

Health Sector Humanitarian Response Strategy



Jordan 2014-2015

Health Sector
Working Group
Updated May 2015

Photo credit: UNICEF, *Save the Children Jordan, Infant and Young Child Feeding Activities*

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Syrian refugees registered with UNHCR

- **Urban areas: 520,422**
- **Camps: 106,381**

**Source: UNHCR registration data – April 25 2015*

1. Introduction

In early 2014, a Health Sector Strategic Advisory Group (SAG) for the Humanitarian Response was formed to further support the work of the Health Sector Working Group in Jordan. One of the SAG's main tasks¹ was to develop the Health Sector Humanitarian Response Strategy, expanding upon the existing response strategy and objectives present in the *2014 Syria Regional Response Plan 6* (RRP6). This second version was updated in early 2015 to incorporate the latest response strategy, as well as reflect significant changes made to the national health policy of provision of services to registered Syrian refugees.

This document, which will be periodically updated, outlines the context of the humanitarian response in Jordan, particularly highlighting the Syrian refugee crisis and its implications on the national health system. Virtually all the data and figures in the strategy are related to Syrian refugees, as a large number of

assessments have been carried out with this population in recent years. It is important to note, however, that the humanitarian response in Jordan also addresses refugees of nationalities other than Syrian, as well as the affected vulnerable Jordanian population. In addition to Syrian refugees, Jordan is also host to a significant Iraqi refugee population (nearly 30,000) and also to refugees of other nationalities (nearly 5,000), testament to the Kingdom's long history of providing safe haven to those fleeing strife in their homeland.

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

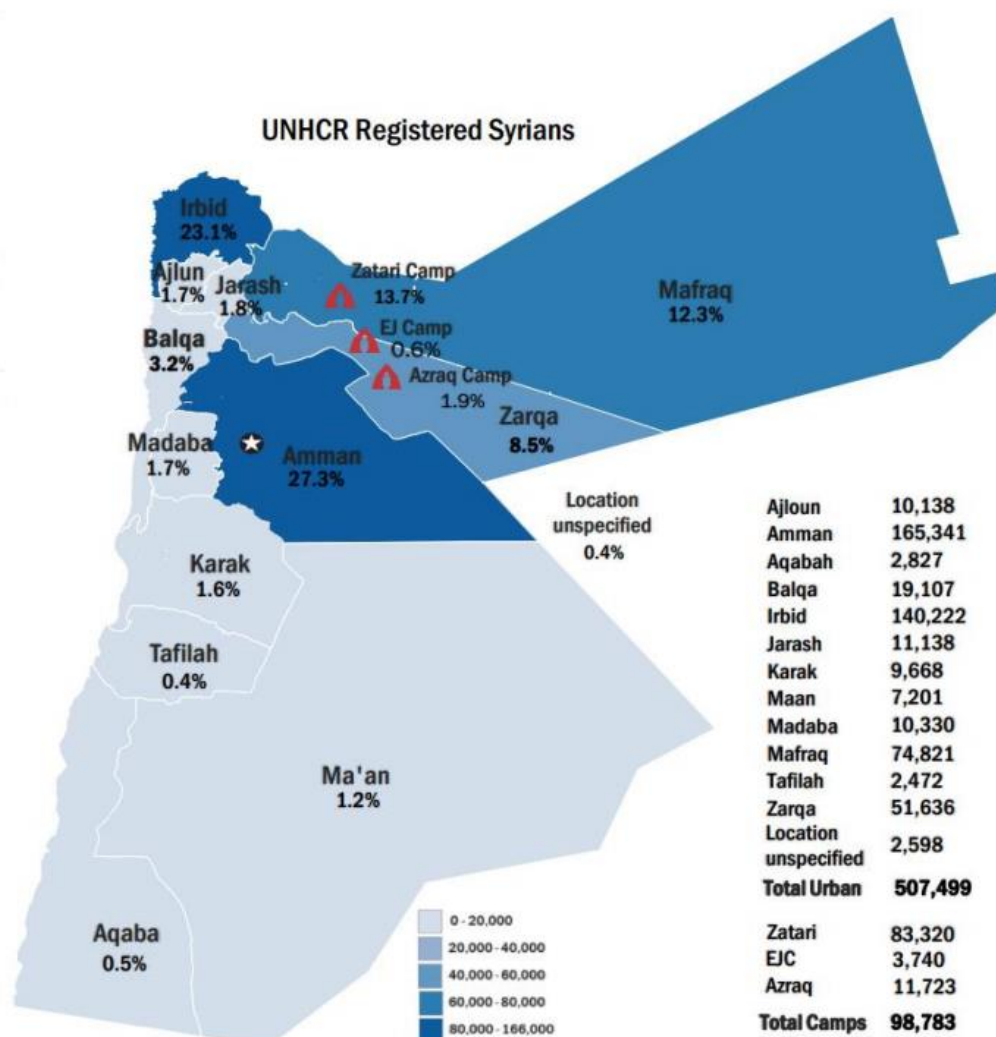
2. Context

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

With the Syrian crisis in its fifth year the evolving humanitarian context poses new demands on health systems in Jordan and consequently on the Health Sector. Planning and coordination need to be strengthened even further to ensure an appropriate response. This includes strengthening national capacity to cope with the increased numbers requiring health services; improving collection and analysis of data and

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

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



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

* Coloured map only reflects refugees living outside camps.

3. Overview of health needs and risks

The Syrian refugee health profile is that of a country in transition with a high burden of **non-communicable diseases** (NCDs); 22% of consultations in Zaatari in 2014 were for NCDs² (diabetes constituted 19%, hypertension 21% and asthma 12%). **Communicable diseases** also remain a public health concern with a measles outbreak in Jordan in 2013 and an ongoing polio outbreak containment measures in the region; there have been 182 cases of tuberculosis diagnosed amongst Syrians since March 2012 with four multidrug resistant cases³; and increasing numbers of imported leishmaniasis in areas hosting large numbers of Syrians.

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

³ As of end of March 2015

The patchy immunization coverage especially of refugees outside of camps is of concern particularly in light of the polio outbreak with 36 confirmed cases in Syria and two confirmed cases in Iraq. The last virologically-confirmed polio case in Jordan was reported on 3 March 1992. There is a need to strengthen uptake of routine immunization (Jordan has 11 vaccines in its schedule) to maintain the gains achieved during the national and subnational campaigns for both refugee and Jordanian children.

Crude and under five mortality rates based on Zaatari data in 2014 were within expected ranges and comparable to Jordan's rates. Neonatal mortality has reduced (from 42 deaths in Zaatari in 2013 compared to 33 in 2014).⁴ Nevertheless, a neonatal and maternal care assessment⁵ conducted in January 2014 in Zaatari and Mafraq demonstrated the need to refocus on appropriate and effective lower technology interventions such as kangaroo mother care, use of the partograph and early initiation of breast feeding as well as ensuring early management of both maternal and neonatal complications prior to referral. In 2014, 47% of under five deaths occurred in the neonatal period.

NCD management is not always satisfactory, with inadequate monitoring, lack of a multidisciplinary approach and treatment interruptions.

According to a survey conducted by UNHCR in February 2014⁶ in non-camp refugees among household members who were ≥18 years, 39.8% were reported to have at least one chronic condition and 23.9% of household members with chronic diseases reported difficulty accessing medicine or other health services. The main reasons mentioned for inability to get care were costs (44.7%), long wait at the clinic (16.3%), and not knowing where to go (14.7%). During in-depth interviews with 51 NCD patients in another assessment,⁷ the main barriers to care expressed were inability to get regular medications due to Ministry of Health (MoH) shortages and then the cost of needing to purchase these medications themselves. Not surprisingly 34 respondents stated that their condition had worsened since leaving Syria. The continuing challenges in adequately addressing NCDs have the potential to seriously impact both quality of life and life expectancy amongst refugees. MoH, WHO, UNHCR and other health stakeholders have established a task force to improve NCD management amongst Syrians.

Morbidity

22% of consultations in Zaatari in 2014 were for NCDs:

- 19% diabetes
- 21% hypertension

• 182 cases of TB since March 2012

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

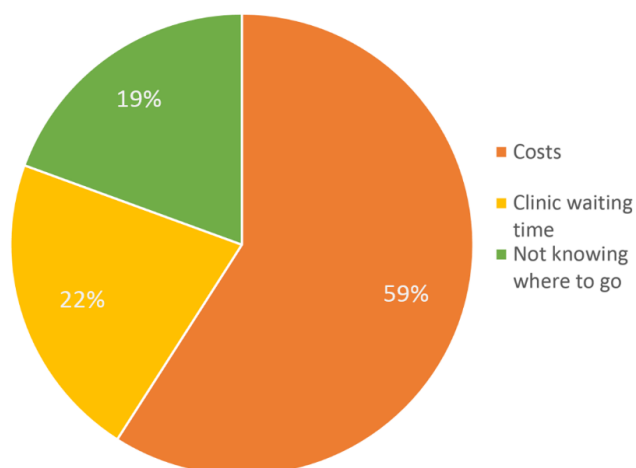


Figure 2– Reasons for not receiving care for chronic diseases

⁴ Rates are not presented here due to the numbers of deliveries in Zaatari in women who live outside the camp

⁵ Ministry of Health, UNICEF, UNHCR, UNFPA, Maternal and New Born Health Services. Rapid Assessment Report Zaatari Camp and Mafraq Women and Children's Hospital. January 2014

⁶ UNHCR and JHAS. Non-Camp Syrian Refugee Household Knowledge, Access and Uptake of Health Services Baseline Survey. February 2014.

⁷ IMC. Health Access Assessment in Non-Camp Refugees in Jordan. December 2013- January 2014.

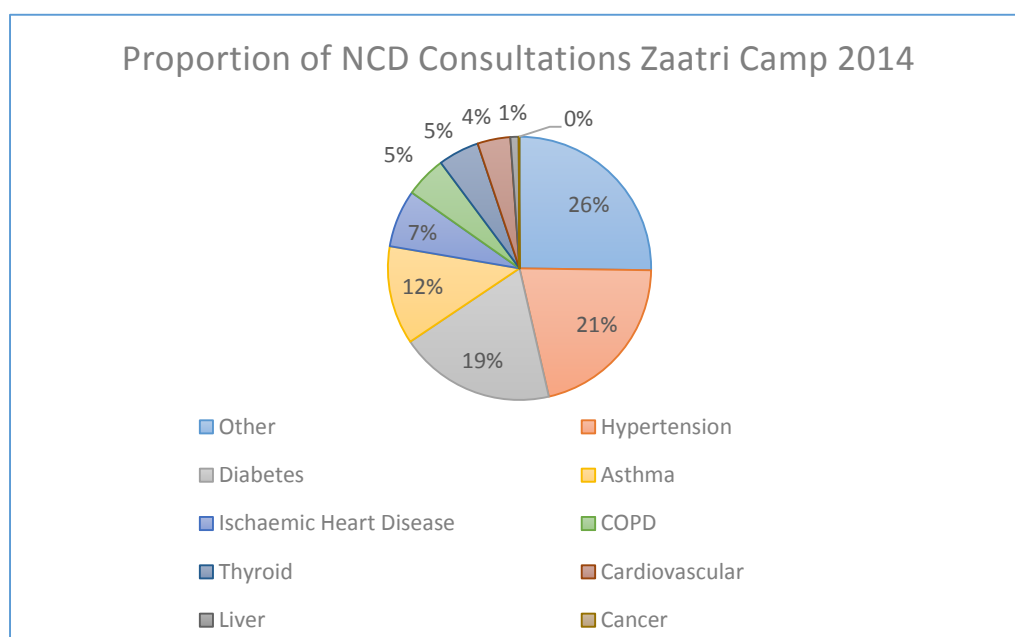


Figure 3– Non-communicable diseases as reported from Zaatari camp, January – December 2014 (n=102,619)

Reproductive health coverage has improved with 96% of deliveries in Zaatari in 2014 attended by a skilled attendant (compared to 92% on average throughout 2013). However, complete antenatal care coverage (at least four visits) and tetanus toxoid coverage both need improvement. The proportion of deliveries in girls under the age of 18 was 8.5% for 2014 which represents an increase compared to the average for 2013 of 5%. Girls under 18 are more likely to experience obstetric and neonatal complications. UNFPA reproductive health needs assessment survey in Zaatari recommended continuation of community outreach activities with an emphasis on family planning programming and improving health care seeking behavior to address reproductive health needs and decrease high risk pregnancies and associated complications. Health Sector actors need to link with Child Protection (CP) and strengthen interventions to reduce early marriage. UNFPA continues to support Jordan Health Aid Society (JHAS) in providing basic emergency obstetric services in Zaatari and has progressively increased the capacity and resources to meet demands. While UNFPA, MoH and other key partners have worked extensively to improve the clinical care for sexual assault survivors through development of guidelines, trainings, and distribution of post-rape kits, there is still a need to improve quality of service in this field. Notably progress has been made in terms of connecting health facilities to other services thanks to the child protection and sexual and gender-based violence (SGBV) standard operating procedures. Messaging on SGBV is very sensitive and community and provider knowledge continues to be limited, however extensive efforts have been implemented at the inter-agency level to improve knowledge of SGBV response services and access to health services.

Reproductive Health

- **96% of deliveries in Zaatari in 2014 attended by a skilled attendant**
- **Amongst non-camp refugees 96.9% delivered in a health facility, of which 30.2% were in a private facility**
- **Deliveries in girls under 18 years old has increased from 5% in first quarter of 2013 to 8.5% in 2014**

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

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

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

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

A Handicap International/HelpAge International assessment⁸ reported that 8% of refugees in Jordan have a significant **injury** of which 90% were conflict-related. Men accounted for 72% of the injured persons with the highest proportion of injuries found amongst those aged 30 to 60 years. The significant impact of injuries on men of productive age increases the vulnerability of entire households. The capacity to address the health needs of the war-wounded has increased substantially, particularly emergency stabilization, acute surgery, and rehabilitation (physical and psychosocial). However, there are major gaps remaining, particularly related to post-operative care, home nursing, medium to longer term rehabilitation (including assistive devices) and community-based rehabilitation. More attention must also be paid to the ongoing care and treatment of common conditions (e.g. pressure sores) experienced by people after complicated trauma (e.g. spinal cord injuries and other neurological trauma) that can quickly become life-threatening. Better patient education, longer-term rehabilitation, and **home-based care models** can drastically reduce morbidity and mortality despite the complexity of these injuries.⁹

Elderly Syrian refugees can face significant challenges in accessing health services due to, inter alia, restricted mobility and need for support for activities of daily living. A recent review of home-assessment data of the most vulnerable families, reported that four and a half per cent of the visited refugee population were over the age of 60, compared to 3.6% in the entire Syrian refugee population outside camps. While

⁸Handicap International/HelpAge International. Hidden victims of the Syrian crisis: disabled, injured and older refugees. 2014.

⁹ Burns and O'Connell. *The challenge of spinal cord injury care in the developing world*. *J Spinal Cord Med*. 2012 Jan; 35(1): 3–8.

almost two-thirds of these live in formal housing, 22% live in tents or spontaneous settlements and 11% live in other informal housing. Seven out of ten face living conditions assessed as bad or urgent. These represent a small but highly vulnerable group amongst Syrian refugees in Jordan.¹⁰

Mental health problems remain a significant concern for refugees in Jordan. There were 19,511 consultations for mental health disorders in 2014 (17% for epilepsy/ seizures, 27% for severe emotional disorder and 8% for psychotic disorder). In general, there is an over-emphasis on trauma and less focus on delivering comprehensive, integrated services, and on supporting natural coping strategies and family/community resiliency. Furthermore, the geographic coverage of services needs to be widened. A comprehensive assessment¹¹ conducted in 2013 revealed an increased need for early detection and referrals, services to address concerns in children, and strengthening outreach, family and community-based activities that promote resiliency, skill building and adaptive coping strategies. More attention is needed for chronic mental health conditions and cognitive impairments.

Mental Health

- **19,511 consultations for mental health disorders in 2014 in Zaatari**
- **17% epilepsy**
- **27% severe emotional disorder**
- **8% psychotic disorder**

The acute **malnutrition** prevalence among refugees is low with a global acute malnutrition level of 1.2% in children under five in Zaatari based on weight for height Z score and 0.8% in refugees out of camp.¹² Anaemia in children under five and women of reproductive age in Zaatari camp was high at 48.7% and 44.7% respectively. Lower but still concerning levels were found in the host community. There is a need to expand

anaemia prevention and treatment initiatives and ensure access to other critical micronutrients. Infant and young child feeding (IYCF) practices were poor pre-conflict including early weaning, and inappropriate complementary feeding practices. Despite the low acute malnutrition levels new arrivals under five years old will continue to be screened with Mid-Upper Arm Circumference (MUAC) in light of the potential deterioration of food security and nutrition status inside Syria.

Until the end of November 2014, MoH maintained a policy of free access to primary and secondary care in their facilities for registered Syrians living outside of camps. Following a decision made by the Cabinet in November 2014 registered Syrian refugees outside of camps now have to pay the uninsured Jordanian rates at MoH facilities. This heavily subsidized rate (around 35 – 60% of what other non-Jordanians pay), while manageable for most refugees,

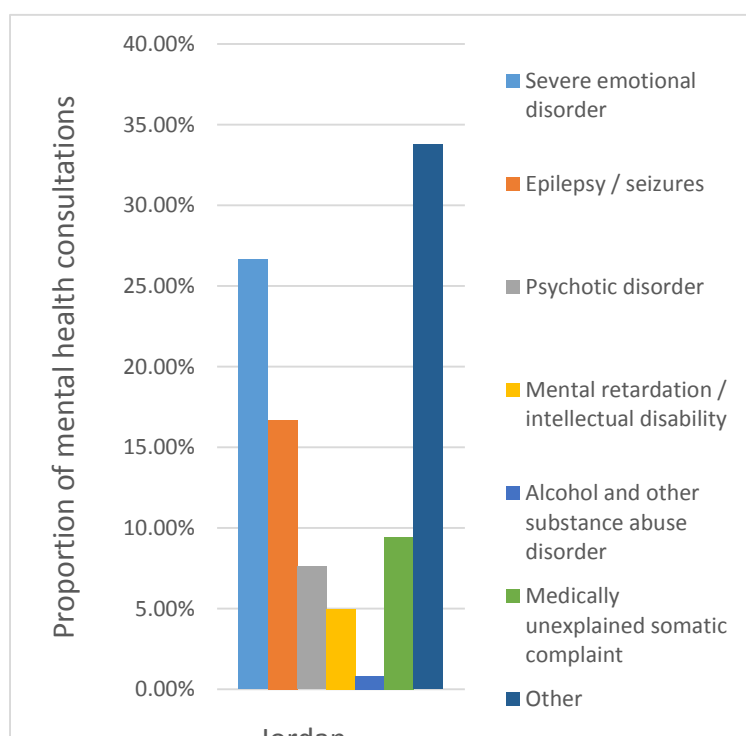


Figure 4 – Mental health conditions in Jordan (Zaatari camp), January – December 2014

¹⁰UNHCR, Living in the Shadows: Jordan Home Visit Report, 2014.

¹¹WHO, IMC, MOH and EMPHNET. Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrians in Jordan. February 2014

¹²UNHCR/UNICEF/WFP/WHO/UNFPA/Medair. Nutrition Survey Preliminary Findings. April 2014.

will nevertheless pose a problem for the most vulnerable. In the wake of this change, UNHCR issued a temporary policy to mitigate its immediate effects. Services are targeted towards the most vulnerable but SGBV, mental health, malnutrition in children, neonatal complications and obstetric emergencies will be supported for all. More information is needed on the impacts of the change in policy before redesigning health service support.

Restriction of movement for women and girls may limit their access to health services, while lack of female providers for reproductive health services, though improved is also a barrier. Recent assessments by IMC¹³ and PU-AMI¹⁴ have also shown that refugees have trouble accessing health services if living in a governorate different from the one where they registered with the Ministry of Interior; transportation to and from health centres incurs a significant cost they cannot afford, and many find the distance to clinics a barrier in itself.

Refugees continue to cite lack of **information on health services** as a major problem. An Oxfam study¹⁵ demonstrated that 75% of respondents in Zaatari wanted more information on medical services while refugees in the host community want clarity on which medical procedures they are entitled to, which they must pay for and why, and how to request additional support if necessary. Women refugees in non-camp settings cited lack of knowledge about available services as a barrier much more frequently than men¹⁶ highlighting the importance of diverse communication strategies to reach women.

Information Needs

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

Secondary and tertiary care need a continued high level of funding to ensure access to essential care such as deliveries, caesarean sections, war injuries, congenital abnormalities including cardiac abnormalities and renal failure. Despite the high level of care available in Jordan, gaps in service delivery exist including long-term post-operative care – especially for injuries – and surgical management of certain complications such as pressure sores. Costly complex treatments such as certain types of cancer cannot be supported with available resources necessitating difficult choices relating to resource allocation. In particular access to critical reproductive health services has been impacted by the withdrawal of free services.

MoH's critical role in providing refugee health services needs to be recognized and supported. Facilities in areas hosting large numbers of refugees are often overburdened. The Health Facility Assessment¹⁷ in the five northern and middle governorates of Irbid, Mafraq, Jerash, Ajloun and Zarqa demonstrated that over 9% of total patient visits were by Syrians. This manifests in shortages of medications – especially those for chronic diseases – and beds, overworked staff and short consultation times. This also fosters resentment amongst the Jordanian population. National capacity to provide inpatient management of acute malnutrition has not yet been developed. The health information system in urban settings needs to be integrated nationwide and to be able to routinely disaggregate Syrians and Jordanians in key areas.

¹³ IMC, UNHCR, UNFPA. Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings Throughout Jordan, With Sub-Investigation on Non-Communicable Disease Management: A Qualitative Cross-Sectional Cluster Survey. March 2014.

¹⁴ PU-AMI. Hashemite Kingdom of Jordan, Syrian Crisis: Health Needs Assessment. March 2014.

¹⁵ Oxfam. Refugee Perceptions Study - Zaatari Camp and Host Communities in Jordan. June 2014.

¹⁶ IMC. Health Access Assessment in Non-Camp Refugees in Jordan. December 2013–January 2014.

¹⁷ MoH, WHO, UNHCR, UNICEF, UNFPA, Harvard/IAPS, JUST & MDM. Joint Rapid Health Facility Capacity & Utilization Assessment. July 2013.

At community level, coverage of **outreach and Syrian community involvement** in the promotion or provision of health services is insufficient ;Amman has one community health volunteer per 3,600 refugees (target >1 per 1000).Syrian refugee providers remain outside of the mainstream coordination mechanisms. This undermines Syrian access and coverage of key services, community capacity building, self-reliance and the ability to withstand future adversity. There is a need for greater access of refugees to information and enhanced refugee participation and engagement in identification of health and disability related needs, provision of information and linkages with health and rehabilitation services.

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

i. Health system performance

MoH has provided 1,258,811 services to Syrians and spent 43 million Jordanian dinars from the onset of the Syrian influx to end November 2014b. Demand on the public sector as well as NGO-supported clinics continues to grow. In March 2014, for example, there were 16,687 consultations for Syrians in primary health care centres, 763 inpatients and 4,767 outpatient visits in hospitals in Irbid governorate alone. Even though the services are no longer free of charge they are still highly subsidised. This continues to be a considerable burden on MoH facilities which will require significant additional support to be sustained.

National Health Systems

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

Frequent shortages of supplies (medicines, family planning commodities, vaccines, and medical equipment) exacerbated by the refugee influx have been reported. Furthermore the pressure on existing infrastructure continues to grow. Bed occupancy in many northern hospitals is continually close to 100 percent. The worst affected are critical care beds such as intensive care, coronary care and neonatal intensive care.

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

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

ii. Target groups and areas

There are two main population groups of concern: refugees (Syrians – over 628,000 women, girls, boys and men registered with UNHCR; Iraqis – over 48,000 women, girls, boys and men registered with UNHCR; Sudanese, Somalis and others – over 6,000 women, girls, boys and men registered with UNHCR); and affected host community.

As of end December 2014, the geographical distribution of Syrian refugees per governorate is as follows: over 170,000 in Amman (28%), over 160,000 in Mafraq (26%, including nearly 85,000 in Zaatari camp); over 140,000 in Irbid (23%); and over 65,000 in Zarqa (11%, including over 11,000 in Azraq camp). The geographic focus on northern governorates is important, but attention will also be given to the acute health sector challenges faced in a number of middle and southern zone governorates.¹⁸

Other refugees registered with UNHCR

- 48,215 Iraqis
- 6,227 other nationalities

**Source: UNHCR registration data –May 31st -June 6th 2015*

Population group	Total Population
Camp refugees	150,000
Non-camp refugees	550,000
Other affected population	700,000 ¹⁹
Refugee children under five	133,000
Refugee women of reproductive age	161,000
Adolescents	126,000
Pregnant women and lactating women	35,000
Refugees with impairment and disabilities	154,000
Refugees with injuries	56,000

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

iii. Coordination

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

¹⁸Such as Zarqa, Maadaba, Balqa, Maan, Karak and Tafilah.

¹⁹ This total does not include the 3,850,000 individuals who will benefit from vaccinations.

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

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

Gender focal points within the sector will assist in ensuring that the differential needs of women, girls, boys and men are considered throughout the response. Together with the other actors in the health sector the gender focal points will identify gaps and challenges in gender equality to promote a gender-responsive environment and reduce or eliminate gender-based discrimination in health related programs.

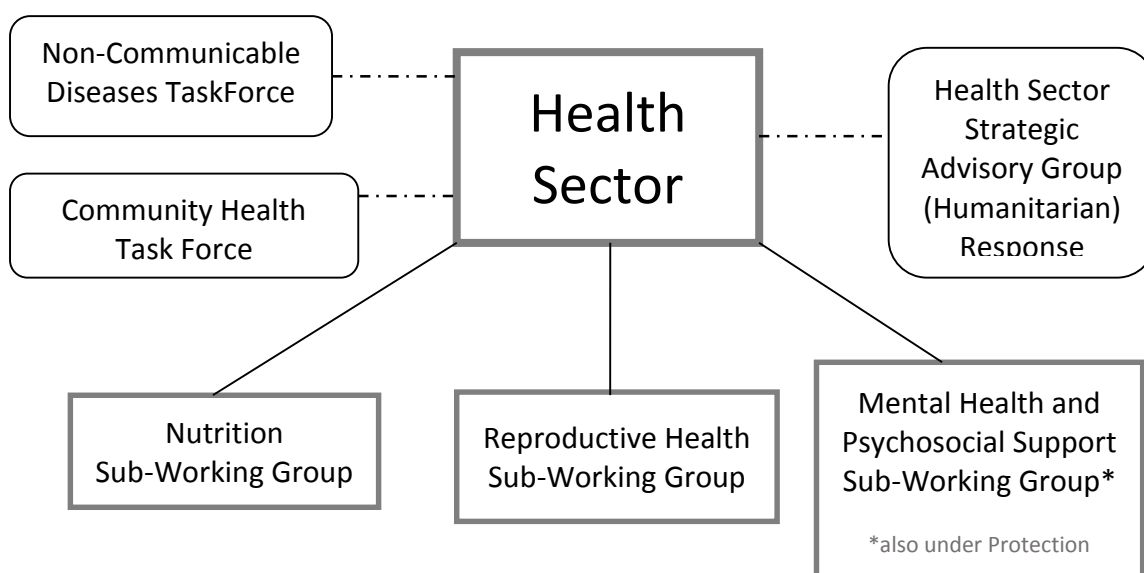


Figure 5 – Health sector response

iv. Strategic Intersections

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

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

4. Goal

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

5. Objectives

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

1. Enhance access, uptake and quality of primary health care for Syrian women, girls, boys and men and Jordanian populations in high impact areas by the end of 2015.

Expected outputs:

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

2. Enhance equitable access, uptake and quality of secondary and tertiary health care for Syrian women, girls, boys and men and Jordanian populations in high impact areas by the end of 2015.

Expected outputs:

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

3. Improve comprehensive health care through integrated community interventions including rehabilitation services for Syrian women, girls, boys and men and Jordanian populations in high impact areas in 2015.

Expected outputs:

- i. Community health volunteer teams and referral system in place

- ii. Community level nursing for those with injuries and complex or multiple impairments provided
- iii. Community management of acute malnutrition programs implemented and monitored
- iv. Community level rehabilitation provided
- v. Community level mental health services provided

4. Contribute to strengthening national health systems to increase adaptive capacity to current and future stresses by the end of 2015.

Expected outputs:

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

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

Expected outputs:

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

6. Strategic Approaches

The overall aims in the 2015 response are to maintain the low mortality rates and address the main causes of morbidity by promoting access to essential services. The response strategy will be throughout the refugee cycle from arrival to durable solutions and will consist of the following:

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

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

In response to the withdrawal of free health services by the Ministry of Health and the expected reduction in humanitarian resources, health agencies should be developing mechanisms to target assistance towards those most in need. Parallel services will need to be continued for those who cannot access Ministry of Health services at the subsidised rate (either not eligible or cannot afford) but should ideally be directed

towards the most vulnerable. Health agencies should coordinate to develop harmonised systems of vulnerability identification and provision of assistance. Access to health services could also be supported by demand side financing initiatives which will be further explored.

In relation to SGBV, health care providers play an important role in receiving disclosure from survivors and provide critical clinical management and referral. This will be strengthened through training and improved monitoring in coordination with the Protection Sector, SGBV sub-sectors, Family Protection Department, and other relevant national institutions, including through the full implementation of the CP and SGBV standard operating procedures. Critical gaps outside the camps which are not able to be met by the MoH will be met through further supporting NGO clinics and support for referrals. Continued support to NGOs to relieve the burden on MoH facilities is needed until the MoH facilities are able to manage the increased workload. UNFPA and UNICEF will be supporting MoH to develop a complete Clinical Management of Rape Survivors protocol in line with internationally defined standards. A health information system has been introduced in UNHCR-supported NGO facilities in order to contribute to the available data on Syrians, including data disaggregated by gender and age. This in combination with the recently established GBV Information Management System, coordinated by UNHCR and UNFPA, will be able to provide increased information of trends and SGBV as well as gaps in service provision. Women are by far the dominant users of the case-management services of SGBV. Girls use these services to a limited extent: this is not consistent with data about needs. Men started to use these services in small numbers; and boys rarely use the services. To further address reproductive health needs for youth, a special emphasis will be set on promoting reproductive health services and rights of young people, especially young women and girls, reinforcement of youth peer network among the refugee population in the camp and the provision of youth-friendly health services. In both camp and non-camp populations two additional approaches will be developed. Firstly, a strategy to strengthen refugee participation and engagement in provision of information and selected health services (e.g. diarrhoea management with oral rehydration solution, behaviour change communication, MUAC screening, referral to primary health care centres), by training and supporting male and female community health volunteers, will be developed by agencies working in the Health Sector and resources sought for this. Secondly, vulnerability identification and scoring will be improved with the aim of better targeting and reaching those most vulnerable with essential services and assistance and monitoring of assistance against needs. Vulnerability assessments will be shared across partners, and will include questions on a range of vulnerabilities related to economic factors and well as physical and social factors, such as age and disability.

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

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

For refugees in non-camp settings the national system will be supported through adequate human resources in areas most affected by Syrians, essential medicines, supplies, equipment and critical infrastructural improvements, and performance-based incentives for staff. Specific capacity gaps will be addressed though

training and development of work plans with partners, such as inpatient management of acute malnutrition, clinical management of SGBV, integration of mental health into primary health care; or through staff secondment or human resources support, such as for chronic disease management and specialized trauma surgery. A network of clinics and other services will be supported to meet the needs of those Syrian refugees unable to access MoH facilities for primary and secondary care.

The following need to be strengthened: post-operative/convalescent care and rehabilitation for war-wounded persons; services for children with sensory impairments and intellectual disabilities; and infant and young child feeding. Essential secondary and tertiary care, including emergency obstetrics not covered by MoH, needs significant funding to ensure access throughout 2015. Clinics operated through NGOs will continue to focus on areas not currently widely available in the national health system (such as mental health and SGBV responses) for Syrian refugees outside of the camps. Furthermore demand side financing mechanisms such as cash to offset the cost of accessing health services will be explored in order to facilitate cost-effective access to Ministry of Health services.

UNHCR has planned an assessment of health services for people with disabilities in order to improve quality and quantity of services offered to these individuals. Because of the current lack of data regarding people with disabilities and health in a humanitarian setting, the study investigators will aim to understand more about the experiences of the refugees living with disabilities with a goal of informing future interventions and protocols, thereby addressing the gaps in care provided.

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

7. Key Overarching Approaches

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

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

ii. Comprehensive Reproductive Health programming

- As the crisis is in its fifth year the emphasis in reproductive health should be on comprehensive programming.
- Minimum initial service package (MISP) will remain an essential component in preparedness.
- Availability of comprehensive emergency obstetrical services inside the camps needs to be secured
- Family planning programming inside and outside the camps should be scaled up including linkages between general health providers, community health volunteers and different level of services to enhance referral and reduce missed opportunities

iii. Balance between Health Systems Strengthening and Services Delivery

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

iv. Support equitable and sustainable access to health services

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

v. Essential medicines and drug donations

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

vi. Guiding documents

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

- ix. IPPF, UNFPA, WHO, The Interagency Working Group on SRH and HIV Linkages SRH and HIV Linkages Compendium: Indicators and Related Assessment Tools :: <http://www.unfpa.org/publications/srh-and-hiv-linkages-compendium-indicators-and-related-assessment-tools#sthash.wWHqINY4.dpuf>, 2014

Annex 1: Health Sector Budgetary Requirements 2015

