Health Sector Humanitarian Response Strategy

Jordan
2019-2020

February 2019

Table of Content

1. Introduction

Syrian Refugees Registered with UNHCR

Urban areas: 545,609
Camps: 126,041
Female: 50.3%
Under 5 Y: 15.2 %
Above 60 Y: 3.8 %

Source: UNHCR registration data December 31st 2016

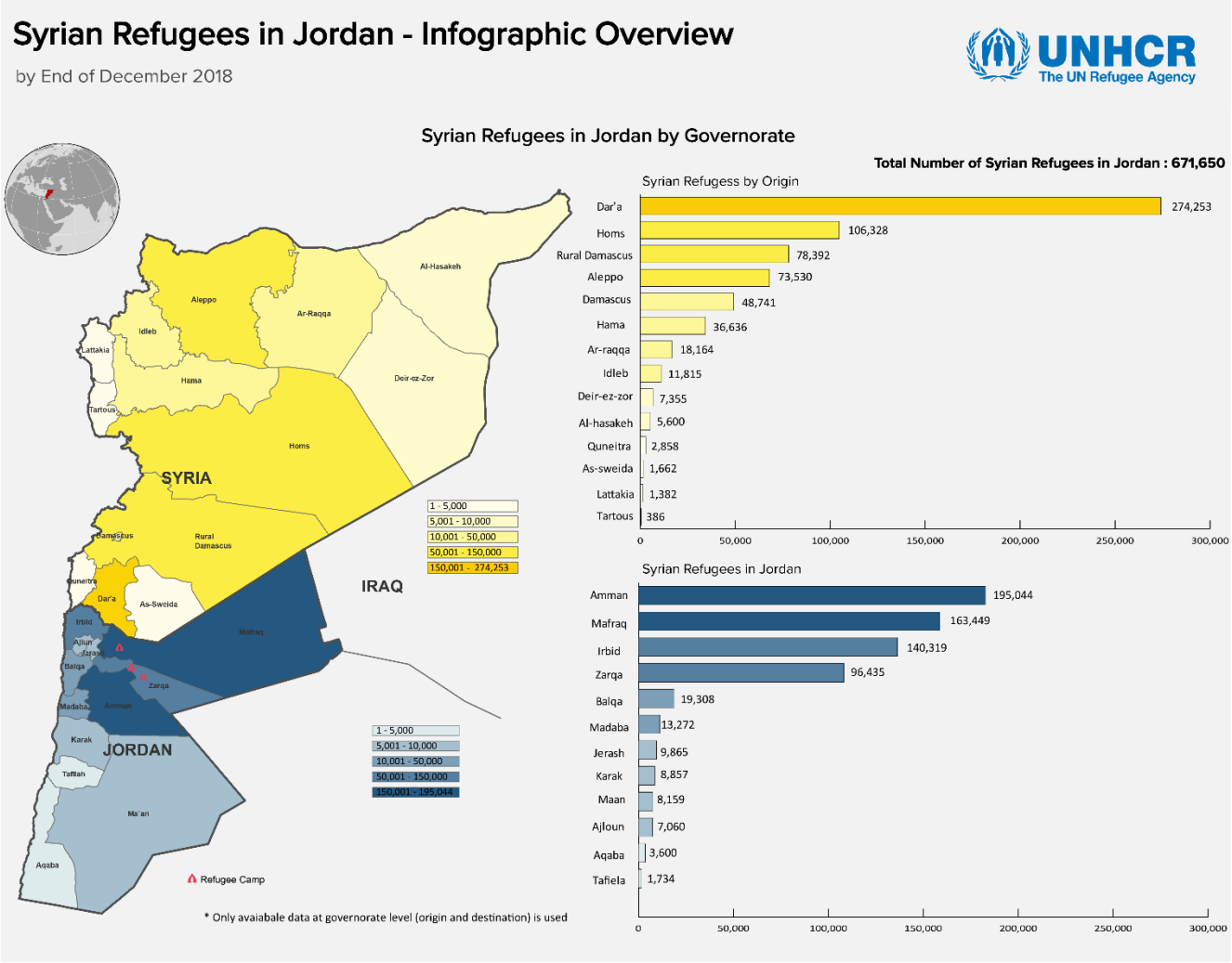
In early 2014, a Health Sector Strategic Advisory Group (SAG) for the Humanitarian Response was formed to further support the work of the Health Sector Working Group in Jordan. One of the SAG's main tasks[1] was to develop the Health Sector Humanitarian Response Strategy, expanding upon the existing response strategy and objectives present in the *Syria Regional Refugees Response Plan (3RP)*. This was updated in late 2018 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 67,000 and also to refugees of other nationalities (nearly 23,000), 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 671,000 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 eighth 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; 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 2018*

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); 15.8 % of consultations in Zaatari in 2018 were for NCDs[2] (diabetes constituted 17%, hypertension 21% and asthma 12%). **Communicable diseases** also remain a public health concern with a measles outbreak in Jordan in 2013 and an ongoing polio outbreak containment measures

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

implemented in the region; there have been 421 cases of tuberculosis diagnosed amongst Syrians living in Jordan since March 2012 with four multidrug resistant cases[3]
The immunization coverage especially of refugees outside of camps has been improved over last years with over 96 % MMR coverage and 97% for Polio[4]. However, immunization coverage remains a concern particularly in light of the polio outbreak in Syria. The last virologically-confirmed polio case in Jordan was reported on 3 March 1992. There is a need to maintain 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 2018 were within expected ranges and comparable to Jordan's rates. Neonatal mortality has reduced (from 13.8 deaths in Zaatari in 2017 compared to 9.7 in 2018). 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

15.8 % of consultations in Zaatari in 2018 were for NCDs:

- **17% diabetes**
- **21% hypertension**
- **421 cases of TB since March 2012**

Urban Survey showed slight increase in NCD's prevalence

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 2018[6] in non-camp refugees among household members, 27% of found with hypertension, 19 with Diabetes and 14% with Asthma. 48% 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 (49%), was not available in the clinic (17%), and affording transport (19%). The continuing challenges in adequately addressing NCDs have the potential to seriously influence both quality of life and life expectancy amongst refugees. MoH, WHO, UNHCR and other health stakeholders have to establishes a task force to improve NCD.

Reasons for inability to obtain medicine	2018 (n=102)	2017 (n=143)
Long wait	3%	2%
Staff were not polite	4%	1%
Was not available in facility	19%	30%
Couldn't afford user fees	52%	76%
Can't afford transport	13%	9%
Don't know where to go	4%	5%
Others	6%	4%

[3] As of end of December 2018

[4] Health Access and Utilization Survey, UNHCR 2018

[5] Newborn Health Baseline Assessment, UNHCR 2016

[6] Health Access and Utilization Survey, UNHCR 2018

Table 1– *Reasons for not receiving care for chronic diseases* management amongst Syrians.

Reproductive health coverage has maintained at 100% of deliveries in Zaatari and Azraq in 2018 attended by a skilled attendant. 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 11.1 % for 2018, which represents an increase compared to the average for 2017 of 10%. 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 17% of the women were pregnant in the last two years, compared to only 15% in 2017; 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 2018 attended by a skilled attendant**
- **Amongst non-camp refugees 100% delivered in a health facility, of which 46% were in a private facility**
- **Deliveries in girls under 18 years old has increased from 10 % in 2017 to 11.1% in 2018**

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 supported 3 static clinics in villages 3, 5 and 6 at Azraq camp and maternity unit in Zaatari camp; Integrated SRH services were provided to Syrian refugees in these clinics to ensure accessibility to comprehensive SRH services to targeted population. Pregnant women were screened for anemia and cases detected and managed through the provision of iron and folic acid supplementation.. 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, 17 % were pregnant at least once in the past two years while in Jordan, and of those who had delivered in Jordan, 10% delivered in a health facility – 46%of those, in a private facility. A range of factors could explain the use of private facilities for deliveries including increased cost, 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, 22.9% of Syrian refugees aged 2 years and above have disabilities[7]. 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. In the Disability Assessment among Syrian Refugees in Jordan and Lebanon 29.9% of persons with disabilities reported illness or disease as the primary cause of functional difficulties. Among persons who reported illness/disease, injury and malnutrition as causes of their disabilities, 24.7% considered the causes were related to the Syrian conflict. Among them, walking was the most common activity with which they faced difficulties, followed by anxiety, depression, fatigue and seeing.

A Handicap International/HelpAge International assessment reported more females (34.6%) than males (24.7%) had disabilities related to illness or disease. Injuries, on the other hand, led to more males having a disability (14.7%) than females (7.1%).

The capacity to address the health needs of the war-wounded still of concern particularly 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].

Mental health problems remain a significant concern for refugees in Jordan. There were 13,647 consultations for mental health disorders in camps in 2018 (30.9% for epilepsy/ seizures, 33.7% for depressive disorder and 14.4% for psychotic disorder). In addition, there were more than 71,423 consultations for mental health disorders in urban in 2018.

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

[7] Disability Assessment among Syrian Refugees in Jordan and Lebanon (HI, IMMAP, 2018)

[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.

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.[9]

Anemia in women of reproductive age has improved over last years with minimal deterioration during last 2 years, 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. In last two years, the prevalence of anemia in Zaatari increased from 10.55% in 2017 to 12.26% in 2018 while in Azraq increased from 17% in 2017 to 22.3% in 2018. Anemia in of reproductive age still at concern and 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 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. **Health care provision policy** still unstable; 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. On January 2018, the Cabinet's issue new decision to identify level of access to public health facilities; the decision states that Syrian refugees have to pay the 80 % of Unified pricing when they use all types of health services provided by the Ministry of Health. The Unified price is the rate that is used for non-Jordanians (foreigners) who live on the Jordan territories and is about 2 – 5 times of what non- insured Jordanians (old rate) are paying. Prior to this decision, the majority of registered Syrians were able to receive healthcare services at the non-insured Jordanian rate from the ministry of health facilities. However, the non-insured Jordanian rate was normally affordable for non-vulnerable individuals this is expected to cause considerable hardship for all refugees.

Information

82% refugees aware of subsidized access to public health services

81% refugees know they can be assisted through UNHCR partner clinics if they can't access government health services

In the wake of this change, UNHCR and humanitarian partners have expanded services coverages and adopted 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

[9] UNHCR/UNICEF/WFP/MOH/SCJ. Nutrition Survey Findings. November 2016.

emergencies will be supported for all. 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 2018[10] have also shown that refugees have trouble accessing health services when only 45% of those who need health services actively sought services.

UNHCR has maintained the annual health access and utilization survey (HAUS) implementation that aim to monitor access and utilization behaviors among Syrian refugees. Monitoring the impact of new health policy was at focus of 2018 version.

The 2018 HAUS preliminary findings revealed alerting indicators with significant increase in health care cost; the survey showed that 43% of household reduce number of visit to health care provider and reduce or stop use of medication as adaption strategy to minimize cost increase impact. Additionally, despite the improvement noticed in full antenatal care (ANC) coverage rate only 17% of women at reproductive age tried to obtain contraceptive in 2018 compared to 35% in 2017 while the cost mentioned as the main barrier to access ANC by 78% of surveyed women.

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 subsidized 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 decrease in percent of Syrians who sought care at MOH facilities in 2018 (14% in first facility and 9% in second facility) compared to 2017 (27% in first facility and 29 in second facility). This manifests in increase health care cost, shortages of medications – especially those for chronic diseases – and beds, overworked staff and short consultation times. This increased burden also fosters resentment 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

[10] Health Access and Utilization Survey, UNHCR 2018

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.

Finally, the recent change in the policy expected to detach more refugees from public health care system due to the increased cost. The UNHCR health access and utilization survey showed significant reduction in number of refugees who are accessing public health facilities as a first choice during 2018[11]. The health sector has to focus more on community health intervention to reattach refugees to the public health care system, particularly in case of old policy return.

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 subsidized. This continues to be a burden on MoH facilities that will require 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/consumables supported by UNHCR.

MoH with the support of UNFPA provides family planning methods for the affected population in Jordan.

[11] The seeker of service at MOH facilities reduced from 27% in 2017 to 14% in 2018.

ii. Target groups and areas

There are two main population groups of concern: refugees (Syrians – over 671,650 women, girls, boys and men registered with UNHCR; Iraqis – over 67,498 women, girls, boys and men registered with UNHCR; Yemenis Sudanese, Somalis and others – over 22,940 women, girls, boys and men registered with UNHCR); and affected host community.
As of end December 2018, the geographical distribution of Syrian refugees per governorate is as follows: over 197,271 in Amman (29.4%), 163,770 in Mafraq (24.4%, including nearly 78,000 in Zaatari camp); over 140,607 in Irbid (20.9%); and over 97,076 in Zarqa (14.4%), including over 40,000 in Azraq camp and 6,903 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 90,438

67, 498 Iraqis

14,300 Yemeni

6,019 Sudanese

793 Somali

1,828 other nationalities

Source: UNHCR registration data December 31st 2018

No.	Population group	Total Population
1	**Camp refugees**	126,041
2	**Non-camp refugees**	545,609
3	**Other affected population**	600,000[13]
4	**Refugee children under five**	102,000
5	**Refugee women of reproductive age**	151,000
6	**Adolescents**	121,000
7	**Pregnant women and lactating women**	33,550
8	**Refugees with impairment and disabilities**	54,000

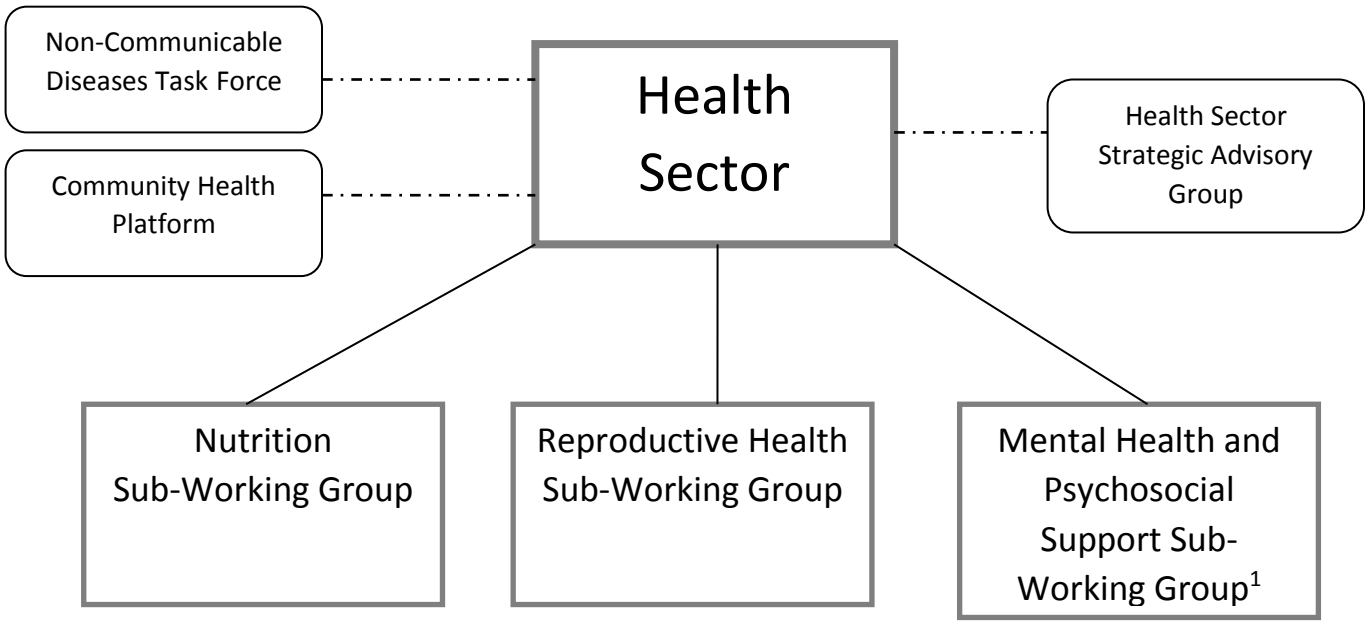
Table 2 – Estimated target populations among Syrians based on end of 2018 projections

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

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

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 platform 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.
Gender Marker focal points within the sector will assist in ensuring that the differential needs of women, girls, boys and men at their different age 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 and age-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

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 2019/2020 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.

4. Respond to the health needs of returnees to reduce threats due to the access barriers to the health services during movement and transition period.

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 subsidized access to the 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 forigner rate 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 provide essential package for vulnerable groups until the MoH return the subsidized access for all refugees. 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. 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 fully utilized 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,
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: 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 2019. 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.

Finally, with the new development and political reconciliation process and the progress made a small scale of returnees reported during 2018. The near future of situation still not clear but a larger scale of repatriation may encountered during next two years; the health sector will be part of repatriation operations. Measure need to be in place to make sure that basic health and nutrition needs of the returnees are reflected in the three phases of the repatriation operation: pre-repatriation, movement, and re-integration.

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 eighth 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 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. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. 2018.(https://www.spherestandards.org/handbook-2018/)

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

vii. 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)

viii. WHO,UNHCR,UNFPA:http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/

ix. Standard Operating Procedures for Emergency Response to Gender Based Violence and Child Protection in Jordan,2015

x. ,2011

xi. Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations

xii. 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

xiii. 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 2018-2019

NO	Organization	Budget 2018		Budget 2019	
		Resilience	Refugees	Resilience	Refugees
1	Caritas	0	3,486,830	0	5,389,549
2	IOM	0	1,500,000	1,056,250	1,500,000
3	UNICEF	4,800,000	3,500,000	3,500,000	2,700,000
4	QRC	0	3,296,301	0	2,753,208
5	CVT	0	3,500,000	0	3,200,000
6	MEDAIR	0	1,416,500	0	2,568,490
7	JHAS	0	1,284,136	0	500,000
8	NICCOD	0	0	0	555,866
9	IMC	3,200,000	2,710,000	2,500,000	5,000,000
10	IRC	0	5,910,737	0	7,902,523
11	SAMS	0	0	0	2,020,500
12	UNHCR	0	31,852,810	0	48,000,000
13	UNFPA	4,450,740	11,037,000	1,880,800	9,438,730
14	IRJ	0	0	0	1,053,356
15	PUI	0	384,574	0	1,035,000
16	IOCC	0	296,000	0	411,000
17	JPS	0	1,359,604	0	1,385,000
18	TDH italy	0	578,000	0	1,430,000
19	AMR	0	0	0	2,134,755
20	UPP	658,000	780,000	16,667	16,666
21	IFRC	0	891,741	0	462,740
22	WHO	2,350,000	400,000	2,205,000	40,000
23	SCJ	0	1,527,000	0	1,250,000
24	HI	1,256,438	1,140,791	0	879,677
25	MDM	175,000	0	0	0
26	RHAS	117,500	0	117,500	0
	Total	17,007,678	76,852,024	11,276,217	101,627,060