State is unwilling or unable to protect its people, then the international community is responsible for doing so.

This was affirmed by the UN General Assembly in 2005 in Resolution 60/1, which stated that that *"each individual State has the responsibility to protect its populations from genocide,*

war crimes, ethnic cleansing and crimes against humanity".²⁷ UN member States also declared that *"we are prepared to take collective action, in a timely and decisive manner through the Security Council should peaceful means be inadequate and national authorities are manifestly failing to protect their populations from genocide, war crimes, ethnic cleansing and crimes against humanity"*.²⁸

However, even draft UN Security Council resolutions condemning the violence in Syria and calling for non-military sanctions have been vetoed to date. Four draft resolutions have been vetoed by Russia and China, none of which sought express authorisation for military intervention. The second draft resolution to be vetoed actually stated that *"nothing in this resolution authorizes measures under Article 42 of the Charter [i.e. military intervention]"*.²⁹

It is no coincidence that the first and only time that R2P has been invoked to justify collective military action through the Security Council against a State was in relation to Libya.³⁰ Russia and China consider that regime change in Libya went beyond the authorisation to protect civilians that was given in Security Council Resolution 1973 (2011)³¹, and are said to be extremely wary that R2P will be abused to effect regime change in the future.³²

Resolution 60/1, in which the General Assembly endorsed R2P, only refers to collective action through the Security Council, which is the UN organ with primary responsibility for international peace and security. However, the ICISS report contemplated that, if the Security

Council fails to act, the General Assembly might authorise military intervention or regional organisations might intervene with the approval of the Security Council.

The General Assembly has no express powers under the UN Charter to authorise the use of force, in contrast to the Security Council's powers under Article 42. However, in 1950 the General Assembly adopted Resolution 377(V), referred to as "Uniting for Peace". Under Resolution 377(V), if the Security Council fails to exercise its primary responsibility for the maintenance of international peace and security due to lack of unanimity amongst permanent members, the General Assembly *"shall consider the matter immediately"* and may recommend collective measures, including the use of armed force where necessary to maintain or restore international peace and security.³³

"Uniting for Peace" and R2P might provide a basis for the General Assembly to make non-binding recommendations for the use of force in Syria, providing greater legitimacy for intervention. However, while the General Assembly has passed resolutions condemning the violence in Syria³⁴, and criticising the Security Council's inaction³⁵, it has not recommended military intervention or sanctions. This is likely to be partly due to the complexity of the conflict (discussed below), and the difficulty of securing support for intervention from a majority of UN members.

Thus, the UN has been unable to enforce its own demands for an end to the violence in Syria and a political resolution to the conflict. We therefore now examine the legal scope for intervention by third States without UN Security Council authorisation.

D. The Legal Scope for Third State Military Intervention in Syria

The Debate Over the Legality of "Humanitarian Military Intervention"

The situation in Syria rekindled the debate over the legality of *"humanitarian military intervention"*. That debate was particularly intense following NATO's intervention in Kosovo in 1999, which NATO undertook without seeking prior UN Security Council authorisation.

The three main positions taken by States and commentators in relation to NATO's intervention in Kosovo have been reiterated in relation to Syria. They are summarised below:

- (1) One group built a forceful argument that "humanitarian military intervention" is un

²⁶ Provisional record of the meeting of the UN Security Council on 22 May 2014, UN Doc. S/PV.7180.7 UN General Assembly Resolution 60/1, 2005 World Summit Outcomes, para. 138. UN Doc. A/RES/60/1.

²⁸ Ibid., para. 139.

²⁹ Draft Resolution proposed by 19 States, dated 4 February 2012, UN Doc. S/2012/77.

³⁰ See Resolution 1973 (2011), UN Doc. S/RES/1973 (2011).

³¹ Resolution 1973 authorised UN Member States "to take all necessary measures...to protect civilians and civilian populated areas under threat of attack in the Libyan Arab Jamahiriya...while excluding a foreign occupation force of any form on any part of Libyan territory". UN Doc. S/RES/1973 (2011), 17 March 2011, para. 4.

³² For a summary of these concerns, see Z. Wnqi, Responsibility

to Protect: A Challenge to Chinese Traditional Diplomacy, 1 China Legal Science 97 (2013).

³³ Uniting for Peace has only been used as the basis for the UN General Assembly to recommend military intervention on one occasion, in 1951 in relation to Korea (Resolution 498(V)).

³⁴ Resolution 66/253 A (21 February 2012), UN Doc. A/RES/66/253.

³⁵ Resolution 66/253 B (7 August 2012) UN Doc. A/RES/66/253 B, preamble.

³⁶ Article 2(4) of the UN Charter provides that "All Members shall refrain in their international relations from the threat or use of force against the territorial integrity or political independence of any state, or in any other manner inconsistent with the Purposes of the United Nations." See for example, Brownlie & Apperley, Kosovo Crisis Inquiry:

Memorandum on the International Law Aspects, (2000) 49 Int'l & Comp. L.Q. 878.

³⁷ Statement of the UK's Permanent Representative to the United Nations to the Security Council on 24 March 1999, cited in Response to Questions from the House of Commons Foreign Affairs Committee, Humanitarian Intervention and the Responsibility to Protect, 14 January 2014. Available at: <http://justsecurity.org/wp-content/uploads/2014/01/Letter-from-UK-Foreign-Commonwealth-Office-to-the-House-of-Commons-Foreign-Affairs-Committee-on-Humanitarian-Intervention-and-the-Responsibility-to-Protect.pdf> (last accessed on 23 May 2014).

³⁸ See, for example, Greenwood, Humanitarian Intervention: The Case of Kosovo, 2002 Finnish Yearbook of International Law, p. 141.

lawful because it is contrary to the prohibition against the use of force under Article 2(4) of the UN Charter.³⁶ There are only two express exceptions to the prohibition against the use of force: the inherent right of individual or collective self-defence (Article 51, UN Charter); and acts authorized by the Security Council under Chapter VII of the UN Charter.

It is often argued that Article 2(4) of the UN Charter was deliberately drafted to create an absolute rule. This protects State sovereignty, and in particular, protects less powerful States from intervention by more powerful States. Permitting exceptions to the prohibition against the use of force may lead to abuse; such as regime change thinly veiled as “humanitarian” intervention.

- (2) A second group argued that military intervention in a State to prevent or avert a humanitarian catastrophe is permissible under international law. This position was taken by the UK government, which argued that “force can also be justified on the grounds of overwhelming humanitarian necessity without a UNSCR.”³⁷

Advocates of this position often argue that the protection of fundamental human rights is also vital to the purposes of the UN, as reflected in the preamble to the UN Charter. They also cite potential precedents for “humanitarian military intervention” such as Uganda, Liberia and now Kosovo.³⁸

- (3) A third group argued that although “humanitarian military intervention” was not permitted under international law as it existed in 1999, the law could or should develop a doctrine of “humanitarian military intervention”. For example, Professor Vaughan Lowe argued that it is: *“desirable that a right of humanitarian intervention...be allowed or encouraged to develop in customary international law. No-one, no State, should be driven by the abstract and artificial concepts of State sovereignty to watch innocent people being massacred, refraining from intervention because they believe themselves to have no legal right to intervene.”*³⁹

In August 2013, the USA and the UK threatened to use force against Syria. However, the threat of force was limited to “*detering and disrupting the further use of chemical weapons by the Syrian regime*”⁴⁰ (UK government position). There now seems to be little support for military intervention in Syria similar to that carried out in Kosovo or Libya.

This reluctance to engage militarily in Syria is partly due to the increasing complexity of the conflict, which would make it extremely difficult to ensure that military intervention would make the humanitarian situation better and not worse. Unfortunately, as the Syrian conflict continues the humanitarian situation for many worsens as both sides flout calls to end violations of international law, and extremist groups such as

ISIS increasingly use torture⁴¹ and disrupt the distribution of aid.⁴²

Criteria for Intervention

If “humanitarian military intervention” can ever be justified, the criteria defining the “exceptional circumstances” in which it may be invoked must be sufficiently clear and narrow to limit the risk of abuse.

The criteria justifying intervention that are often proposed usually include the following:

- an impending or actual humanitarian disaster*, involving large-scale loss of life or ethnic cleansing, which is generally recognised by the international community;
- last resort* – there must be no practicable alternatives to avert or end the humanitarian disaster; and
- necessary and proportionate use of force* – the force used must be limited in time and scope to that which is necessary and proportionate to the humanitarian need.

A further criterion, which is acutely highlighted in the Syrian crisis, is the need for military intervention to be an effective means to provide humanitarian relief. In Syria, it would be very difficult to ensure that military intervention would improve the humanitarian situation in both the short and the longer term.

More limited forms of intervention than the direct use of force in Syria may also pose problems from the perspective of international law. For example, the arming and funding of rebel forces may constitute the threat or use of force or an intervention into Syrian internal affairs.⁴³ Permanent aid corridors, as proposed by the French and Turkish governments, would be likely to necessitate military enforcement, involving the threat or use of force.

Despite the ongoing debate concerning “humanitarian military intervention” in international law, one thing is clear: humanitarian assistance itself is lawful under international law. In the words of the International Court of Justice:

*“There can be no doubt that the provision of strictly humanitarian aid to persons or forces in another country, whatever their political affiliations or objectives, cannot be regarded as unlawful intervention, or as in any other way contrary to international law.”*⁴⁴

E. Conclusion

Despite the grievous violations of international law that threaten the lives of many civilians in Syria, there is no consensus of will or legal thinking around “humanitarian military intervention”. Meanwhile, both the Syrian government and the international community appear to be failing in their responsibility to protect the Syrian people, as the conflict leaves many people cut-off from essential humanitarian assistance.

Lack of unity over “humanitarian military intervention” may appear to show the dominance of State sovereignty over human rights. The reality, as reflected in the R2P doctrine, is that

the two normally go hand-in-hand because the State should protect and promote the human rights of its people. In exceptional circumstances, there may come a point when “humanitarian military intervention” may be justified, particularly where the use of force can prevent a humanitarian disaster in which the State itself is complicit. However, to reach that point there must be a real prospect of improving and stabilising the humanitarian situation through the use of force. Sadly, if that point ever existed in the Syrian crisis, it may have long been surpassed.

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Author's note:

Since this article was written, ISIS declared a caliphate⁴⁵ on 29 June 2014 and changed its name to “Islamic State”. The United States launched air strikes against ISIS in Iraq on 8 August 2014, and on 22 September 2014, the United States and its allies also launched air strikes against ISIS in Syria.

The government of Iraq requested assistance to fight ISIS. Therefore, the use of force in Iraq can be justified on the basis that it was carried out with the consent, and at the request, of the Iraqi government.

However, the legality of the air strikes in Syria is the subject of legal debate. Significantly, the United States did not justify intervention on the basis of humanitarian assistance, despite the atrocities committed by Islamic State in Syria. Instead, the United States relies mainly on the collective self-defence of Iraq because ISIS carries out attacks in Iraq from safe havens in Syria. The United States argues that it does not need consent from the Syrian government to carry out air strikes in Syria because that government is “unable or unwilling” to combat ISIS in its territory. The UN Secretary-General also appeared to lend some support to this argument. Reacting to the air strikes in Syria, Ban Ki-moon observed that they were carried out in areas no longer under the effective control of the Syrian government and that they were targeted against extremist groups, which he said undeniably “*pose an immediate threat to international peace and security*”.

³⁹ Lowe, *International Legal Issues Arising in the Kosovo Crisis*, (2000) 49 *Int'l & Comp. L.Q.* 934, at p. 941.

⁴⁰ Guidance Note, *Chemical weapon use by Syrian regime: UK government legal position*, 29 August 2013, para. 4.

⁴¹ Independent International Commission of Inquiry on the Syrian Arab Republic, *Oral Update*, 16 June 2014, p. 6, para. 40.

⁴² The Assessment Capacities Project, *Regional Analysis Syria – Brief*, 3 June 2014, p. 2.

⁴³ Article 2(7) of the UN Charter prohibits intervention in matters “essentially within the domestic jurisdiction of any state”. See *Military and Paramilitary Activities in and against Nicaragua (Nicaragua v. United States of America)*, Merits, Judgment, I.C.J. Reports 1986, p. 14, at p. 118, para. 228 and p. 124, para. 242.

⁴⁴ See *Military and Paramilitary Activities in and against Nicaragua (Nicaragua v. United States of America)*, Merits, Judgment, I.C.J. Reports 1986, p. 14, at p. 124, para. 242.

⁴⁵ A form of Islamic political-religious leadership which centres around the caliph (“successor”) to Muhammad.

Gabrielle Fänder/Medair, Jordan, 2014

The Syria Needs Assessment Project

By Yves Kim Créac'h and Lynn Yoshikawa



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A special acknowledgement goes to Nic Parham, former SNAP Project Lead, whom with his team has established the SNAP Project and developed a totally new approach to information within the humanitarian system.

A year after the start of the Syrian crisis, ACAPS¹ was approached by a range of donors to consider a small project to bring together all existing information concerning the humanitarian situation of those affected by the crisis. Many organisations (humanitarian, governmental, media etc.) were reporting on elements of the crisis, usually specific to a particular problem in a particular age-group or in a particular country, such as shelter for refugees in Lebanon or food for Palestinians in Syria. With UNHCR country offices responsible for the coordination of the response in refugee-hosting countries, (the exception being Turkey where government took responsibility for coordination), and OCHA responsible for coordination in Syria, obtaining a holistic picture of the situation was challenging. It was also impossible to determine what was known and what the gaps in information were, due to the sensitivities of reporting on the humanitarian situation, particularly by agencies working from Damascus, as well as those working cross-border without registration. Most actors engaged in the Syria conflict response agreed that there was an incoherent picture of the humanitarian situation in Syria and neighbouring countries, and how dynamics in Syria affected host countries and vice versa. Humanitarian stakeholders had an insufficient shared situation

awareness, and there were significant and persistent inconsistencies in reports on the actual number of affected Syrians both inside and outside the country, the movement and flows of populations, general humanitarian needs and the longer-term impact on infrastructure and livelihoods in-country. This problem was further exacerbated by the sensitivities associated with information management while ensuring continued access to the affected population. It was for this reason that SNAP (the Syria Needs Analysis Project) was born in December 2012.

SNAP was initially conceived as a two to three person project with some remote support from the ACAPS and MapAction² headquarters, aimed at improving the humanitarian response by creating a shared situational awareness. Using ACAPS' skills and experience in the analysis of secondary data, SNAP would seek to build trust with sufficient stakeholders in the region so as to gain access to as much information as possible then, bearing in mind the various levels of confidentiality by which information is shared, create products to inform the strategic decisions to be made by the humanitarian community. As such, SNAP created the RAS (Regional Analysis of Syria), which was initially monthly and would cover both humanitarian issues in Syria and neighbouring countries. In addition, due to increased demands from humanitarian stake-

holders, thematic reports of governorate profiles³, cross border access analysis⁴, etc. were produced as well. Within a month of starting the project, SNAP took advantage of an opportunity to support a joint multi-sectoral needs assessment in northern Syria (J-RANS). By providing the bulk of the technical capacity (analytical skills, geographical information system (GIS) and assessment expertise), SNAP facilitated the process for the humanitarian community to gain the first comprehensive overview of needs in northern Syria. As a result, SNAP expanded its objectives to include the provision of support to coordinated assessment initiatives and staffing increased accordingly, with additional needs assessments facilitated in Dar'a and Quneitra governorates in southern Syria.

Concurrent to this support to primary data collection in northern Syria, SNAP worked to develop relationships with humanitarian actors throughout the region. Linking quickly with UNHCR and some key non-governmental organisations (NGOs) in Lebanon and Jordan proved essential in understanding the refugee context. It quickly became clear that few organisations made public their most useful and interesting data due to operational sensitivities, particularly with host governments and at times, with donors. Thus SNAP strove to build personal relationships with key stakeholders across the humanitarian community which necessitated a further expansion, deploying additional analysts

Table 1: Outline of SNAP's information sharing protocol

Category	Level of anonymisation for public disclosure
Unprotected	Open - can be quoted and attributed to the organisation
Protected	Can be quoted and attributed to 'an international NGO' or 'a national NGO' etc.
Restricted	Can be quoted and attributed to 'a trusted source'
Confidential	Cannot be quoted directly but can be used for analysis and the analytical deduction published without any attribution

¹ ACAPS (The Assessment Capacity Project) is a consortium of NGOs created at the end of 2009 to strengthen assessment and analysis methodologies as well as providing surge capacity for the IASC in time of crisis
² <http://www.mapaction.org/>
³ For example, see latest Idlebl governorate profile at <http://www.acaps.org/en/pages/syria-snap-project>
⁴ For example, see: http://www.acaps.org/reports/downloader/cross_border_movement_of_goods/67/syria

in Jordan and Turkey and expanding the core team in Lebanon. Over the first six months of the project, the SNAP team grew from three to nine, with further expansion to 20 staff planned in 2014.

Key to accessing data and information in the Syrian context has been confidentiality; many organisations are sensitive about details of their operations – particularly in Syria, due to the complex nature of the crisis and the need to work in areas under control of the various parties to the conflict. SNAP quickly developed a simple information sharing protocol to facilitate the sharing of information and clarify the level at which it could be made public (see Table 1⁵).

SNAP also aims to source and hyperlink all information in the reports to enable readers to further investigate and judge the reliability of the source. However, where organisations are reluctant to be associated by name with information sharing, two levels of general sourcing are used: a) ‘an INGO’ or a UN agency’ etc. or b) ‘a trusted source’. Where partners share information on the understanding that it is not shared publicly, SNAP uses it to triangulate data from other sources and to inform general analysis. ‘Off the record’ conversations with experts in a particular field are useful as they may either confirm or question information from other sources, highlight issues of which we are unaware, assist us in reprioritising issues, as well as contribute to our overall understanding of the situation. Support to assessment initiatives across the region also contributes to SNAP’s overall aim, by increasing the quality of timely data available.

The absence of systematically collected, reliable information from Syria also presents a challenge in deciding the level of information that is ‘good enough’. When information is scarce, a particular piece of information can seem especially valuable, but if it is highly specific (such as information on a particular village) and no comparable information is available, it is misleading to include it in a report as it gives the impression that the information is the most important piece of information. For example, credible and reliable information might be available that village X has suffered repeated aerial bombardment and that food is scarce and insufficient for the population. Without information on the situation in other villages in the area, reporting this information may give the impression that village X is the only part of the district witnessing direct attacks and in need, or that it is the most in need.

Collecting information on nutrition in the Syrian context has been particularly challenging due to the need for specialised training of enumerators and achieving proper sampling in a context where population estimates and displacement are highly dynamic. In the second iteration of the J-RANS in April 2013, SNAP included nutrition in the multi-sectoral assessment, however, it was found that enumerators lacked adequate training to properly distinguish

between food security and nutrition needs. Hence, the results blurred the lines between the two sectors, and in subsequent assessments, nutrition was not included as a standalone sector.

Underpinning SNAP’s work is the view that information is never perfect and thus we strive to give analysis deemed ‘good enough’ to enable decisions to be based on the best possible evidence. To this end, SNAP seeks to highlight information gaps and the most recent information while giving a sense of the reliability of the information.

Various challenges have arisen: the sheer number of actors in the crisis; the significant part played by actors who do not link to the international humanitarian architecture (such as diaspora, armed groups, community-based and faith-based organisations, etc.); the political sensitivity of headline numbers; the operational sensitivity of information in Syria (especially regarding access and border crossings); lack of access to and information on certain areas within Syria; lack of information on certain groups and sectors; the dynamic nature of the crisis and thus humanitarian decision-makers’ information needs.

SNAP thus adopts a graduated approach to information collection that starts with a daily trawl of the internet. Each piece of information is captured in a spreadsheet which categorises it according to geographic location, affected group, sector, date, type of information (conflict; needs; response etc.), source, etc. The data can then be filtered by sector and location, say health in Ar-Raqqa governorate, to view all the recent/new information on health in that governorate. Combined with unpublished information gathered directly from other sources, this gives a basis for identifying key issues (or gaps in knowledge) of the situation. Weekly team analysis sessions help the team identify issues for further investigation/data collection. Prior to the drafting of a report, SNAP invites specialists in particular fields, and some general humanitarian analysts, to help analyse the issues that have been identified as particularly important, and that will be highlighted in the report.

One of SNAP’s strengths is that it is independent – in that, not being an operational response organisation, SNAP has no cause to promote the needs in one sector, location, or of one group over another. That all SNAP’s analysts are generalists also reduces this risk – although it does necessitate the involvement of specialists in the analysis process. Not being operational in Syria also means that SNAP can publish information with which the Government or opposition might disagree, although the need to ensure that our publications do not compromise the safety and security of staff in Syria or jeopardise humanitarian operations remains paramount.

A second strength is that SNAP has no mandate for coordination or information management in a specific context and can produce independent analysis of the whole humanitarian situation based almost entirely on information provided

by others. Many organisations see this as useful, as it gives them evidence from a trusted source to support interventions and appeals for donor funding. UNHCR in Lebanon and Jordan also see SNAP’s products as contributing to their effort to coordinate the response. Coordination with OCHA is more of a challenge due to the constraints faced by Damascus-based organisations on publicly sharing information and analysis, since most information coming out of Damascus-based operation have to be approved by the Government of Syria.

A growing part of SNAP’s focus is direct support to humanitarian needs assessments, especially within Syria but also in Jordan and Lebanon. SNAP only supports initiatives that are coordinated with multiple actors such as the J-RANS⁶ and SINA⁷ exercises in Syria and the MSNA⁸ in Lebanon. As SNAP’s added value is in secondary data collation and analysis, we are working increasingly closely with other specialist primary data collection organisations such as REACH. Further to that, in both Turkey and Jordan, SNAP has provided a number of assessment training to the humanitarian communities and intends to further expand this service that would include in the future, in-depth trainings in specific topics, such as analysis or devising sampling methodologies.

Monitoring the use of SNAP’s analysis and the catalytic effect the project has had on assessment coordination and information sharing is one of the more challenging parts of the project. An independent evaluation undertaken nine months into the project found that SNAP “offered significant value to the humanitarian community in strengthening the targeting of assistance and in making an important contribution to a shared situation awareness” and that its relevance “stemmed from its ability to fill critical gaps in the information and analysis of the humanitarian community”. While anecdotal evidence suggests many donors and NGOs, both international and national, use and value SNAP products, their value to the humanitarian community within Syria, especially the Humanitarian Country Team, remains unclear.

Over the first 15 months of SNAP, it has become clear that there is a huge appetite for independent analysis and a consolidated report on the overall humanitarian situation, although views differ as to the level of detail required. SNAP has also proved that it is possible to gain the trust of a variety of organisations, UN, NGO, faith-based etc., and gain access to otherwise confidential information. However, to do this takes both time and staff and it is a constant challenge to ensure that the value of SNAP’s products is worth the cost of the project.

For more information, contact: Yves Kim Créac’h, email: SNAPLead:acaps.org

⁵ The more detailed SNAP information sharing classification system is available at <http://www.acaps.org/en/pages/syria-snap-project>

⁶ J-RANS: Joint Rapid Assessment of Northern Syria

⁷ SINA: Syria Integrated Needs Assessment

⁸ MSNA: Multi-Sector Need Assessment

Syria INGO Regional Forum (SIRF)

This profile of SIRF is based on ENN interviews with Misty Buswell and Rob Drouen.

Misty Buswell is a member of the SIRF Board and co-chairs the SIRF Advocacy Working Group. She is Regional Advocacy, Media and Communications Director for Save the Children in the Middle East and Eurasia region.

Rob Drouen is the former chair of the SIRF Board and is the Action Contre la Faim Regional Representative for the Middle East.

What is the SIRF?

SIRF is an INGO led regional forum based in Amman, Jordan, set up in April 2013 to give voice to INGOs conducting humanitarian responses in the Syria region. The move towards a regional hub/coordination in Amman, Jordan for the Syria response by many agencies working in the region coincided with the creation of the Syria INGO Regional Forum (SIRF). Member organisations, as well as representatives of country coordination fora, have gathered regularly since SIRF's inception to discuss and address priority issues.

Who are the members and how does SIRF operate?

All members are registered INGOs in their home country and are committed to humanitarian principles, implementing responses to the Syrian Crisis, active in two or more affected countries, willing to actively participate in SIRF, and able to appoint senior individuals as focal point for participation. Membership is exclusively for INGOs although national NGOs are represented in the country level NGO fora, which have linkages to the SIRF.

Currently there are 38 INGOs and observers in SIRF; together they are present in more than 11 countries in the region. A board of six individuals drawn from the member INGOs and elected by these members steer the group. The Board members are chosen on personal title and do not represent the INGO they are coming from. Working groups on issues of particular interest are established as required. For example, there is an advocacy working group within the SIRF and a communications working group comes into play when SIRF are looking to speak publicly on issues.

General members have monthly meetings in Amman and the Board meets twice a month. Many SIRF members are based in Amman in regional agency offices or commute from Beirut. The biweekly advocacy working group meetings tends to generate most of the concrete outputs of the SIRF – talking points, briefings – that are publicly or privately shared to raise issues and influence policies.

Until now, SIRF members have worked on a voluntary basis, with the Board members taking on the majority of the workload. This is not considered to be a sustainable model and SIRF are in the process of hiring, for the first time, a dedicated representative to help with coordination.

Advocacy issues and target audience?

A key focus of SIRF's advocacy work has been on the situation inside Syria. Much of this work is highly sensitive and goes on 'behind the scenes' and relates to issues of access, cross border and cross line programming and coordination mechanisms. SIRF shares information on these various issues to relevant stakeholders across the region and at global levels where appropriate. One of our key successes has been in ensuring that global events and meetings are informed by messages and policy positions that are developed by the region and channelled to global levels.

What else has SIRF 'brought to the table'?

The SIRF provides a mechanism for interaction with existing country level coordination forums (NGO forums). SIRF also participates in regional processes such as the development of the regional resilience refugee response plan. One of the strengths of SIRF is that it has multiple contacts and channels of communication at various levels in the humanitarian system. SIRF can advocate to donors and UN agencies at regional and headquarters level thereby channelling field level perspectives to higher levels within the humanitarian system.

SIRF's added value is in the provision of 'current on the ground information' that benefits both donors and UN agencies.

What is it about the NGO perspective that needs representation?

NGOs are doing the bulk of implementation and working on a daily basis at the heart of the Syria response. They are closer than many UN agencies and donors to the affected people, and have a firmer grasp of issues around programme implementation that may require addressing at a strategic and policy level. It is important to consider that the combined funds of 7-8 larger INGOs are significant and carry weight.

When it comes to speaking out, as a group of NGOs, there can be safety in numbers. However it is also true that there is a critical role for the UN in speaking out. The UN has a mandate that is given by UN member states so that it is often safer for them to speak out than for NGOs who may risk jeopardising their field presence.

What is your opinion of the sustainability of the Syrian crisis response and how to manage it, given the significant shortfall in funding?

This is a challenge we all are faced with. Members see the importance of increasingly integrating relief programming with development and resilience work and longer term resource flows. It is important to recognise that we haven't seen a crisis of this scale in a long time, if ever. We are concerned that fatigue around this regional emergency will ensue and that other emergencies and priorities will emerge that displace the attention and focus on this regional crisis. As a global humanitarian community, we don't have the capacity to deal with all the many humanitarian challenges around the world. We need to be thinking about what kind of new approach is needed, as this situation isn't going away.

What have been SIRF's challenges?

One of the main challenges for SIRF has been managing membership of 38 organisations with different mandates and modalities of working; it is difficult to be truly representative of the membership. Consequently there are times when we cannot speak as SIRF but as a "coalition of the willing" on particular issues. In practice this means we may need to produce a document endorsed by a group of INGOs rather than SIRF as a whole. SIRF provides the umbrella to coordinate and solicit views and we always endeavour to represent the membership as fully as possible.

We always endeavour to represent the views of the membership but inevitably members do not always agree completely and there is often lack of time and capacity to undertake the outreach, consultation and consensus building with all members. It is hoped that with a dedicated SIRF representative this is something we will be able to do more effectively in the future.



Nutrition response to the Syria crisis: UNICEF's perspective

A man and a boy in Atma, an encampment for displaced persons, near the border with Turkey

UNICEF/NYHQ2013-0691/Diffrident

By James Kingori, Dr Hayder Nasser, Muhiadin Abdullahi and Dr Khaldoun Al-Asaad

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NB: The opinions expressed in this article are those of the authors and not of the organisations mentioned.

Background

Syria is in the fourth year of escalating crisis¹ and the impact on the population cannot be overestimated. The humanitarian situation in Syria has deteriorated significantly since late 2012/early 2013 with an estimated 6.5 million people displaced as of October 2013 (2014 Syria Humanitarian Assistance Response Plan – SHARP, Dec 2013) and 2.3 million refugees by the end of 2013 (Regional Response Plan for Syrian Refugees, Dec 2013). On-going conflict, population displacement, breakdown in social and public services, intermittent reports of droughts since 2011 and disruption of peoples' livelihoods, have the potential to have an effect on the health, food security and eventually on nutritional status of the affected population. The refugees are hosted in Lebanon, Jordan, Iraq, Turkey and Egypt.

The overall nutrition situation before the crisis was poor with an estimated 23% stunting prevalence, 9.3% wasting and 10.3% underweight². Exclusive breastfeeding rates stood at 42.6% while the proportion of newborns introduced to breastfeeding within the first hour of birth was 42.2% (SFHS, 2009). Micronutrient deficiencies have also been recorded in Syria in the past, presenting risk for sub-optimal growth among children, e.g. pre-crisis anaemia prevalence among 0-59 month old children was 29.2% (MOH, nutrition surveillance system report 2011), 8.7% Vitamin A deficiency rate (MOH, 1998) and 12.9% iodine deficiency prevalence (MOH, 2006).

The ongoing crisis in Syria has disrupted peoples' daily life, affected their livelihoods, caused displacement and threatened people's wellbeing. As this crisis persists, a considerable proportion of the population continues to depend on food aid (channelled through direct distribution or via cash and voucher systems) for survival. Compromises that would have impact on nutrition are, however, likely in terms of dietary diversity and frequency, separation of children from caretakers thus affecting infant and young child feeding (IYCF) practices, poor water sanitation and hygiene (WASH) conditions predisposing to diseases, destruction of health facilities and loss of health professional leading to insufficient health care, among others. These prevailing factors necessitate increased attention to nutrition, to prevent any deterioration and nutrition-related deaths.

There has been no documented nutrition crisis to date in Syria and the neighbouring countries of Turkey, Iraq, Jordan and Lebanon that are receiving Syrian refugees. However, the ongoing conflict in Syria and the resultant population displacement necessitates response to address prevailing sub-optimal nutrition issues while developing preparedness plans to be able to deliver any critical nutrition responses that may be needed in the future. This involves enhancing capacity for close monitoring of the nutrition situation for women and children, identifying and treating cases of acute malnu-

trition that arise and strengthening preventive interventions like infant and young child feeding (IYCF) support and micronutrient supplementation. It is important to note that all these countries are categorised as middle income countries (World Bank, 2013³). Generally speaking, nutrition is often not a priority sector in some middle income countries and they happen to have limited emergency nutrition preparedness and response capacity; e.g. no government endorsed national nutrition guidelines/ protocols for both prevention and treatment for malnutrition or fully fledged nutrition department with trained nutrition technical staffs; few, if any, technical nutrition non-governmental organisations (NGOs); limited government budget for nutrition, etc .

This article describes the evolution and status of the Syria crisis nutrition response and nutrition response advocacy effort from UNICEF's perspective and provides an overview of UNICEF supported regional and national capacity strengthening initiatives around nutrition in emergencies.

¹ The crisis is associated with violence, attacks on social and economic infrastructure and disruption of services. The unilateral economic and financial sanctions have further exacerbated the humanitarian situation (SHARP, Dec 2013, page 14).

² Syrian Family Health Survey (SFHS), 2009.

³ <http://data.worldbank.org/news/new-country-classifications>: Syria and Egypt are lower Middle Income Countries while Jordan, Iraq and Lebanon are upper Middle Income Countries

Evolution of the Syria crisis nutrition response

Positioning of nutrition in the humanitarian response

The need to establish the nutrition situation of the affected Syrian population was identified back in late 2011 following reports of below normal rains in the northern governorate of Syria. However, with the escalation of the conflict and subsequent limited access, this initiative could not proceed and was superseded by other humanitarian priorities, such as tracking population movement and facilitating population safety, ensuring adequate daily food and water, etc. With the intensification of the crisis in Syria and the neighbouring countries receiving refugees, sectors like water, sanitation and hygiene (WASH), health, protection, education and food security were identified as priorities back in 2012, with nutrition not featuring prominently.

Advocacy for nutrition as a first line of intervention and raising its profile nationally was nevertheless pursued by UNICEF and other stakeholders. However, 'selling' nutrition to the wider humanitarian community was challenging as there was no glaring 'nutrition crisis' (i.e. no severely emaciated children reported) like in most global emergencies. The only official government report on nutrition within Syria⁴ reported a 'poor' situation, according to WHO nutrition situation classification criteria. The 2009 SFHS was viewed by most stakeholders as old data to depict the current situation and therefore not adequate for response planning. Furthermore, the absence of any significant caseload of acutely malnourished children reported during the routine screening in health facilities and the delay in implementing the proposed nutrition survey in Syria (a nutrition assessment was eventually started in March 2014) meant that it was difficult to convince many in the humanitarian community, including some donors, of the need to prioritise a nutrition response within Syria. The identified need for preventative nutrition interventions (support to IYCF and micronutrient interventions, basic capacity strengthening and associated coordination),

in spite of their relevance, didn't trigger much interest at the early stages of nutrition response.

Despite these challenges, nutrition advocacy has continued unabated through building evidence, making presentations in various fora, and bilateral discussions and sensitisation of strategic partners since late 2012. The basic messages communicated through this active nutrition advocacy has been that though there is no documented evidence of a nutrition crisis as yet, malnutrition and related preventable death can occur should there be a lapse in other basic services of water sanitation and hygiene, health, food security and other relevant interventions. Hence preventive nutrition activities and capacity strengthening are regarded as paramount to avert nutritional deterioration. The need to know what infants and young children are eating and the importance of preventing acute malnutrition and stunting through an integrated response were some of the strategic messages used in advocating for more resources to be directed towards nutrition in the current emergency.

In the pre-crisis period in Syria, some aspects of IYCF and micronutrient issues (iron deficiency, in particular) were given some attention through the advocacy for food fortification and iron supplements delivered to mothers through antenatal care services. Advocacy for dietary diversity has been maintained during the emergency response, with deliberate targeting of children and mothers. Lipid-based Nutrient Supplements (LNS) (Plumpy'doz) and micronutrient powders (MNP) have been distributed in Syria and Lebanon while Super Cereal Plus targeting children aged 6-23 months and beyond has also been distributed in Syria and Jordan. UNICEF has been procuring some of these products in coordination with WFP. Much of the response, coordination and strategic discussion are held under the auspices of UNICEF.

Further, due to the recognised need for improved IYCF related programming in the emergency context, the Global Nutrition Cluster (GNC) in collaboration with nutrition stake-

holders in the Syria, Lebanon, Iraq and Jordan compiled a comprehensive presentation on promotion and protection of appropriate IYCF practices in emergencies. This was used for some of the specific targeted advocacy within the region by some GNC members led by UNICEF, through presentations in meetings, wide sharing of the comprehensive presentation, and maintaining regular contacts. IYCF support and close monitoring of the nutrition situation through facility based screening and rapid assessment became the primary nutrition response across the five countries significantly affected by the Syria crisis.

Overall, these various advocacy efforts have led to some successes in positioning nutrition as one of the sectors to be prioritised in the ongoing humanitarian response.

Successes from the nutrition advocacy effort

Nutrition reflected in the Syria Arab Republic's Humanitarian Assistance Response Plan (SHARP): For the first time, an independent sector response plan for nutrition was introduced in the SHARP (version 5) document developed in April 2013. This sectoral plan articulates the priority for nutrition sector and associated funding needs to allow delivery of a response in the challenging operating environment within Syria and in the countries hosting the refugees. The (Syria) Regional Response Plans (RRP) drafted by the countries hosting Syrian refugees (Iraq, Jordan, Lebanon, Egypt and Turkey) do not have an independent nutrition response plan; instead nutrition is integrated in the health and food security response plans.

Nutrition sector established in Syria with Ministry of Health (MOH) and UNICEF co-leadership since April 2013: The advocacy for nutrition led to its recognition as a critical life-saving sector, in order to facilitate close monitoring of nutrition situation and evidence building, sector priority setting and sector specific strategy development, capacity strengthening, partnership fostering, nutrition response coverage and gaps analysis, etc. Nutrition response coordination is currently ongoing and opportunities for integration with other sectors is being explored and exploited in an effort to protect and promote better nutrition. A number of capacity building initiatives (training sessions, sharing of guidelines and technical discussions) have been organised; a nutrition assessment has been planned (see below); partnerships have been fostered (e.g. UNICEF, WHO and WFP with and the Syrian Arab Red Crescent (SARC) and other national NGOs; and a response matrix (4W) has been drafted to enhance coverage and gaps analysis.

Syria nutrition sector strategy drafted and approved by the Ministry of Health (MOH) Syria in October 2013: This articulates broad priority response strategies for consideration by the various nutrition stakeholders. These include:



Refugee home in the north of Jordan

Gabrielle Fänder/Medair, Jordan, 2014

⁴ Syrian Family Health Survey (SFHS), 2009

- Prevention of undernutrition through accelerated promotion of appropriate IYCF, ensuring improved coverage of appropriate micronutrient intervention and promotion of nutrition sensitive responses alongside positive behaviour change activities
- Supporting the identification and treatment of acutely malnourished cases using internationally approved guidelines and treatment products
- Strengthening the nutrition surveillance system through supporting facility based and community based screening for malnutrition, as well as conducting comprehensive nutrition assessments
- Strengthened coordination of the nutrition response through promotion of the nutrition sector priority responses (surveillance, IYCF, micronutrient supplementation and treatment of identified malnourished child), and
- Supporting integration of nutrition with other sectoral responses.

Nutrition assessment to update nutrition situation:

Two rounds of nutrition assessments for the refugees in Jordan and Lebanon have been accomplished, i.e. Lebanon Sept 2012 and Nov/Dec 2013 and Jordan Oct/Nov 2012 and April 2014 while a series of governorate level assessments among IDP children in collective shelters are in their final stages in Syria (April – Aug 2014). These new data will complement the facility based screening data on weight and height for children, programme reports and other qualitative information in the consolidation of the evidence on the nutrition situation for the Syrians within and outside Syria.

Capacity strengthening initiatives: A series of trainings have been conducted targeting technical public health specialists from Syria, Lebanon, Jordan, Iraq, Turkey and Egypt. These include a number of Nutrition in Emergencies trainings with emphasis on IYCF in emergencies, specific IYCF training and briefing sessions during co-ordination, rapid assessment and community and facility based screening, and full five day sector/cluster coordination training (see details below). Various United Nations (UN) agencies and NGOs have also deployed technical nutrition staff in the past year to facilitate implementation of various nutrition related programmes. An IYCF in emergencies specialist was deployed by



UNICEF (in collaboration with Save the Children Jordan) for six months (mid Feb – mid Aug 2014) to support the consolidation of information and bridging of technical gaps particularly with respect to IYCF (again, see details below).

Conclusions

In conclusion, although advocacy for nutrition has led to a stronger positioning of nutrition within the overall regional response, much is yet to be accomplished. The established humanitarian coordination structure with nutrition being one of the prioritised sectors in Syria, building of an evidence base to inform the response, monitoring, as well as response capacity, will need continued investment and support to ensure adequate provision for the treatment of identified malnourished children and to prevent deterioration of the situation.

Regional and country capacity strengthening development on nutrition

Nutrition related capacity strengthening efforts undertaken by the UNICEF Middle East and Northern Africa Regional Office (MENARO), as well as country offices and other nutrition stakeholders, are described below. This capacity strengthening effort has been necessitated by the technical gap existing on nutrition in emergencies in the Syria crisis affected countries, the need to adequately prepare for any possibility for nutrition situation deterioration and the need to enhance the quality of the ongoing nutrition response.

Nutrition in Emergencies (NIE) training (2012 and 2014)

To address the existing capacity gap for identifying and treating acutely malnourished children, two regional/multi-country training were organised by UNICEF in Jordan (June 2013) and Lebanon (June 2014), followed by additional cascaded training at country level. These NIE trainings were based on the Global Nutrition Cluster (GNC) endorsed Harmonised Training Package (HTP)⁵ with an emphasis on IYCF in emergencies (IYCF-E) and screening for acute malnutrition at the community level. UNICEF MENARO organised the training in June 2013 in Jordan reaching 41 MOH, UN and NGO public health

professionals from Syria, Turkey, Lebanon, Jordan, Iraq and Egypt (See Table 1).

UNHCR conducted NIE training using the same package in December 2012 for their staff and partners in Jordan. In May 2014, UNICEF Turkey conducted NIE training for NGOs, UN agencies and the Turkish Red Crescent, benefiting 25 participants. In June 2014, UNICEF Lebanon in partnership with the American University of Beirut (AUB) in collaboration with the Institute of Child Health of the University College of London (UCL) organised a similar NIE training, largely targeting nutrition stakeholders from Lebanon and Syria, benefiting 35 participants from UN agencies, NGOs and MOH.

UNICEF, in collaboration with MOH Syria, has facilitated a series of Community based Management of Acute Malnutrition (CMAM) training activities for MOH and NGO staff⁶ from various governorates largely focusing on the identification of acutely malnourished children, their referral and treatment, as well as the integration of IYCF-E services into CMAM. This effort aims to ensure reasonable capacity exists to trigger an emergency nutrition response in every governorate, if the need arises or as access improves. The NIE training materials used in the June 2013 Jordan training have been translated into Arabic for use at national and sub-national levels.

Infant and Young Child Feeding in emergencies (IYCF-E)

As described above, IYCF-E has been integrated into the NIE training⁷. In addition, UNICEF, in partnership with Save the Children Jordan (SCJ), has engaged the services of an IYCF-E specialist to conduct a situation analysis of the IYCF-E implementation activities, identify IYCF capacity

Table 1: MENA RO/NIE training participants, June 2013

Country	UN	NGO	MOH/ Government	Total
Jordan	4	6	0	10
Iraq	2	0	2	4
Syria	5	3	3	11
Lebanon	3	5	2	10
Egypt	1	1	0	2
Turkey	2	0	2	4
Total participants	17	15	9	41

⁵ Available at: <http://www.ennonline.net/resources/htpversion2>

⁶ UNICEF, WHO and WHO boosted capacity of over 2000 staff from MOH and NGOs in Syria between Jan – October 2014 in the fields of CMAM, Infant and Young Child Feeding (IYCF), health facility screening and rapid assessments

⁷ The IYCF-E issues addressed included aspects of maternal nutrition, early initiation of breastfeeding, exclusive breastfeeding, complementary feeding and dealing with non-breastfed children. The emphasis slightly varied depending on the length of training as it was not fully standardized in the beginning.

Table 2: Cluster Training Participants

Countries	WASH	Nutrition
Yemen	4	4
Sudan	2	2
Jordan	3	1
Syria	8	4
Lebanon	2	1
Palestine	1	0
Total	20	12

gaps and provide guidance on IYCF programme implementation and progress monitoring. Implementing partners in Lebanon, Jordan, Iraq, Turkey and Syria have been supported by the IYCF-E specialist in accessing the appropriate IYCF-E training materials, translation of IYCF-E operational guidance for programmes and in the IYCF-E response monitoring. Lebanon IYCF programmes are also benefiting from the technical leadership of the National Breastfeeding Committee and the technical expertise of the International Orthodox Christian Charities (IOCC), facilitated through the IOCC partnership with UNICEF and in close collaboration with the Ministry of Public Health, Lebanon. In Turkey, special IYCF sessions were conducted in the Syrian refugee camps targeting women's groups. These sessions were conducted in collaboration with the women's committees that were organised by UNHCR. The sessions were conducted in an open forum where women could learn about the importance of exclusive breastfeeding, timely and adequate complementary feeding and feeding of non-breastfed infants. In Syria, IYCF-E has been integrated into the CMAM programmes established in various governorates while independent IYCF interventions are under development in partnership with national partners that are undertaking health promotion activities in the county.

Assessment and screening

Aspects of basic nutrition screening have been covered in the NIE training but additional training on rapid screening using Middle Upper Arm Circumference (MUAC) and height and weight measurements, as well as data interpre-

tation, has been conducted in Jordan, Iraq, Lebanon and Syria. Assessment teams involved in the recent nutrition assessment in Syria have been exposed to the SMART methodology and the associated task of taking accurate anthropometric measurements. A SMART Survey Manager training for the MENA region was successfully conducted between 23rd and 29th August 2014, benefiting 26 public health professionals from emergency prone countries in MENA, particularly Syria and neighbouring countries.

Cluster/sector coordination

The MENA regional cluster/sector coordination training was conducted between 6th – 10th October 2013 targeting the emergency prone countries in the MENA countries, benefiting 12 nutrition/public health professionals and 20 water and sanitation technical staff. A deliberate effort was made to conduct this joint nutrition/WASH training to foster inter-sectoral coordination, which is necessary in the prevention of malnutrition. All those trained can be deployed in any of the countries within the region on short notice to support response coordination. The training covered such topics as humanitarian reform, division of roles and responsibility among different stakeholders in an emergency context, humanitarian programme cycle, collaborative leadership, information management, resource mobilisation, inter-cluster coordination, systems and processes necessary for stronger coordination, transformative agenda, and technical standards/ references in emergency response and partnership. Additional sector-specific topics were also covered when the two groups (WASH vs Nutrition) were separated to focus on updating the participants' technical knowledge on nutrition and WASH issues.

General support and supplies

Relevant guidelines have been provided to various stakeholders for reference. In addition, distant and on-site support has been provided through field visits and surge support by persons with specific technical expertise and experience. There has been ongoing communication with technical staff involved in programme implementation (through phone, webinars, skype

calls) and technical discussion during the coordination meetings. The outlined capacity strengthening effort has been complemented by strategic pre-positioning of essential supplies such as micronutrients, therapeutic and supplementary food supplies, anthropometric equipment and development of information education and communication (IEC) materials necessary for the community level training and awareness raising/social mobilisation.

Conclusions

Additional capacity strengthening effort is needed through on the job training and regular guidance and supportive supervision for improved quality of intervention. This is an ongoing process that continues to be underscored in the various coordination forums in an effort to enhance nutrition programme quality and quality.

Final reflections by UNICEF

There is often an assumed association between a humanitarian crisis and a high global acute malnutrition rates with a resultant 'automatic' dispatch of Ready to Use Therapeutic Food (RUTF) and Ready to Use Supplementary Food (RUSF) thus translating into a misinformed response. There may also be an assumption that a nutrition crisis in a middle income country can be responded to by medical staff within the existing health care services, who could at times be without adequate exposure to emergency nutrition response. This necessitates consideration of the nutrition response capacity and the health system that existed before the crisis in the overall response planning and actual implementation. On IYCF, the need to monitor and prevent distribution of feeding bottles, facilitation of bottle substitution with cups and delivery of related education, may need to be better captured in the existing guidelines. Integration of IYCF-E and CMAM is often viewed as a new approach that requires a whole set of refresher training – yet it should be viewed as a best practice of dealing with situation that need both programme elements. Countries such as those in the Syria sub-region, need to be encouraged to have some contingency measures, such as capacity, essential nutrition supply in the pipeline, or at least knowledge of the channels through which to obtain these resources and support.

The Syria crisis experience has demonstrated that an occurrence of a humanitarian event does not always translate into an immediate nutrition crisis but this should not mean that nutrition is automatically relegated to a non-priority sector in the response planning by agencies and donors. Capacity strengthening and support to preventive services are critical. Efforts on regular generation of data, even in normal times, are essential to inform appropriate response while existing global guidelines play an important role in providing guidance to inform the response. Ingenuity will be required to ensure that global guidelines are adapted to the needs of contexts such as those in the MENA region.

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JHAS, Jordan, 2014



A young child attending OTP in Zaatari camp

An infant in Zaatari camp in Jordan



Suzanne Mboya, Jordan, 2014

Artificial feeding in emergencies: experiences from the ongoing Syrian crisis

By Suzanne Mboya



Suzanne Mboya is a consultant nutritionist. In 2014 she completed a sixth month mission supporting the Syrian crisis IYCF-E

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This article describes elements of the infant and young child feeding response in the Syrian crisis and the author's perspective on the major issues arising from it, with particular consideration of challenges around artificial feeding. It draws on the findings of a six month UNICEF/Save the Children Jordan mission to support optimal IYCF practices and take account of the IYCF in emergencies (IYCF-E) response¹. It is accompanied by five case studies of individual mothers compiled by the author during her time in the region, to give an insight into the complexities and realities around infant feeding in the crisis.

Context

The provision of infant formula and milk for infants and young children during emergencies remains a very controversial subject. Humanitarian aid agencies have continued to struggle with how to tackle this problem since the early 1990s, when emergency responses in countries such as Iraq and Lebanon revealed that a significant percentage of women had been using breastmilk substitutes (BMS), typically infant formula, before the crises hit. Previously, relief work had focused on countries where the pre-crisis breastfeeding rate was nearly 100%; although breastfeeding practices were often less than ideal, at least that lifeline for infants was there.

The recurring challenges in infant feeding during emergencies over the last decade or more prompted agencies to develop infant and young child feeding in emergencies (IYCF-E) policies, initiatives and training materials. However, the ongoing conflict in Syria has again highlighted the difficulties in supporting formula-fed infants, while at the same time promoting breastfeeding.

According to the Syrian Family Health Survey (SFHS) (2009), conducted prior to the crisis, the nutrition situation of children under five years of age was poor, with an estimated

23% stunted, 9.3% wasted and 10.3% underweight. Exclusive breastfeeding rates stood at 42.6% while the proportion of newborns introduced to breastfeeding within the first hour was 42.2%. Micronutrient deficiencies were also recorded in Syria, presenting risk of sub-optimal growth among children, e.g. anaemia prevalence among 0-59 month old children was 29.2%², Vitamin A deficiency rate was 8.7%³ and iodine deficiency prevalence was 12.9%⁴.

At time of writing, more recent IYCF data from Syria are not available but a rapid nutrition assessment conducted in August 2013 revealed that many women in Syria are misinformed about the ability of mothers to breastfeed during the current crisis and that the exclusive breastfeeding rate is decreasing^{5,6}. Lack of privacy and lack of time were cited as barriers to exclusive breastfeeding. This is exacerbated by the fact that some local and international non-governmental organisations (NGOs) are importing BMS and providing it in a way that is undermining breastfeeding and increasing infants' risk of diarrheal diseases, malnutrition and death.^{7,8}

Policy guidance & regulation

Two important policy guidance are the International Code of Marketing of Breastmilk Substitutes (the Code) and the Operational Guidance on IYCF-E; both are endorsed in World Health Assembly Resolutions (see Box 1). Based on an overall analysis of IYCF indi-

¹ Syrian Crisis IYCF-E end of mission report, 31st August, 2014

² MOH, nutrition surveillance system report 2011

³ MOH, 1998

⁴ MOH, 2006

⁵ Rapid Nutrition Assessment report in Northern Syria; Emma Littlelike for Nutrition sub-working group 9/3/2014

⁶ Desk review of nutrition rapid assessment reports compiled by Nutrition Working Group; Turkey, May 2014

⁷ HIHS Policy on the use and distribution of powdered infant formula milk, 2014

⁸ Experiences and Reports by INGOs and NGOs responding in Syria

Box 1 International policy guidance on IYCF-E

The *International Code of Marketing of Breastmilk Substitutes* is an international health policy framework for breastfeeding promotion adopted by the World Health Assembly (WHA) of the WHO in 1981. The Code applies in both emergency and development contexts. The Code was developed as a global public health strategy and recommends restrictions on the marketing of BMS, such as infant formula, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed. The Code also covers ethical considerations and regulations for the marketing of feeding bottles and teats. A number of subsequent WHA resolutions have further clarified or extended certain provisions of the Code, including around emergencies. On its own, the International Code is not legally enforceable. Companies are only subject to legal

sanctions for failing to abide by the Code where it has been incorporated into the legislature of a nation state. Access at: <http://ibfan.org/code-monitoring/114>

The *Operational Guidance on Infant Feeding in Emergencies* provides concise guidance for emergency relief staff on how to ensure appropriate infant and young child feeding in emergencies. It is endorsed by WHA Resolution 23.23 (2010). It is produced and managed by a collaboration of NGOs, UN agencies and individual experts (IFE Core Group). First produced in 2001, it has been updated in 2004 and 2007 in response to lessons from emergency experiences. Sphere IYCF Standards (2011) are based on its recommendations. It is available in 13 languages. Access at: <http://www.enonline.net/operationalguidanceiycfv2.1>

Hannah Kalbourneth, Save the Children Jordan, 2014



An infant in Zaatari camp in Jordan

sanctions and efforts being made to improve them, Syria is considered a 'category 2' country by the International Baby Food Action Network (IBFAN)⁹ in that there are laws that partly comply with the Code. For example, whilst the Code states there should be no promotion of BMS⁹, bottles and teats in any part of the health care system, the Syrian law permits promotion of BMS if the Ministry of Health (MOH) gives approval¹⁰. BMS were widely used in Syria before the crisis. Infant formula (a nutritionally appropriate BMS) was manufactured in Damascus and imported through Latakya. It was then provided to pharmacies throughout Syria where it could be purchased. The Drug and Food Standards Authority Institute of the Government of Syria controlled the distribution of infant formula¹¹.

Violations of the Code (and non-compliance with the Operational Guidance on IYCF-E) during the response in Syria have been noted and include:

- Foreign governments mainly from the Gulf region have donated infant formula, bottles and pacifiers to the health care system in both community and refugee camps with packaging sometimes not in Arabic (violation of Code 1994, non-compliance with Ops Guidance on IYCF-E 6.4.2; Violation of Code Article 9.2 and non-compliance with Ops Guidance on IYCF-E 6.3.6).
- NGO's distribute 'baby kits' including infant formula and bottles to hospitals, municipalities and directly to refugee and IDP households (Untargeted distribution is a violation of Code Article 6.6 and non-compliance with Ops Guidance on IYCF-E 6.4.1 and 6.4.3).
- Single tins of infant formula (defined as 'samples' by the Code) are distributed to mothers by health workers (violation of Code Article 7.4) without undertaking that the supplies would continue for as long as the infant concerned needed them (violation of Code Article 6.7 and non-compliance with Ops Guidance on IYCF-E 6.3.5).
- Tins of formula milk received by NGOs as

donations are in a foreign language (violation of Code Article 9.2 and non-compliance with Ops Guidance on IYCF-E 6.3.6).

Arising challenges

The direct and indirect effects of the ongoing Syrian crisis have heightened the vulnerability of mothers and children to undernutrition. The types of IYCF-E interventions implemented to widely varying degrees in the Syria response are listed in Box 2.

The prolonged conflict in Syria has caused a disruption of supply networks and market systems, including for infant formula. Although breastfeeding remains the preferred mode of feeding, particularly for babies up to the age of six months, there are some situations in Syria where breastfeeding is not a viable option. Mothers who had already made an informed choice not to breastfeed now have babies dependent on infant formula but are no longer able to access supplies. This has resulted in use of non-milk substitutes, including herbal drinks, tea and sugar-water to feed babies and infants exacerbating the problems of malnutrition¹². In addition, babies and infants who have lost their mothers in the conflict are being cared for by relatives and friends, making maternal breastfeeding impossible. Whilst re-lactation remains the first option for the non-breastfed infants, the absence of skilled lactation support in Syria means there is no support to help caregivers' initiate/practice re-lactation. Very limited and intermittent access across borders and between governorates makes assessments and the estimation of non-breastfed infants in need of support difficult. Internally displaced people who are living in besieged areas within Syria beyond the reach of international aid agencies are mostly affected.

"One thing that is of concern is the number of requests on the internet and social media from individuals' and charities for the donation of 'formula milk' for babies from individuals and charities within the region."

Umm Nasayba, UK based columnist

Providing support to IYCF in a crisis is a relatively new concept for countries in the Middle East such as Jordan and Turkey which are host countries to fleeing refugees. What it entails is little understood, even by health and nutrition staff. Most NGOs and front-line relief workers believe that IYCF-E is only about promoting breastfeeding and thus is not highly prioritised in early phase of emergencies. In countries

Box 2

Emergency interventions to promote, protect and support optimal infant feeding in the Syria response

- Revitalisation and adoption of mother and child friendly related policies and guidelines
- Individual and community level counselling on safe infant feeding practices
- Establishment of mother/baby friendly spaces
- Bottle exchange programmes (where feeding bottles are exchanged for cups)
- Prescription and provision of infant formula
- In a few settings, monitoring violations of the Code
- Blanket distribution of ready-to-use foods for children and women to boost their micronutrient status and prevent malnutrition
- Micronutrient supplementation of mothers and children with iron-folic acid supplements, vitamin A supplements and de worming tablets
- Close monitoring of the situation including nutrition screening on arrival and periodically in the community, nutrition assessment, etc.

⁹ According to the Code, a breastmilk substitute is any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months.

¹¹ Syrian Code of Marketing of Breast-Milk Substitutes, Regulative Resolution Number 19/T Date 03/07/2000

¹² See the article by MSF on the subject of acute malnutrition in infants under 6 month of age in Northern Syria in this edition of Field Exchange.

such as Iraq, Lebanon and Syria, where many women use infant formula in non-emergency settings and “know how to do it”, many people fail to understand why infant formula should not be freely distributed during an emergency. Is it time to re-consider infant and young child feeding guidelines in urban settings where pre-crisis practices indicate infants were predominantly formula fed.

Agencies recognise the significant importance of breastfeeding to the health and wellbeing of infants and are mindful of the need to ensure that the supply and distribution of infant formula does not undermine the health benefits of breastfeeding. NGOs have adopted and endorsed statements in line with the position of the United Nations (UN) and the World Health Organisation (WHO) on infant feeding in refugee settings, the international conventions on breastfeeding, including the Code and the Operational Guidance on IYCF-E¹³. However infant formula prescription, dispensing and follow up remain a major challenge for aid workers and partner agencies. Although artificial feeding was established in Syria before the crisis, the current artificial feeding situation is unclear due to lack of documentation on the numbers and locations of non-breastfed infants, on the situation regarding BMS use and on complementary feeding for non-breastfed infants. Some agencies do not document for fear of criticism for not upholding the Operational Guidance on IYCF-E;

“We sometimes distribute infant formula to non-breastfed infants but we don’t document it.



Hannah Kalbounieh, Save the Children Jordan, 2014

An infant in Zaatari camp in Jordan

The infant formula is mainly sourced through donations and thus we only distribute when we receive supplies. We recognize that we should only distribute when we have adequate and sustainable pipeline but the current context doesn’t guarantee that. Currently there is a shortage of available formula milk and external aid agencies with experience in supplying infant feeds are also absent yet the numbers of non-breastfed infants and orphans are increasing.”

An aid worker, Syria

In Iraq, an already serious humanitarian crisis is growing worse with hundreds of thousands of men, women and children fleeing their homes in the wake of escalating conflict. Recent reports indicate that caregivers are requesting that infant formula be part of baby kits as happened during the national oil for food programme in the mid-1990s¹⁴.

Lessons drawn from the ongoing Syrian crisis IYCF-E response

Although significant gains have been made in the development of IYCF-E policies, initiatives and training materials, we are not there yet. Recurring challenges in translating the policies into practice suggest the need to revisit the current guidelines in establishing a way forward. Although breastfeeding remains one of the most scientifically researched topics, a universal model of determinants of breastfeeding that applies to every country is yet to be developed.

Although some national level gains were made during past emergencies in Iraq and Lebanon (e.g. adoption and endorsement of the Operational Guidance on IYCF-E), the momentum was lost at the end of the crises. In Lebanon, the national policies that were developed and adopted were not translated into practice. For example, despite the adoption and revitalisation of the BFHI during the crisis, the BMS industry remains rife in Lebanon today with health professionals being strong advocates:

“When I delivered a month ago, I had to fight to be allowed to breastfeed my baby. Immediately after delivery, my baby was taken to the nursery and kept away from me. Being a nutritionist, I requested to have my baby close to me. After delivery, I was brought a tin of formula milk with a note from the paediatrician saying it’s good for my baby. When I declined to give my baby the formula milk, I was given a declaration form to sign. The declaration form was clearly supporting formula feeding and citing my refusal to formula feed.”

A nutritionist and humanitarian worker, Lebanon

Support for IYCF-E is still regarded as solely a nutrition/health issue while in reality, it is cross-sectoral and can be supported through shelter programmes, food security sectors and protection sectors. Furthermore, limited political will to support IYCF programmes through legislation and adoption of national IYCF policies and guidelines, such as the Baby Friendly Hospital Initiative (BFHI) and the Code, hinders implementation.

“Infant formula is a serious political issue within the Middle East region. I will therefore advise that we approach the issue with a lot of caution.”
A government official

The lack of policies, support and an enabling environment for IYCF makes it difficult to implement IYCF support during emergencies. In the ongoing crisis, some international NGO’s have established parallel systems to provide IYCF support to affected populations, which are generally not sustainable post emergency and thus gains are often lost. Furthermore, some field personnel have shown limited ability to establish and provide successful models of IYCF services. There is limited documentation of what works or not which hinders development of models and references.

Although agencies normally review their IYCF-E policies, funding policies and programming responses during crisis, past crisis, particularly Lebanon and Iraq, suggest the momentum is lost after the emergency ends. The experiences and lessons learnt during the Lebanon crisis triggered a review and update of the Operational Guidance on IYCF-E at the global level, yet today Lebanon still has no emergency preparedness plan on IYCF-E. Furthermore, nutrition policies and guidelines that were developed after the crisis ended are yet to be reviewed and implemented. This raises the question, how can we ensure that the gains made during emergencies are sustained and embedded into existing national policies? Besides, in the current Syrian context where artificial feeding was established pre-crisis, should a policy aimed at guiding aid workers and agencies about how to source, distribute and handle infant formula milk within the Syria response be considered? The policy should ensure that sourcing, distribution and handling of infant formula is done in line with international standards whilst maintaining a flexible and pragmatic approach in accordance with the developing security situation in Syria and across Middle East region.

Emergencies can happen anywhere, and humanitarian response plans must be flexible, while still following guidelines. This is especially the case with regard to IYCF, where agencies need to respond to the local context. Agencies must also be aware that addressing IYCF is important in all emergency settings, including middle-income countries, and has inter-sectoral implications. Since emergencies happen fast and unexpectedly, NGOs and staff from all sectors should ensure that IYCF-E policies are in place, and that IYCF-E is included in staff training and materials so that programming is swift and of the highest quality, and that infants and young children are protected.

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¹³ Version 2.1 (2007) Available at <http://www.ennonline.net/operationalguidanceiycfv2.1>

¹⁴ Infant Formula Distribution in Northern Iraq. Field Exchange 20, November 2003. p5. www.ennonline.net/fex/20/infant

CASE STUDY ONE

Jordan: The experience of a young mother who fled the ongoing conflict in Syria

Noor is a first time mother with a five month old daughter-Leila living in Zaatari camp, Jordan for two years. She has been attending baby friendly spaces by Save the Children Jordan since she arrived in Zaatari camp. "I didn't have much to do at our family caravan so I always accompanied my neighbour, Lizah to the baby friendly spaces. The caravan provides a relaxing atmosphere and allows women to meet and share experiences." Noor decided prior to delivery that she would practice exclusive breastfeeding having attended many sessions on breastfeeding and infant feeding practices. Although she had hoped to deliver naturally, complications during labour compelled her to undergo a caesarean section making her unable to initiate breastfeeding im-

mediately, as it took long for the anaesthesia to wear off. When she regained consciousness, her baby was already receiving infant formula. When she tried breastfeeding, her baby refused the breast and for ten days, her baby did not breast-feed. "I fed Israh sugar water, herbal- chamomile tea and powdered milk. My breasts were very painful and swollen because Israh was not feeding. I was stressed because I knew the benefits of breastfeeding". On the 11th day after delivery, Noor was visited by an IYCF counsellor who counselled her about the possible reasons for baby's refusal to breastfeed.

After three hours of trying to breastfeed with the assistance of the IYCF counsellor, she was able to

breastfeed. "I was really happy. After eleven days of agony, Leila was able to latch on and suckle the breast. My nipples were painful and sore but I was happy to finally position and try breastfeeding. The milk did not flow immediately; the right breast flowed first after three days of trying while the left breast flowed after four days." Noor was pleased by the kind of breast feeding support she received. "The IYCF counsellor really helped me, she sat with me every day and assisted me with breastfeeding and even after the milk came in, she continued to visit me and support me. I am still breastfeeding Leila exclusively" Noor is looking forward to giving Leila complementary foods when she soon turns six months old. Leila is a healthy baby girl who rarely gets sick.



A young child attending OTP in Zaatari camp



Infants and young children attending OTP in Zaatari camp

CASE STUDY TWO

Jordan: The experience of a multi-para mother who fled the ongoing conflict in Syria

Basma is a mother of five children. Basma arrived in the heat and dust of Zaatari refugee camp in December 2012 after fleeing the ongoing conflict in Syria. "There was bombing and explosions everywhere. I decided to flee when a bomb fell near our house". She was exhausted and hungry after travelling for two days with her children. Basma's husband followed five months later. Basma has practiced artificial feeding with all her children. She was advised to do so by doctors back in Syria after she lost her first two children. "After losing my first two children, I was told my breastmilk was poisonous and should give infant formula instead". Basma's older children were often sick and very irritable. "I was always in and out of hospital because of constant diarrhoea." After learning about safe artificial feeding practices following interaction with IYCF counsellors,

Basma has changed the way she feeds her last baby, now four months old and in good health.

"With this child I can sleep well because she is not sick" she said. "I give her only infant formula. I prepare her milk using the preparation instructions given to me by the IYCF counsellors; I prepare small quantities enough for single feeds. I have to maintain hygiene and safely prepare the milk to prevent contamination." Basma receives infant formula every two weeks from UNHCR through the Jordanian Health Aid Society (JHAS). She recalls that during the earlier days in the Zaatari camp, infant formula was provided by agencies, particularly in field hospitals, to all mothers.

This feeding experience is a sharp contrast to Basma's previous experience with motherhood when she fed her baby infant formula, sugar

water, herbal drinks and sometimes cow milk or yoghurt. "I often took my children to the health centre with abdominal cramping, diarrhoea and vomiting. I would lose money paying the health centre. I used to buy the infant formula from supermarkets and pharmacies back home. It was very expensive so I sometimes used other milks" she recalls. She was not given any information regarding preparation and safe artificial feeding by the hospital staff back in Syria.

Basma is happy with the key messages and support she has received on safe artificial feeding. The key messages she recalled included: need for exclusive formula feeding; preparation procedures-quantity of water and milk to be used; amount to be prepared according to age; hygienic preparation and safe storage of infant formula.

CASE STUDY THREE

Turkey: Experience of a mother of a non-breastfed infant who fled the ongoing conflict in Syria

Sawsan is a mother with three children living in a refugee camp in Nizip, Turkey. Sawsan's last born Wael, who is now 2 years old, was born in Syria. On the onset of the crisis, after her neighbour's house was bombed, Sawsan came with her three children and her husband followed later. Sawsan and her family arrived in the dust and heat of after two exhausting days. "Wael was six months old when we arrived in Nizip. Since birth, I have always given Wael infant formula. In Syria, infant formula was easily accessible and available from pharmacies and supermarkets. When the bombs went off, I left my home with only one tin of Nido powdered milk¹⁵. I prepared this milk for Wael during the journey". Liza and her older children ate bread and water. Unfortunately her for-

tunes turned worse at the entry point when someone stole the Nido tin of milk when she was attending to her other children. "At the border, Wael's tin of milk was stolen and I was left with nothing. I was really stressed and had nothing to give Wael. I gave him water that was given to us at the resting areas at the borders and it really broke my heart."

Upon arrival at the refugee camp, Sawsan thought she would receive a can of infant formula to give to Wael. However upon examination by the midwife, she was told she did not qualify for the infant formula since Wael was already six months old. She was instead advised to start complementary feeding. "I felt angry and

frustrated. How could they deny me the infant formula after everything I had gone through? I felt like the midwife was not really supporting me. However, after two hours of yelling, the midwife finally gave me the formula. I understand that complementary foods should be introduced at six months; the security situation back home did not allow me to do that. I believe the midwife should have given me formula and allowed me to wean Wael gradually. I had to buy formula to give Wael as I gradually gave him the recommended complementary foods. Wael is two years and healthy now; that puts a smile on my face."

¹⁵ This is dried milk powder and is not an infant formula

CASE STUDY FOUR

Syria: The experience of an internally displaced mother living in Syria

Zainab is a mother of five children living in Idleb, Syria. After a bomb explosion in which she lost some of her relatives, she took in three children whom she cares for. "I was in the house when the bombs went off. After the chaos, the blast and the commotion died down. The aftermath was beyond comprehension. Yes, I and my children were safe; I just couldn't say the same for my two sisters and brother-in-law. I had lost three relatives in the explosion. I had to take care of three children-Ahmad, Amira and Rasha who had lost their mothers. Ahmad and Rasha were four and five months respectively. It was a very difficult time for me and my family."

"My last born, Ammar was 4 years old then. When Amar was young, I breastfed him though I some-

times gave him formula milk. The doctor told me to use formula because Ammar used to cry a lot. My breastmilk was not enough. Infant formula was easily available and accessible from the pharmacies. However since the start of the crisis, things have really changed. When I took in Ahmad and Rasha, I was not really prepared on how I would feed them." Zainab faced a difficult challenge providing for her new adopted children with the ongoing crisis. "Although I received counselling on the possibility of re-lactation, I was not able to try it. Getting infant formula was really difficult. Sometimes I would find and sometimes not. I had to complement with tea, sugar water and any available milk." The prolonged duration of the Syrian conflict is

leading to a widespread shortage of commercially available powdered infant, particularly in opposition-held areas. In addition, any available infant formula is very costly, making it prohibitively expensive for many people.

Zainab introduced complementary foods at seven months. She was faced with further difficulty in obtaining nutritious complementary foods due to market shortages. "I am honestly glad Ahmad and Rasha are above one year old now. They are now eating family foods. It's still not easy getting food sometimes but it's much better than searching for infant formula. It sure has been a roller coaster but I am grateful to Allah for his beneficence."

CASE STUDY FIVE

Jordan: The experience of a first time Syrian mother in Jordan

Nazreen, a first time mother of one month old Heeba recently moved to Zaatari camp from Amman. Nazreen arrived in Amman 21 months ago after 4 long exhausting days. "I fled Syria alone in the heat of the conflict and went to Amman to work as a nanny for a family. I stayed with family for six months then moved to Zaatari camp because the family left Jordan. Back home, I lived with my sister after we lost our parents. I fled leaving my only sister behind."

Arriving in Zaatari camp, she felt depressed having no one to turn to. She therefore decided to get married to escape loneliness. "I was very lonely and depressed. I married my first husband but things changed after a few weeks. My husband would really beat me up and verbally abuse

even when I was pregnant. When I was 7 months pregnant, he beat me up and experiencing intense bleeding, I had to be taken to hospital. I was put on drugs but had to deliver Heeba preterm."

"After delivery, I divorced my first husband and met my current husband two months later. I experienced complications at birth and had to be separated from Heeba. In addition, Heeba refused to breastfeed and so I gave her dates soaked in water and infant formula. On my discharge date, I met Israh, an IYCF counsellor at the protection centre after referral by UNHCR. Israh was very good to me. She advised me on the importance of breastfeeding and offered breastfeeding support with positioning and latching. After three hours, Heeba was able to

latch onto my breast and start suckling. I was also given a breast pump to help with expressing milk. After three days, milk begun to flow. I am currently breastfeeding Heeba exclusively."

Living alone with no family support and prior breastfeeding experience, IYCF counsellors provide a lot of IYCF support to Nazreen. She also receives information about childcare practices, immunisation and hygiene. "I am very grateful to Save the Children for their support. The IYCF counsellors visit me on a weekly basis and assist me with my nutrition needs." Fortunately her current husband is very supportive and caring for both her and Heeba.

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Save the Children
Suzanne Mboya
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WFP photo library
WHO
Yolanda Romero/ACH

The Emergency Nutrition Network (ENN)

grew out of a series of interagency meetings focusing on food and nutritional aspects of emergencies. The meetings were hosted by UNHCR and attended by a number of UN agencies, NGOs, donors and academics. The Network is the result of a shared commitment to improve knowledge, stimulate learning and provide vital support and encouragement to food and nutrition workers involved in emergencies. The ENN officially began operations in November 1996 and has widespread support from UN agencies, NGOs, and donor governments. The ENN enables nutrition networking and learning to build the evidence base for nutrition programming. Our focus is communities in crisis and where undernutrition is a chronic problem. Our work is guided by what practitioners need to work effectively.

- We capture and exchange experiences of practitioners through our publications and online forum
- We undertake research and reviews where evidence is weak
- We broker technical discussion where agreement is lacking
- We support global level leadership and stewardship in nutrition

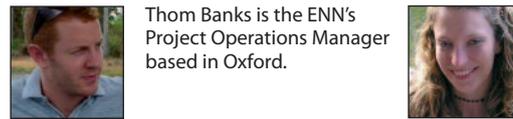
Field Exchange is one of the ENN's core projects. It is produced in print and online three times a year. It is devoted primarily to publishing field level articles and current research and evaluation findings relevant to the emergency food and nutrition sector.

The main target audience of the publication are food and nutrition workers involved in emergencies and those researching this area. The reporting and exchange of field level experiences is central to ENN activities. The ENN's updated strategy (following mid-term review in 2013) is available at www.ennonline.net

The Team

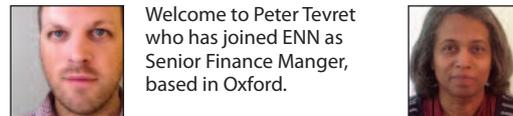


Jeremy Shoham is Field Exchange Editor and Marie McGrath is Field Exchange sub-editor. Jeremy Shoham, Marie McGrath, Carmel Dolan and Emily Mates are Technical Directors.



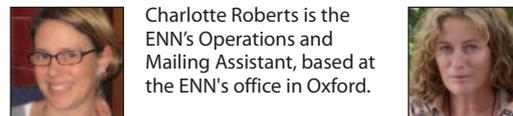
Thom Banks is the ENN's Project Operations Manager based in Oxford.

Chloe Angood is a nutritionist working part-time with ENN on a number of projects and supporting Human Resources.



Welcome to Peter Tvetv who has joined ENN as Senior Finance Manager, based in Oxford.

Clara Ramsay is the ENN's Finance Assistant, based in Oxford.



Charlotte Roberts is the ENN's Operations and Mailing Assistant, based at the ENN's office in Oxford.

Orna O'Reilly designs and produces all of ENN's publications.



Phil Wilks (www.fruitysolutions.com) manages ENN's website.



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A big thanks also to the hundreds of individuals, too numerous to mention, who 'behind the scenes' contributed to the content of this special edition through conversations with ENN, reviews of colleagues' draft articles and field trip support. Thanks to their agencies for giving their staff licence to write.

Cover

The main mosque in Harem Town, Idlib Governorate, Northern Syria; Davy Adams/GOAL, Northern Syria, 2013.

The Emergency Nutrition Network (ENN) is a registered charity in the UK (charity registration no: 1115156) and a company limited by guarantee and not having a share capital in the UK (company registration no: 4889844). Registered address: 32, Leopold Street, Oxford, OX4 1TW, UK. ENN Directors/Trustees: Marie McGrath, Jeremy Shoham, Bruce Laurence, Nigel Milway, Victoria Lack, Arabella Duffield.

The opinions reflected in Field Exchange articles are those of the authors and do not necessarily reflect those of their agency (where applicable).