Health Sector Humanitarian Response Strategy

Jordan 2017-2018

Health Sector Working Group

Updated January 2017

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1. Introduction

Syrian Refugees Registered with UNHCR

Urban areas: 514,274
Camps: 141,070
Female: 50.6%
Under 5 Y: 15.6 %
Above 60 Y: 3.7 %

Source: UNHCR registration data December 31st 2016

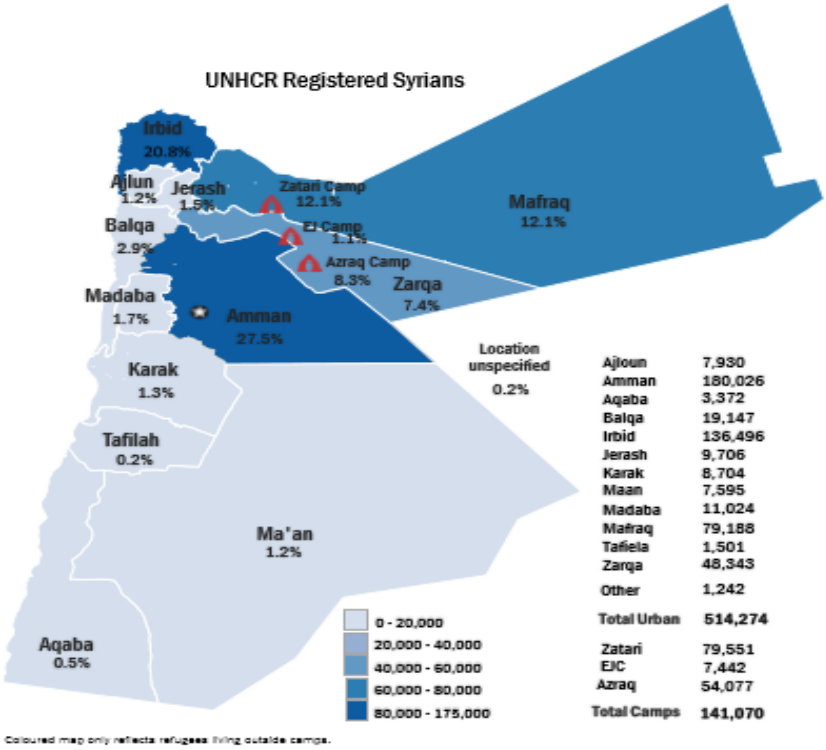
In early 2014, a Health Sector Strategic Advisory Group (SAG) for the Humanitarian Response was formed to further support the work of the Health Sector Working Group in Jordan. One of the SAG's main tasks[1] was to develop the Health Sector Humanitarian Response Strategy, expanding upon the existing response strategy and objectives present in the *Syria Regional Refugees Response Plan (3RP)*. This was updated in late 2016 to incorporate the latest response strategy, as well as reflect significant changes made to the national health policy of provision of services to registered Syrian refugees.
This document, which will be periodically updated, outlines the context of the humanitarian response in Jordan, particularly highlighting the Syrian refugee crisis and its implications on the national health system. Virtually all the data and figures in the strategy are related to Syrian refugees, as a large number of assessments have been carried out with this population in recent years. It is important to note, however, that the humanitarian response in Jordan also addresses refugees of nationalities other than Syrian, as well as the affected vulnerable Jordanian population. In addition to Syrian refugees, Jordan is also host to a significant Iraqi, government estimate about 600,000 Iraqis reside in country while refugee population are about 60,000 and also to refugees of other nationalities (nearly 10,000), testament to the Kingdom's long history of providing safe haven to those fleeing strife in their homeland. over 1.2 million Syrians living in Jordan based on 2016 census data, the numbers of Syrians who have sought refuge here (over 655,000 to date), and the resulting impact on the national infrastructure has required ongoing humanitarian support. As the crisis continues, there is a need to shift focus from short-term interventions to longer and more sustainable ones, expanding national capacity to respond to this, and future crises. During that transition, adequate health coverage must continue to be provided for all affected populations.

2. Context

Within the overall coordination approach to the Syrian refugee response in Jordan, the Health Sector brings together different UN agencies, national and international NGOs, donors and government actors who are all working to support the continued provision of essential health services to Syrian refugee women, girls, boys and men.
With the Syrian crisis in its sixth year the evolving humanitarian context poses new demands on health systems in Jordan and consequently on the Health Sector. Planning and coordination need to be strengthened even further to ensure an appropriate response. This includes strengthening national capacity to cope with the increased numbers requiring health services; improving

[1] Jordan Refugee Response. Health Sector Strategic Advisory Group for the Humanitarian Response Terms of Reference August 2016. http://data.unhcr.org/syrianrefugees/download.php?id=6354

collection and analysis of data and dissemination of information; emergency preparedness; and, crucially, improving the alignment of international responses with national structures and strengthening the link between the humanitarian and the development responses.



**Source: UNHCR Registration data – end December 2016*

3. Overview of health needs and risks

The Syrian refugee health profile is contributes to the overall Jordanian health outlook, as the country faces an epidemiological transition to a high burden of **non-communicable diseases** (NCDs); 15.4 % of consultations in Zaatari in 2016 were for NCDs[2] (diabetes constituted 18%, hypertension 22% and asthma 13%). **Communicable diseases** also remain a public health concern with a measles outbreak in Jordan in 2013 and an ongoing polio outbreak containment measures implemented in the region; there have been 285 cases of tuberculosis diagnosed amongst Syrians living in Jordan since March 2012 with four multidrug resistant cases[3]; and increasing numbers of imported leishmaniasis in areas hosting large numbers of Syrians.

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

[3] As of end of December 2016

The immunization coverage especially of refugees outside of camps has been improved over last years with over 93 % MMR coverage and 94% for Polio[4]. However, immunization coverage remains a concern particularly in light of the polio outbreak in Syria and Iraq. The last virologically-confirmed polio case in Jordan was reported on 3 March 1992. There is a need to strengthen uptake of routine immunization (Jordan has 11 vaccines in its schedule) to maintain the gains achieved during over last years for both refugee and Jordanian children.

Crude and under five mortality rates based on Zaatari data in 2016 were within expected ranges and comparable to Jordan's rates. Neonatal mortality has reduced (from 14 deaths in Zaatari in 2015 compared to 10 in 2016). Nevertheless, a newborn health baseline assessment[5] conducted in March 2016 in Zaatari and Azraq camps demonstrated the need to focus on developing the capacity of health care provider, reinforced use of appropriate and effective lower technology interventions such as skin-to-skin care and early initiation of breast-feeding. As well as improve management of both maternal and neonatal complications at camp level.

Morbidity

15.4 % of consultations in Zaatari in 2016 were for NCDs:

- **18% diabetes**
- **22% hypertension**
- **285 cases of TB since March 2012**

51% of households have at least one patient with chronic condition

NCD management is not always satisfactory, with inadequate monitoring, lack of a multidisciplinary approach and treatment interruptions. According to a survey conducted by UNHCR in December 2016[6] in non-camp refugees among household members, 51% of survey households were reported to have at least one member with chronic condition and 36% of household members with chronic diseases reported difficulty accessing medicine or other health services. The main reasons mentioned for inability to get care were costs (74%), long wait at the clinic (7%), and affording transport (19%). The continuing challenges in adequately addressing NCDs have the potential to seriously impact both quality of life and life expectancy amongst refugees. MoH, WHO, UNHCR and other health stakeholders have established a task force to improve NCD

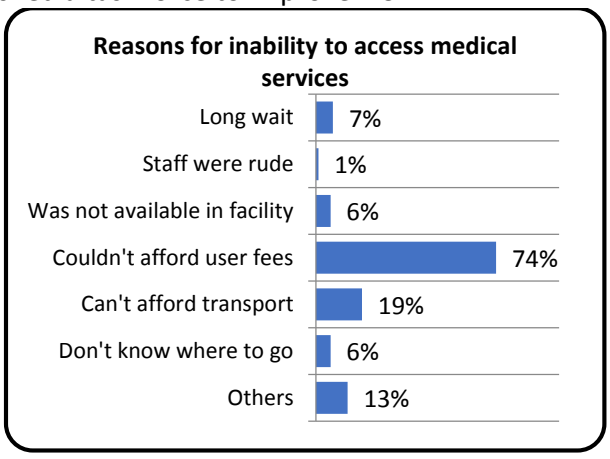


***Figure 2**– Reasons for not receiving care for chronic diseases* management amongst Syrians.

[4] Health Access and Utilization Survey, UNHCR 2016

[5] Newborn Health Baseline Assessment, UNHCR 2016

[6] Health Access and Utilization Survey, UNHCR 2016

Reproductive health coverage has maintained at 100% of deliveries in Zaatari and Azraq in 2016 attended by a skilled attendant (compared to 96% on average throughout 2014). However, both complete antenatal care coverage (at least four visits) and tetanus toxoid coverage need improvement. The proportion of deliveries in girls under the age of 18 was 12.3 % for 2016, which represents an increase compared to the average for 2015 of 9.5%. Girls under 18 are more likely to experience obstetric and neonatal complications. A cross sectional health survey was conducted among Syrian refugees living in Jordan, to assess refugee access and utilization of key health services. Key findings highlighted that 51% of household members were female and 15% of the women were pregnant in the last two years, compared to only 4% in 2014; women had difficulty accessing ANC services. UNFPA reproductive health needs assessment survey in Zaatari recommended continuation of community outreach activities with an emphasis on family planning programming and improving health care seeking behavior to address reproductive health needs and decrease high risk pregnancies and associated complications.

Reproductive Health

- **100% of deliveries in Zaatari and Azraq in 2016 attended by a skilled attendant**
- **Amongst non-camp refugees 98% delivered in a health facility, of which 41% were in a private facility**
- **Deliveries in girls under 18 years old has increased from 9.5 % in 2015 to 12.3% in 2016**

Men place a key role in determining women's access to critical health services, they need to be able to make informed decisions. Men as well as women need to know why ANC and skilled birth attendance are important, the risks associated with pregnancy and childbirth, how to prepare for childbirth and how to recognize signs of complications. Health Sector actors need to link with Child Protection (CP) and strengthen interventions to reduce early marriage. UNFPA continues to support Jordan Health Aid Society (JHAS) in providing basic emergency obstetric services in Zaatari and has progressively increased the capacity and resources to meet demands. While UNFPA, MoH and other key partners have worked extensively to improve the clinical care for sexual assault survivors though development of guidelines, trainings, and distribution of post-rape kits, there is still a need to improve quality of service in this field. Notably progress has been made in terms of connecting health facilities to other services thanks to the child protection and sexual and gender-based violence (SGBV) standard operating procedures. Messaging on SGBV is very sensitive and community and provider knowledge continues to be limited, however extensive efforts have been implemented at the inter-agency level to improve knowledge of SGBV response services and access to health services.

According to the UNHCR survey in non-camp refugees among women and girls aged between 14 and 49 years, 40 % were pregnant at least once in the past two years while in Jordan, and of those who had delivered in Jordan, 98% delivered in a health facility – 41%of those, in a private facility. A range of factors could explain the use of private facilities for deliveries including administrative barriers for registered refugees, lack of knowledge of available services, shortage of female doctors in the public sector and preference for private care. UNFPA with MoH and other stakeholders also supports reproductive health services. UNFPA work's on youth is to ensure that comprehensive health awareness and services are provided to accelerate youth's potential and development to the highest level. UNFPA strategic contribution commitment to youth has five areas; Evidence based advocacy, promote comprehensive sexuality education, SRH service delivery, reach marginalized and disadvantage youth, and promote youth leadership and participation.

People with disabilities and **elderly persons** are under-represented in UNHCR's registration database and more needs to be done to ensure that registration data is disaggregated by age and disability in order to better plan services and ensure equitable access to services for these persons with specific needs. According to the Handicap International/HelpAge International assessment, 22% of Syrian refugees in Jordan and Lebanon have an impairment (physical, visual, auditory, intellectual/cognitive and/or mental). People with disabilities often experience specific barriers to accessing health services including physical barriers at health centers, lack of understanding of staff regarding their health-concerns, and long distances to health care centers coupled with the high cost of transport.

The significant prevalence of disability amongst Syrian refugees in Jordan can be attributed to a variety of factors including the large numbers affected by war-related injuries, high burden of chronic NCDs, congenital and early-onset conditions (such as cerebral palsy), complications arising from untreated (or inadequately treated) conditions (for example, pressure sores, urinary tract infections and other conditions arising from inadequate nursing care in acute settings).

Specific medical and rehabilitation services are currently inadequate. More robust prevalence data disaggregated by age and type of impairment would be useful in better tailoring services. Disability and age-disaggregated data needs to be collected during registration, needs assessment and during regular project monitoring and evaluations done by all actors.

A Handicap International/HelpAge International assessment[7]reported that 8% of refugees in Jordan have a significant **injury** of which 90% were conflict-related. Men accounted for 72% of the injured persons with the highest proportion of injuries found amongst those aged 30 to 60 years. The significant impact of injuries on men of productive age increases the vulnerability of entire households. The capacity to address the health needs of the war-wounded has increased substantially, particularly emergency stabilization, acute surgery, and rehabilitation (physical and psychosocial). However, there are major gaps remaining, particularly related to post-operative care, home nursing, medium to longer term rehabilitation (including assistive devices) and community-based rehabilitation. More attention must also be paid to the ongoing care and treatment of common conditions (e.g. pressure sores) experienced by people after complicated trauma (e.g. spinal cord injuries and other neurological trauma) that can quickly become life-threatening. Better patient education, longer-term rehabilitation, and **home-based care models** can drastically reduce morbidity and mortality despite the complexity of these injuries.[8]

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

[8] Burns and O'Connel. *The challenge of spinal cord injury care in the developing world*. J Spinal Cord Med. 2012 Jan; 35(1): 3–8.

Elderly Syrian refugees can face significant challenges in accessing health services due to, inter alia, restricted mobility and need for support for activities of daily living. A recent review of home-assessment data of the most vulnerable families, reported that four and a half per cent of the visited refugee population were over the age of 60, compared to 3.6% in the entire Syrian refugee population outside camps. While April 2015 almost two-thirds of these live in formal housing, 22% live in tents or spontaneous settlements and 11% live in other informal housing. Seven out of ten face living conditions assessed as bad or urgent. These represent a small but highly vulnerable group amongst Syrian refugees in Jordan.[9]

Mental Health

- **19,511 consultations for mental health disorders in 2014 in camps**
- **26% epilepsy**
- **32% severe emotional disorder**
- **14.5% psychotic disorder**

It has been recently highlighted that children with developmental difficulties/disabilities particularly those with "mild to moderate disabilities", are not identified until they reach school age in camps and host community. Those children require special attention in terms of health, medical and nutritional needs to support their survival, development and growth. Hence, systems for early identification of these vulnerable cases are required in order to facilitate timely access to health, nutrition and other social services to support the development of all children are required in humanitarian settings

Mental health problems remain a significant concern for refugees in Jordan. There were 15,763 consultations for mental health disorders in camps in 2016 (27% for epilepsy/ seizures, 14% for depressive disorder, 11% for anxiety disorder and 9% for psychotic disorder). Also there were more than 28,886 consultations for mental health disorders in urban in 2016 (27% for depressive disorder, 24% for psychotic disorder, 19% for anxiety disorder, 15% for epilepsy/ seizures and 7% for post-traumatic stress disorder).

In general, there is an over-emphasis on stand-alone interventions, focus on trauma and less focus on delivering comprehensive, integrated services, and on supporting natural coping strategies and family/community resiliency. Furthermore, the geographic coverage of services needs to be widened. Integrated MHPSS within other health service provided can lead to a better response and less stigma. Support for developmental disorders and the parents of children with developmental disorders is still a need.

The acute **malnutrition** prevalence among refugees is low with the survey results show a level of Global Acute Malnutrition (GAM) (WHZ<-2 z-scores and/or edema) for the three survey sites, with respectively 2.7% (95% CI 1.4-5.0), 1.9% (95% CI 0.9-4.2) and 1.8% (95% CI 1.0-3.4) for Za'atri camp, Azraq camp and in host communities.[10]
Anemia in women of reproductive age has improved over last years but still at concern, in Zaatari camp was high at 44.7% in 2014 while ANC data in 2016 showed that only 12.2% of pregnant women were suffering from Anemia. There is a need to expand anemia prevention and treatment initiatives in all service provision places and ensure access to other critical micronutrients including continue the provision of food vouchers in both camps and host community and continue the distribution of

[9] UNHCR, Living in the Shadows: Jordan Home Visit Report, 2014.
[10] UNHCR/UNICEF/WFP/MOH/SCJ. Nutrition Survey Findings. November 2016.

fortified flour and fortified bread in the camps. Infant and young child feeding (IYCF) practices were poor pre-conflict including early weaning, and inappropriate complementary feeding practices. Despite the low acute malnutrition, levels will continue screening with Mid-Upper Arm Circumference (MUAC) in light of the economic deterioration, food security and nutrition status.

Until the end of November 2014, MoH maintained a policy of free access to primary and secondary care in their facilities for registered Syrians living outside of camps. Following a decision made by the Cabinet in November 2014, registered Syrian refugees outside of camps now have to pay the uninsured Jordanian rates at MoH facilities. This subsidized rate (around 35 – 60% of what other non-Jordanians pay), while manageable for most refugees and those patients with long-term, costly chronic conditions, will nevertheless pose a problem for the most vulnerable and those patients with long-term, costly chronic conditions. In the wake of this change, UNHCR issued a new policy to mitigate its immediate effects. Services are targeted towards the most vulnerable but SGBV, mental health, malnutrition in children, neonatal complications and obstetric emergencies will be supported for all. More information is needed on the impacts of the change in policy before redesigning health service support. Restriction of movement for women and girls may limit their access to health services, while lack of female providers for reproductive health services, though improved is also a barrier. HAUS 2016[11] have also shown that refugees have trouble accessing health services when only 30% of those who need health services actively sought services.

Information

70% refugees aware of subsidized access to public health services

52% refugees know they can be assisted through UNHCR partner clinics if they can't access government health services

Refugees continue to cite lack of **information on health services** as a major problem. HAUS Survey demonstrated that only 70% of respondents in urban setting aware of subsidized access to public health services while 52% were aware of free access through UNHCR supported services. Only 47% of urban refugees were able to detect the nearest clinic.

Secondary and tertiary care requires a continued high level of funding to ensure access to essential care such as normal and assisted deliveries, caesarean sections, war injuries, congenital abnormalities including cardiac abnormalities and renal failure. Costly complex treatments such as certain types of cancer cannot be supported with available resources necessitating difficult choices relating to resource allocation. In particular, access to critical reproductive health services has been impacted by the withdrawal of free services.

The MoH's critical role in providing refugee health services needs to be recognized and supported. Facilities in areas hosting large numbers of refugees are often overburdened. HAUS survey revealed an increase in percent of Syrians who sought care at MOH facilities in 2016 (28% in first facility and 57% in second facility) compared to 2015 (23.9 in first facility and 42.9 in second facility). This manifests in shortages of medications – especially those for chronic diseases – and beds, overworked staff and short consultation times. This increased burden also fosters resentment

[11] Health Access and Utilization Survey, UNHCR 2016

amongst the Jordanian population. National capacity to provide inpatient management with focus on most affected areas including maternal, neonatal, critical care and pediatrics. The health information system in urban settings needs to be integrated nationwide and to be able to routinely disaggregate Syrians and Jordanians.

At community level, coverage of **outreach and Syrian community involvement** in the promotion or provision of health services is insufficient; Amman has one community health volunteer per 2000 refugees (target >1 per 1000).Syrian refugee providers remain outside of the mainstream coordination mechanisms. This undermines Syrian access and coverage of key services, community capacity building, self-reliance and the ability to withstand future adversity. There is a need for greater access of refugees to information and enhanced refugee participation and engagement in identification of health and disability related needs, provision of information and linkages with health and rehabilitation services.
While the focus of the international and donor community in Jordan is on the large numbers of Syrian refugees. Refugees of other nationalities also constitute a significant number of persons of concern. Care needs to be taken to ensure that they are also being provided with enough information on their rights to access health care and are receiving assistance as appropriate from MoH, UN agencies and NGOs.

i. Health system performance

Demand on the public sector as well as NGO-supported clinics continues to grow. Even though the services are no longer free of charge they are still highly subsidized. This continues to be a considerable burden on MoH facilities which will require significant additional support to be sustained.

Frequent shortages of supplies (medicines, family planning commodities and medical equipment) exacerbated by the refugee influx have been reported. Furthermore the pressure on existing infrastructure continues to grow. Bed occupancy in many northern hospitals is continually close to 100 percent. The worst affected are critical care beds such as intensive care, coronary care and neonatal intensive care.
MoH immunization capacity was strengthened with in-kind support of cold chain equipment, vaccines and capacity building support provided by UNICEF, essential supplies supported by WHO and equipment supported by UNHCR. The MoH has also partnered with Medécins Sans Frontiers and opened a trauma surgery facility in Ramtha Public Hospital for the management of injured Syrians crossing the border. In addition, MoH, with the support of WHO Jordan has begun creating weekly epidemiological bulletins that highlight the key communicable disease related issues that have arisen in Jordan in the previous week.
MoH with the support of UNFPA provides family planning methods for the affected population in Jordan.

ii. Target groups and areas

There are two main population groups of concern: refugees (Syrians – over 655,344 women, girls, boys and men registered with UNHCR; Iraqis – over 61,004 women, girls, boys and men registered with UNHCR; Sudanese, Somalis and others – over 11,073 women, girls, boys and men registered with UNHCR); and affected host community.
As of end December 2016, the geographical distribution of Syrian refugees per governorate is as follows: over 180,026 in Amman (27.5%), 179,739 in Mafraq (24.2%, including nearly 79,000 in Zaatari camp); over 136,000 in Irbid (20.8%); and over 109,000 in Zarqa (16.8%, including over 54,077 in Azraq camp and 7,442 in EJC).
The geographic focus on northern governorates is important, but attention will also be given to the acute health sector challenges faced in a number of middle and southern zone governorates.[12]

Other Refugees 72,077

- **61, 004 Iraqis**
- **5,697 Yemeni**
- **3,266 Sudanese**
- **773 Somali**
- **1,355 other nationalities**

Source: UNHCR registration data December 31st 2016

No.	Population group	Total Population
1	**Camp refugees**	141,070
2	**Non-camp refugees**	514,274
3	**Other affected population**	600,000[13]
4	**Refugee children under five**	103,000
5	**Refugee women of reproductive age**	148,000
6	**Adolescents**	118,000
7	**Pregnant women and lactating women**	32,750
8	**Refugees with impairment and disabilities**	144,000
9	**Refugees with injuries**	52,400

Table 1 – Estimated target populations based on end of 2016 projections

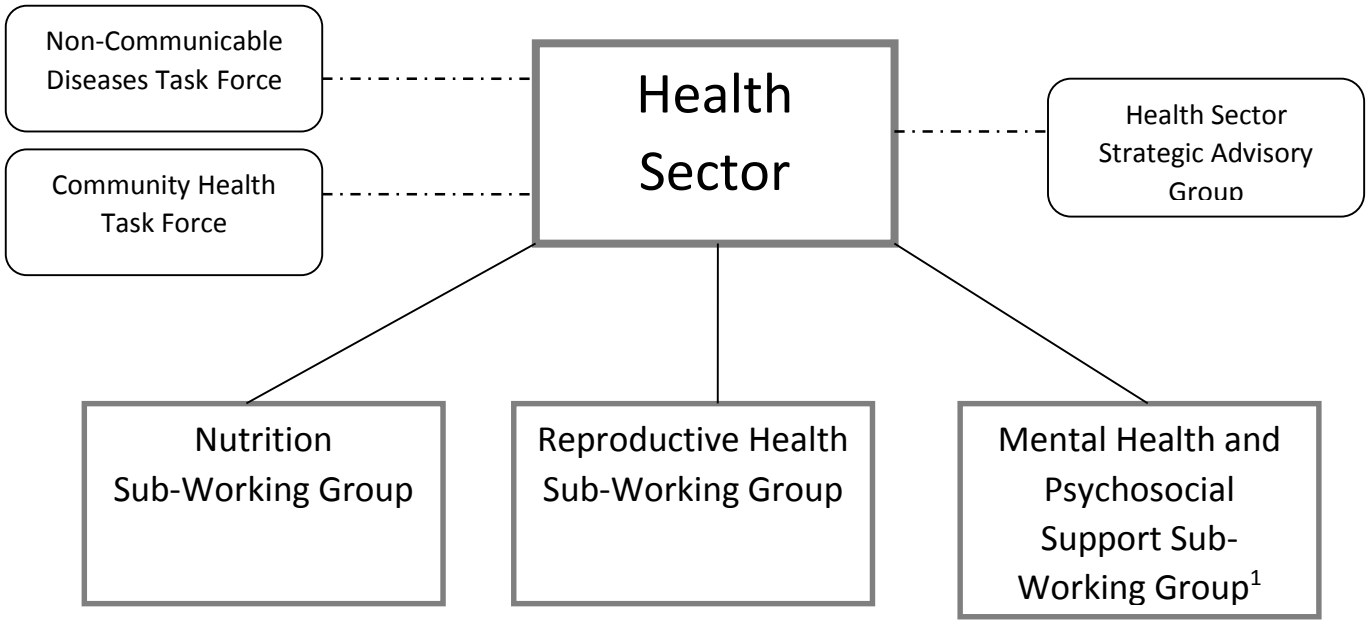
iii. Coordination

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

[12] Such as Zarqa, Maadaba, Balqa, Maan, Karak and Tafilah
[13] This include Non UNHCR registered Refugees

efforts, and elaboration of longer-term plans to strengthen gaps highlighted by the humanitarian situation.

In early 2014, a Strategic Advisory Group was created to provide technical and strategic support to and increase ownership and joint accountability within the Health Sector. Currently, the Health Sector is comprised of a main working group and two sub-working groups (Nutrition and Reproductive Health); a third sub-working group, Mental Health and Psycho-Social Support, falls under both the Protection and Health Sectors. In late 2013, a Community Health Task Force was also formed, to harmonize the approach to community health, including developing a Community Health strategy and reaching consensus on the definition and main tasks of Community Health Volunteers; in early 2014, a NCD Task Force was formed to support MoH in increasing the response capacity for NCDs, and for actors to share experiences and consolidate NCD interventions. Gender focal points within the sector will assist in ensuring that the differential needs of women, girls, boys and men are considered throughout the response. Together with the other actors in the health sector the gender focal points will identify gaps and challenges in gender equality to promote a gender-responsive environment and reduce or eliminate gender-based discrimination in health related programs.



[1]Also reports to the protection sector

Figure 5 *– Health sector Coordination structure*

iv. Strategic Intersections

The Health Sector liaises with other sectors including Cash, water, sanitation and hygiene (WASH) and SGBV, to ensure consistency in programming and mutual assistance in meeting objectives. Emergency cash assistance can be used to meet health sector objectives by supporting transport to and from health services or covering some costs not able to be covered elsewhere. There are clear

linkages between WASH services, Education, protection and health status. Gender-based violence requires a multi-sectoral response with health services being integral to the detection, prevention and response to GBV and increasing attention to mainstream Early Childhood Development (ECD) early detection and early initiation through PHC systems and services.
The Health Sector will take account of the different needs of women, girls, boys and men, recognize the potential barriers they may face in accessing services and ensure that women, girls boys and men can access health services equally. This will be assessed, integrated, monitored and evaluation throughout all stages of the response.

4. Goal

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

5. Objectives

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

1. Enhance access, uptake and quality of primary health care for Syrian women, girls, boys and men and Jordanian populations in high impact areas.

Expected outputs:
i. Management of communicable diseases, including Expanded Program on Immunization (EPI) services in place.
ii. Management of common non-communicable diseases strengthened
iii. Comprehensive RMNCAH health services provided to Syrian refugees and affected Jordanian population
iv. Promotion of healthy life styles and empowerment of young people to make responsible decisions through interactive youth friendly methods and tools.
v. Increased availability of safe and confidential GBV related medical services
vi. Appropriate nutrition, better parenting, early child care and development (ECD) and IYCF feeding practices promoted
vii. Improved access to mental health services at the primary health level

2. Enhance equitable access, uptake and quality of secondary and tertiary health care for Syrian women, girls, boys and men and Jordanian populations in high impact areas.

Expected outputs:
i. Referral system for secondary and tertiary care supported

ii. Secondary mental health services provided
iii. Physical rehabilitation (occupational and physical therapy) for persons with injuries and/or disabilities provided
iv. Access to emergency obstetric care provided
v. Facility based convalescent and longer term post-operative care provided for those with injuries and complex or multiple impairments

3. Improve comprehensive health care through integrated community interventions including rehabilitation services for Syrian women, girls, boys and men and Jordanian populations in high impact areas.

Expected outputs:
i. Community health volunteer teams and referral system in place
ii. Community level nursing for those with injuries and complex or multiple impairments provided
iii. Community management of acute malnutrition programs implemented and monitored
iv. Community level rehabilitation provided
v. Community level mental health services provided
vi. Community health volunteers influence behavior change through communication, health education and promotion to raise awareness on preventable diseases.

4. Contribute to strengthening national health systems to increase adaptive capacity to current and future stresses.

Expected outputs:
i. Access to primary and essential secondary and tertiary health care supported through equipment, financial support, medication and medical supplies especially essential chronic disease drugs
ii. Strengthening monitoring and evaluation mechanism to ensure accountability of partners in implementing interventions.
iii. Capacity building MoH services and staff as well as other national actors developed

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

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

6. Strategic Approaches

The overall aims in the 2017/2018 response are to maintain the low mortality rates and address the main causes of morbidity by promoting access to essential services. The response strategy will be throughout the refugee cycle from arrival to durable solutions and will consist of the following:

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

The response strategy in Zaatari and Azraq camps will be to ensure effective coordination to address gaps, including logistical and human resources support to MoH in order to strengthen their lead coordination role; continued monitoring of refugee health status, coverage and access especially for the most vulnerable; and promoting linkages with national health systems so that support will go to nearby MoH facilities where possible rather than creating high-level systems inside the camps.
In response to the withdrawal of free health services by the Ministry of Health and the expected reduction in humanitarian resources, health agencies should be developing mechanisms to target assistance towards those most in need. Parallel services will need to be continued for those who cannot access Ministry of Health services at the subsidized rate (either not eligible or cannot afford) but should ideally be directed towards the most vulnerable. Health agencies should coordinate to develop harmonized systems of vulnerability identification and provision of assistance. Access to health services could also be supported by demand side financing initiatives.

In relation to SGBV, health care providers play an important role in receiving disclosure from survivors and provide critical clinical management and referral. This will be strengthened through training and improved monitoring in coordination with the Protection Sector, SGBV sub-sectors, Family Protection Department, and other relevant national institutions, including through the full implementation of the CP and SGBV standard operating procedures. Critical gaps outside the camps which are not able to be met by the MoH will be met through further supporting NGO clinics and support for referrals. Continued support to NGOs to relieve the burden on MoH facilities is needed until the MoH facilities are able to manage the increased workload. UNFPA and UNICEF will be supporting MoH to develop a complete Clinical Management of Rape Survivors protocol in line with internationally defined standards. A health information system has been introduced in UNHCR-supported NGO facilities in order to contribute to the available data on Syrians, including data disaggregated by gender and age. This in combination with the recently established GBV Information Management System, coordinated by UNHCR and UNFPA, will be able to provide increased information of trends and SGBV as well as gaps in service provision. Women are by far the dominant users of the case-management services of SGBV. Girls use these services to a limited extent: this is not consistent with data about needs. Men started to use these services in small numbers; and boys rarely use the services. To further address reproductive health needs for youth, a special emphasis will be set on promoting reproductive health services and rights of young people, especially young women and girls, reinforcement of youth peer network among the refugee population in the camp and the provision of youth-friendly health services. In both camp and non-camp populations two additional approaches will be developed. Firstly, a strategy to strengthen refugee participation and engagement in provision of information and selected health services (e.g.

diarrhea management with oral rehydration solution, behavior change communication, MUAC screening, referral to primary health care centers), by training and supporting male and female community health volunteers, will be developed by agencies working in the Health Sector and resources sought for this. Secondly, vulnerability identification and scoring will be improved with the aim of better targeting and reaching those most vulnerable with essential services and assistance and monitoring of assistance against needs. Vulnerability assessments will be shared across partners, and will include questions on a range of vulnerabilities related to economic factors and well as physical and social factors, such as age and disability.

The Health Sector will continue, in a coordinated manner, to conduct assessments of needs and capacities (including refugee women, girls, boys and men), coverage and impact (gender disaggregated), as well as ensure periodic monitoring and evaluation and the availability of the necessary information to inform strategic planning processes. In particular the observed gender differences in mental health consultations (more males than females), psychiatric admissions (more females than males) and injuries (more males than females) will be explored to determine if this represents a morbidity pattern or differential access.

For refugees in non-camp settings the national system will be supported through adequate human resources in areas most affected by Syrians, essential medicines, supplies, equipment and critical infrastructural improvements, and performance-based incentives for staff. Specific capacity gaps will be addressed though training and development of work plans with partners, such as inpatient management of acute malnutrition, clinical management of SGBV, integration of mental health into primary health care; or through staff secondment or human resources support, such as for chronic disease management and specialized trauma surgery. A network of clinics and other services will be supported to meet the needs of those Syrian refugees unable to access MoH facilities for primary and secondary care.

The following need to be strengthened: post-operative/convalescent care and rehabilitation for war-wounded persons; services for children with sensory impairments and intellectual disabilities; and infant and young child feeding. Essential secondary and tertiary care, including emergency obstetrics not covered by MoH, needs significant funding to ensure access throughout 2016. Clinics operated through NGOs will continue to focus on areas not currently widely available in the national health system (such as mental health and SGBV responses) for Syrian refugees outside of the camps. Furthermore demand side financing mechanisms such as cash to offset the cost of accessing health services will continue in order to facilitate cost-effective access to Ministry of Health services.

Certain gaps are beyond the capacity of the Health Sector to address, including the MoH restrictions on hiring new staff which limits their ability to respond to the increased workload, or major infrastructure gaps. Furthermore, humanitarian funding channels often preclude general budgetary support to the MoH but require funds to be channeled through humanitarian partners and in-kind support.

7. Key Overarching Approaches

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

- The use of Inter-agency Health Kits is no longer required and agencies should be using procurement based on consumption and local morbidity patterns.

- RH kits can be used for emergency preparedness and response to critical gaps but only the Clinical Management of Sexual Violence kit is suitable for ongoing needs due to the very specific drugs provided.

ii. Comprehensive Reproductive Health programming

- As the crisis is in its sixth year the emphasis in reproductive health should be on comprehensive programming.
- Developing the capacity of health care providers on sexual reproductive health (SRH), Sexual-Gender based Violence (S-GBV), Minimum Initial Services Package (MISP) and Clinical Management of Rape (CMR) will remain an essential component in preparedness.
- Availability of comprehensive emergency obstetrical services inside the camps needs to be secured
- Family planning programming inside and outside the camps should be scaled up including linkages between general health providers , community health volunteers and different level of services to enhance referral and reduce missed opportunities
- Post abortion care and counselling is important to improve maternal health and reduce maternal morbidity
- Strengthening Reproductive health care providers' capacity to respond to complicated cases and enhancing clinical skills, quality and scope.

iii. Balance between Health Systems Strengthening and Services Delivery

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

iv. Support equitable and sustainable transition to access health services

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

- Communication for development in priority areas
- Gender mainstream in all of the above activities by using gender analysis

v. Essential medicines and drug donations

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

vi. Guiding documents

i. Jordan Response Plan 2017/2019
ii. Technical Standards Applicable: UNHCR's Essential Medicines and Medical Supplies Policy and Guidance.
   a. 2011. (http://www.unhcr.org/4f707faf9.pdf)
   b. 2013. (http://www.unhcr.org/527baab09.pdf
iii. Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas. 2011. UNHCR (http://www.refworld.org/docid/4e27d8622.html)
iv. UNHCR's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern. 2009. (http://www.unhcr.org/4b4c4fca9.html)
v. UNHCR Regional Public Health and Nutrition Strategy for Syrian Refugees EGYPT, IRAQ, JORDAN, LEBANON AND TURKEY 2016 – 2017
vi. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 2011.(http://www.sphereproject.org/handbook/)
vii. UNHCR's Health Information System http://www.unhcr.org/pages/49c3646ce0.html
viii. Core Commitments for Children in Emergencies, Health, UNICEF. (http://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/UNICEF/UNICEF1%20-%20Core%20commitments%20for%20children%20in%20emergencies.pdf)
ix. WHO,UNHCR,UNFPA:http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/
x. Standard Operating Procedures for Emergency Response to Gender Based Violence and Child Protection in Jordan,2015
xi. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings,2011
xii. Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations
xiii. Refocusing Family Planning in Refugee Settings: Findings and Recommendations from a multi-Country Baseline Study, November 2011 UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender,2014
xiv. IPPF, UNFPA, WHO, The Interagency Working Group on SRH and HIV Linkages SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools :: http://www.unfpa.org/publications/srh-and-hiv-linkages-compendium-indicators-and-related-assessment-tools#sthash .wWHqlNY4.dpuf, 2014

Annex 1: Health Sector Budgetary Requirements 3RP 2017-2018

NO	Organization	Budget 2017		Budget 2018	
		Resilience	Refugees	Resilience	Refugees
1	IOM	0	2,000,000	0	1,840,000
2	UNICEF	5,200,000	5,550,000	5,460,000	5,106,000
3	QRC	0	3,496,301	0	3,216,597
4	CVT	0	2,400,000	0	2,208,000
5	MEDAIR	0	1,450,000	0	1,334,000
6	JHAS	0	1,000,000	0	1,012,000
7	MDM	0	1,060,960	0	982,483
8	IMC	0	5,110,000	0	4,701,200
9	IRC	0	5,713,731	0	3,273,117
10	HI	3,000,000	4,950,000	3,000,000	3,956,000
11	UNHCR	1,767,618	28,524,956	0	26,152,997
12	UNFPA	6,160,000	12,516,182	5,885,000	10,754,616
13	IRD	0	1,000,000	0	920,000
14	PU-AMI	0	1,225,000	0	1,127,000
15	IOCC	0	194,000	0	161,920
16	JPS	0	550,000	0	667,000
17	TDHI	0	973,740	0	910,340
18	AMR	0	1,369,952	0	1,215,158
19	ACF	0	100,000	0	92,000
20	IRW	0	1,000,000	0	1,748,000
21	WHO	1,250,000	400,000	400,000	276,000
total:		17,377,618	80,584,822	14,745,000	71,654,429