Programming experiences and learning from the nutrition response to the Syrian crisis
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*An Informal Settlement during storm in December 2013, 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 remains) 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 this 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 community; 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, on 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 (available at www.ennonline.net/fex) and this smaller print edition. For print, we have selected 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 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 jeopardise future programming.

The special issue provides a truly unique overview of programming experiences in the region, as well as insights into the institutional architecture and challenges involved in supporting programming. If you can, we encourage you to access the ‘bonus’ content online. 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 implemented 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 A4ID. 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 coordination 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)

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

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

3 http://a4id.org/

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Photo: Mathew Livesey, UNHCR
While the ENN’s role is first and foremost to capture programming experiences and lessons learned (and 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 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 Syrian refugees 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 Zaatari 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 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.

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.
4 file://C:/Users/Marie/Downloads/TurkeySyriaSitrep12.09
5 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.
6 Ruba Ahmad Abu-Taleb. Experiences of emergency nutrition programming in Jordan.
7 Sura Alasman. Managing infant and young child feeding in refugee camps in Jordan.
8 James Kingori. UNICEF experiences on nutrition in the Syria response; Najwa Rizkallah. UNICEF experiences of the nutrition response in Lebanon.
9 ENN interviews in Jordan and Lebanon.
10 Linda Shaker Berbari, Dima Ousta and Farah Asfahani. Institutionalising acute malnutrition treatment in Lebanon.
11 Jamila Karinova and Jo Hammoud. Relief International nutrition and health programme in Lebanon.
12 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.
A subsequent cross-sectional cluster survey in Lebanon in 2014 appeared initially to confirm the feared nutrition crisis, with an increase in 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 Jordan20 or found in other assessments21. Furthermore, the few cases that were detected often had pre-existing co-morbidities22. Increasing uncertainty about the reliability of the Lebanon survey data, led to UNICEF requesting CDC23 to carry out a re-analysis of the data in 2013. This revealed that there had been some data manipulation regarding height measures24 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 survey25, 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 refugees26.

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 treatment of acute malnutrition was unnecessary in both Lebanon and Jordan but this has not been the case in southern Iraq27, wherein increasing uncertainty about the reliability of the earlier Lebanon 2012 survey and Jordan 2012 nutrition survey28, 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 refugees29.

Views

In other aspects of the response (notably within Syria) there has been a lack of representative nutrition data to inform programming30. Small-scale assessments, in Idleb, Ar raqqa and Aleppo governorates in Northern Syria, described in an article by World Vision International31, 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-Albab District of Al Raqqa governorate found a prevalence of 0.6% GAM32. However, Medecins sans Frontieres (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 months33.

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)34, exclusive breastfeeding rates are low, and breastfeeding falls off considerably by 1 and 2 years of age35. Infant formula use is a recent and increasing form of infant feeding that is culturally accepted36. 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 breast-feeding support in a bid to protect and ideally increase breastfeeding rates. This has yielded some strong and necessary breastfeeding support programming in Lebanon37 and Jordan40 and is the focus of attention on IYCF support within Syria. However, there have been large gaps in attention and action on supporting non-breastfed infants (for infants who are breastfed but heavily dependent on infant formula), especially to refugees in host communities and in Syria. Support to non-breastfed infants has not been entirely absent – we feature articles on successful targeted programmes of support in Zaatar1 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 needs38.

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 deliver39, and in host communities where refugees are scattered and difficult to identify and follow up40. The region has a track record of misuse of infant formula in crisis times41. 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 infants42. The Joint Rapid Assessment of Northern Syria (JRANS) 2012, the Syria Integrated Needs Assessment (SINA)43 in Dec 2013 and GNC mapping in Syria44, 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, espe-

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

36 Emma Littlechild and Claire Beck. Experiences and challenges of programming in Northern Syria.

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

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

39 Maartje Hoetjes, Wendy Rhymere, Lea Matasci-Phelippeau, Saskia van der Kam. Emerging cases of malnutrition amongst IDPs in Tal Aybdi district, Syria.

40 Susana Moreno Romero. WFP experiences of vulnerability assessment of Syrian Refugees in Lebanon.

41 Nasja Ramirez. UNICEF experiences of the nutrition response in Lebanon.

42 Centres for Disease Control and Prevention. Nutrition screening and management as part of the nutrition response in Lebanon, personal communication.

43 Personal communication. It is not possible to confirm these 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 months.

44 Infant and Young Child Feeding (IYCF)
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 Za’atari camp in Jordan; a three-month ‘stop gap’ supply was provided in 2013 by UNHCR46 with only a sustained supply of SuperCereal Plus eventually established by WFP in February 201447. It was not well accepted by the community and significant follow up has been necessary to support its use48. 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 expensive49. 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 adults50 but no evidence of concerted action. In Lebanon, no one organisation was willing to undertake blanket distribution of micronutrient powders (MNP)s for children aged 6-59 months51. The consequences of inadequate support to complementary feeding are now reflected in the high prevalence of anaemia in both countries; amongst Za’atari camp refugees in Jordan is now at 48.4%, a “problem of major public health significance” according to WHO criteria52.

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 Za’atari camp in Jordan and subsequently, tensions around subjecting mothers to physical assessments to determine whether they could breastfeed or not53. Infant formula is excluded from the voucher programmes documented in Jordan, only stocked in pharmacies and so not available through the WFP-supported food voucher schemes for non-camp refugees54. 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 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 unsuccessful56. These experiences challenge us to rethink our conception of what IYCF in emergencies entails and the IYCF programming models in the Middle Eastern context.57 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 IYCF58, 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 current IYCF programmatic approaches to deferring breastfeeding support, given the reality of the IYCF challenges and the humanitarian sector is really ready to support ‘informed decisions’ by mothers to not breastfeed59.

There is no question that there is a need for protection and support of breastfeeding in mixed populations. These contexts are 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 conflict60 laid the groundwork for a Lebanese national programme focused on strengthening Code implementation61. It is important that humanitarian crises and the associated response don’t undermine national efforts to strengthen policy and programming around breastfeeding support and protection. A mother from Syria has the same right to support for breastfeeding as a mother in Sudan. But equally, a non-breasted 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 unsuccessful. These experiences challenge us to rethink our conception of what IYCF in emergencies entails and the IYCF programming models in the Middle Eastern context. 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 IYCF, 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 current IYCF programmatic approaches to deferring breastfeeding support, given the reality of the IYCF challenges and the humanitarian sector is really ready to support ‘informed decisions’ by mothers to not breastfeed.
hand in the lack of sectoral critical analysis of this focussed its attention on additional areas of need emergency nutrition problems, raises the question which were prevalent in the Syrian population pre- micronutrient deficiencies), child stunting, overweight, problems facing infants, children, mothers and other children reported70. Added to this, flawed/suspicious glaring nutrition crisis (no severely emaciated chil- tarian community was challenging without a
We feel that the momentum to scale up of treatment out of the response, as described earlier. However the nutrition community appeared to adopt and stick with a largely Afrocentric lens to the nutrition pre- dition to monitor micronutrient deficiency disease prevent micronutrient deficiencies; in Jordan, there has been been blanket supplementary feeding programmes (BSFPs) in Za’atari 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 ac- tion to reduce levels of anaemia in emergency contexts56. We also know from recent work amongst other refugee populations that high levels of anaemia in refugee settings may indicate high levels of iron or micronutrient deficiency78. Our ar- ticles describe how within Syria, WFP and UNICEF have been distributing micronutrient powders to pre- vent micronutrient deficiencies; in Jordan, there has been been nutrition community to challenge a warning nutrition crisis (no severely emaciated chil- dren reported70). Added to this, flawed/suspicious nutrition survey data in Lebanon and Jordan and the low breastfeeding rates helped paint the picture of a refugee popudifficult without a “atonion 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 which remain a problem and 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 more 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 response58. This was the case in Lebanon and Jordan. The new programme was set up in response to an article de- scribing their cross line and cross border program- ming in Syria. Here, there has been the recent introduction of Nutributter® (a nutritional supple- ment) 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 chil- dren in Aleppo and Al-Hassake were assisted out of 24,249 children. As with anaemia, UNCHR has well developed guidelines and a menu of options for as- sessing and managing stunting in refugee popula- tions, which includes the promotion of food supplemen- tation products and a range of interven- tions spanning health, WASH and food secu- dary on the brink of a nutritional crisis with the concomitant need to provide acute malnutrition treatment and promote breastfeeding at all costs.
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17 James Kingori. UNICEF experiences of the nutrition response in the Syria response.
18 Anon. Coordinating the response to the Syria Crisis: the southern Turkey cross border experience.
21 Najwa Rizkallah. UNICEF experiences of the nutrition response in Lebanon.
23 Frank Tyler. Characteristics and challenges of the health sector response in Lebanon.
25 View
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 government's national response, 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 coordination.

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. CCTs 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 the 'multiple burdens are the new normal' added to this is the issue of overweight (18% prevalence overweight in U5’s pre-crisis) which is a risk factor for NCDs. Mean weight-for-height z-scores in Za’atari and outside the camp in the 2014 surveys were below the standard population mean, indicating that Syrian refugee children in Jordan on average were slightly overweight rather than suffering from wasting. As with the artificial divide which separates policies and programmes for wasting and stunning, it is rare for overweight to be recorded in separate reports unless these reports are clustered in a programme and in-kind programmes even where these are prevalent and the situation, as with Syria, is fraught. 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 community 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’?

Nutrition coordination and leadership

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Within Syria, agencies are responding to the needs of the internally displaced through operations run by the capital Damascus in coordination with the Assad Government. Aid is provided to go-
vernment and non-government (so called cross-line pro-
gramming) held areas of Syria.28 In Syria, protec-
tion and education with UNHCR at the
time the displaced in the northern non-government held
areas of Syria. Coordination of cross line and cross
border operations are characterised as complex,
highly political, fast changing and, particularly in the
case of the cross border programme, highly
sensitive, resulting in tensions amongst the interna-
tional agency actors.29 As a marker of the sensitivi-
ties, 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 on their agency activities. Despite all these challenges, the Syria re-
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 for-
minally activated in the refugee hosting countries as UNHCR has over-extended its 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 mir-
or image of the cluster system30,31. Within Syria, similar working groups exist to coordinate
activities. Until very recently, nutrition working
groups had not been established in any of the coun-
tries, possibly because the low levels of GAM were
not seen by agencies (including donors32) 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 inter-
national 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 meetings33.
The Jordan nutrition sub-working group has been
particularly active with infant formula control, ac-
cess and management, arguably not a good use of
coordination energies.34 A nutrition sub working
group has also been formed in Lebanon. 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 scop-
ing mission in Sept 2013, deployed a cluster coordinator
for southern Turkey for 3 months (Dec 2013 to Feb 2014). This deployment met with a number of dif-
ficulties and did not lead to a longer-term nutrition
coordination appointment.

With the benefit of overview of the different
country responses and multiple agency program-
ming, 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 nutri-
tion situation for a wider audience to inform pro-
gramme design. However, the lead nutrition
has been limited to a focus on acute malnutrition treat-
ment in the context of low levels of GAM and a sub-
set of IFYG, namely breastfeeding protection and
support. If we therefore accept that the nutrition
community has not adapted its nutrition lens to re-
fect the range of nutrition needs that typify a
Middle East emergency, it has been almost entirely
absent from the design and implementation of an
unprecedentedly large scale social protection pro-
gramme (cash and vouchers), a number of ques-
tions about coordination and leadership arise, which
include:

i) Should the nutrition sector have had dedicated
working groups to enhance analysis and re-
sponse 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 coordi-
nated and who should have resourced this?
ii) Should the Nutrition Cluster have remained
active in southern Turkey’s cross-border pro-
grame 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 acti-
vated to support the affected host community in
default/debt?
iv) What is the role of nutrition-related develop-
ment actors to prepare for a crisis and to
actively influence the international emergency
emergency 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 lead-
ership 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 as-
"sments, analysis, and interpretation and in turn, the
shape and content of the nutrition related con-
siderations across all related sectors? Arguably, had
there been robust leadership and ownership, the
nutrition sector may have avoided the dominant
emphasis on the scale up 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 situ-
ation, some innovation and new types of program-
ning 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
analysis, 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, re-
sponsibilities and leadership in the nutrition sector.
At the very least, we need to commit to sectoral eval-
uation activity. The risk of not learning from this
imminent large-scale emergency programme of this
type would add real value to collective learning.

Within 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 emer-
gency responses to ensure that we learn for the next
time, do we have sufficient collective will to pull to-
gether 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 complex-
ity. There has been an extraordinary response from
a variety of stakeholders and sectors, and nutrition
indicators suggest that a large-scale nutri-
tional emergency has thankfully been largely averted.
However, nutrition vulnerabilities remain poorly
analysed and inadequately addressed and, indeed,
such vulnerabilities may well worsen as the availabil-
ity of resources for the Syria crisis rapidly decline.
The nutrition community - both emergency and de-
velopment is needed as much now as in the height of
the crisis. Let’s hope we can rise to the challenge.
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 Collenette (Save the Children Lebanon) and Carla Lacerda (Senior inter-agency Cash Adviser in Lebanon) for their insight and support. This article is a reflection of the author’s professional experience and does not necessarily reflect the position of Save the Children more broadly.

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

Background/lessons learned from Lebanon’s winterisation cash programme

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

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

Specifically, there was no baseline market assessment undertaken as part of the feasibility assessment for winterisation cash programming. Rather, the decision to implement the cash transfer programme was based on agency concerns related to the delivery of an in-kind or voucher response for winter, following significant operational delivery challenges (including documented fraud) with these modalities in winter 2012/13. In October 2013, the Lebanon CWG commissioned a study of the stove market to assess market availability and access to this key winter item. This report did highlight the elasticity of the stove market in Lebanon, but also warned of a considerable gap if the majority of targeted refugees chose to purchase a stove unit at the outset of winter. The risk of additional stove demand being met through imports from Syria (thus to the detriment of the Syrian market) was also emphasised. However, the timing of the report, which was released when the decision on the choice of cash as an assistance modality had already been made, and the lack of sufficient buy-in...
within the wider inter-agency coordination structure (particularly the NFI working group), unfortunately reduced the value of this piece of work, and the take up of its recommendations, which included monitoring of supplies and prices; and mitigating efforts including in-kind contingency stock and very strong beneficiary communication regarding the upcoming cash programme.

In parallel, the lack of technical input into programme design resulted in a cash transfer value calculated based on perceived sector-specific needs (fuel and stove cost) rather than on overall understanding of household income gaps and needs. The downfall of this approach in the Lebanon context is reflected in the inter-agency impact evaluation of the winterisation programme led by IRC. 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 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 VAStR 2013 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 contingently 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 re-deemed 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 harmonise 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.

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

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1 See article by IRC Lebanon on the evaluation of the Lebanon winterisation programme.
3 CaLp, Comparative Study of cash coordination Mechanisms, June 2012, and Fit for the Future – Cash Coordination, May 2014
4 The experience of this winterisation cash programme, led to a desire and willingness to (a) further harmonise 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.

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Field Article

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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
Field Article

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 2,100 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.

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

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

Figure 2: Multiplier effect of cash-based assistance

struck in a refugee operation between technical good practice, and operational reality and scale at a time of funding 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 humanitarian coordination structure 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 the perception that the roles of specific sectors or institutions are being challenged. In Lebanon, the perception that the roles of specific sectors or institutions are being challenged.

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 inequality 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 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.
Lebanese households by the end of 2014). Another concern alluded to by the GoL has been the broader economic and 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 multi-purpose cash assistance. As of August 2014, the Lebanon M&E framework had been produc-

**Evolution 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 has been 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. FDID and ECHO in particular have been very engaged in supporting key decisions, and then feeding to the wider donor group. This coordination implies a need for a more strategic and transparent inclusion of donors.

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

Based on the ongoing challenges detailed here, fundamental lessons have emerged for applicability to future humanitarian contexts. Implementing a multi-purpose cash assistance programme inevitably implies agencies, donors and governments relinquishing control over the use of cash assistance at household level. This fact continues to create discomfort at agency level, and in engaging with governments, particularly in a refugee setting. Hence, as with all significant changes in the role and perception of cash assistance globally, robust M&E and impact evaluations (such as that led by IRC) 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 prioritised 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 programme may be exemplified by one agency leading on the 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 avenue 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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Institutionalising acute malnutrition treatment in Lebanon

By Linda Shaker Berbari, Dima Ousta and Farah Asfahani

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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 arise during emergencies, and health services were not equipped to respond to such crises.

Nutrition programme

International Orthodox Christian Charities (IOCC) started its nutrition programme in 2012, focusing on emergency preparedness that mainly involved capacity building activities for health care providers. From 2011 to 2013, as the number of refugees increased and cases of acute malnutrition started to appear, there was a need to provide case management. The ensuing acute malnutrition treatment programme is implemented by IOCC with support from UNICEF and UNHCR and in partnership with the Ministry of Public Health (MoPH) in vulnerable localities 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 and 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 privately 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). 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) or other nutrition in emergency trainings. To date (July 2014), the team has trained more than 250 health care staff across the country.

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
3 See article by AUB regarding the training initiative. http://www.nietraining.net/
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.

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 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 17,000 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 incorporated given their 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 an alternative antibiotic. The team working with the MoPH to formalise a national protocol for treatment that will be adopted by paediatricians.

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

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

Activated PHCs provide a variety of services including screening for malnutrition amongst children under 5 years, 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 NGO that subsidises the acute malnutrition treatment service, the training and follow up is all implemented by IOCC.

Programme materials and supplies, including lipid-based Ready to Use Therapeutic Food (RUTF), Ready to Use Supplementary Food (RUSF) 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 (WHF) measurements and for oedema. Children are admitted to the supplementary therapeutic feeding programme depending on the diagnosis. Children are provided with treatment at the PHC level through weekly or bi-weekly visits and are followed by trained staff at the community level as needed. Children with complicated severe acute malnutrition (SAM) are referred to secondary care for in-patient therapeutic treatment. On average, the IOCC-supported PHCs assess a total of around 125 children under 5 years per month, out of which around six children are admitted for acute malnutrition. It is important to note that the programme is still in development.

IOCC has also trained eight hospitals across the country on in-patient treatment of malnutrition using the WHO revised protocol for the treatment of malnutrition. 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 the use of materials and supplies. Again, supplies such as F75, F100 and RUTF are provided by UNICEF.
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 anemia, immunoglobulins, intolerances, CT-scans, endoscopies etc.) all of which are only subsidised at 85%.

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 are often 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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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. IOCCs role in the 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 policy, 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 childhood and adult obesity, hypertension and high cholesterol3 in Lebanon are comparable to recently low in Lebanon, with only 14.8% of infants 0-5 months of age exclusively breastfed (MICS, 2009). Rates of childhood and adult obesity, hypertension and high cholesterol3 in Lebanon are comparable to...
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 lactation 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, latch 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 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 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 order to mitigate such violations, in both ‘normal’ and emergency situations. In order to mitigate such violations, IOCC is helping create mother friendly spaces for breastfeeding in PHCs, hospitals and public buildings, 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 breastfeeding 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. In the fact that breastfeeding is only possible for 6 months to 1 year, everyone, regardless of age and circumstance, 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 1 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 much higher than the existing capacity to ensure safe and adequate artificial feeding or in the case when mothers are willing to breastfeeding, lactation. 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.
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 (SAM) 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 Syrian 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 (PLW’s), 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.

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.

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

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

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

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

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

| Table 1: Number of children under 5 years with MAM and SAM managed as outpatients though the home based treatment as part of RI programming, November 2013–June 2014 |
|---|---|---|
| Cases | SAM cases | MAM cases |
| Identified | 58 | 461 |
| Discharged | 42 | 411 |
| Defaults | 9 | 43 |
| Under treatment | 7 | 7 |

<p>| 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 |</p>
<table>
<thead>
<tr>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAM</td>
<td>5.9%</td>
<td>81/1384</td>
<td>2.2%</td>
</tr>
<tr>
<td>MAM</td>
<td>4.8%</td>
<td>67/1384</td>
<td>1.8%</td>
</tr>
<tr>
<td>SAM</td>
<td>1%</td>
<td>14/1384</td>
<td>0.4%</td>
</tr>
<tr>
<td>Oedema</td>
<td>0.4%</td>
<td>6/1384</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

| 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% |
in Lebanon. On reflection this indicated a need to shift attention in the nutrition programme. The 'true' scale of risk of acute malnutrition has proven to be lower than originally believed and therefore requires a different approach/programming emphasis that than 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 was 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 strengthen 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 acute malnutrition treatment can be reduced and more emphasis placed on prevention of stunting, anaemia prevention and treatment, and improvement in IFYC 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 are as follows:

**Recommendation 1: Infant and young Child feeding**
- Strengthen positive IFYC 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 programme
- Support emergency and community 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**
- The way forward 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
- Integrated screening in regular public health work (e.g. 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.
WFP e-voucher programme in Lebanon

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

Families in need received one e-card that is automatically uploaded with US$30 worth of credit per person each month. The e-cards can then be redeemed in any of 340 small and medium size shops spread across the country. The automatic reloading of credit means beneficiaries no longer need to attend large-scale monthly distributions, 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 than before. In 2013, WFP began its cash transfer programme, called WFP Cash, which allows 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 than before.

WFP also provides monthly food parcels to vulnerable newly arrived refugees awaiting registration. 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, as with the Arsal 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 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 refrigerators allows collection of a range of data including the 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). 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

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Field Article
same PDM also reported that sixty eight percent of households used the WFP voucher as their main source of food. Close to half of all 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 vouchers, the participants 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 of all 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 partners, is in place.

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 collaborates 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 them 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 UNRWAs 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 Programmes to inform the low-income Lebanese. WFP 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 tensions and help build national capacity, to supplement the GoL 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 a revised shop strategy is implemented (see below). WFP will also intensify sensitization efforts within households to take full advantage of the e-card, 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 majority 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 surveys. 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 the WFP 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 in Lebanon, who 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 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
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 shops...) 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-supported 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 re-assessing 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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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

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.

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

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

A Multi Sector Needs Assessment (MSNA) was conducted in 2014 by a team of UN agencies and NGOs and the findings shared by sectors in the form of chapters. The MSNA team aimed to provide an objective overview of the available data and Sector Working Group (SWG) views. It involved identification of information needs, secondary data collation, data categorisation, together with consultation with sector working groups. This article shares some of the key observations and recommendations emerging from this review which are documented in the MSNA Health Chapter. It also draws on findings from a subsequent health access and utilisation survey by UNHCR in July 2014.
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 divisions in the Lebanese government meant there was a lack of an overall strategic approach 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 administration or coordination 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 conflessional 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 health care. Lebanon’s health system is semi-autonomous and referral care is used to fill shortfalls in the public health system. Less than 10% belong to the public sector (MoPH or MoSA). Public secondary and tertiary healthcare institutions in Lebanon are semi-autonomous and referral care is expensive. Not all adhere strictly to the MoPH flat rate for hospital care. To harmonise access to secondary healthcare and manage costs, UNHCR has put in place referral guidelines in Lebanon.

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 serves, 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 utilisation 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). To date, and to the credit of the humanitarian effort, disease outbreaks have been largely prevented. However, measles and increased risk of epidemics such polio, and waterborne diseases remain. Data on immunisation and coverage rates in Lebanon prior to the crisis is of variable quality. Access to vaccination

<table>
<thead>
<tr>
<th>Box 1 Services covered by UNHCR and partners</th>
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<tbody>
<tr>
<td>• 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.</td>
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<tr>
<td>• All routine childhood vaccinations are free for children &lt;12 years.</td>
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<tr>
<td>• Malaria prevention interventions are free for all refugees at Ministry of Public Health (MoPH) and Ministry of Social Affairs (MoSA) linked clinics.</td>
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<tr>
<td>• For chronic medications, a handling fee of LP 1000 (USD 0.67) is paid by refugees for each refill of prescriptions.</td>
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<tr>
<td>• Family planning services including pills, condoms, insertion of IUDs are provided for free.</td>
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<tr>
<td>• Dental care is subsidised through designated primary healthcare centres.</td>
</tr>
<tr>
<td>• For lab and diagnostic tests, UNHCR covers up to 85% of costs for children &lt;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%.</td>
</tr>
<tr>
<td>• UNHCR pays up to 75% of the total cost of hospital services only if admission is for life-saving emergency care, 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.</td>
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</table>

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

<table>
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<tr>
<th>Box 2 Sources of health information and data on Syrian refugees in Lebanon</th>
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<tr>
<td>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.</td>
</tr>
<tr>
<td>• The MoPH operates its own system of routine health surveillance on communicable diseases, which sources data from hospitals and primary healthcare centres.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

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.
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 diseases 8. 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 45% 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 infections and skin infections 9. The health needs among elderly Syrian refugees are particularly acute with limited access to care and medications 10.

**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 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 the proportion of population numbers, the incidence of various NCDs (cardiovascular, diabetes and hypertension) has risen; amongst older refugees, the prevalence of chronic diseases such as hypertension, diabetes, and cardiovascular diseases is high 13.

A UNHCR survey in July 2014 found that 14.6% of households had at least one chronic condition amongst >218 years. The proportion varied by age, increasing from 18 to 29 years (10.9%), 30–49 years (14.6%) for household members who were 60 years or older. The main reported chronic conditions were hypertension (25.4%), diabetes (17.8%), other cardiovascular disease (19.7%), lung disease (10.3%) and ischaemic heart disease (6.2%).

**Health care access**

A UNHCR household health access and utilisation (HAUS) telephone survey of 560 refugee households was conducted in July 2014 14. 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 pre-crisis conducted in July 2014 15. It found an estimated equivalent to an annual 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 (5.5%). To cope with the healthcare expenditure, refugees borrowed money (53.9%), used household income (39.4%), and or relied on relatives or friends for payment (27.8%).

Referral for secondary and tertiary medical care is expensive. According to UNHCR analysis 16, the estimated total hospital bill for January to June 2014 was USD17.5 million. The estimated share of the cost for UNHCR was USD17 million. The estimated annualised per capita hospital cost was USD37 per registered refugee. Approximately 48% of referrals were for obstetric care, followed by respiratory infections (8%), gastrointestinal conditions (7%) and trauma and other injuries (7%). Deliveries (births) account for 92% obstetric admissions). In Lebanon, 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 Lebanon 18 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-term investment. This will benefit both refugees and the host population. The approach involves engagement with local civil society groups and facilities of the MoSA that work within the network and with private health care providers.

b) **Hospital care**

Referral healthcare to secondary and tertiary services continues to need improved support to cope with limited government finance and additional utilisation of Syrian refugees. The national referral system presents a number of challenges in terms of its approach to refugees entering into the system. Delivery care and its complications (obstetrics) account for nearly 48% of referral healthcare utilisation of Syrian refugees 19. The health sector will continue to support the MoPH in assessing and improving alternative modalities for deliveries with a community based focus, with the view to adopting a 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 overcoming the funding 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 are one of epidemic potential. Efforts to ensure cold chain logistics and management are improved 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 NCD services can be covered by the response 13. 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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1. See footnote 2.
2. See footnote 1.
3. Health Information System 2013
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 and register the 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) 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.

b) 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 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, medium 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 recommends 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

Box 1 Food security classification

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

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

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

2 http://54.225.218.247/wfp/documents/Lebanon/VASyR.pdf
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 diarrhea (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 diarrhea.

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. 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 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 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 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%), coughing (45%) and diarrhea (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 diarrhea 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 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.

2 The SMART survey results were subsequently reviewed and corrected. This found a lower prevalence of acute malnourishment than initially estimated. For more details, see article by UNICEF in this issue (p.22).
• The time spent by Syrian refugees in Lebanon may have positive or negative effects. Refugees may develop a social network that could lead to a better understanding of the local context and potentially improve their living conditions.

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 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 tended 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. 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). In 2013, undernutrition was not assessed. These results were lower than malnutrition prevalence determined by weight for height in the SMART nutritional survey of 2012 (4.4% GAM), as well as the results that were later released in the 2013 SMART nutritional survey. The decision to remove MUAC from the 2014 survey was based on the following reasons:

1. In this population, MUAC underestimates acute malnutrition compared to weight for height.
2. The wide acute malnutrition prevalence in the population based on MUAC, the precision needed to track potential changes would require a much larger sample size than needed for VASyR purposes.
3. 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 impeccable health standards. Instead, 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 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 VASyR does not provide all the detailed information needed for each sector; it does not replace in-depth sector-specific surveys. Only the most critical indicators are selected per sector so that the overall questionnaire can be feasibly rolled-out. The approach was to conduct a wide-ranging multi-sectoral, higher-level survey that can be carried out without requiring an overly long assessment of interviewees. Challenges and means to address these are as follows:

1) Improve on information collected, through identifying key sector-specific questions that provides the essential information needed for decision-making and help better define the thresholds that more accurately identify vulnerability. This process requires intra and inter-sectoral discussions with each sector attempting to attain the most information possible for their own purposes. Although the questionnaire should be contextualised and revised in line with lessons learnt from previous assessment exercises, it is feasible and possible to conduct a multi-sectoral survey that can be carried out without requiring an overly long assessment of interviewees. Challenges and means to address these are as follows:

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.

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 responsibility for the household expenditures. 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 may 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 does not have any access to water. 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 taking more frequent 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 more tense 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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Towards a 21st century humanitarian response model to the refugee crisis in the Lebanon

By Simon Little

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Views

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 against $881 million secured against RRP5 in 2013, though refugee numbers are expected to continue to grow.

The need for continued humanitarian and/or stabilisationdevelopment 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 haemorrhaging 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 capable of providing long-term employment to thousands of refugees and poor Lebanese, many households will continue to rely on the assistance provided by the humanitarian community.

A model response or a challenging response model?

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

A scaled up response was predicated on the delivery of blanket food assistance, hygiene, baby kits etc., complemented by more selective transfers of education, health and shelter support. The mode of delivery drew heavily on experience and practice acquired in successive crises over the past three decades, reinforcing the traditional response hierarchy with UN agencies securing the lion’s share of donor funds, and thereafter subcontracting the bulk of on the ground delivery to a range of international non-governmental organisations (INGOs)/NGOs. 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 model that is heavily influenced and shaped by practice in Africa, the humanitarian community may have failed to acknowledge the contextual differences of responding in middle income Lebanon, with well-established basic service delivery and a functioning private sector. Whether a model that is predominantly focused on disbursing vast quantities of material assistance was best suited to the specificities of the crisis in Lebanon – even during the peak period of refugee influx – is debatable.

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

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 principle 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).
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.
Over the past couple of years, the humanitarian response in Lebanon has grown in direct proportion 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 staff.7 The collective cost of staffing this operation is conservatively estimated at 50% 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 benefit of funding. 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 annum9? 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 that the response simply loses its 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 adjusted and 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 190 INGOs. 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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1 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 personnel engaged in the response clearly runs to hundreds of posts with thousands of national staff engaged.

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

3 At the start of 2013, 22 INGOs were included in RRP4. By the end of the year, this number had risen to 51 INGOs. The number of INGOs represented in RRP4 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).

4 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.

5 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.
he conflict in Syria, which began in 2011, has continued to create a worsening refugee situation. There is currently a growing population of 3,033,972 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 Service 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:

a) Definition of vulnerable groups/households in need of assistance, and agreement on minimum sectoral data to inform this definition with partners
b) Identification of vulnerable households
c) 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 Za’atari 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 ACAPS to support the project as a non-operational entity in the region, i.e. without any assistance programming. Furthermore, ACAPS have specific as-
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 with and in social groups)
- scale dependent (with regard to time, space and units of analysis such as individual, household, region, etc.)
- 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 implementation.

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. Further, 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 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 lists 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.

7 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.

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

9 More specifically the weighting of scorecards was different.

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

In March 2014, an inter-agency participatory assessment was conducted with Syrian refugees, through 70 key contact points 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 task team has conducted a detailed analysis of indicators used by UNHCR for Cash Assistance decisions, using proGres® 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 house-holds 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 householdswas developed. This model predicts 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 and launched in beta version8 to assist in the process.

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 inter-agency 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 the UNHCR define the 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. The 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 work conducted in Lebanon to define sector level vulnerability decision trees. 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 not accurately assessed and thus 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/in-ter-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 model 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. For more information, contact: Kate Washington, email: washingk@unhcr.org
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 co-operating 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 in Syrian 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

1 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.
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, allowed them to continue their regular approach to purchasing 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.


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 communities. 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

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

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 financial literacy training for beneficiaries.

By Gabriele Fänder and Megan Frega

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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.

2 WHO http://www.who.int/nutrition/anemia/data/database/countries/jor_nda.pdf
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
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 children. 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 stabilise the bottle/nipple, artificial ingredients in breastmilk substitutes (BMS), and lack of sustain- ability, 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 colostrum 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 NGO. 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 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, Ma’fraq, Ramtha and Irbid. The mobile clinic covers the South of Jordan (Karak, Madaba, Tafila, Mzwin, 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 Ma’fraq (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, Ma’fraq, Irbid, Jerash and Akkar). 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 were 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 relactate 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 target 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 (7 USD) 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 2014). 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.

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9 Colostrum is the breastmilk produced during pregnancy and immediately after birth. It is low in fat, and high in carbohydrates, proteins, 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.
The survey showed an increase in breastfeeding knowledge but not an improvement in breastfeeding practice among mothers of all ages. 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%). 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 (64.4%, 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). 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 the cooked food they all agreed it was quite possible to eat. 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 clinic and 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 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 Equipment. Those guidelines were promoted 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 Zaatar 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) 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 specialists 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 BMS 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 for BMS as a 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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14 Available from: http://www.unhcr.org/3f66b4461.html

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

By Sura Alsamman

Sura Alsamman is nutrition supervisor at Save the Children Jordan, responsible for the overall coordination of the IYCF technical functions and activities in camps and host communities in 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 2012. 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 MICS3 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 DHS 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:

2. 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).

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 the 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 45,000.

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.

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 breastfeeding 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 appointed for each district. On average,

1 Inter-agency nutrition assessment Syrian refugees in Jordan host communities and Za-atri camp. Final report. January 2013
3 Demographic and Health Surveys (DHS) for Jordan. Final report. January 2013
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)
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 counsellor to investigate relocation, offer at a minimum, ensure that 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 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.

In order to respond to mothers concerns, IYCF educators were faced 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 Zaatar 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

Early development and implementation of infant and young child feeding (IYCF) practices in Zaatar Camp. She is such a strong advocate of breastfeeding and so we are happy to have her among our team after her successful experience in breastfeeding her youngest child and seeing how this affected his health compared to his four older sisters.

Sara is one of the community mobilisers working with the IYCF team in Zaatar 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, tranquility 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 Zaatar Camp. She is such a strong advocate of breastfeeding and so we are happy to have her among our team of Syrian camp mobilisers.
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 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 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.

Box 2 Individual level assessment for infant formula prescription

Infant formula is prescribed based on any of the medical indications for infant formula use as recommended by WHO 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.

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 SCI stop-gapped with an intended short term (4 month) blanket distribution of a local fortified porridge, targeting children 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 food distribution period found a global acute malnutrition rate of 12% in Za’atari camp (camp population 79,708), and 7 mothers in Emarati Jordanian camp (EJC) and 40,000 children under 5 years (total contacts).

Complementary feeding

During the early days in Za’atari 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 fortification of the infant food used in the distribution 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. It took a while to convince the community; if the community had been involved in the decision-making process, they 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. It took a while to convince the community; if the community had been involved in the decision-making process, they would not receive the product.

The food distribution period found a global acute malnutrition rate of 12% in Za’atari camp (camp population 79,708), and 7 mothers in Emarati Jordanian camp (EJC) and 40,000 children under 5 years (total contacts). More than 47,000 beneficiaries (mothers, fathers, and children) have attended the IYCF sessions conducted in different partner’s locations.

It is becoming clear that building capacity and cooperation with health providers for IYCF is important. The implementation of 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 Breastmilk Substitutes 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 Za’atari camp, the needs of formula fed infants are being met - supplies are always available, there is a clear pathway and providers are now aware of IYCF cases who need formula and there is follow up of infants.

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The articles by Medair and Save the Children highlight the challenges in protecting and promoting 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 has been little guidance 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 of Conduct for Humanitarian Action 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 Equipment 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-breastfeeding mothers or relactation. 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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The situation of older refugees and refugees with disabilities, injuries, and chronic diseases in the Syria crisis

By Lydia de Leeuw

Lydia de Leeuw is the Regional Inclusion Programme Manager for both HelpAge International and Handicap International in the Syria crisis. She has extensive experience in the Middle East working on refugee protection, rights based advocacy, research, and project management, and holds a BSc and MSc in Criminology.

Thanks to Becky Achan, Technical Advisor on Inclusion with HelpAge International and Handicap International in Jordan, who helped conceptualise and develop the article outline.

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, in collaboration on age and disability related issues through the Disability & Older Age Working Group in Lebanon, and the Age & Disability Task Force in Zaratari 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 household 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 often lack 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
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 assessment 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, sometime lifelong care.

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

**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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**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 communities 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). 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 Agenda and is distinct from the Cluster system. More recently it has been

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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 strategy 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/scar槚p96

3 For more information, see www.humanitarianinfo.org
reaffirmed at the global level through the Refugee Coordination Model\(^1\). In short, in collaboration with a number of Jordanian managers and on the advice of 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 series of global and national memorandum 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 international agencies 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 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.

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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 Compact 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 and community leaders. 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...
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**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 reduced 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. Fuels and foods have been severely hit by price inflation particularly in northern governorates. On the other hand, prices have actually dropped in some southern governorates. As available resources have been depleted over time and resilience weakened, households have increasingly resorted to 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 fighting among multiple armed groups closed access routes and deadlocked assistance to Al-Hasakah 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 remained the top 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-Hasakah 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-Hasakah through Nusaybin 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 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

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**Field Article**

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**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 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.

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**Figure 1:** WFP planned and reached general food distribution beneficiaries

- January 2014
- February 2014
- March 2014
- April 2014
- May 2014
- June 2014
- July 2014

Planned

Reached
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 Lattakia due to availability of bakeries. Governorates that receive 100% of wheat flour include Rural Damascus, Hama, Idlib, Ar-Raqqah, 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 2.400,000 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 NGO 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.

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 Idlib 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 Lattakia 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, 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.

Field Article

Kindergarten student receives nutritional support

WFP working with the Syrian Arab Red Crescent (SARC) Packaging Food Before Distribution

\(^{2}\) http://unscr.com/en/resolutions/2165
Upon arrival in Syria, food commodities are assembled in five storage and packaging facilities strategically located in 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 maximizes 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 handshake points to partners inside Syria, without being processed through WFP facilities. Wheat flour milling is undertaken outside of the country, in Lebanon 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 (FPDs) agreed upon with partners. Due to the instability of security conditions on the ground, the number of FPDs and their locations vary from month to month, as partners may no longer be able to distribute food 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 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 insecurity 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 2013 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 process to build trust and create a level of trust among the partners in order to establish 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
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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 calorific 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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GOAL’s food and voucher assistance programme in Northern Syria

By Hannah Reed

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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 ECHO). Under OFDA, GOAL implements voucher-based and in-kind Non-Food Items (NFI) 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 NFI 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 countries1. 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 need2.

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 impact negatively on the ability of affected populations to meet basic food and other needs without assistance. Increased reliance on coping strategies reduces household re-
siliency 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 operational 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%), 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 survey6. 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).

All food assistance was designed to meet a target of 2,400 kcals p/d adjusted from the Sphere standard (2,100 kcal p/p/d) by an additional 300 kcals 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 quantity 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 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 (35%) and previous savings (7%). 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 generate 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 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 sustainable. Sixty 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%).

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 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 relying 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 rate 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 function and

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 with 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 weekly 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

Table 1: Trends in Household Food Consumption Score (FCS)

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th>Male headed households</th>
<th>Female headed households</th>
</tr>
</thead>
<tbody>
<tr>
<td>% households scored 'acceptable'</td>
<td>43%</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>% households scored 'borderline'</td>
<td>50%</td>
<td>47%</td>
<td>42%</td>
</tr>
<tr>
<td>% households scored 'poor'</td>
<td>7%</td>
<td>31%</td>
<td>43%</td>
</tr>
</tbody>
</table>
vouche 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)\(^\text{11}\). Punitive measures are in place and communicated to traders regarding infractions to the stated terms of the contract. These include suspension of all temporary earning and 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 the prices charged are not intended to be lower than the same good purchased in the same markets by non-beneficiaries and using cash. GOAL vouchers continue to incorporate a series of security features\(^\text{12}\), while a rigorous system of checks ensures 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 investigation\(^\text{14}\).

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, Kafir Takharim, Maaret Tamsrin, Qurouen, and Salquin) 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 those infants with breastfeeding, those infants 0-5m who were breastfeeding were reported, such as too stressed to breastfeed (13%) and inadequate maternal food intake (29%).

Access to breast-feeding 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, through which this may be expanding which may bring an additional layer of flexibility to beneficiaries than direct distributions. 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.

Lessons learnt on voucher programming so far and vision for future.

To date, GOAL’s 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 GOAL’s 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 GOAL’s 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.\(^\text{15}\)

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@galoil.org.

Box: 1 Decision making around exclusion of infant formula and milk powder from the voucher scheme and food distribution

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Access to breast-feeding 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. This includes: price setting with participating shops to reduce the risk of unauthorised duplication or use of GOAL vouchers.

\(^{11}\) Note that shopkeepers include a strict ban on the exchange of vouchers for alcohol, cigarettes, infant formula and powdered milk: GOAL and traders are determined to 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 breastfeeding for exclusive breastfeeding needs for populations in northern Syria.

\(^{12}\) There are two serial numbers, one is random and one is computer generated, and these are 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 assigned to them; there is an exchange against ‘basket’ of selection of shopkeepers against established accessibility and stock level criteria followed by signatures of contracts agreeing to monitor the terms and conditions of the GOAL 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.

\(^{15}\) PDM Irish Aid Vouchers Rounds 1 and 2
WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management

By Hala Khudari, Mahmoud Bozo and Elizabeth Hoff

Hala Khudari, WHO Technical Officer at WHO Syria, joined WHO in 2011 and is a BSc (Nutrition and Dietetics) and MSc in Nutrition graduate from the American University of Beirut. For the last 3 years she has helped develop the WHO nutrition response programme in Syria.

Mahoud Bozo is a nutrition expert/ paediatrician and a WHO consultant since Nov 2013. He has widespread experience in research in paediatric gastroenterology and nutrition and was former general coordinator of paediatrics in MOH Syria (2005-2012).

Elizabeth Hoff was appointed WHO representative in Syria in April 2014 (acting representative July 2012 - April 2014). She has more than two decades experience in Africa, the Middle East, Asia and Eastern Europe and previously was coordinator for resource mobilisation and external relations under the Emergency Risk Management and Humanitarian Response department in WHO HQ, Geneva.

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 has turned increasingly 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, socio-economic limitations, instability 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 rate and 12.9% iodine deficiency prevalence. Neonatal mortality rates, infant mortality rates and under-five mortality rates stood at 12.9/1000, 17.9/1000 and 1.4/1000 respectively.

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 international 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 within 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 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 system has suffered from a reduction in the quality of nutrition service provisioning 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, availability 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 telecomm-
munication-reporting utilities were cited as challenges by a number of Governorates. These obstacles were especially evident in the case of Deir-ez-Zor, with a significantly under-staffed health centre, 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.

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 Management 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 Talmoor), 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 measures. 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 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), Quneitra (1), Sweida (1), Deraa (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, Lattakia, 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 hospitalisation care. Future centres will be located in hospitals to situate at least one centre per governorate to manage the caseload of SAM cases requiring hospitalisation care. Future centres will be located in hospitals.

Breastfeeding promotion has been streamlined across all WHO nutrition activities. It has been included in all training courses conducted on nutrition surveillance allowing 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 across all WHO nutrition activities. It has been included 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.

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 breast milk, stopping breastfeeding all together and resorting to other practices. During an observational 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, Quneitra, Sweida, Homs, Deraa, Hama, Lattakia, Hassakeh, Tartous and Dara’a in cooperation with the MOH-primary health care department. Trainings covered the importance of breastfeeding, its constituents, techniques on initiation of breastfeeding and its benefits for both child and mothers.

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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.

For more information, contact: Hala Khudari, WHO Technical Officer - khudarih@who.int
Experiences and challenges of programming in Northern Syria

By Emma Littledike and Claire Beck

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 deficiency. 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). The percentage of children under 2 years who are not breast-fed is estimated at 10% (2009). According to national data from 2006, the timeally 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%.

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 IDPs and the 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

WVs 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.

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 sensitised 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 used.

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

In addition to this article, a personal account of the Emma Littledike’s experiences in stop-gapping nutrition coordination of the Syria response is included in Field Exchange 48 online, www.ennonline/net/fex
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 governnorates in northern Syria. Both found low prevalence rates of SAM (<0.4%) and moderate acute malnutrition (MAM) (<2.4%). Both assessments had limitations. The large rapid assessment in Ar raqqa1 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 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 custom cost to import products is excessive. For example, an RUTF order worth $630 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 Mabni 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).

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1 The actual number of children measured is not confirmed.
The pilot targets children under 5 years in select areas of Manbij. They will receive a voucher entitling them to purchase any private medicine from a pharmacy over the 12 month project period. At WV’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 minimum of four 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 provider, 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. WV 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 number of vouchers will be issued from the agency’s procurement and transport of medicines and supplies from Turkey has been a huge challenge.

**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 the most feasible depending on available resources. This led WV to develop a distance learning package in the style of Khan Academy videos. Also, WV has worked with a regional GNC/UNICEF IYCF consultant to produce a harmonised translated IYCF training package using training videos and data collection is automated. There 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 can be sent to the agencies to 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 morbidity 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 field staff and data collection is automated. 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 morbidity into consideration. In addition to data management systems, 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 retained interest in the given topics to sustain consultant and lack of support. 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 videored 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 the reintroduction of temporary suspensions of activities in a number of areas. 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 clinical activities had a huge impact on the population as there are no other health providers. We learned that detailed contingency planning is essential, requiring the 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 essential. 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, or the time it 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. WV has developed an assessment tool to gain more information about procurement regulations and also the quality of Syrian pharmacists and 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 for a larger number of doctors to remain in their post, rather than the establishment of more clinics 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 WV 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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A personal account of the experiences of Emma Littledike in stop-gapping nutrition coordination of the Syria response is included in Field Exchange 48 online, page 126.

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https://www.khanacademy.org
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-Salham, 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
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.\(^1\) 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\(^6,\(^5\)\).

Undernutrition was a problem in pre-war Syria, reflected in 9.7% of children under five years underweight for their age, 2.3% wasted\(^6\) and 29% stunted\(^6\). Underweight and wasting were reported to be more prevalent in Al-Raqqa governorate, with the 6-11 months age group mostly affected\(^6\). 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 fuel\(^6\). 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 increased\(^6,\(^2\)\).

MSF operations in Northern Syria
Médecins Sans Frontières Operational Centre Amsterdam (MSF OCA) has been working in Northern Syria, Al-Raqqa governorate, 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

\(^1\) Hoetjes, M. The impact of armed conflict on health in Al-Raqqa governorate, Syria. IIT/Royal Tropical Institute; August 2014
\(^7\) 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
\(^10\) 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

References
Al-Raqqah governate, Syria

By Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Philippeau, Saskia van der Kam

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Wendy Rhymer started working with MSF-OCA in 2007 as a nurse/ midwife and was MSF medical coordinator for Northern Syria from December 2013 to May 2014. Wendy was interviewed by the ENN in early May 2014.

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Sections of this publication are part of Maartje Hoetjes’ dissertation for a Masters in International Health.\(^1\)
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 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**

Figures 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 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 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 some 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 think food is more expensive now?” almost 72% (n=29/39) of those interviewed replied “yes”. Unfortunately, meal 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 lower. Almost 72% (n=29/39) of the surveyed population 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 children”14. 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

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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 use 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-Raqqah, the exclusive breastfeeding rates was estimated even lower, only 26.5%.

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 (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% stated that they were boiling water. 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 IDP’s 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 clinical activities at the beginning of June 2013. MSF also supported an ATFC 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 < -3 or oedema is admitted. Patients are admitted to the in-patient ward (which is within the paediatric inpatient facility in the national hospital) and a caregiver is present from admission to discharge. Usually the 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 indicated 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 < 12 months. 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 re-lactation 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 ATFC 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 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 staff 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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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 default 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.
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 Coordination 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 groups’ 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

Notes
1. See later for updates in this regard with respect to UN Resolution 2165.
2. The formation of the Assistance Coordination Unit (ACU) 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.
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.
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 constraint. According to many stakeholders 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 effective targeting of 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 firewalling of 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 border*. 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 2165 – considered a “breakthrough in efforts to get aid to Syrians in need” – 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 IdlibGovernorates were transported. The Syrian authorities and local authorities in Syria were given 48 hours to give clearance. 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 displaced. Added to this has been the limitation of the global benchmark information and data about ‘nutrition in emergencies’ 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 midDecember 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, the profile of nutrition remained hugely constrained and was essentially “short lived” given the short term nature of the UN’s deployment in Syria. 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.

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* Footnote 7

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.

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4 Under-secretary-general for humanitarian affairs/emergency relief coordinator Valerie Amos, executive director of the WFP

5 Enthusiastic outreach and Executive Director of the WFP

6 Under-secretary-general for humanitarian affairs/emergency relief coordinator Valerie Amos, executive director of the WFP

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10 Under-secretary-general for humanitarian affairs/emergency relief coordinator Valerie Amos, executive director of the WFP

11 GNC End of Mission Report (Feb, 2014)
DRC experiences of cash assistance to non-camp refugees in Turkey and Lebanon

By Louisa Seferis

Louisa is the MENA Regional Livelihoods & Cash Advisor for the Danish Refugee Council (DRC). She has worked for three years with the DRC for the Syrian crisis 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 protection, livelihood, and reconciliation initiatives with international NGOs. She holds a master’s degree in humanitarian assistance and conflict resolution from Tufts University.

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

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1 http://data.unhcr.org/syrianrefugees/regional.php

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Views

- A day in the life of a WFP field monitor working in the Syrian refugee camps in south-eastern Turkey

www.ennonline.net/fex
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% 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, 108,349 in Sanliurfa, 134,275 in Hatay, and 45,200 in Kilis. 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/weekly) 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. In Turkey, refugees outside of camps face integration challenges such as language barriers3 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 services, 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 week, and they cannot pursue any business because they have no right to work in Turkey.4 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).5 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, the cost of 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 vs Turkey context

In both Lebanon and Turkey, Sysrians face challenges to generate stable income, which in turn affects their ability to meet basic needs as assistance wanes. Overcrowded 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 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.

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2 For more information, please see http://www.cashlearning.org/resources/library/417-unconditional-cash-assistance--a-transfer-implementation-learning-summary&searched=1&x=58&y=15.
3 UNHCR SitRep, 7 July 2014
4 UNHCR SitRep, 7 July 2014
5 In Hatay Province, 66% of Syrian families assessed by DRC reported that the language barrier was a main problem they faced in Turkey.
6 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 (each municipality can have different standards for occupations or geographic areas).

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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.
The majority of humanitarian protection and social responses concentrate on services to 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 everyday. 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 define 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 voucher programs (purchase of 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, such as health care. This is despite extensive research and advice 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 expenditure, 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 Anticipated expenditure is an aspect about planning expenditures is that there is no plan-book, 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 copings 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 as a result 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.9 They are reducing their main purchases 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 food and protein. Moreover, the humanitarian assistance could address dietary diversity 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.

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, 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.

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 humanitarian 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

Table 1: Coping strategies to meet food needs adopted by Syrian refugees, Hatay Province, Turkey, 2014.

<table>
<thead>
<tr>
<th>Coping mechanism (families could list more than one)</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumed less preferred or less expensive foods</td>
<td>84%</td>
</tr>
<tr>
<td>Reduced the number of meals per day</td>
<td>73%</td>
</tr>
<tr>
<td>Reduced spending on non-food items</td>
<td>72%</td>
</tr>
<tr>
<td>Limited portion size</td>
<td>49%</td>
</tr>
<tr>
<td>Spent savings on food</td>
<td>30%</td>
</tr>
<tr>
<td>Restricted adult consumption (so children could eat)</td>
<td>16%</td>
</tr>
<tr>
<td>Purchased food on credit or borrowed money to buy food</td>
<td>16%</td>
</tr>
<tr>
<td>Had school aged children working</td>
<td>13%</td>
</tr>
<tr>
<td>Asked for food (including begging)</td>
<td>12%</td>
</tr>
<tr>
<td>Skipped entire days without eating</td>
<td>4%</td>
</tr>
<tr>
<td>Not applicable</td>
<td>5%</td>
</tr>
</tbody>
</table>

Moreover, evidence from other contexts demonstrates that consumption patterns change over time10 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 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.

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 cash to meet debt sources, and therefore have limited time to accumulate enough money to buy food and meet rent/utility obligations.
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.”
Field Article

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 household members 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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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.

Experiences of the e-Food card programme in the Turkish refugee camps

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 Syrian 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 card ID 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 urban centres. All laminations 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, which varied from camp to camp. In the last week of July 2012 (when WFP and AFAD conducted the initial voucher feasibility assessment), half 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, Syria remains home to more than 1.5 million displaced people and about 1.2 million refugees, residing in nearly 2,000 informal settlements across Turkey.

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 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...
First home-cooked meal since arriving in Turkey: Nazari household

On the first day of launching the e-Food Card Programme in Naz pi camp in April, 2013, WFP staff spoke with the Nazari household to learn what the family’s first cooked meal would be since fleeing their home in Syria several months before. The father was preparing a Syrian dish, “Simit Khiydar”, made from fresh bread 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 sharing 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-making facilities where infrastructure and resources permit.

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.

By July 2013, the programme had rapidly expanded to reach 10,000 beneficiaries living in camps in ten provinces. At this stage, owing to WFP funding constraints, expansion plans were 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$1) 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 22 existing camps.

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 increases. 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 also damaged reservoirs 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

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 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.

For more information, contact: Kathleen Inglis, email: kathleen.inglis@wfp.org and Jennifer Vargas, email: jennifer.vargas@wfp.org

To read about the day in the life of a WFP field monitor, Afaf Shasha, working in the Syrian refugee camps in south-eastern Turkey, visit Field Exchange 48 online, p148.

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.
Syrians in Iraq: Refugee response within a major humanitarian and political crisis  

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.

Views

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 became 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 Syrians4, 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\textsuperscript{7} 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 programming for refugees,\textsuperscript{8} 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 other areas of Iraq and 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 Sulaymaniya 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 and to have the line of departure the 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 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.\textsuperscript{9} The KR-I’s budget crisis also affected its 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.

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.\textsuperscript{10} 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.\textsuperscript{11} To date, UN agencies have primarily targeting refugees residing in camps with little official attention 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.\textsuperscript{12} 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,\textsuperscript{13} while 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 Nineveh 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 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 returnees and about 100,000 stateless people. While there are common drivers of conflict fueling 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 Iraqi 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 or 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.\textsuperscript{14} While Saudi Arabia committed USD 100 million to UN agencies for the Iraq crisis,\textsuperscript{15} 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 coordination architecture has become fragmented between those responding to the IDP crisis through the cluster system and those operating in through UNHCR 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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\textsuperscript{7} UNHCR, 6 May 2014. http://reliefweb.int/sites/reliefweb.int/files/resources/UNHCR-Iraq_Syrain_Update-1_15_Apr_14_2.pdf


\textsuperscript{9} World Food Programme, 24 March 2014, http://reliefweb.int

\textsuperscript{10} UNHCR, 5-9 May 2014.

\textsuperscript{11} Displacement Tracking Matrix, IOM, 3 October 2014.

\textsuperscript{12} New York Times, 1 July 2014.
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.1

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”).2

This article examines the legal consequences of the humanitarian crisis in Syria. It addresses:

a) the serious breaches of international humanitarian law and international human rights law committed by the parties to the conflict (Section B)
b) the responsibility of the international community to react to the crisis in Syria, and in particular, the “Responsibility to Protect” (Section C), and
c) 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

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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.

rights law continues to apply in Syria. 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

(1) Protection of civilians and distinction: the parties to the conflict must not attack civilians, and must always distinguish between civilians and combatants. Under international humanitarian law, civilians include persons not taking part in hostilities. The parties to the conflict must not undertake "indiscriminate attacks", which they can then use to justify their military campaigns. 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."1

(2) Torture and inhuman treatment: the use of torture is absolutely prohibited, and cannot be justified by a state of emergency or war.2 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.3 Recently, certain rebel groups such as the Islamic State of Iraq and Al-Sham (ISIS) are reported to have increased their use of torture against civilians.4

(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.5 Human rights groups have accused the Syrian government of using starvation as a weapon of war.6

(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.7

(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. 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".8 Some health facilities have been repeatedly attacked, and over 400 health-care workers have reportedly been killed in Syria.9 UN staff and medical professionals have also been abducted or detained by the Syrian authorities and rebel groups.10

(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.11 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 children and elderly. The Security Council must take action to deal with these flagrant violations of the basic principles of international law."12

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 allow cross-border deliveries of aid through border crossing points that it does not control13, including crossing points identified as "vital" to reach over one million people in areas that are otherwise impossible to reach.14

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.15 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 authorizes such operations under Chapter VII of the UN Charter.16

In a recent report, the UN Secretary-General called on the Syrian government to allow cross-border aid deliveries and said that by withholding

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1 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.
3 Common Article 3 to the Geneva Conventions 1949, Articles 7 and 14(2) (non-discrimination) of the ICCPR, and Article 3(2) of the Convention Against Torture 1984.
5 Also known as the Islamic State of Iraq and Syria or the Islamic State of Iraq and the Levant.
7 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.
13 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.
16 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).
17 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?ArticleUid=73b714f8-cb65-4ae7-bbaf-76947ab8c6ac (last accessed on 23 May 2014).
18 Under Chapter VII, measures to enforce decisions of the UN Security Council may be adopted.
its consent, the Syrian government “is failing in its responsibility to look after its own people”, 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. In the meantime, however, aid organisations that engage in unauthorised cross-border activities risk expulsion or even attack by the Syrian government.21

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”.22 War crimes are grave breaches of international humanitarian law, and crimes against humanity are acts such as murder, torture and sexual violence 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 2014.23

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 “each individual State has the responsibility to protect its populations from genocide, war crimes, ethnic cleansing and crimes against humanity”.24 UN member States also declared that “we are prepared to take collective action, in a timely and decisive manner 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.25

“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 Syria, and criticizing the Security Council’s inaction, 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 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 unlawful because it is contrary to the prohibition against the use of force under Article 2(4) of the UN Charter.26 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.

24 Ibid.
27 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.
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.
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 United 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)).
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, Browne & Apperley, Kosovo Crisis Inquiry: Memorandum on the International Law Aspects, (2000) 49 Int’l & Comp. L.Q. 678.
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 UNSC vote.” 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 them selves 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 “deterring 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:

(a) an impending or actual humanitarian disaster, involving large-scale loss of life or ethnic cleansing, which is generally recognised by the international community;

(b) last resort – there must be no practicable alternatives to avert or end the humanitarian disaster; and

(c) 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. Permanently 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.”43

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 caliphate44 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.”


38 See, for example, Greenwood, Humanitarian Intervention: The Case of Kosovo, 2002 Finnish Yearbook of International Law, p. 141.


45 A form of Islamic political-religious leadership which centres around the caliph (“successor”) to Muhammad.
The Syria Needs Assessment Project

By Yves Kim Créac’h and Lynn Yoshikawa

A year after the start of the Syrian crisis, ACAPS’ 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 MapAction 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 System) 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 stakeholders, thematic reports of governorate profiles1, cross border access analysis2, 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 in Jordan.

Table 1: Outline of SNAP’s information sharing protocol

<table>
<thead>
<tr>
<th>Category</th>
<th>Level of anonymisation for public disclosure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected</td>
<td>Open - can be quoted and attributed to the organisation</td>
</tr>
<tr>
<td>Protected</td>
<td>Can be quoted and attributed to ‘an international NGO’ or ‘a national NGO’ etc.</td>
</tr>
<tr>
<td>Restricted</td>
<td>Can be quoted and attributed to ‘a trusted source’</td>
</tr>
<tr>
<td>Confidential</td>
<td>Cannot be quoted directly but can be used for analysis and the analytical deduction published without any attribution</td>
</tr>
</tbody>
</table>

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 Idleb 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
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 1).

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 travel of the internet. Each piece of information is captured in a spreadsheet which categorises it according to geographic location, affected group, sector, data 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 (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 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-RANS and SINA exercises in Syria and the MSNA 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, other organisations have 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 co-ordination 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”. That is, that SNAP “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

* The more detailed SNAP information sharing classification system is available at http://www.acaps.org/enj/pages/syria-project
* J-RANS: Joint Rapid Assessment of Northern Syria
* SINA: Syria Integrated Needs Assessment
* MSNA: Multi-Sector Need Assessment
Nutrition response to the Syria crisis: UNICEF’s perspective

By James Kingori, Dr Haydar Nasser, Muhaidin Abdullahi and Dr Khaldoun Al-Asaad

James Kingori is the UNICEF Regional Nutrition Specialist for UNICEF’s Middle East and Northern Africa (MENA) Regional Office since April 2011, based in Jordan.

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Muhaidin Abdullahi is Nutrition Specialist with UNICEF Syria.

Dr Khaldoun Al-Asaad is Nutrition Officer with UNICEF Syria.

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 (2013 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 malnutrition 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 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.

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 ad-

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
4 Syrian Family Health Survey (SFHS), 2009
equate 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 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 stakeholders 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:

a) Prevention of undernutrition through accelerated promotion of appropriate IYCF, ensuring improved coverage of appropriate micronutrient intervention and promotion of nutrition sensitive responses alongside positive behavioural change activities
b) Supporting the identification and treatment of acutely malnourished cases using internationally approved guidelines and treatment products
c) Strengthening the nutrition surveillance system through supporting facility based and community based screening for malnutrition, as well as conducting comprehensive nutrition assessments
d) 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 e) 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-June 2014). These reports 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 coordination, 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 collection 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) 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, benefitting 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 staff 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 training. 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 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-E training was arranged by 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. In Turkey, special IYCF-E 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-E 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 IYCF-E training but additional training on rapid screening using Middle Upper Arm Circumference (MUAC) and height and weight measurements, as well as data interpretation, has been conducted in Jordan, Iraq, Lebanon and Syria. Assessment teams involved in the recent nutrition assessment in Lebanon and Syria have used 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, benefitting 26 public health professionals from emergency prone counties 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 counties 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 the participants’ technical knowledge in 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 teams with specific technical expertise and experience. There has been ongoing communication with technical staff involved in programme implementation through phone calls and technical discussion during the coordination meetings. The outlined capacity strengthening effort has been complemented by strategic 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 clearly 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 misconceived 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 was in place before the event of 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刷新 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, essentially 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. Engagement will be required to ensure that global guidelines are adapted to the needs of contexts such as those in the MENA region.

For more information, contact: James Kingori: jkingori@unicef.org

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Table 2: Cluster Training Participants

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<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Lebanon</td>
<td>8</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Palestine</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>12</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 1: MENA RO/NIE training participants, June 2013

8 Available at: http://www.ennonline.net/resources/htpversion2

1 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 assessment.

2 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.
People in aid

Participants in the NIE training in Jordan in 2012

Clinic staff outside one of the primary health centres in Jarabulus

NIE Regional training, Lebanon

Breastfeeding eliminates problems of lack of access to infant formula.

Naah! I can sort that out in a jiffy!...

Bang! Bang! Wzzzzzzz...

Chukka chukka COUGH

Later... Ta-daa!

Okay, I'm getting the vibe that infant formula is not a motor sport for toddlers.....
Many people underestimate the value of their individual field experiences and how sharing them can benefit others working in the field. At ENN, we’ve kept the scope of individuals and agencies that contribute material for publication and to continue to reflect current field activities and experiences in emergency nutrition.

Many of the articles you see in Field Exchange begin as a few lines in an email or an idea shared with us. Sometimes they exist as an internal report that hasn’t been shared outside an agency. The editorial team at Field Exchange can support you in write-up and help shape your article for publication.

To get started, just drop us a line. Ideally, send us (in less than 500 words) your ideas for an article for Field Exchange, and any supporting material, e.g. an agency report. Tell us why you think your field article would be of particular interest to Field Exchange readers. If you know of others who you think should contribute, pass this on – especially to government staff and local NGOs who are underrepresented in our coverage.

Send this and your contact details to: Marie McGrath, Sub-editor/Field Exchange, email: marie@ennonline.net. Tel: +44 (0)1865 324996 Fax: +44 (0)1865 597669

Visit www.ennonline.net to update your mailing details, to make sure you get your copy of Field Exchange. If you are not the named recipient of this Field Exchange copy, keep it or pass it on to someone who you think will use it. We’d appreciate if you could let us know of the failed delivery by email: office@ennonline.net or by phone/post at the address above.

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

Welcome to Peter Torvet who has joined ENN as Senior Finance Manager, based in Oxford.

Charlotte Roberts is the ENN’s Operations and Mailing Assistant, based at the ENN’s office in Oxford.

Phil Wilks (www.fruitysolutions.com) manages ENN’s website.

The Team

Thom Banks is the ENN’s Project Operations Manager based in Oxford.

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 registration no: 06610576.

Registered address: 32, Leopold Street, Oxford, OX4 1TW, UK. ENN Directors/Trustees: Marie McGrath, Jeremy Shoham, Marie McGrath, Carmel Dolan and Emily Mates are Technical Directors.

Chloe Angoad is a nutritionist working part-time with ENN on a number of projects and supporting Human Resources.

Clara Ramay is the ENN’s Finance Assistant, based in Oxford.

Oma O’Reilly designs and produces all of ENN’s publications.

Field Exchange supported by: