

Syria



WFP beneficiary in damascus; WFP/Abeer Etefa

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SARC volunteers
at a distribution
centre in rural
Damascus

Dina Elkassaby/WFP-Syria, 2013

WFP's emergency programme in Syria

By Rasmus Egendal and
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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 Compact¹ and the WFP Code of Conduct.

Considerable efforts to strengthen local capacity have been made throughout 2013 including supplying crucial equipment and providing training on warehouse management, safe distribution practices, and programme monitoring. While allocation to partners varies on the basis of needs, capacity and access, on average approximately 55% of total food rations are allocated to SARC, while the remaining 45% are distributed by the NGO partners. SARC implements distributions through its branches and sub-branches, or through local charities in locations where it has no presence.

The number of WFP staff in country has gradually increased to over 200; the majority of these are national staff. WFP and local partners are currently implementing three main schemes – general food distribution, BSFPs for young children and ready-to-eat rations. The latter are distributed to newly displaced families with limited access to food or cooking facilities during the initial days of their displacement. In late 2014, two additional components were added: a school feeding programme to encourage regular attendance in school and distribution of food vouchers to promote dietary diversity for pregnant and breastfeeding mothers.

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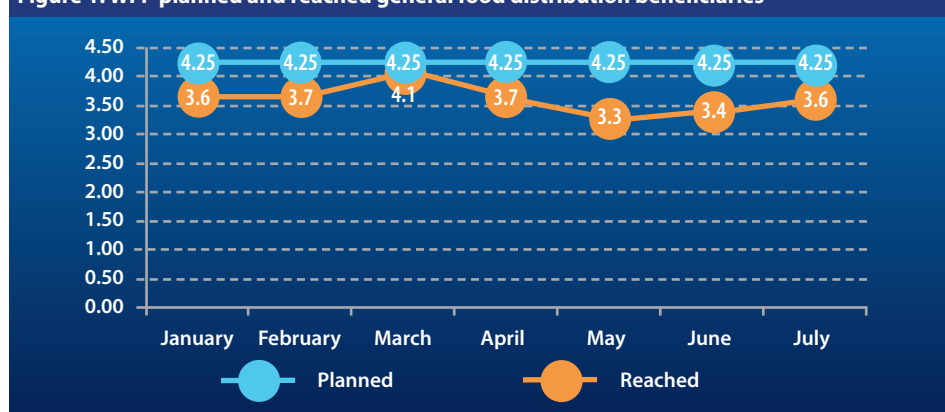
¹ <https://www.unglobalcompact.org>

Box 1 WFP's targeting approach

WFP establishes the ration type in consultation with partners, according to nutrition considerations, local preferences and procurement capacity. The ration is then approved by the relevant government authorities. Targeting criteria are also established in consultation with partners, based on the following vulnerability criteria:

- Persons and households that have been displaced and have little or no income for food
- People located in or near areas subject to armed activities with little or no income for food
- Persons and households hosting a displaced family with little or no income for food
- Poor people in urban and rural areas affected by the multiple effects of the current events and who have little or no income for food.

Figure 1: WFP planned and reached general food distribution beneficiaries



WFP/Dalia Khamisy



Syrian refugees go shopping with e-vouchers

Needs assessment in November 2013

A WFP/FAO Joint Rapid Food Needs Assessment was conducted in November 2013 in Syria, in collaboration with the Ministry of Agriculture and Agrarian Reform and the Ministry of Social Affairs. It indicated that some 9.9 million people were estimated to be vulnerable to food insecurity and unable to purchase sufficient food to meet basic needs. Of these, some 6.3 million were estimated to be particularly exposed to the effects of conflict and displacement and in critical need of sustained food assistance. A severe reduction in agricultural production, combined with constraints in marketing available produce, as well as weakened import capacity to meet domestic demands, have increasingly limited food availability over time. Compounding the devastating effects of the conflict, exceptionally low levels of rainfall during the 2013/2014 winter season conditions impacted food production in 2014 and further exacerbated Syria's humanitarian crisis. Furthermore, inflation, high commodity prices and growing rates of unemployment significantly reduced household purchasing power. Foods and fuels have been severely hit by price inflation particularly in northern governorates. On the other hand, prices have actually dropped in some southern governorate areas. As available resources have been depleted over time and resilience

weakened, households have increasingly resorted to negative coping strategies including a reduction in both the quantity and quality of food consumed, a decrease in dietary variety, withdrawing children from school and selling assets.

General food distribution (GFD)

Targeting

WFP's GFD targets the most vulnerable households across all 14 governorates. WFP establish the target for each governorate on the basis of available needs assessment as well as consultation with partners (see Box 1). The assistance prioritises displaced households who have lost their main source of income, as well as poor communities hosting a large number of displaced families. Each household receives a food basket sufficient to feed a family of five for one month. The monthly family food basket consists of a variety of commodities such as rice, bulgur wheat, pasta, pulses, vegetable oil, sugar and salt. In 2014, the food basket was revised from 1680 kals to provide up to 1,920 kcal per person per day. This increase was effected as WFP's programme monitoring findings suggested that families were increasingly less able to access additional food from alternative sources, mostly relying on the GFD. The quantity and composition of the basket has been subject to changes depending on commodity availability and pipeline status. Figure 1 presents the target and reached populations up to July 2014. In August 2014, food distributions reached over 4.1 million people, or 98% of the month's target.

Challenges

Distributions are conducted on a monthly basis in order to balance meeting the immediate food needs of beneficiaries with logistical challenges associated with such wide-scale activity across insecure areas. In 2013, widespread insecurity restricted access to many areas of the country, preventing the distribution of assistance at the planned scale. Particularly in the north, escalating infighting among multiple armed groups closed access routes and deadlocked assistance to Al-Hasakeh for most of the year, to rural Aleppo from August 2013 and eastern Aleppo city from September 2013. By November, the entire north-east was cut off as routes to Ar-Raqqa and Deir-ez-Zor were also blocked by continuous clashes. Haphazard access narrowed the scope of monitoring activities which could not be conducted

in Ar-Raqqa, Deir-ez-Zor and Quneitra for the entire year. Furthermore, shifting patterns of active conflict prevented WFP teams from visiting the same sites each month, obliging them to rotate distributions among locations as security conditions permitted. Access constraints continued into 2014 as the crisis became more protracted. WFP planned and 'reached' general food distribution beneficiaries are shown in Figure 1 (Jan – July 2014).

Food assistance to millions of civilians trapped in besieged locations, including an estimated 800,000 in Rural Damascus, remained sporadic despite unrelenting appeals for unhindered access. Al-Hasakeh is one of the hardest governorates to reach with humanitarian assistance. The continued closure of border crossings, active fighting in neighbouring governorates and radical armed groups blocking passage of trucks severely disrupted overland food deliveries since July 2013. As needs in the governorate continued to grow and food security of affected populations deteriorated, on three instances WFP was compelled to resort to costly but necessary emergency airlifts as the only means to deliver food to the targeted 227,170 civilians. The first airlifts were conducted in December 2013 when 6,025 food rations for 30,000 people were airlifted from Erbil to cover just 13% of the monthly requirements. Through the second round of airlifts, conducted between February and March 2014, WFP was able to deliver just over 16,000 rations out of a planned 32,500 to support 80,000 people in the governorate. These were suspended in mid-March after Turkish authorities granted the long awaited greenlight for the passage of 10,000 food rations into Al-Hasakeh through Nusaybeen on the Syria-Turkey border. However from April 2014, the governorate was once again cut-off from access. As a result, in July 2014, a third round of airlifts was implemented from Damascus. A total of 10,000 family food rations for 50,000 people and 3,000 ready-to-eat rations to support the immediate needs of newly displaced families were delivered. During January 2014, 17,500 people were assisted with 3,500 ready-to-eat rations in Homs and Rural Damascus.

Each monthly cycle is typically completed over the course of 45 days, due to access constraints and extended dispatch cycles. WFP has

WFP/Laure Chadraoui



In areas like Homs and Dier Ezzor, WFP in partnership with the Syrian Arab Red Crescent (SARC) conducts door-to-door food distributions.



Syrian refugees go shopping with e-vouchers

continuously had to make adjustments to the ration due to funding and supply chain issues. This has resulted in reductions in ration size. There have been many constraints to providing a full ration including delays in procurement, inspection and quality issues that delay approval in country and insufficient pledges from donors. To date (September 2014), cash flow problems have been mitigated by the use of WFP's internal advance funding mechanism, which have allowed borrowing against future contributions. However inadequate funding commitments have become a severe constraint (see later).

In April 2013, WFP added wheat flour to the food basket in response to widespread wheat flour and bread shortages. Targeting 70% of WFP's planned beneficiaries, the flour is provided to households living in areas where the effects of the conflict have decreased availability and reduced milling and bakery capacities, to the extent that target beneficiaries are reliant upon WFP wheat flour distributions to meet their bread needs. For the beneficiaries that receive fortified wheat flour, the food basket provides approximately 80% of daily caloric requirements. The food basket satisfies approximately 52% of minimum daily caloric needs for those residing in areas not targeted by wheat flour distributions. In areas where home baking is common, wheat flour is distributed directly to beneficiaries, while in other locations, wheat flour is supplied to functioning bakeries through SARC and other partners. Governorates that do not receive wheat flour include Damascus, Tartous and Latakia due to availability of bakeries. Governorates that receive 100% of wheat flour include Rural Damascus, Hama, Idleb, Ar-Raqqa, Al-Hassakeh, Deir ez-Zor and Dar'a. All remaining recipient governorates receive 70% of wheat flour. Those that do not receive flour do not get any additional items.

Monitoring

WFP have common monitoring tools and platforms in the region, as well as dedicated monitoring staff, although monitoring has been weak in Syria (only 15% coverage for 2013) due to insecurity and access constraints. However, by

January 2014, WFP was able to augment its monitoring capacity by engaging third-party monitors who are able to access locations WFP staff cannot. This has led to an improvement of the monitoring coverage to 41% of distribution locations. WFP monitors all accessible distributions by examining the process of beneficiary verification and the performance of cooperating partners. Beneficiary satisfaction with the distribution procedures is also monitored. Both female and male beneficiaries are consulted in the process. Shop monitoring examines the redemption of vouchers, type of commodities purchased, prices charged as well as beneficiary and shopkeeper satisfaction with the overall process. Beneficiary monitoring examines household outcome indicators including food consumption scores, dietary diversity and the various coping mechanisms used.

Monitoring data allowed comparison of beneficiary and non-beneficiary households and findings indicated poorer dietary diversity of the latter – especially with regard to access to fruits, vegetables, meat and dairy products.

Prevention of acute malnutrition

In March 2013, a BSFP was initiated to provide nutrition support to young children, prioritising 240,000 children aged 6-59 months. In 2014, over 189,000 children at risk of malnutrition were provided with nutrition support, including those in hard-to reach areas in Hama and Rural Damascus for the first time in months. Two programme variations (using different products) have been employed in different governorates. Implemented in partnership with the Ministry of Health and UNICEF, one scheme provides monthly rations of Plumpy'Doz® (a nutritional supplement for children) to children aged 6-59 months living in internally displaced persons (IDP) collective shelters. Since September 2013, three NGOs in partnership with WFP extended the feeding programme beyond official IDP collective shelters to reach vulnerable children residing in host communities in Tartous, Homs and Hama. Under the second BSFP variant, the supplementary product Nutributter® for the prevention of micronutrient deficiencies is being distributed to children aged 6-23 months living in collective shelters and among host communities in the northern governorates of Syria.

Fuel distribution

In response to anticipated harsh winter conditions during 2013/14, WFP provided emergency fuel support to vulnerable families with limited access living in collective IDP shelters, in partnership with UNHCR. A total of 58 collective shelters in Homs, Hama and Damascus were supplied with 100,000 litres of fuel to cover heating requirements for four months while 10,000 heat-retention Wonder-bags® were distributed to families unable to cook WFP food rations. A total of 2,500 Wonder-Bags® (out of 4,100 dispatched), were distributed to families in rural Damascus, Damascus and Idleb while over 24,000 litres of fuel were supplied to the 58 targeted collective shelters.

Voucher scheme targeting pregnant and lactating (PLW) women

The October 2013 Humanitarian Needs Overview (HNO) estimated that 300,000 PLWs across the country were at risk of micronutrient deficiencies and required nutrition support, as well as improved awareness of appropriate feeding practices. In addition, WFP's monitoring findings illustrated that access to and consumption of fresh produce (such as fruits, vegetables and animal protein) by families, including PLW, was very limited, increasing their vulnerability. Hence, WFP introduced a targeted voucher-based nutrition programme to complement the GFD ration and improve dietary diversity for pregnant and lactating women. Launched in July 2014, the pilot is targeting initially 3,000 women in Homs and Latakia cities. Beneficiaries receive vouchers to the value of US\$23 to purchase fresh products, including vegetables, fruit, meat and dairy products, which are not part of the general food ration. It is planned to target up to 15,000 women as this programme is fully rolled out.

School feeding

An estimated 2.3 million children in Syria are no longer regularly attending school or have dropped out completely. As part of the UNICEF-led 'Lost Generation' strategy to improve access to learning and facilitate a return to normalcy, in 2014, WFP introduced a school feeding programme targeting some 350,000 children in four critically affected governorates, including Rural Damascus, Homs, Tartous and Aleppo. The first phase of the project was launched in July 2014,



WFP beneficiaries in Syria



Kindergarten student receives nutritional support

targeting schools in critical districts in Rural Damascus and Tartous. During the first phase, up to 100,000 elementary school children aged 6-12 years received daily rations of fortified date bars, conditional on attendance. The programme, which was initially implemented in summer schools, has been transferred to regular schools when classes resumed in September.

Inter-UN coordination

WFP has had a Memorandum of Understanding (MoU) with UNICEF in Syria, since January 2013, whereby both agencies have committed, through joint programming, to scale up nutrition interventions to address malnutrition, as well as to tackle micronutrient deficiencies and promote the population's nutrition status. Accordingly, WFP currently focuses on the prevention of acute malnutrition (using Plumpy'Doz), while UNICEF focuses on its treatment (using Plumpy'Sup and Plumpy'nut). In addition, both agencies collectively focus on the prevention of micronutrient deficiencies (using Nutributter and micronutrient powder). A key challenge for both organisations has been the lack of current nutrition data to guide programming, due to access constraints to certain areas. WFP's programme for PLW complements the support already provided by UNICEF, WHO and the United Nations Population Fund (UNFPA), in

the form of micronutrient supplementation and reproductive health services. Through the Nutrition Sector Working Group, led by UNICEF, nutrition assessments are conducted to update the nutrition situation as well as define nutrition strategies.

Logistics

Logistical needs inside Syria are continuously changing due to the fluidity of the security and access situation on the ground, and require a high degree of flexibility in planning. In this context, a complex chain of delivery underpins the implementation of these programmes.

WFP imports food into Syria through the primary supply corridors of Beirut and Tartous, while the use of Lattakia port was also increased during 2013. In addition, a fourth corridor through Jordan has been activated in July 2014 following the adoption of UN Security Council Resolution (UNSCR) 2165. WFP retains the capability to rapidly adjust its use of available corridors in response to changes in the operating environment. Accordingly, the expansion of additional corridors through Turkey is also under use, thanks to UNSCR 2165.

Upon arrival in Syria, food commodities are assembled in five storage and packaging facilities strategically located in Safita, Lattakia, Homs and Rural Damascus. To avoid assembling the food basket on-site under challenging security conditions, food is packaged prior to dispatch, thus mitigating the risks of losses and ensuring that each family receives the adequate food items. Each packaging facility produces up to 10,000 food rations every day, which are then dispatched by over 1,000 trucks each month to governorates allocated to each centre according to respective strategic advantages. Facilities in Safita, Lattakia and Homs offering a good staging point to cover the requirements of central and northern governorates, while facilities in Damascus serve the southern governorates. This allocation maximises the efficiency of food dispatches while reducing travel times, thus mitigating exposure of cargo to security threats.

Once packaged, the family food rations are dispatched to secondary storage points inside Syria and delivered to WFP partners on the basis of monthly allocation plans. In some cases, WFP purchases pre-packed rations which are transported by suppliers directly at the handover

points to partners inside Syria, without being processed through WFP facilities. Wheat flour milling is undertaken outside of the country, in Mersin and Beirut. Subsequently, bagged wheat flour is shipped respectively to Syrian ports or trucked to Damascus. For transport inside Syria, WFP utilises existing commercial transport settings, encouraging local capacities where possible. Previously working with one single transport partner, WFP contracted five additional transport companies in September 2013 to increase its delivery capacity and respond to the growing need for humanitarian assistance within the country. Each transporter is allocated specific areas on the basis of a previously established presence in certain parts of the country. This maximizes WFP's ability to deliver to all locations. For specific areas where surface access can be sporadic and the humanitarian situation particularly dire, contingencies for airlift of life-saving supplies are arranged.

Food distributions take place at final distribution points (FDPs) agreed upon with partners. Due to the instability of security conditions on the ground, the number of FDPs and their locations vary from month to month, as partners may no longer be able to perform distributions in previously accessible locations, or beneficiaries may be unable to reach planned distribution sites.

Activation of the Logistics Cluster

Following the recommendation of the UN Regional Emergency Coordinator for the Syria Emergency, the Logistics Cluster was activated in January 2013 to support overall logistics co-ordination and provide services to humanitarian actors responding to the emergency in Syria. The Logistics Cluster, led by WFP, fills logistics gaps in emergencies on behalf of the humanitarian community, whilst also providing a platform for coordination and sharing of key logistics information among partners. As such, it provides free-to-user services to its humanitarian partners, including dedicated warehousing space for inter-agency cargo, as well as transport services throughout Syria. In addition, the Cluster ensures support for inter-agency convoys to deliver assistance to the most vulnerable communities in otherwise inaccessible parts of the country. The Logistics Cluster offers also humanitarian flights to Qamishli, on a cost-sharing basis.

Furthermore, the Logistics Cluster has established a logistics coordination forum in Damascus, Beirut and Amman. Over 30 organisations (UN agencies, NGOs, INGOs, and donor agencies) regularly attend meetings where participants discuss logistics bottlenecks and develop common solutions for improved humanitarian response. In addition, the Cluster produces regular logistics information products including situation reports, maps, assessments, meeting minutes, snapshots and flash updates on the Syria Logistics Cluster webpage, and shares them via a Cluster mailing list. As of June 2014, a total of 17 organisations were benefiting from the Logistics Cluster services



A Syrian boy collects his family's monthly ration of rice, flour, pasta, beans, vegetable oil, sugar and yeast.

² <http://unscr.com/en/resolutions/2165>

for their operations inside Syria. As additional organisations are allowed to work in Syria, the number of service requests has been increasing. Accordingly the Cluster has been rapidly scaling up its operations, and continues to be ready to expand further if required.

In 2014, WFP logistics in close coordination with procurement and shipping units, updated the Concept of Operations for the Syria Operation's Supply Chain and put in place measures to mitigate pipeline breaks and ensure timely arrival of commodities in Syria. Arrangements with suppliers now ensure a readily available stock of food commodities for immediate purchase upon receipt of funds by WFP. Additionally, procurement will be conducted solely within the Mediterranean, significantly accelerating lead times for the arrival of food in the country.

Risks to staff safety continue to represent the greatest threat to sustaining WFP operations in the country. Should the security environment deteriorate further, WFP may be forced to reduce its footprint inside the country by deploying both national and international staff to work from alternative locations. Remote management plans have been developed, including the increasing use of WFP's Lebanon and Jordan offices if necessary.

Ongoing challenges and lessons learnt

WFP's ability to deliver and distribute adequate food is affected by access restrictions and shrinking humanitarian space. However, WFP continues to work with the UN Country Team and partners to maintain a presence on the ground, implement activities and continuously advocate for unhindered humanitarian access.

WFP, and hopefully the Syrian population, have benefited from a clear WFP operational strategy at the outset. Recognising the political nature of the crisis and that high levels of inse-



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

curity were going to prevent WFP from operating as normal, the decision was taken early on to adopt a pragmatic and opportunistic approach. WFP began its Syria emergency operation in 2011 and was the first organisation to launch an emergency operation without the full approval of the Syrian government, gradually building on its programming base to expand the humanitarian space through engagement and negotiation. This has been a slow process requiring persistence. Although at first and for many months it was only possible to work through SARC, WFP were gradually allowed to engage with more local NGOs and were not shut down as a result. WFP did not control the modus operandi but found that they could expand humanitarian space in a way that was acceptable and met needs of millions of people, including other organisations working on behalf of the conflict affected population. WFP has worked through numerous local partners since they have better access to most of the governorates. This has been a very positive development and has effectively changed the landscape of civil society in Syria by investing in building up capacity of national agencies.

While working in Syria, WFP have had to tread carefully with regard to the cross-border programme from southern Turkey as this expanded with an increasing number of agencies basing themselves in Gaziantep and Antakya in southern Turkey. With mounting criticism of the UN's lack of engagement in the cross-border programme, WFP began engaging with INGOs involved in cross-border work in early 2013 and sent a number of staff to liaise with the NGOs and ACU in order to focus on information management and nurture mutual understanding. This was followed by the deployment of a Global Food Security Cluster lead to work with NGOs doing cross-border work and to improve collaboration. This was a slow consensus and trust building exercise leading to the establishment of systems for sharing information about programming from southern Turkey and Damascus.

In May 2014, additional measures to improve operational coordination and joint planning were taken. This involved constructing a joint forward looking plan that indicated where there were operational overlaps and engaging in discussions with partners about how to decide on 'who does what, where'. Another meeting was held in July 2014 where an action plan was agreed for cross-border programming from

Turkey, Jordan and programming from Damascus, looking at the whole of Syria. A key challenge for all stakeholders is how to determine numbers in need.

Adoption of UNSCR 2165 on 14th July has had a positive impact in enabling WFP use the most direct route to reach cut-off communities. All WFP programming, including cross-border and cross-line, is now managed from Damascus. There are no WFP cross-border operations managed from Turkey or Jordan. This position has been taken in order not to undermine the mandate under UNSCR 2165. This has made programming harder in one sense as there are complex discussions and negotiations with the Syrian Government but WFP is gradually overcoming challenges related to fragmented and uncoordinated responses. While information about INGO programming is treated confidentially, any WFP cross-border programming from Turkey is planned from Damascus and the government is informed accordingly through the office of the Humanitarian Coordinator. An unexpected consequence of the UNSCR 2165 has been an increased readiness of the Government of Syria to facilitate cross-line convoys, a welcome development for WFP. This may partly reflect the battle for hearts and minds as the threat of ISIS appears to have increased.

Against the backdrop of these positive humanitarian and political 'sea-changes' is a looming resource crisis affecting WFP, who will effectively be running out of money for this and other programmes in the region in late 2014, resulting in dramatic scaling back of programming. This could not be happening at a worse time as winter approaches. The irony is that in August 2014, WFP managed to reach almost 4.1 million Syrians in Syria, the highest number since the emergency response began in 2011. In October, WFP hopes to still reach 4.25 million Syrians in country but will provide a food basket with a 40% reduction of the planned caloric requirement. WFP will do everything it can to advocate and strengthen resource mobilisation efforts in order to avoid a reduction of WFP assistance.

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Food For Syrian Refugees In Jordan

³ <http://www.theguardian.com/global-development/2014/sep/18/world-food-programme-cut-aid-syria>



Syrian refugee and her child

Purvis/UNHCR

WHO response to malnutrition in Syria: a focus on surveillance, case detection and clinical management

By Hala Khudari, Mahmoud Bozo and Elizabeth Hoff



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Three years into a brutal crisis, the protracted conflict in Syria has had an immensely negative impact on essential living conditions of the Syrian population. Access to basic services and commodities such as food, livelihoods, safe drinking water, sanitation, education, shelter and health care has been compromised. This in turn has increased the populations' vulnerability to poverty, violence, food and nutrition insecurity, and disease. The volatile nature of the crisis has created unpredictable and unstable living conditions for the population. The ongoing conflict has caused forced displacement, socioeconomic limitations, insecurity and a lack of access to basic services. Coupled with recurrent droughts, the conflict has significantly affected food security and livelihoods and thus, has adversely impacted nutritional status, especially in children under 5 years; an already vulnerable population. More specifically, chronic poor dietary diversity, inadequate/improper infant, young child and maternal feeding practices, as well as geographical and gender inequalities have heightened the risk of malnutrition in children under five years.

According to the Syrian Family Health Survey (2009), conducted prior to the crisis, the nutritional situation of children under five years of age was poor, with an estimated 23% of them being stunted, 9.3% wasted and 10.3% underweight. Exclusive breastfeeding rates stood at 42.6% while the proportion of newborns introduced to breastfeeding within the first hour was 42.2%¹. 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%², while there was an 8.7% Vitamin A deficiency rate³ and 12.9% iodine deficiency prevalence⁴. Neonatal mortality rates, infant mortality rates and under-five mortality rates stood at 12.9/1000, 17.9/1000 and 1.4/1000 respectively⁵.

Coordinating response

The confluence of factors and lack of solid data on the nutritional status alerted the humanitarian community to the possibility that cases of malnutrition in Syria were going undetected. This prompted interna-

tional organisations and national counterparts to address the prevention, detection and treatment of emerging malnutrition cases. With the establishment of the Nutrition Sector Working Group headed by UNICEF and the Ministry of Health (MOH) in the second quarter of 2013, which emerged as a result of expanded nutrition activities and increased nutrition partners in the field, the response to malnutrition has gradually been strengthened. This has been realised through the involvement of key UN agencies including the World Health Organisation (WHO), UNICEF and the World Food Programme (WFP) and key national authorities and implementing partners including the MOH, Ministry of Higher Education (MOHE), as well as international and national non-governmental organisations (NGOs) such as International Medical Corps, Action Against Hunger (ACF) and the Syrian Arab Red Crescent (SARC). These stakeholders have scaled up their response by adopting a holistic strategic approach that covers i) preventative micronutrient supplementation; ii) screening for and referral of malnutrition cases; and iii) outpatient and inpatient treatment of acute malnutrition. WHO's response has focused on strengthening screening of children under five years for malnutrition and hospitalised care of complicated cases of severe acute malnutrition (SAM).

Scaling up WHO nutrition activities

Revitalising the Nutrition Surveillance System

Prior to the conflict, in 2009, a national nutrition surveillance system was established to report on acute and chronic malnutrition of children under 5 years visiting health facilities for their routine immunisation. The system extended to providing parents with information and a service to monitor child growth. However, with the conflict driven damage to the health system and the consequential shortage in nutrition personnel, the national nutrition surveillance

¹ WHO/MOH, Syrian Family Health Survey, Syria, 2009.

² Ministry of Health, Nutrition surveillance system report, Syria, 2011.

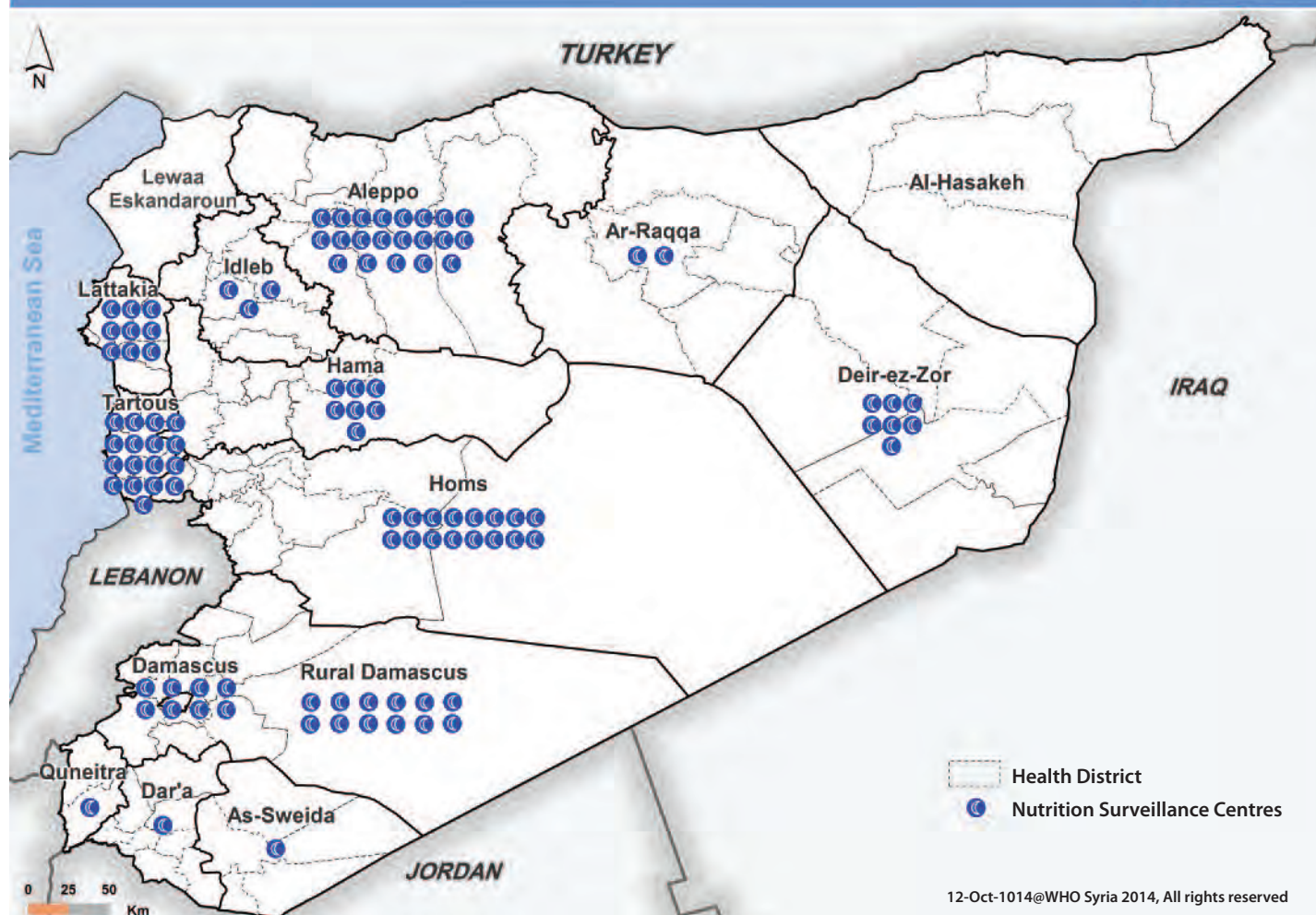
³ Ministry of Health, Vitamin A deficiency Study, MOH, 1998

⁴ Ministry of Health, Study on Iodine deficiency prevalence in Syria, MOH, 2006.

⁵ See footnote 1

Map 1

Syrian Arab Republic: Revitalised Nutrition Surveillance Centres



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system has suffered from a reduction in the quality of nutrition service provision and deterioration in reporting and monitoring. With an expected increased number of acute malnutrition cases, and a scarcity of nutrition services, there was a concern that malnutrition cases were going undetected.

In order to understand the impact on overall nutrition related morbidity and mortality, detection and reporting on cases would need to be improved. In order to enhance the detection of malnourished children and fill the information gap, WHO is collaborating with the MOH and other partners to improve and strengthen the Nutrition Surveillance System. Between April and July 2014, twelve health centres from 12 governorates were selected to pilot a modified surveillance system. This modification encompassed revised reporting and monitoring tools and providing trained human resources. The pilot governorates were selected using two criteria: (i) conflict-impacted areas (Daraa, Homs, Aleppo, Rural Damascus, Idlib, Quneitra and Deir-ez-zor) and (ii) densely populated areas with high numbers of Internally Displaced Persons (IDPs) (Damascus, Tartous, Latakia, Hama and Sweida). Coverage rates of nutrition surveillance, capacity of human resources, avail-

ability of physical space, and equipment needs were also assessed and evaluated within the pilot timeframe. Aside from the pilot centres, nutrition surveillance was also started up again in the highly conflict-affected governorate of Ar-Raqqa, through the coordinated efforts of WHO field staff.

Numerous constraints were reported by the pilot nutrition surveillance centres. The lack of human resources, space, equipment and telecommunication-reporting utilities were cited as challenges by a number of Governorates. These obstacles were especially evident in the case of Deir-ez-Zor, 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).

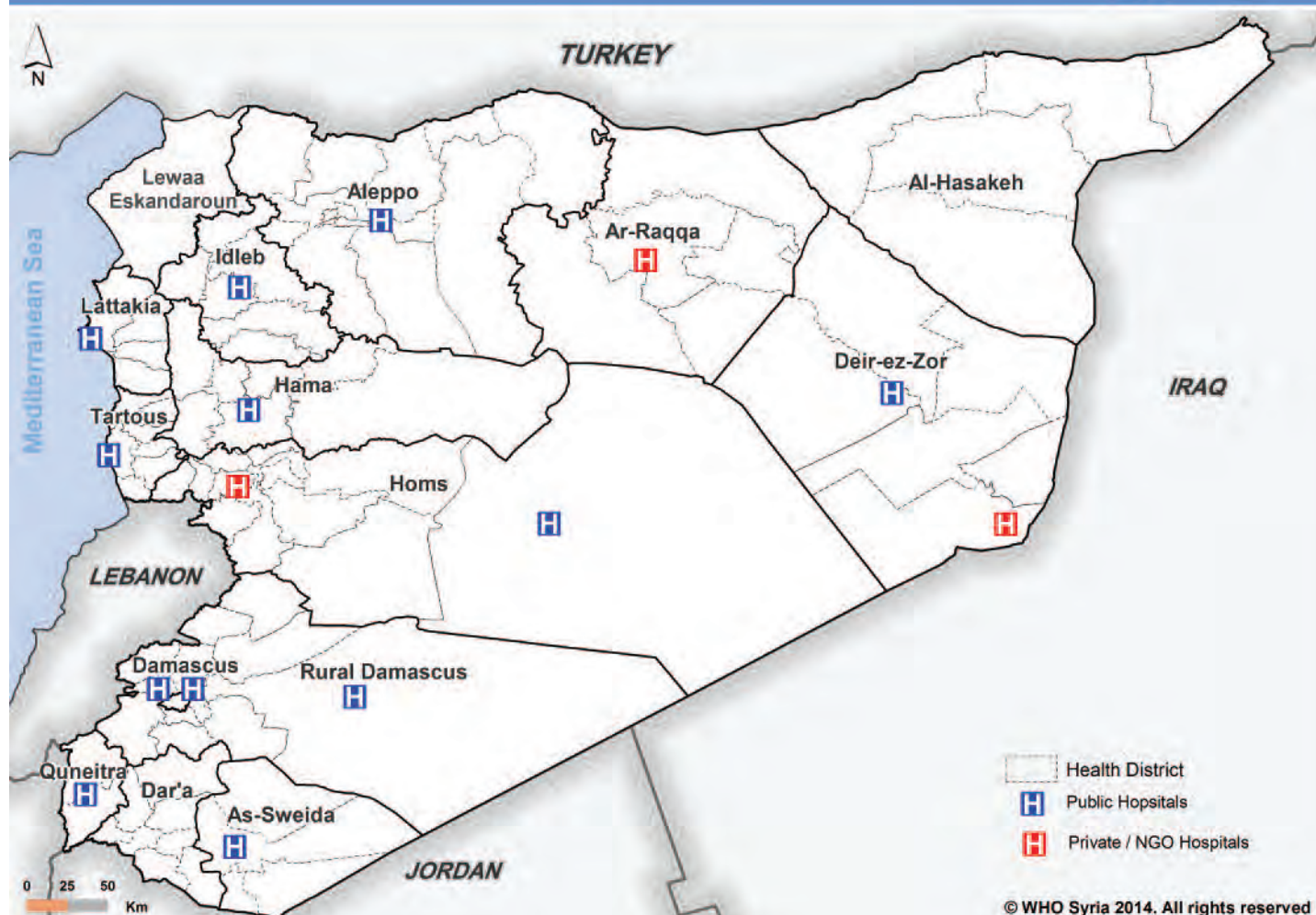
By the end of 2014, it is anticipated that more than 115 health centres will be integrated into national surveillance system. In 2015, a number of NGOs will be integrated into the programme in order to reach more children in affected and hard-to reach areas. The regular and accurate flow of information 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.

Map 2

Syrian Arab Republic: Stabilisation Centres



World Health Organisation



A step towards success: active surveillance in Aleppo Governorate

The surveillance system in the northern Governorate of Aleppo has set a high standard and many ways been exemplary. As one of the main population centres in Syria, Aleppo city was once considered the industrial heart of the country. It is surrounded by large rural areas that have been severely affected by violent conflict for over 2 years. Huge population displacement, food shortages and economic losses are some of the many hardships Aleppo Governorate inhabitants have faced, making families and especially their children more susceptible to malnutrition. With a very active surveillance team, screening for malnutrition was optimised not only through screening cases entering facilities but also via mobile teams visiting shelters for the internally displaced in the city and conducting referrals for cases in need of treatment.

Since the start of 2014, the surveillance in Aleppo has consistently reported on cases from four health centres in four health districts in the governorate of Aleppo (the numbers available so far are limited to specific locations in the governorate, are not statistically representative and therefore not included here). In the month of August, 12 facilities have been activated in

urban and rural areas of Aleppo. These facilities are expected to screen an approximate 4000 children per month. In locations experiencing intermittent violence like north Aleppo, due to the security situation, some health centres stop reporting when the security situation is dire. This varies the total number of centres reporting from month to another with a typical difference of 1-2 centres.

Referral of detected cases and hospital care of complicated cases of severe acute malnutrition (SAM)

The implementation of the pilot phase of the modified Nutrition Surveillance System led to an increase in the detection of cases of malnutrition requiring treatment and confirmed morbidity and mortality due to nutrition related disease. Data collection and analysis on SAM is still ongoing; the full report will be out by early 2015. This increase highlighted the importance of establishing a solid referral system for specialised treatment to reduce associated mortality and morbidity.

Since January 2014, WHO has supported the establishment of Stabilisation Centres (SC) for the management of SAM in hospitals across the country in line with WHO's SAM Manage-

ment Protocol, updated in 2009 and 2013. So as to not create parallel systems within hospitals, these centres have been integrated within paediatric departments at the main public hospitals. Support to these SCs has been extended in three main areas, (i) building the capacity of the health workforce, critical for effective SAM management and treatment (ii) filling gaps in medicines, medical supplies and equipment for treatment of complicated SAM, e.g. anthropometric equipment, antibiotics, minerals, vitamins and F100, F75 formulas and (iii) providing technical support for treatment protocols and reporting. To date, over 350 health professionals from MOH, MOHE and private hospitals in Damascus, Rural Damascus, Homs (including Homs city and Tadmor), Hama, Aleppo, Idlib, Latakia, Deir-ez-zor, and Quneitra have been trained on the WHO SAM Management Protocol adopting best practice techniques and food safety measures⁶. Additionally, systemised reporting through a developed hospital reporting template, has been initiated in collaboration with MOH.

As of August 2014, SCs in hospitals were established in nine governorates with MOH and

⁶ World Health Organisation, Training course on the management of severe malnutrition, WHO/NHD/02.4, 2009



Baby girl admitted to WHO supported SC who was successfully treated and discharged 12 days later

local NGOs. Centres within the public hospitals are available in Damascus (2), Aleppo (1), Hama (1), Latakia (1), Qutaifeh in Rural Damascus (1), Homs (1-Tadmor), Quneitera (1), Sweida (1), Deir-ez-Zor and Idlib (1) (see Map 2). Eight of these centres have received SAM cases in Damascus, Aleppo, Latakia, Idlib, Deir-ez-Zor, Sweida and Hama. In cities where public health facilities have been significantly damaged such as Homs, Deir-ez-Zor (Boukamal), Dara'a and Ar-Raqqa, cases are referred to private or NGO hospitals.

Reports from Damascus, Homs, Dara'a, Aleppo, Latakia, Hama and Deir-ez-Zor have been received on complicated cases of SAM requiring urgent medical attention. In the case of Hama, over a period of three months (April-July), 42 cases of complicated SAM were admitted in comparison to six cases admitted between January and March before the establishment of the SC. Further expansion of SCs to all governorates is planned with the aim to situate at least one centre per governorate to manage the caseload of SAM cases requiring hospitalised care. Future centres will be located in hospitals in Deir-ez-Zor (Deir-ez-Zor city), Dara'a, Tartous, Sweida, Qamishli, and Hassakeh.

Mainstreaming Infant and Young children feeding promotion

Infant and young child feeding (IYCF) and breastfeeding promotion has been prioritized and mainstreamed within most nutrition support activities. In Syria before the crisis, the rate of six-month exclusive breastfeeding had been consistently low (approximately 43%). Without the proper support of health staff and community based initiatives, lactating mothers have been struggling during the crisis with initiating breastfeeding. In many cases, due to displacement and overcrowded living conditions compounded by conflict-related distress, mothers lose confidence in the quantity and quality of their breastmilk, stopping breastfeeding all together and resorting to other practices. During an obser-

vational mission in early 2013, doctors and midwives reported an increasing number of women who wished to breastfeed their infants, mainly because they could not afford infant formula. Due to the short stay in health facilities following delivery, help with initiation of breastfeeding had been insufficient. Also during 2013, WHO received numerous requests from NGOs supporting populations in need including the displaced to provide breast-milk substitutes like infant formula. These requests were not supported as they counteract WHO/UNICEF global guidance to promote exclusive breastfeeding; instead, WHO focused on promoting optimal IYCF practices. Requests for infant formula over 2014 significantly decreased.

A capacity building and programme-strengthening project was identified as an essential element to promote breastfeeding at the health facility and community level with the aim of raising awareness among lactating mothers in both displacement shelters and host communities. Since early 2014, WHO has conducted five trainings for more than 190 doctors and health workers from Aleppo, Damascus, Rural Damascus, Quneitera, Sweida, Homs, Derezor, Hama, Latakia, Hassakeh, Tartous and Daraa in cooperation with the MOH-primary health care department. Trainings covered the importance of breastmilk, its constituents, techniques on initiation of breastfeeding and its benefits for both child and mothers.

Breastfeeding promotion has been streamlined across all WHO nutrition activities. It has been included in all training courses conducted on nutrition surveillance allowing surveillance health workers to conduct breastfeeding consultations for concerned visiting mothers. Data collection on breastfeeding rates will also be included through the nutrition surveillance system in the upcoming months, providing information for analysis of trends and further investigations on causal factors of the changes to breastfeeding rates. As yet, no assessment has been conducted to investigate any links between breastfeeding status and acute malnutrition.

Preventative micronutrient supplementation

Equally important to strengthening treatment capacity, preventative measures against micronutrient deficiencies have also been scaled up by nutrition working group partners through blanket distribution of ready-to-use supplementary foods (RUSF). WHO has also contributed to this initiative through the distribution of micronutrients for children and mothers during immunisation campaigns and in health facilities. In 2014, up to 900,000 children and 7500 adults were provided with micronutrient supplementation.

The way forward

During the second half of 2014, WHO will be further enhancing its nutrition activities across

four main areas:

1) Further strengthening of the nutrition surveillance system will be achieved through conducting decentralised trainings on nutrition surveillance to expand the re-activation of nutrition surveillance in 10 health centres in Latakia, Tartous, Idlib, Hama, Dara'a and Homs. Efforts will also be made to improve data entry, collection and reporting through strengthened operational capacity and procedures at the nutrition surveillance centres.

2) Distribution of supplies to SCs to improve and enhance treatment of admitted SAM cases. In order to expand geographical coverage, WHO is drawing on NGO and private sector capacities across the country. NGOs operating hospitals will be trained and supported with in-kind donations to also be able to treat detected complicated SAM cases.

3) Mainstreamed IYCF activities through extensive trainings for health workers in the health centres providing nutrition surveillance, allowing them to deliver key messages to mothers on the importance of breastfeeding and complementary feeding. Furthermore, two courses of training of trainers will be implemented to decentralise IYCF trainings across the country, contributing to raising the awareness of mothers visiting health centres or hospitals, or residing in displacement shelters or the host community.

4) Strengthened coordination with the Nutrition Working Group partners will be crucial in enhancing a coordinated referral process from surveillance centres, outpatient and inpatient treatment centres. Nutrition sector partners including MOH and SARC predominantly supported by UNICEF have worked to establish Outpatient Therapeutic Programmes (OTPs) in health centres to include the follow up and management of both SAM and MAM (moderate acute malnutrition) cases. Additionally, preventative nutrition services and blanket supplementation has been supported by WFP. These efforts have been strongly coordinated and continue to be through regular Nutrition sector meetings and bilateral meetings with UN sister agencies to bridge programmes and fill in gaps working towards a holistic CMAM approach.

WHO in coordination with nutrition sector partners has scaled up its nutrition response to help alleviate nutrition insecurity from a health perspective, aiming to provide quality nutrition services at health facilities to prevent, detect and treat cases of malnutrition and related mortality and morbidity. Efforts continue to obtain a clearer picture of the prevalence of malnutrition across the country. Halting the increase of malnutrition prevalence during the protracted Syrian crisis is crucial for children's health, well-being and physical and cognitive development.

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Experiences and challenges of programming in Northern Syria



Measuring height during the WVI supported anthropometric assessment

Anon, Northern Syria

By Emma Littledike and Claire Beck



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World Vision International (WVI) set up offices in southern Turkey in May 2013 and began work in Jarabulus and Manbij, Aleppo governorate in response to the escalating violence in Syria and reports of large scale internal displacement. This article describes their experiences in supporting nutrition and related primary healthcare programming to internally displaced persons (IDPs) between May 2013 and April 2014.

Current IDP situation (May 2014)

The total number of IDPs in Jarabulus is currently estimated at 22,875 and the total catchment population is approximately 68,000. The total number of IDPs in Manbij is estimated at 115,518 with an estimated catchment population of over 1 million. In Jarabulus, the camps are managed by an independent Syrian individual with strong relationships in the community. Informal camps have been established in collective community spaces such as schools and unfinished buildings. There are a greater number of informal camps in Manbij than Jarabulus. Organised and established camps in Manbij are managed by other INGOs. The majority of IDPs at the camps are from Homs, Hama and within Aleppo governorates.

Early needs assessment

At the time of initial assessment by WVI, only background nutrition data from Syria was available. Pre-crisis, Syria had a high global acute malnutrition (GAM) prevalence of 9.3%, stunting (23%) and underweight (10.3%). Micronutrient deficiencies in children 0-59 months were also prevalent: 29.2% anaemia, 8.7% Vitamin A deficiency and 12.9% iodine deficiency¹ Pre-crisis infant and young child feeding (IYCF) practices

were poor. National figures show a low initiation of breastfeeding within the first hour of birth (42.2%) and low exclusive breastfeeding amongst infants < 6 months (42.6%) (national survey, 2009)². The percentage of children under 2 years who are not breast-fed is estimated at 10%. (2009)³. According to national data from 2006, the timely complementary feeding rate for children 6-9 months was 36.5% and the proportion of children 6-11 months who received the recommended minimum number of complementary foods per day was 20.8%⁴.

In May 2013, an observational rapid area assessment was conducted by WVI in Jarabulus District, Aleppo governorate, Northern Syria to determine the need for and nature of health and nutrition interventions. The assessment team was made up of members of WVI's Global Rapid Response Team. The target population for the assessment comprised internally displaced persons (IDPs) living both in one camp and amongst the host community (four additional camps were later established to meet the needs of the increased number of IDPs arriving). The priority needs voiced by the IDP and host community during the rapid assessment in Jarabulus, Aleppo governorate were access to health services food, shelter and improved water, sanitation and hygiene (WASH) facilities for the camp residents and town inhabitants. Access to breast milk substitutes was also reported as a major issue.

Programme response

Primary health service support

WVI's immediate priority was to establish support to primary health care services. Health services were limited, consisting of a number of private doctors and a Qatari Red Crescent Field Hospital.

The Syrian Arab Red Crescent clinic had not functioned for a while. IDPs could not afford to visit the private doctors and the camp management was unable to cover the cost of medicines for the residents. In conjunction with the local leadership, including the health committee, a small primary health care centre (PHC) was established in June 2013 next to the main camp in the area. A paediatrician, midwife and two nurses were hired to provide services, while a community mobiliser was hired to conduct health and nutrition assessments, to provide psychosocial support to women and to counsel on optimal IYCF in all the collective centres. An English and Arabic speaking coordinator linked expatriate and Syrian staff. All staff were qualified within the Syrian health system and selected with support from the local council and the health committee, who approved all appointees. Initially, expatriate staff visited the projects biweekly for ongoing training and support, but once the border was closed to expatriates in July 2013, all support, supervision and training was done either remotely through phone or skype access, or at the nearest border crossing on a bi-monthly basis. Few Syrian staff could cross the border to meet with management staff as this was time consuming and had to be well planned due to the busy work schedules in the field and the need to keep services running. Lack of identification documents was also an issue.

¹ Revised Syria Humanitarian Assistance Response Plan (SHARP), Syrian Arab Republic, January- December 2013

² Syrian Family Health Survey, 2009

³ Figure estimated from area graphs in Trends in Infant Feeding Patterns, January 2009

⁴ Multiple Indicator Cluster Survey, Syrian Arab Republic, 2006

Building IYCF and SAM treatment capacity

Supports to IYCF and SAM treatment capacity were also provided. A planned IYCF training for all health and water, sanitation and hygiene (WASH) staff was postponed due to insecurity in the field. Instead, two doctors crossed the border for accelerated two day training. They were equipped with training materials and technical guidelines in Arabic language, and equipment to replicate it back in Syria during the afternoons when the clinic was closed. In practice, they could only deliver part of the training due to clinical demands. Guidance on the treatment of severe acute malnutrition (SAM) was also provided through technical resources and discussion. This proved sufficient for the paediatrician to begin treating acutely malnourished children who came to the clinic, rather than referring them for treatment at the hospital, which was 45 minutes travel by road and not always secure. F75 and F100 were made using locally available ingredients as commercial product was not available (see later for issues around supplies). Until then, the few children that presented at the clinic with SAM had complications and were referred to the hospital for medical treatment where no nutrition support was provided.

The initial rapid assessment was observational; it was not possible to collect data on feeding practices. Informed by background (national) data, all health staff were sensitized to the importance of exclusive breastfeeding. However the demand for BMS was high from the IDP and vulnerable host community. There was no BMS programme at the time although infant formula was available to purchase locally (see later under 'challenges'). As a result of consultation with the governing group, WVI adapted the organisation's Women, Adolescent and Young Child Space (WAYCS) model and instead of having separate dedicated spaces for women and children, an alternative more culturally appropriate approach was decided upon which was to set up WAYCS within clinic facilities. Staff began to hold small meetings for women in one of the clinic rooms to support them in breastfeeding and complementary feeding. It meant, however, that it was harder to include husbands and wider family in these sessions. To help overcome this, staff made tent-to-tent visits and collection centre visits to all pregnant and lactating women to provide support and education.

Further nutrition assessments

When WVI programmes began in June 2013, there were no current nutrition data available. By August 2013, two rapid mid upper arm circumference (MUAC) assessments had been conducted by two INGOs among children in Idleb and Ar Raqqa governorates in northern Syria. Both found low prevalence rates of SAM (<0.4%) and moderate acute malnutrition (MAM) (<2.4%). Both assessments had limitations. The larger rapid assessment in Ar Raqqa⁵ was conducted alongside a measles

vaccination campaign making it difficult to ensure quality data collection and the majority of children measured were <12 months. The rapid assessment in Idleb on 4,230 children did not provide enough information on the sampling methodology and household selection to determine how representative it was.

Given these limitations and the report of 30 cases of severe and moderate acute malnutrition to clinics between June and December 2013, WVI undertook an anthropometric survey amongst IDPs in Jarabulus district, Aleppo governorate on 20th – 24th December 2013. Both weight-for-height z score (WHZ) and MUAC were assessed. Given the operational constraints, training on anthropometric assessment was compromised and relied on guidance documents, video links and a survey leader (paediatrician) with research experience in nutrition and anthropometric assessment. The assessment was carried out during a difficult time (snow and conflict) and the methodology had to be adapted to survey accessible areas. The prevalence of acute malnutrition was again found to be low: 2.6% global acute malnutrition (GAM), 0.5% SAM and 8.1% underweight (low weight for age). Prevalence of stunting was 22% (7.7% severe). A photograph of each child's measurement was taken and examined for accuracy; the main limitation was an inaccurate adjustment for clothing weight (see images).

In September 2013, a joint scoping mission was carried out by the Global Nutrition Cluster (GNC) Rapid Response Team (RRT) consultant in Northern Syria to assess the nutrition situation.

Scaling up services: small scale needs, large scale challenges

Case management of SAM

Whilst the prevalence of SAM was low, there was a need for small-scale treatment capacity. Existing capacity was weak given lack of training and low exposure of staff to WHO treatment protocols. The majority of in-patient facilities did not follow WHO protocols and used intravenous fluid as one of the main treatment methods for children with SAM and complications. Exceptions were specialised children's hospitals in Aleppo and Damascus that are part of the Syrian Ministry of Health (MoH) and which follow WHO treatment protocols. In Syria, there was no commercially produced F100 or F75 available so locally prepared F75/F100 was used instead. An example of case management of a SAM case is given in Box 1.

In general, community based management of acute malnutrition is being explored but there is no community health worker network in existence so cases are being managed by a select few INGOs at their supported inpatient and outpatient facilities across the country. WVI is the only external (INGO) health

⁵ The actual number of children measured is not confirmed.

Severe acutely malnourished child on admission at PHC in Aleppo governorate



Anon, Northern Syria

Box 1 Treatment of a case of SAM

An infant presented to the clinic with acute watery diarrhoea having already received treatment with antibiotics and oral rehydration salts (ORS) from a private physician. The child had a history of chronic diarrhoea and had been formula fed since birth (never breastfed). The child had a WHZ <-3 and MUAC 11cm at 9.5 months of age. The infant showed signs of marasmus and dehydration. He had a fast pulse and dry hair. His weight on presentation was 5.5kg (a weight recorded at the private clinic was 6kg).

The staff began treatment by stopping the course of antibiotics, given the lack of evidence for the infection diagnosed. For the first two days, ReSoMAL solution was provided (5ml/kg = 30ml every half an hour). This was prepared as 5% Dextrose, 1.8g of sodium chloride and 1.5g of potassium chloride in one litre of water. F100 was also given and it was prepared as: 80g powdered full fat milk, 45g olive oil, 50g cane sugar, 1g potassium chloride, 0.5g magnesium citrate, 2mg copper acetate and 20mg of zinc acetate dissolved in 1 litre of boiling water and set to cool. The F100 was given to the child in 60ml doses every 2 hours. Vitamin A was also given for 2 days. The clinic staff reported that they cannot prepare F75 as there is no skimmed milk.

On the fourth day they gave the child Bactrim syrup and on the 8th day, gave iron. The child recovered and then maintained his pre-hydration weight (6kg) during this stabilisation period.

During the following 10 days, the quantity of F100 was increased and under supervision, he proceeded to gain weight at a rate of 15g/kg/day (90g/day). For another 20 days, the child was managed at home with increased F100; his father was capable of preparing F100. The child's weight increased to 8kg and MUAC increased to 12.5cm. He was discharged on lactose free milk until one year of age and then transferred to full fat milk (reconstituted NIDO). The child now drinks full cream milk, one boiled egg, and fruit daily. He returns to the clinic for regular weigh in.

Source: INGO worker

Severe acutely malnourished child after 3 weeks treatment



Anon, Northern Syria

Ingredients for making F100

Anon, Northern Syria



provider in our operational areas in Northern Syria.

Due to cultural norms and medical hierarchy, it is also proving difficult for humanitarian agencies to support in-patient facilities to improve the treatment of SAM with training and support. Designated in-patient referral facilities need to be identified in each governorate and there is a requirement for training events inside Syria to be delivered by a highly qualified consultant. Many health personnel that are both employed by the regime, working independently or for an INGO are unable to cross the border into Turkey without a passport. Travel to Aleppo to acquire a passport carries substantial safety risk. The need was therefore identified for a strong distance learning training package comprised of narrated videos in Arabic that could be stored on USBs and disseminated in-country. Whilst this is inferior to practical 'on the job' training at in-patient facilities, it is perhaps the only way to improve treatment, particularly in areas with poor access such as Deir ez zor and Homs.

Of note, we have seen a higher caseload of malnutrition cases in the past two months. There have been around 30 cases of malnutrition (24 moderately malnourished and six severely malnourished) identified at the clinics.

Therapeutic food supplies

Establishing a supply of therapeutic and supplementary feeding products has been problematic. Our agency could find no local equivalents of RUTF in Turkey and acquiring therapeutic feeding products from reputable suppliers has been difficult. The customs cost to import products is excessive. For example, an RUTF order worth \$650 carried a customs clearance cost of \$5000 on top of a \$1500 shipment cost. Increasing the order quantity did not improve the cost efficiency. Our agency managed to find a supplier who helped to secure customs clearance free of charge as a one-off gesture of support. However supplies had to be shipped straight into Syria (since the agency was not registered in Turkey and so goods could not be stored in-country). Thus it was not possible to share the supplies with other Turkey-based INGOs and Syrian NGOs as planned. Border closures further prevented staff sending supplies back to Turkey to share with other agencies. Importing and storing products in Turkey requires agencies to be registered as organisations undertaking medical activities. A number of agencies are not yet registered, despite their efforts, due to the length

of time required to submit and get feedback from applications.

Access to health care: the role of the private sector

In Manbij city, Aleppo governorate, there are 289 doctors working privately providing high quality care. IDPs are not able to pay the commercial prices for treatment at private clinics. Many primary and secondary clinic health care staff provide free consultations or a negotiated lower payment rate but given financial and time constraints, they are only able to see a small number of patients per day. WVI has recently embarked on a 1 year pilot of a small-scale health care voucher system using the private sector to provide quality services to IDPs who had little or no household income (April 2014 – 31st March 2015).

The pilot targets children under 5 years in select areas of Manbij. They will receive a voucher entitling them to one consultation at any private clinic and medicine from a pharmacy over the 12 month project period. At WVI's primary healthcare facilities in Jarabulus and Manbij, children under 5 years have the highest proportion of respiratory tract infections, gastrointestinal diseases and acute malnutrition. They are also the most vulnerable group to acquire diseases with outbreak potential such as acute jaundice syndrome, acute watery diarrhoea, polio and measles.

The caregiver presents the voucher to an accredited primary or secondary healthcare provider that they select, along with the eligible child's IDP registration card. After the consultation, the provider then submits a claim to the agency to obtain reimbursement for the services provided with all required paperwork, including detailed patient records. If the healthcare provider issues a prescription, the caregiver can obtain medicine from an accredited pharmacist by presenting it along with the voucher and the eligible child's IDP registration card.

Healthcare providers will receive an induction on the voucher system detailing the beneficiary age group eligible to receive treatment, records required for verification and how they can claim. Additionally, a number of vouchers will be issued from the agency's PHCs in Manbij to patients in need of quality secondary healthcare treatment from specialist doctors.

A demand-side financing scheme such as this is expected to reduce financial barriers to access and therefore should improve utilisation of health facilities by IDPs. Since the voucher scheme allows the caregiver to choose the providers, this should encourage quality health care services through increased competition in the market. Targeting children under 5 years should also reduce the possibility of voucher selling and misuse. By design, revenue earned by a health facility from IDPs is directly proportional to the number seen. Therefore, this scheme should enhance the quality and quantity of targeted private healthcare services. WVI will monitor quality of consultations randomly

to ensure clinics signed up to the scheme are providing adequate services.

BMS supplies and support

As reflected in the early needs assessment, the demand for BMS was high from the community; a reflection of its common use. Uncontrolled and untargeted distributions of BMS remain common, however determining the extent to which this is happening is extremely difficult, especially given the response is managed remotely. Some actions have been taken at coordination level to try and minimise risks (see postscript).

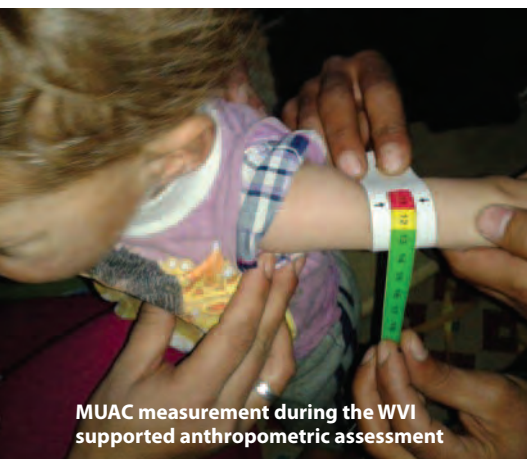
The need for support with safe artificial feeding was identified as particularly important in areas receiving large supplies of BMS. Information, Education and Communication (IEC) materials (posters and flyers) were provided to all agencies on how to prepare formula safely. There was one observational report of infant formula being distributed into cups from a large tank / container and handed out so in addition to the IEC, the working group also identified the need for safe feeding kits to be distributed.

Infant formula availability in the markets in Syria has been very sporadic and prices are higher than before the conflict. It is not affordable for IDPs and vulnerable host communities. Prices range from \$7-10 for 1kg in Jarabulus and Manbij when it is available. A small amount is available in pharmacies but it is not enough to meet the needs of the communities. It is also available in some markets. Currently (May 2014) there is almost none available. WVI has not procured infant formula as the programming focus was on breastfeeding support and procurement and transport of medicines and supplies from Turkey has been a huge challenge.



Medical examination at a primary health centre in Aleppo governorate

Anon, Northern Syria



MUAC measurement during the WVI supported anthropometric assessment

Anon, Northern Syria

Innovations

Remote training delivery

There have been many challenges in delivering training, such as lack of Arabic speaking trainers available in Turkey, border closures preventing travel, and limitations on the number of participants at venues. A training of trainers relies upon staff prioritising delivering training in-country which may not be feasible depending on the area, workload and available resources. This led WVI to develop a distance learning package in the style of Khan Academy videos⁶. Also, WVI has worked with a regional GNC/UNICEF IYCF consultant to produce a harmonised translated IYCF training package using training materials from many NGO nutrition actors working in the region. A series of videos on all nutrition topics, particularly IYCF-E and nutrition in emergencies, will be produced on USBs for distribution to all NGOs and passed onto Syrian health staff. Pre- and post-training tests are also being developed and added to the USBs so that agencies can check and verify that the staff have watched the videos and understood the content. Given the high turnover of medical staff in many areas, this also ensures that training new staff is not an additional burden.

Discussion

Remote management led to the development of robust data collection mechanisms which were set up in the early stages of the programme in September. A Health Information Management System (HMIS) was developed to monitor consultations for all morbidities including malnutrition. The HMIS automatically calculates incidence, prevalence and case fatality rates per geographic area. Data can be cross checked with patient records. Data entry is simple for field staff and data collation is automatic. There is a need for a standardised database system which can be used by all INGOs and Syrian NGOs and patient ID cards. Given the difficulties with ensuring a consistent supply of medicines, establishing a strong pharmacy system is also integral to provide inventory reports and determine needs ahead of time. The HMIS and pharmacy system combined enabled us to produce an annual forecast of pharmaceutical products required per clinic on a monthly basis, taking seasonal fluctuations in morbidities into consideration. In addition to data management sys-

tems, beneficiary feedback mechanisms were also important to ensure quality of service provision. Putting these standardized systems into place in each project early was essential to gain an in-depth understanding and provide a greater level of support.

Remote management calls for strong and consistent communication via telephone daily at designated times, and regular trainings (in Turkey, online and in Syria). Given access to programmes was not feasible, the building of health worker managerial skills became as integral as health technical guidance, particularly for Health Coordinators in each location. Provision of training about humanitarian standards and regulations was also critical given all health staff had no prior experience of working on a humanitarian programme. Creativity was critical to ensure staff received quality training given the difficulties with border closure and lack of passports. Training delivery was through a variety of methods including Webex, training of trainers, videos and contracting Syrian consultants. Trainings are often conducted in a large community space and videoed for the benefit of new staff who may join in the future.

Effective contingency planning was another important lesson learned, given conflict and escalations in fighting have led to hibernation (temporary suspensions of activities) and border closures. These factors have complicated both movement of staff into and out of Syria and distribution of medical and therapeutic food supplies. The temporary cessation of clinic activities had a huge impact on the population as there are no other health providers. We learned that detailed contingency planning is essential. Supplies need to be pre-positioned and stored appropriately and staff need to have completed security training and be thoroughly briefed on security standard operating procedures.

Given the difficulties with procurement for unregistered agencies and transportation of supplies amidst border closure, early hire of a medical procurement specialist is essential to support supply chain establishment and management. The hiring of pharmacists within Syria to dispense medicines to patients and manage and plan stock from an early stage was also es-

sential. Our INGO has procured drugs from Turkey and within Syria. Sourcing drugs from within Syria can be a challenge for staff since not all pharmacies have the amount in stock that is required, forcing them to visit many times and buy piecemeal. Research also needs to be conducted evaluating the quality of medicines and supplies available for purchase inside Syria. WVI has developed an assessment tool to gain more information about production, regulation and gauge the opinion of Syrian pharmacists and health staff about the quality of medicines. Procurement and distribution of essential primary health care medicines across the border has posed significant challenges. Supplies have had to be sent out with biscuit shipments and once across the border, transporting them within areas affected by conflict to the project sites has been extremely difficult.

A thorough understanding of the situation in terms of health staff and facilities existing in the areas and resources available is very important. Establishing an ambulance was a real challenge given there were no equipped suitable vehicles for use. A large van, which had been badly damaged and abandoned in the conflict, was donated by local authorities and refurbishing and fixing the vehicle was a major effort. Procurement of specialist ambulance equipment from Turkey was also extremely time consuming and problematic. Both of these factors led to a time delay in the establishment of ambulance services which was not anticipated at the beginning of the programme. Gaining knowledge of the health care system generated the idea for voucher provision instead of the establishment of more clinics which may not be sustainable. It was deemed more effective for a larger number of doctors to remain in their private clinics and benefit from supplementary pay to treat IDPs than for a smaller number to give up their work for a position at a WVI clinic which may not be able to run sustainably. An in-depth assessment of the capacity of all private clinics and pharmacists is currently being conducted.

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⁶ <https://www.khanacademy.org/>



Clinic staff outside one of the primary health centres in Jarabulus

Anon, Northern Syria

Postscript

Stop-gapping nutrition coordination for the Syria response

By Emma Littledike

This is a personal account of the experiences of Emma acting to stop-gap nutrition coordination around the cross border operations into Syria from Turkey.

The Global Nutrition Cluster (GNC) seconded a Rapid Response Team (RRT) Nutrition consultant to the Syria response for a three month period (13 Dec 2103-13 Feb 2014) to provide technical, strategic and coordination support to the Northern Syria Nutrition Sector response. On her departure, I was appointed as interim Nutrition Cluster Coordinator for a two month period to stop gap the lack of data and information on the nutrition situation. This appointment was on a voluntary basis, in addition to a busy full time job managing three large health and nutrition programmes for World Vision International (WVI).

In this role I have led weekly meetings and tried to build an evidence base for the nutrition situation. A key task in my role as coordinator was to evaluate critically existing data on the nutrition situation (e.g. review three anthropometric assessment surveys in Aleppo, Arraqa and Idlib (see earlier article)) and emerging from this, to advocate for and help support securing more nutrition information, especially in areas where accessibility, food security and humanitarian assistance were poor. During my tenure, a lead partner and survey methodology (SMART) was eventually agreed for a representative SMART nutrition survey in each governorate and a purposive sample in sub-districts that were more likely to have malnutrition¹. The survey is now underway in Idlib (May 2014) and other governorates will be surveyed post Ramadan.

There is a need to improve nutrition surveillance through clinics, community spaces and community workers. This is particularly important in areas where there is very little humanitarian support and for areas dependent on food assistance that can be affected by hibernation (when agencies have to suspend activities due to conflict) and border closure. Camps also need to screen new arrivals that may have travelled from highly food insecure areas. Many health actors do not record malnutrition in their health monitoring systems and few cases of malnutrition are reported amongst health partners (this may be due to low caseload and/or low awareness at management or field level). A Mid Upper Arm Circumference (MUAC) screening package with guidance materials and a training video is in development to help address this. The aim is to disseminate the screening kit to all actors and all community stakeholders and to offer online support to practice measurements via WebEx or Skype video. The cascade training of trainer's model is not far reaching enough in this context. Provision of a screening package such as this, whilst not ideal, could be a partial solution to the problem of poor access. Referral facilities also need to be identified and incorporated into the screen-

ing package and they in turn, require training in the treatment of severely malnourished cases. There is also a need to incorporate data collection on underlying causes of malnutrition into all multi-sector rapid surveys to gather more information on camp and host community needs. A multi-sector assessment is currently in planning (May 2014).

A major coordination challenge has been around the management of breastmilk substitutes (BMS), including around untargeted distributions to the population. To try and gain more information, in my coordination role, I advocated for inclusion of questions about BMS distribution in all general rapid surveys being conducted. A BMS distribution indicator was subsequently included in the Response Plan. Awareness amongst actors of the Operational Guidance on infant and young child feeding in emergencies (IYCF-E)² and the International Code of Marketing of Breast-Milk Substitutes³ was improved through handouts and making resources available on the google drive established for the working nutrition sub-group.

Sourcing therapeutic food supplies has been problematic (see earlier article which reflects the issues well under 'challenges').

Nutrition coordination in itself has been challenging in this context. Nutrition is not considered a sufficiently important issue to be a stand-alone sector as there is no evidence of acute malnutrition. This has led to the formation of a nutrition sub-group in the health working group. However participation and engagement of agencies in the nutrition sub-group has been minimal. There are very few nutrition experts in-country and only six agencies implementing nutrition activities. Many structured sessions had to be postponed because of poor attendance. All agencies were regularly sent agendas, meeting presentations and technical guidance documents to ensure they were supported with adequate resources.

The focus of coordination on nutrition has been on assessments, management of acute malnutrition and on IYCF. The degree of scale up needed for these nutrition interventions is unclear due to lack of current data on acute malnutrition prevalence and IYCF practices. While there are cases of SAM reported, the number of reporting facilities and catchment populations is unknown. We suspect there may be high levels of SAM cases in specific pockets of the country with poor access to food distribution and humanitarian support.

Additional significant nutrition problems are stunting and micronutrient deficiencies which have received little programming attention. There is a

need to build a solid evidence base and to focus on prevention activities in the immediate future. Syrian agencies have much greater access and need greater technical support from international NGOs to programme according to the needs they are witnessing in their areas of operation. In the immediate term, more nutritionists are anticipated to arrive to contribute expertise to the nutrition working group that may encourage participation.

My coordination time would have benefited greatly from more support with obtaining supplies such as ready to use therapeutic food (RUTF), safe feeding kits (for infants using BMS) and anthropometric equipment. Given the nature of the Syria response, the usual support of UNICEF with regard to supplies was not available. More support in securing Arabic speaking trainers would also have helped enable trainings. It is questionable whether a working group lead can be effective without good resource provision.

My coordination role has now ended and nutrition is incorporated into the health working group. There are advantages to this, as it allows nutrition issues to be discussed repeatedly with a larger group of actors for which it should be a concern. Integration into the health working group has led to increased attention and nutrition now comprises a substantial part of the new annual response plan. By July 2015, primary health facilities will improve screening and referral through standardised nutrition service packages. Treatment of acute malnutrition according to WHO protocols will be improved at designated health facilities. Access to support on IYCF practices will be improved through the training of focal points. Children and pregnant and lactating women will access micronutrients from targeted supplementary or fortified foods, supplements or multiple-micronutrient preparations. Encouraging the mainstreaming of nutrition activities into other sectors will also be very important. I continue to play an active nutrition role supporting with updates, discussion points and technical support to agencies on a voluntary basis.

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¹ A specialist agency developed a database ranking areas by likelihood of higher prevalence of acute malnutrition using food security and health data from the Syrian Integrated Needs Assessment (SINA)

² An international policy guidance endorsed by the World Health Assembly. Available at: <http://www.enonline.net/resources/6>

³ Access the full Code at: <http://ibfan.org/the-full-code>

Non-food cash voucher programme for IDPs in Northern Syria

By an international NGO

Written April 2014

The war in Syria is now in its third year and having displaced over four million Syrians internally - with over 2 million fleeing their country to Jordan, Lebanon, Iraq and Turkey - there is no end in sight. In Northern Syria, over 200,000 Syrians are living in internally displaced population (IDP) camps, namely Atmeh, Qah, Karameh, Aqqrabat, Bab-Al- Hawa and Al-Salhah, while 35,000 people are living in non-camp settings in villages.¹

Provision of assistance to such a large number of displaced people in camps with inadequate infrastructure is a challenge to humanitarian organisations. Most of the emergency response involves in-kind distributions of food and non-food items. These interventions have been effective in saving lives and preventing a further deterioration in the humanitarian situation. However, the approach has several drawbacks, including the fact that it is a huge logistical burden and time consuming activity - from procurement to stocking and transporting commodities to distribution. This is made all the more difficult in conflict affected areas. Also, it disempowers the affected population as it does not provide them with the ability to decide what commodities they want or prefer. With the aim of mitigating these problems, a pilot voucher programme was designed and implemented by an international non-governmental organisation (INGO) in one of the IDP camps.

Overview of voucher programme

This involved voucher distribution and the arrangement of two market days at which to spend the vouchers. The programme was implemented over one month. The programme was informed by a needs assessment and market assessment (1 week) by the INGO, followed by vendors' selection and beneficiary registration before implementation.

The needs assessment involved four focus group discussions (FGD) to understand the IDPs' need for non-food items. The FGDs were conducted with men, women, young boys and young girls. They indicated that the top three priorities were hygiene items, clothing, and kitchen items. The preference was for Syrian made items that met their social and cultural values, such as scarves, long skirts, specific shampoos and detergents. Based on the identified needs, market prices were collected for the major items and maximum prices were agreed with the vendors that would apply for the two market days. This was undertaken to protect the value of the vouchers that was based on the findings of the market assessment. Findings from the market and price assessments were shared with both vendors and beneficiaries. The

arrangement was governed by a signed memorandum of understanding with the INGO office to keep the price as agreed or constant. An exception was if vendors wished to sell at a lower rate (while maintaining quality) to attract buyers, they were free to do so. Beneficiaries had also the right to negotiate on price in order to buy more items. Either way, better deals could be made for the same quality of product. The agreements also included clauses on the respect of humanitarian principles and using an agreed upon stable exchange rate of Syrian Pound (SP) to United States Dollar (USD). Field monitoring and support was undertaken by the field staff.

Vendors were identified from nearby Syrian cities and their capacity to meet the identified needs was assessed. Twelve vendors were selected to participate in the market day to create enough competition to lower the prices, however only seven were able to participate. The five vendors who did not participate pulled out at the last minute; no reasons were given but may have been due to security issues or lack of sufficient stock.

Implementation

A total of 420 IDP households benefited from the pilot programme in the camp. Each household was provided with 12 vouchers, worth 12,000 SP (69 USD). The vouchers had denominations of 3,000, 1,500, 600 and 300 SP, to provide more flexibility in shopping for smaller or bigger items.

Two market days were selected and agreed on with the beneficiaries and vendors. The vendors trucked their goods to the camps on the agreed dates and the camp leaders were responsible for securing a space for the market place and for crowd control. The INGO staff monitored all activities during both market days and provided guidance when needed. At the end of the first market day, the vendors packed their remaining items and carried them back to their

home towns. With a better understanding of what the IDPs wanted to buy, the vendors increased the amount and the diversity of the items they brought to the second market day.

Feedback

A rapid post distribution survey was conducted which found that all 420 households had spent 100% of their vouchers. The top three purchased commodities were hygiene materials, plastic mats, and clothing (see Figure 1). Beneficiaries indicated that they were highly satisfied with the programme and commented that it was the first time in two years that they were able to do their own shopping. They were pleased to regain their ability to make their own decisions about what to purchase for their families. However they commented that the price of goods had risen sharply over the past years due to loss of SP value. Some of the beneficiaries observed that prices were three times higher compared to what they used to pay in their hometowns a couple of years ago. Overall, the pilot programme was appreciated by the beneficiaries because it gave them the opportunity to choose goods depending on their needs, the goods were from Syria, the suppliers were Syrian, and the response time between the need assessment and the market days was very short. There was no security problem and no complaints were registered from the beneficiaries or the vendors. To date (May 2014), the programme has not been repeated but the team is preparing to scale up the voucher system to other camps.

Conclusions

The voucher programme was a speedy response to the camp IDPs and the best way to address their basic needs. Satisfaction among the beneficiaries was very high mainly due to a high level of participation (involving the beneficiaries) during the needs assessment, the market assessment and consultations at various levels. Also, use of local suppliers (Syrian) who are known by the community and part of the same culture helped to supply materials that fit to the context and cultural values of the IDPs. The voucher system has proven to be applicable in an IDP camp setting. It was implemented quickly in an emergency context to address basic needs of the IDPs, and carried lower risks due to the requirement for less logistic activities and low visibility of the approach.

Above all, the voucher approach empowers beneficiaries and respects their dignity as it gives them the right to choose how they meet their needs, which is fundamental principle of the humanitarian charter.

Figure 1: NFI voucher spending in Syrian IDP camp



¹ Turkey and Syrian refugees: the limits of hospitality. <http://www.brookings.edu/research/reports/2013/11/14-syria-turkey-refugees-ferris-kirisci-federici>

Crowds gather as an aid delivery arrives at a GOAL office in Idlib Governorate, Northern Syria



Davy Adams/GOAL, Northern Syria, 2013

GOAL's food and voucher assistance programme in Northern Syria

By Hannah Reed



Hannah Reed is the former Assistant Country Director for Programmes in GOAL's Syria Programme. She has over 10 years of

experience in the humanitarian and development sector, working in Bolivia and the Fairtrade Foundation, before joining GOAL in 2011. Since joining GOAL, Hannah has worked in the field and support offices in GOAL's Sudan, Haiti and Syria programmes.

With thanks to Hatty Barthorp, GOAL's Global Nutrition Advisor, and Alison Gardner, Nutrition Consultant, for their technical support.

Context

GOAL's response to the Syria crisis began in November 2012. To date, it has provided vital food and non-food aid to over 300,000 beneficiaries through both direct distributions and voucher programming in Idlib and Hama Governorates, Northern Syria, in addition to increasing access to water for over 200,000 people in northern Idlib.

GOAL Syria currently receives funds from four donors (OFDA, FFP, UKAID and ECHO¹). Under OFDA, GOAL implements voucher-based and in-kind Non-Food Items (NFIs) and winterisation support. FFP funding provides Family Food Rations (FFR) and support to bakeries with wheat flour alongside a voucher-based system for the most vulnerable households to access bread. A UKAID grant focuses on improved access to safe water, hygiene and sanitation and improved food security through a mixed-resource transfer model combining dry food distributions with Fresh Food Vouchers (FFV). Finally, Irish Aid and ECHO support unrestricted vouchers and cash for work to increase access to food and NFIs in areas with safe access to functional markets.

At the time of writing (May 2014), GOAL's food assistance programme is reaching upwards of 240,000 direct beneficiaries each month. Monthly unrestricted (food and NFI) vouchers are targeting 5,790 people, expanding to a total 13,200 direct beneficiaries each month from June 2014, while voucher-based assistance to meet winterisation needs reached over 72,000 people during winter 2013/14. Funding has also been secured to expand voucher-based assistance to increase access to inputs required for the protection and recovery of livelihoods and to include food production.

GOAL's Food Security programme implementation and design has been informed by

various assessments and studies completed over the past six months. These include a Food Basket Assessment (August 2013), Emergency Market Mapping and Analysis (EMMA) studies on markets for wheat flour and vegetables (January 2014) and dry yeast, rice and lentil (May 2014), a Food Security Baseline (December 2013) and Multi-sector Needs Assessment (January 2014). Design and implementation also continue to be informed by ongoing Post Distribution Monitoring (PDM) of all programme activities.

Programming context, including challenges due to access and security

The protracted conflict has resulted in urgent, humanitarian needs across Syria. The United Nations (UN) estimates that the conflict has displaced at least 6.5 million people within Syria, with a further 2.5 million refugees in neighbouring countries². A combination of direct and indirect factors has led to in excess of 9.3 million people classified as in need of humanitarian assistance. With reference to aid required per sector, the Syria Integrated Needs Assessment (SINA) found the highest number of people in need across the sub-districts surveyed were in need of food assistance, with an estimated 5.5 million people food insecure in assessed areas of northern Syria, including 4.9 million in moderate need and 590,600 in acute or severe need³.

Resulting in displacement, reduced access to livelihoods and market disruption, in addition to the direct loss of life and damage to infrastructure, the protracted conflict continues to

¹ US Office for Disaster Assistance; US Food for Peace; UK Aid Department for International Development (UK), European Commission Humanitarian Office

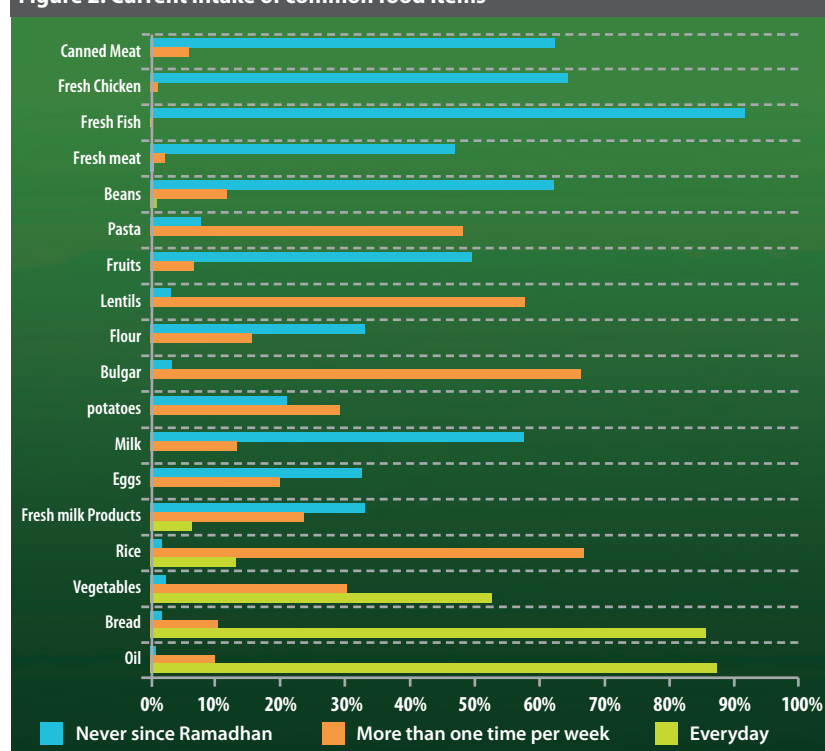
² UNOCHA Syrian Humanitarian Bulletin Issue 44, 27 February – 12 March 2014

³ Syria Integrated Needs Assessment, December 2013

Figure 1: Sources of food accessed by respondents



Figure 2: Current intake of common food items



impact negatively on the ability of affected populations to meet basic food and other needs without assistance. Increased reliance on coping strategies reduces household resiliency and results in increased immediate and sustained humanitarian need.

In tandem, the operational and security context continues to present challenges to the impartial and safe delivery of humanitarian aid. An increasingly fractured opposition force and changes in power dynamics requires continual operational adjustments to ensure aid can pass freely through check-points held by different and continually changing factions. Highly fluid changes within the opposition movement are accompanied by an increasing trend of Government military action in opposition-held areas of northern Syria, resulting in continued population displacement and a highly insecure opera-

tional environment for aid agencies. Deterioration in security in areas of Syria close to the border with Turkey, have also resulted in periodic and often prolonged border closures (notably in January 2014) which in turn prevent and/or delay cross-border delivery of aid to conflict-affected populations in Syria.

Assessments which informed the food kit design

The designs of GOAL's Family Food Ration (FFR) and complementary fresh food vouchers⁴ for distribution from Autumn 2013 up to early Summer 2014, were informed by GOAL's Food Basket Assessment⁵ (and supporting assessment of fresh food availability on local markets) completed in August 2013. The survey objectives were to obtain information on diet quantity, diet diversity, feed frequency, food availability, nutritional deficiencies

and access to produce an evidence base and recommendations for the contents of GOAL's FFR, and to reassess the profile of GOAL beneficiaries, including household size and composition of the household.

Key survey findings were:

- Percentage of households with at least one household (HH) member with specialised nutritional requirements: children aged 5 years and younger (66%), elderly (15%), Pregnant and Lactating Women (PLW) (30%), and members with chronic illness or disability (27%).
- Average monthly income per HH is SYP 7,279 (\$29) while average monthly expenditure on food per HH was reported as SYP 9,265 (\$37).
- Ratio of HH member contributing to income to dependent HH members = 1:4

Figure 1 shows that the primary source of all food groups was purchase from local markets. The average monthly food expenditure reported exceeds average monthly income, suggesting a high risk of food insecurity in the absence of assistance to access food, and a need to rebuild livelihoods to increase income levels.

To assess current dietary diversity, respondents were also asked how often they consumed food items from a specified list of foods common in Syria (see Figure 2). Ramadan was 3 weeks before the household survey⁷. The results (Figure 2) reveal very low levels of dietary diversity with the population heavily reliant on bread and vegetables. The main additional foods consumed (eaten more than once a week) were other cereals, such as rice, bulgur and pasta, as well as lentils. Results of the assessment in terms of the % Recommended Daily Allowance (RDA) for kilocalories and micro- and macro-nutrients showed that households were able to meet an average of 900 kilocalories per person per day without assistance. The % RDA met without assistance was high for vitamin A (91%) and Vitamin C (92%) and low for protein (49%), fat (41%), iron (24%) and iodine (15%).

Design of different food kits and resulting operational difficulties

In response to these findings, GOAL designed two types of food ration. The FFR included tahini, raisins, fava beans and chick peas for distribution in areas without functioning markets, and therefore not receiving vouchers to access fresh food. In areas with safe access to functioning markets, a dual-transfer food assistance package was distributed that included both a dry food ration and vouchers to access food (see Figure 3 for nutrient composition including % RDA).

⁴ Fresh Food vouchers were distributed with dry food rations over this period, and only in areas where local markets will sustain a voucher-based approach

⁵ A household survey was conducted in August 2013, using convenience sampling of 607 randomly selected households in GOAL's operational areas. The sample covered 82% beneficiaries (of non-food aid) and 18% non-beneficiaries and a mix of rural and urban areas. Data were then triangulated through in-depth interviews in the same districts. The 'NutVal' tool was used for analysis of nutrient composition, while secondary data from FSLWG and OCHA, WFP documents were also referenced. In terms of limitations, some areas were inaccessible to the data collection team due to security constraints while challenges were also experienced with regards to respondents' ability to recall daily food intake.

⁶ Of which the average households sampled had 0.46 household members aged two years and younger, and 0.90 household members aged between three and five years.

⁷ Possible answers were: never since Ramadhan, more than once per week, and everyday

Figure 3: GOAL mixed modality Food Assistance package: % RDA met by dry food ration and fresh food vouchers

Food items	Energy	Protein	Fat	Calcium	Iron	Iodine	Vit. A	Thiamine	Riboflavin	Niacin	Vit. C
Current consumption (kcal)	900	26	19	220	6	25	557	1	0	13	30
Dry rations (kcal)	1212	38	31	94	11	251	26	1	0	15	4
Fresh foods (kcal)	184	11	7	139	1	20	591	0	0	5	20
Total	2296	75	57	454	19	295	1173	1	1	32	55
Required ration (adjusted for winterisation) (kcal)	2400	53	46	430	26	161	613	1	2	16	32
% of requirements supplied by current consumption	37%	49%	41%	51%	24%	15%	91%	60%	24%	80%	94%
% of requirements supplied by dry rations	51%	71%	69%	22%	44%	155%	4%	74%	20%	95%	13%
% of requirements supplied by fresh foods	8%	21%	15%	32%	5%	12%	96%	19%	15%	29%	62%
% of total requirements met	96%	141%	124%	105%	73%	183%	191%	152%	59%	204%	169%

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

	Average			Male headed households			Female headed households		
	Oct-13	Dec-13	Jan-14	Oct-13	Dec-13	Jan-14	Oct-13	Dec-13	Jan-14
% households scored 'acceptable'	43%	22%	15%	40%	23%	15%	58%	43%	18%
% households scored 'borderline'	50%	47%	42%	56%	48%	45%	40%	43%	0%
% households scored 'poor'	7%	31%	43%	4%	28%	40%	2%	14%	82%

All food assistance was designed to meet a target of 2,400 kcal p/d adjusted from the Sphere standard (2,100 kcal p/p/d) by an additional 300 kcal p/d in order to meet increased calorific requirements during the winter period. For areas targeted by direct distribution of dry food rations only, GOAL designed two types of food kit – a full FFR and a reduced FFR. The latter was provided where targeted beneficiaries were also receiving a daily bread ration (457 kcal per person per day (pppd) via bread vouchers) under complementary GOAL programming; in this instance, the FFR contained reduced quantities of pasta, rice and bulgur wheat. For both FFR types, full and half kits were also provided, designed to ensure the RDA pppd was met and allocated according to household size.

In practice, disruption to border crossings resulted in frequent delivery of only one type of food ration. This disrupted distribution as it was necessary to wait for delivery of contingents of all food ration specifications to cross the border. Otherwise, distributing food kits to all registered households in any given village at different times had the potential to create security issues.

Modified food assistance modality

Given the unreliability of border crossings, the design of food kits has been greatly simplified for the next round of food security programming with one type of half kit only. Households will receive between one and three half kits each month depending on household size. A repeat of the Food Basket Assessment is planned for early June 2014 to inform the final specifications of the FFR. This will focus specifically on the % RDA currently met by targeted groups without assistance, and will ensure the RDA per person per day is met in terms of calorific and nutrient requirements. It is expected that the % meeting the RDA without assistance will have declined since August 2013, due to:

- Continued trend of price increases in food items

- Reduced purchasing power as conflict affected households deplete remaining savings, and
- Disruption to livelihood activities pre-conflict and the corresponding decrease in income generation capacity for much of the population.

GOAL's assessments in 2014 demonstrate a trend of decreasing food security within populations without access to regular food assistance. Table 1 shows average Household Food Consumption Scores (FCS) for populations surveyed in GOAL's operational areas during October 2013, December 2013 and January 2014.

Table 1 demonstrates progressive deterioration in household food security across targeted areas, with a striking increase in the number of female headed households ranked with a 'poor' FCS (82%) in January 2014 when compared to male headed households surveyed at the same time and in the same areas (40%). A sharp decline can also be seen in January 2014 figures when compared to the % of female headed households ranked with poor FCS in October (2%) and December 2013 (14%).

Food security is undermined by the type of income source, with the majority of households surveyed currently relying on irregular jobs (44%), the sale of personal assets (29%), assistance received from relatives (17%) and previous savings (7%)⁸. This represents a worrying trend as there are only a finite number of assets that may be sold or savings that may be utilised. On average, irregular jobs only generated USD \$65 / 9,724 Syrian Pounds (SYP) in the month prior to the survey, compared to the sale of personal assets (the highest source of income reported) which generated an average of USD \$415.5 / SYP 62,018 over the same period.

Correspondingly, the average monthly expenditure on food alone across the sample was USD \$81/SYP 12,105 significantly higher than the average income generated by irregular jobs,

which represents the most common source of income referenced. Households also reported that most of their income was not generated by jobs or livelihoods but by the use of coping strategies; 22% of the income source was through the sale of personal assets, whereas a further 22% was credit – strategies which are not sustainable⁹. Sixty eight per cent of households surveyed also reported outstanding debt, with 72% of these reporting that credit obtained had been used to purchase food. Other coping strategies identified to meet food needs include relying on less preferred or less expensive food (62%), taking on credit (29%), limiting portion sizes (25%), borrowing food (19%), and taking children from education to work (17%) or sending children or other family members to live with relatives (15%)¹⁰.

Recent surveys, reinforced by Emergency Market Mapping & Analysis (EMMA) studies on critical markets for tomatoes, potatoes, rice and lentils, reinforced the trend that food remains available in areas with functioning markets (see Figure 4). However, food remains inaccessible to many households in these areas due to reduced livelihood options and the widening gap between household expenditure and income.

Change of GOAL direction to include voucher programming

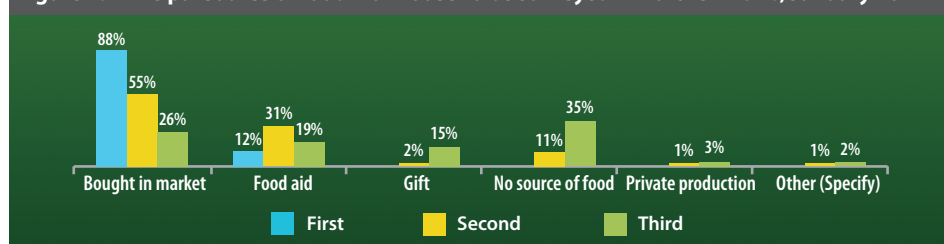
Given that access as opposed to availability represents the critical barrier to households meeting basic food needs without assistance, GOAL will expand the current FFV modality to include vouchers for both dry and fresh food in the next phase of food security programming. This recognises increased flexibility afforded by a market-based approach in areas with functional markets and when compared to direct distributions alone, reducing reliance on border crossings and the transportation of food rations when re-

⁸ Needs Assessment in northern Idlib, January 2014, GOAL.

⁹ See footnote 8

¹⁰ See footnote 8

Figure 4: Principal source of food* for households surveyed in northern Idlib, January 2014



*Respondents could give up to three sources of food ranked in order of importance as principal source of food.

lying only on direct distributions. This approach also recognises beneficiary preference for vouchers. A dual resource transfer approach also provides maximum operational flexibility, with the option to increase or decrease the ration of assistance provided via vouchers and via direct distributions in response to changes in market systems or in the security context.

This approach has been informed by GOAL's understanding of market systems developed through EMMA on critical markets for dry and fresh food, and by experience to date with fresh food vouchers and in addition to ongoing unrestricted and NFI voucher programming. Food assistance will be delivered through monthly food voucher distributions in areas which will sustain a market-based approach, and through dry food rations in areas without safe access to functioning markets.

The use of vouchers – when market systems permit – also seeks to 'do no harm' both to local markets and to livelihoods, by avoiding the potentially negative impact of large volumes of imported food goods being distributed in areas where markets continue to function¹¹.

GOAL welcomes the formation of a Cash Based Response Technical Working Group (Cash TWG) for actors implementing the cross-border response in northern Syria. GOAL is participating actively on the working group and has recently presented GOAL's voucher process (outlined below) in response to requests from other members. The Cash TWG has been formed to support lesson learning and exchange of best practice with reference to cash and voucher based programming in northern Syria and to improve coordination. With a market-based approach to assistance, it is critical that actors coordinate to ensure a 'Do No Harm' approach is applied to local markets. This will mitigate against the risk of 'flooding'/crashing local markets should there be a significant and uncoordinated increase in voucher-based programming by other actors, reliant on the same markets, within the same timeframes.

Details of the voucher programme design

Food vouchers will build on GOAL's established voucher modality, taking the form of printed, cash-based vouchers distributed on a monthly basis and exchangeable for food items only at selected and registered traders.

Following an assessment by GOAL field staff of trader's stock and capacity to restock and to

gauge willingness to engage with the conditions of GOAL's voucher scheme, traders sign a contract with GOAL to participate in the voucher scheme. This includes a commitment on the part of the trader only to redeem agreed items for GOAL vouchers exchanged by beneficiaries, namely dry and fresh foods for food security interventions (see Box 1 for decision making regarding vouchers related to infant feeding)¹². Punitive measures are in place and communicated to traders regarding infractions to the stated terms of the contract. This includes temporary moving to permanent exclusion from the voucher scheme if substantial evidence exists that vouchers have been exchanged for items outside the scope agreed by GOAL with traders and stipulated on the vouchers, in addition to other breaches of the contract signed.

Food vouchers are eligible for one month and redeemed for food by beneficiaries in a range of registered shops. Lists of shops participating and the prices charged for key food goods are distributed to beneficiaries with vouchers. Participating shops are also required to display the agreed price list in their outlets to reduce the risk of voucher beneficiaries being punitively charged for goods purchased with vouchers. Prices for food goods exchanged with vouchers are set in line with average market prices for these goods, and are not intended to be 'cheaper' than the same good purchased in the same markets by non-beneficiaries and using cash. GOAL vouchers continue to incorporate a series of security features¹³, while a rigorous system of checks ensure only the selected families receive and redeem the vouchers; that the vouchers are used for NFIs only; that the traders cannot increase prices arbitrarily and that any

complaints are quickly relayed to GOAL for investigation¹⁴.

Shopkeepers redeem vouchers with GOAL staff on a weekly basis and are reimbursed for the value of food items exchanged for vouchers. There are currently over 200 outlets registered with GOAL's voucher scheme offering a wider range of food and NFIs. GOAL is currently providing fresh food assistance to upwards of 10,000 households each month via a voucher-based modality. Initial assessments and demand from traders not currently registered demonstrate that scope exists to expand further the food voucher scheme under the proposed modification.

Both breastfeeding and use of breastmilk substitutes (BMS) – typically infant formula – is common in the population. In the January 2014 Needs Assessment, in nine sub-districts (Armanaz, Badama, Darkosh, Harim, Janudiyeh, Kafr Takharim, Maaret Tamsrin, Qourqeen, and Salqin) of Idlib Governorate, 25% of respondents reported infants 0-5m were being fed milk (regular, tinned, powdered or fresh animal milk), a further 17% of infants 0-5m were being fed infant formula and 41% reported other foods/liquids. Three-quarters (75%) of respondents also reported breastfeeding their infant. Various difficulties with breastfeeding were reported, such as too stressed to breastfeed (13%) and inadequate maternal food intake (29%).

Access to breastfeeding support and to BMS supplies for mothers is very limited in our target population. An international non-governmental organisation (INGO) is running an IYCF programme in just five of the 134 villages that GOAL currently operates in, though this may be expanding which may bring more opportunities

¹¹ The EMMA on rice and lentil critical markets completed in May 2014 by GOAL suggested that large-scale influxes of these food types via aid agency distributions may be impacting local markets systems for these commodities

¹² Note that shopkeepers include a strict ban on the exchange of vouchers for alcohol, cigarettes, infant formula and powdered milk. GOAL programme and M&E staff will continue closely to monitor shopping periods to ensure contractual requirements are met, and including that NFIs are not exchanged for food vouchers. The ban on exchange of vouchers for infant formula and powdered milk is in line with GOAL's policy of safeguarding children and the international Operational Guidelines for Infant Feeding in Emergencies (2007) which state that "infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues" See Box 1 for more considerations around infant formula/powdered milk exclusion from the voucher scheme.

¹³ There are two serial numbers, one is random and one is computer generated and therefore unpredictable. Each

voucher has a hologram which is GOAL-specific, patented and only produced in one factory in Turkey. There is a different colour for each batch of vouchers. Watermarks are incorporated into the design, which are very difficult to forge and there is also a complex pattern on the surface and exact measurements of the font. Replication of vouchers is therefore extremely difficult.

¹⁴ This system includes: price setting with participating shopkeepers prior to each round of distributions with price lists then displayed in participating outlets; the use of 'shopkeeper books' to register beneficiary names, ID numbers and voucher numbers against the items these are exchanged against; careful selection of shopkeepers against established accessibility and stock level criteria followed by signatures of contracts agreeing to abide by the terms and conditions of GOAL's voucher scheme; and clearly defined shopping and voucher redemption periods to guarantee close monitoring by both programmes staff and GOAL's M&E team to ensure guidelines are adhered to and to reduce the risk of unauthorised duplication or use of GOAL vouchers.

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

Both breastfeeding and use of breastmilk substitutes (BMS) – typically infant formula – is common in the population. In the January 2014 Needs Assessment, in nine sub-districts (Armanaz, Badama, Darkosh, Harim, Janudiyeh, Kafr Takharim, Maaret Tamsrin, Qourqeen, and Salqin) of Idlib Governorate, 25% of respondents reported infants 0-5m were being fed milk (regular, tinned, powdered or fresh animal milk), a further 17% of infants 0-5m were being fed infant formula and 41% reported other foods/liquids. Three-quarters (75%) of respondents also reported breast feeding their infant. Various difficulties with breastfeeding were reported, such as too stressed to breastfeed (13%) and inadequate maternal food intake (29%).

Access to breastfeeding support and to BMS supplies for mothers is very limited in our target population. An international non-governmental organisation (INGO) is running an IYCF programme in just five of the 134 villages that GOAL currently operates in, though this may be expanding which may bring more opportunities to collaborate. Infant formula is expensive; the price of infant formula has risen significantly through the crisis. Untargeted distribution of

infant formula (ready-to-use and powdered products) is happening in the northern governorates (source: GNC scoping mission, Sept 2013); one INGO is collaborating with a number of these to minimise risks.

On balance, it was decided that GOALs vouchers and dry rations should not include a BMS as we do not have the capacity or relevant partnerships established to ensure appropriate targeting and also provide the requisite level of support/guidance to mothers. The hygiene-sanitation conditions are poor and access to safe water is a problem. Households still have a certain level of income from various sources, whereby GOAL FSL project is trying to protect assets and the 'income generation pot', by providing access to as replete a diet as possible. We excluded BMS to reduce the risk of families choosing BMS or other powdered milks over breastfeeding. Those who are dependent on BMS still have the potential to buy from local markets, as a greater proportion of their personal income would be available to spend on 'essential items', given the food/ vouchers provided by GOAL. In January 2014, the predominant expenditure for all households remained food, followed by health, water then fuel.

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

To date, 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.¹⁵

GOAL will therefore continue to increase access to food and other basic needs through a voucher-based modality, as the preferred option in areas with safe access to functional markets. This will be supported by continued direct distributions of food assistance when security or market capacity does not permit a market-based approach. Through continued emphasis on robust monitoring of the impact of assistance on food security, and on market impact of modalities employed, GOAL will scale up the use of vouchers in preference to direct distributions.

For more information, contact: Vicki Aken, Country Director, GOAL Syria, email: vaken@goal.ie



Families receiving food assistance from GOAL

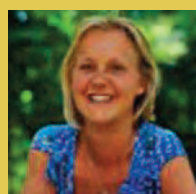
¹⁵ PDM Irish Aid Vouchers Rounds 1 and 2



Small market in a town located in Idlib area, Syria

Emerging cases of malnutrition amongst IDPs in Tal Abyad district, Syria

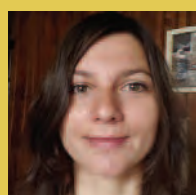
By Maartje Hoetjes, Wendy Rhymer, Lea Matasci-Phelippeau, Saskia van der Kam



Maartje Hoetjes is a Medical member of the MSF emergency team, currently working in South Sudan. She worked as Medical Coordinator in Syria from February to November 2013.



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.



Lea Matasci-Phelippeau is psychologist and worked in Syria as mental health officer. He is currently working as Mental Health Officer in South Kivu, Democratic republic of the Congo, for MSF OCA.



Saskia van der Kam is the nutrition expert of MSF in Amsterdam.

The authors gratefully acknowledge the work of Medecins Sans Frontieres Operational Centre in Amsterdam (MSF OCA), the team MSF OCA in Syria and Vanessa Cramond, Emergency Manager (Medical) at the Emergency Support Desk at MSF-OCA.

Sections of this publication are part of Maartje Hoetjes' dissertation for a Masters in International Health¹.

Pre-war food and nutrition situation

Al-Raqqah governorate is in the North of Syria and has Al-Raqqah city as its capital. The governorate is divided into the three districts of Tal-Abyad, Al-Tawrah and Al-Raqqah. 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-Raqqah governorate was agriculture, with the Euphrates as an important source of water for irrigation^{2,3}. In combination with imports from neighbouring countries, food availability generally met the needs of the growing population. With fixed price policies from the government, staple food was accessible for all. The agricultural sector was hit hard by the water crisis that peaked in 2008, which increased unemployment and reduced local food production. The event coincided with external economic factors and neo-liberalisation policies driving up prices of food, fertilisers and energy. These developments caused many Al-Raqqah farmers to move from their lands to the southern cities, in the hope of finding a job^{4,5,6}.

Undernutrition was a problem in pre-war Syria, reflected in 9.7% of children under five years underweight for their age, 2.3% wasted⁷ and 29% stunted⁸. Underweight and wasting were reported to be more prevalent in Al-Raqqah governorate, with the 6-11 months age group mostly affected⁹. In Al-Raqqah governorate, there were no specific protocols or programmes in place for the treatment of moderate and severe acute malnutrition. Since the outbreak of the conflict, agricultural production has been further hampered by insecurity limiting access to fields and markets, as well as the high price of fuel¹⁰. Moreover, the region experienced damage to its irrigation canals (10%)¹¹. Shortages of food, due to limited production as well as import problems, have been regularly reported and the prices of bread and other food have significantly increased¹².

¹ Hoetjes, M. The impact of armed conflict on health in Al-Raqqah governorate, Syria. KIT/Royal Tropical Institute: August 2014

² Masri A (2006) Country Pasture/Forage Resource Profiles. Rome.

³ Goodbody S, del Re F, Sanogo I, Segura BP (2013) FAO/WFP crop and food security assessment mission to the Syrian Arab Republic. Damascus.

⁴ Nasser, R; Mehchy, Z; Ismail AK (2013) Socioeconomic roots and impact of the Syrian crisis. Damascus.

⁵ International Crisis Group (2011) Popular protest in North Africa and the Middle East (IV): the Syrian people's slow motion revolution. Brussels/Damascus.

⁶ Rifat H, Ismail KA, Nawar AH (2010) Syrian Arab Republic Third National MDGs Progress Report.

Damascus.

⁷ Wasted defined as acute malnourished with weight-for-height <-2 z score. This includes moderate (MAM) and severe acute malnutrition (SAM)).

⁸ Stunting defined as Height-for-Age <-2 z score
⁹ UNICEF (2008) Syrian Arab Republic Multi Indicator Cluster Survey: 2006. Geneva, Switzerland

¹⁰ The wheat production of 2013 showed a decline of 40% compared to the trend of the previous 10 years and the livestock sector in Syria has significantly reduced. Source: See footnote 2.

¹¹ See footnote 2.

¹² Hoetjes M (2014) The impact of armed conflict on health in Al-Raqqah governorate, Syria

Table 1: MUAC screening during vaccination campaign, May, 2013, Tal Abyad district, Syria

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	38	180	1,161	33,618	34,997
%	0.1%	0.5%	3.3%	96.1%	100%

Table 2: MUAC screening in mobile clinics, 3rd August - 21st September, 2013

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	3	2	29	637	671
%	0.4%	0.3%	4.3%	94.9%	100%

Table 3: MUAC screening in inpatient clinics, 1st July -15th September, 2013

MUAC	<115 mm	115-<125 mm	125-<135mm	>135 mm	Total
Number	16	8	22	383	429
%	3.7%	1.9%	5.1%	89.3%	100.0%

MSF operations in Northern Syria

Médecins Sans Frontières Operational Centre Amsterdam (MSF OCA) has been working in Northern Syria, Al-Raqqa governorate, Tal-Abyad district, since February, 2013. Medical programmes include inpatient paediatrics, as well as general outpatient services for adults and children. Services also include antenatal care, postnatal care, sexual and gender based violence care, family planning, as well as routine immunisation. The mental health programme includes individual and group counselling sessions, psycho-educational sessions and outpatient psychiatric care. The nutrition programme includes inpatient therapeutic feeding and ambulatory therapeutic feeding care. Expanded Programme of Immunisation (EPI) support has been provided to outlying villages. Donations of emergency medicines and medical supplies to other facilities in the surrounding area are also provided.

Until May 2014, the expatriate team included two Medical Doctors, two Nurses, a Mental Health Officer, a WASH (Water, Sanitation and Hygiene) officer, a Project Coordinator and a Logistician. To this date, 78 Syrian national staff were working with MSF, either directly or through a partnership with the national hospital in both medical and non-medical positions. When MSF OCA first began working in Northern Syria, the expatriate staff were able to live and work alongside the national staff. In January, 2014, with significant changes in the leadership of the area, a major security incident and closure of the border crossing from Turkey into Syria, MSF withdrew expatriate staff from Syria and

switched to a remote management style of working. National Staff were then supported by expatriate staff in Turkey via phone, email and skype. With regards to the nutrition programme, this meant that with each admission, the Syrian medical doctor would call the expat medical doctor responsible and discuss the patient's condition and treatment plan. These patients were followed up by the expat daily, via phone calls with the on duty physician. Trainings for national staff doctors and nurses were conducted via emailed power point and skype, and proved to be successful even with this unusual method of management. In May 2014, MSF closed the programme completely (see discussion for more details).

Nutrition situation 2013

In March 2013, an exploratory mission by MSF found no cases of acute malnutrition. Two months later, in May 2013, a mid-upper arm circumference (MUAC) screening was included as part of a measles vaccination campaign (including children from 9 months old to five years). This was undertaken to update information on the nutritional status of the IDP community given their situation (displacement, lack of income), a recent measles outbreak and anecdotal reports that that mothers had difficulties finding appropriate food (infant formula) for their children.

The MUAC screening found a 0.6% prevalence of global acute malnutrition (GAM). Thirty eight cases (0.1%) of severe acute malnutrition (SAM) were identified amongst 34,997 children screened (see Table 1). The vast majority of the identified cases were children younger than 1

year of age. The highest numbers and percentages of malnourished were found in the Central area, with the majority in Tal Abyad town. In the city, the malnourished cases were clustered. Percentages of children with a MUAC <125mm ranged from 0-10% per area in the city. The most common explanation for malnourished children with no underlying medical issues was that caregivers had no money to purchase infant formula. Seven medical cases were children with "a hole in the heart" (a congenital heart defect). MUAC screening by mobile clinics was also used as a way of monitoring the trend in the population. This showed no increase in malnutrition (see Table 2). MUAC screening from July to September 2013 of children attending the inpatient clinic did not show an alarming number of malnourished (Table 3).

Despite the low number of malnourished cases identified in the vaccination campaign, an increasing number of malnourished cases were attending in the mobile clinics in between April and May 2013. This triggered the opening of an Ambulatory Therapeutic Feeding programme (ATFP) at the end of May 2013, followed by an Intensive Therapeutic Feeding Centre (ITFC, inpatient facility) at the beginning of July 2013. Since the start of the programme, the number of admissions has increased slightly week by week. In order to have a better picture of the factors affecting the nutritional status amongst the Tal-Abyad population, MSF undertook a small qualitative survey among the most vulnerable populations in the Tal-Abyad region of Syria in August 2013.

Qualitative survey

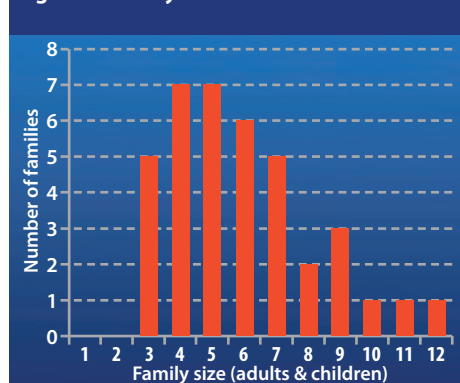
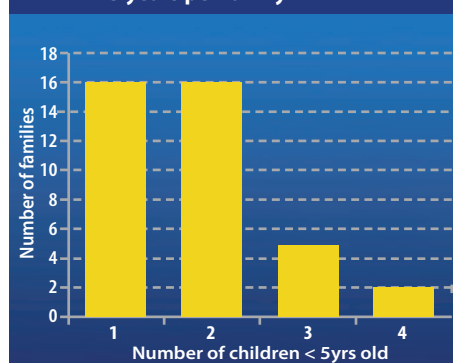
The surveyed population was IDPs living in schools in the Tal Abyad region¹³. A total of 39 persons were interviewed, all women, about their living circumstances and food security. The data were collected using a questionnaire administered by MSF staff working with the mobile clinics. The data covered a period between mid-August and mid-September 2013.

Family composition

Figure 1 shows the family size amongst those surveyed. The average family size was 5.9 with 79% (n=30) having 3-7 family members. The majority of the families (84% (n=32)) had one or two children aged 5 years or under (see Figure 2). Twenty two families (58%) had one or more children younger than 12 months (one family had two children under this age).

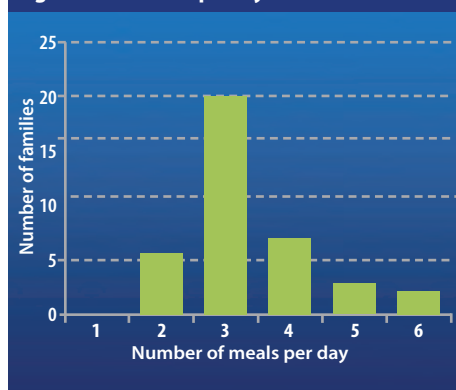
Availability and access to food

All but one interviewed woman (n=38/39) reported that a wide range of food was still accessible at local markets. However, for some of the women (n=9), access to markets was not easy since they live 10-15 km away. Public transportation is expensive (100 Syrian Pounds); most walk long distances to reach the market, sometimes arriving too late to find the items

Figure 1: Family size**Figure 2: Number of children younger than 5 years per family**

¹³ Matasci-Phelippeau L (2013). Nutrition status of IDP population in Tal Abyad district

Figure 3: Meal frequency



they need as the market starts early in the morning. Culturally, men are supposed to do the shopping. Only women with 'special circumstances' (widows, divorced) are 'allowed' to go out shopping. Married women should not leave the house regularly. Those interviewed reported the major problem affecting people's nutrition is that prices continue to rise and there is a lack of money due to unemployment (see Table 4). This has a direct influence both on the quantity and quality of food that can be purchased.

Almost 100% of the respondents reported having received at least one donation of food and non-food items (NFI) from different actors (Turkish Red Crescent (TRC), Qatari Red Crescent (QRC), Saudi Arabia, local court, private donations). Most of them, however, stressed that donations occur sporadically and they need regular donations. Mothers spontaneously expressed fears for their children, in particular lack of fresh milk, since this item is never included in food donations. Infant formula milk is generally available but the prices are very high; mothers simply cannot afford it. The only item that was received on a regular basis by IDPs living in some of the schools was free bread, donated by different armed groups. IDPs living in one of the schools reported receiving free rice regularly.

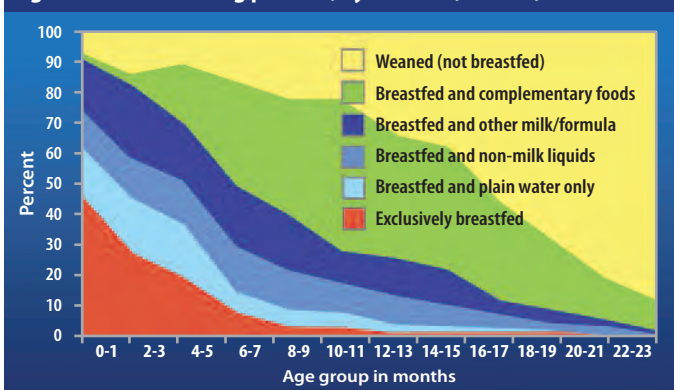
Meal frequency

Before the war, Syrians used to have three meals per day (breakfast, lunch and dinner). The survey investigated the number of meals IDPs are currently eating each day. As Figure 3 shows, 52% of the women interviewed (n=20/38) reported that their families are having the usual number of meals, 16% are having only two meals (n=6/38) and one third of the families are eating more than three meals (n=12/38) per day. In response to the question "do you often feel hungry?" almost 75% (n=29/39) of those interviewed replied "yes". Unfortunately, meal

Table 4: Average price increase between pre-war and August 2013

Food	Average price increase %
Bread	+ 233 %
Oil	+ 294 %
Flour	+ 424 %
Milk	+ 424 %
Rice	+ 639 %

Figure 4: Breastfeeding practice, Syria 2006 (UNICEF)



Source: MICS

quantity could not be ascertained. However, since three-quarters of respondents reported often feeling hungry, it can be inferred that those who are still having three meals (or more) are actually eating smaller quantities of food.

Diet diversification

In Syria, all the family usually eats together, unless there are guests or in the case of a special event, when women and children eat separately. The diet pre-crisis was varied and mainly composed of grains (bread, rice, bulgur, etc.), vegetables (soup, salads, etc.), beans (chick peas in hummus and falafel, lentil soup, etc.), dairy products (yoghurt, milk, cheese) meat and eggs. The survey revealed that people's current daily diet is generally composed of grains (bread, spaghetti, rarely rice) and vegetables (73% of adults, 63% of children). Only two people reported eating dairy products (milk, yoghurt). Meat and eggs are scarce and not consumed but beans and lentils are part of the diet. For some IDPs, the variety of food is even more limited; seven people reported that adults are only eating grains, with five people saying that the same is true for their children. In some cases, adults are favouring their children (n=6/33), by giving them the available vegetables and/or milk. In a small number of cases (4/33) the opposite is true, and parents report eating more vegetables than their children.

Infant nutrition and breastfeeding practices

"And mothers should breastfeed their children two complete years for those who want the breastfeeding to be complete"
(Qu'ran, 2nd verse, Al Bqarah, 233:37)

Breastfeeding is a practice accepted and even promoted by the holy Qu'ran. In fact, in "Islamic instruction, mothers are entitled a monthly payment from their husbands to breastfeed their children¹⁴". Breastfeeding was also used sometimes as a social regulator; if a mother breastfed another baby in addition to her own baby, they would become "brothers of milk". Marriage would therefore be forbidden between the two children in later life in a culture where intra-familial marriages are still common. Also, according to custom, the parents of a woman who has been breastfed can ask for a larger dowry than if she was not breastfed.

However, according to national staff, using formula milk became the new "fashion" in pre-war Syria. There are several possible 'cultural' reasons for this: people started to think that formula milk was better than mother's milk, some (urban) women started to have concerns about preserving the beauty of their breast and men who refused formula milk for their wives felt they might be perceived as mean. All these factors have meant that duration of breastfeeding has been decreasing and that some mothers have not breastfed at all. Furthermore, Syrian mothers also believe that babies benefit from water, water and sugar, a local type of "sheep clear butter", or tea in addition to breastmilk. Exclusive breastfeeding was and is still far from being a generalised practice. These findings are supported by a UNICEF survey which showed that less than half of infants were exclusively breastfed at birth in 2006; in Al-Raqqa, the exclusive breastfeeding rates was estimated even lower, only 26.5%¹⁵.

In the past decade, many efforts were made by the Ministry of Health (MoH), in collaboration with UNICEF, to provide breastfeeding education and promote exclusive breastfeeding for the first 6 months. According to data collected by UNICEF, from 2007 to 2011, 43% of women exclusively breastfeed during the first 6 months, and 25% continued partial breastfeeding until their baby was 2 years old. According to the data collected in the MSF survey, 68% (n=26/38) of the women interviewed reported that they were currently breastfeeding. Among them, 20 had babies aged < 12 months and four of them reported exclusively breastfeeding. When asked if infant formula was available, only three mothers replied affirmatively. For the majority of women, infant formula had become too expensive.

Health and sanitation

Lack of access to good quality water was the second most common complaint amongst respondents after lack of access to food. The surveyed IDPs got their water supply from three different sources: city water (tap), water trucking, and wells (See Figure 5). Out of the 39 people interviewed, 49% (n=19) complained about water quality, mainly saying that it is "bad", "dirty" or "salty". Only one respondent complained that there was "not enough" water. Despite this, only 3/39 stated that they were boiling water.



Ambulance in front of an advanced medical post supported by MSF in Idlib area, Syria

Lack of fuel was a main reason for this. The third most common complaint (7 people mentioned it) was poor hygiene due to overcrowding. Hygiene supplies were included in donations but again, this happened too sporadically.

These findings support observations during the assessments in the IDP collective centres in June/July 2013 where the MSF team concluded that the IDPs living there suffer from skin diseases, such as scabies, lice and ringworm. Furthermore, 80% of the IDPs interviewed reported suffering from diarrhoea, due to bad hygiene and water quality. Following the findings of the June/July 2013 assessment, MSF launched a water and sanitation intervention in the most affected schools and started up mobile clinics targeting the collective centres.

Nutrition programme

Doctors and nurses in Syria have not been trained on how to diagnose and treat malnutrition and protocols and guidelines were not in place to support the medical practitioners, as malnutrition was not common. This gap in medical care was one of the reasons for MSF to intervene given the cases of malnutrition identified in the MUAC screening. MSF began by integrating Ambulatory Therapeutic Feeding Centre (ATFC) services into outpatient clinic activities at the beginning of June 2013. MSF also supported an

ITFC in the paediatric ward in Tal Abyad hospital from July 2013. Out of an estimated under 5 population of 30,000 in Tal Abyad, the team expected 10-15 admissions per month for complicated SAM (0.5%).

Between July 2013 and April 2014, malnutrition was the principal reason for 5.3% of all admissions in the in-patient paediatric ward. In the same period, SAM was the main cause of mortality (21%) in the ward, followed by respiratory tract infection (RTI) and accidental intoxication (drinking petrol, cleaning solutions) (both 10.5%). All deaths due to malnutrition occurred amongst infants under 6 months. This does show an important trend compared with the mortality profile before the conflict, when malnutrition did not appear in the under-five's mortality profile.

All patients under 5 years, presenting to either the paediatric inpatient facility or the outpatient facility, are screened for malnutrition. Children whose MUAC is below < 135 mm are assessed using weight-for-height z score (WHZ). All children are also assessed for oedema. Any child with WHZ < -3 or oedema is admitted. Patients are admitted to the inpatient ward (which is within the paediatric inpatient facility in the national hospital) and a caregiver is present from admission to discharge. Usually

this caregiver is the mother, although sometimes an alternative female family member is designated to stay. MSF ITFC nutritional guidelines are followed, which include the use of F-100, F-75 and Ready to use Therapeutic Food (Plumpy'nut) as needed. In the ATFC, patients are seen and assessed by the nutrition nurse in the outpatient department on a weekly or bimonthly basis, depending on the condition of the patient.

To date, the majority (75%) of cases have been direct admissions to the inpatient feeding programme. Between July and December 2013, 70 children were admitted to the ITFC of which 36% (n=25) were younger than 6 months. From January to April 2014, 49 patients were admitted to the ITFC of which 59% were younger than 6 months. This indicates that the malnutrition was a larger problem in Tal Abyad district than could have been expected based on surveillance data, which does not include this age-group. According to the ITFC medical staff, the majority of the children included in the programme were infants < 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

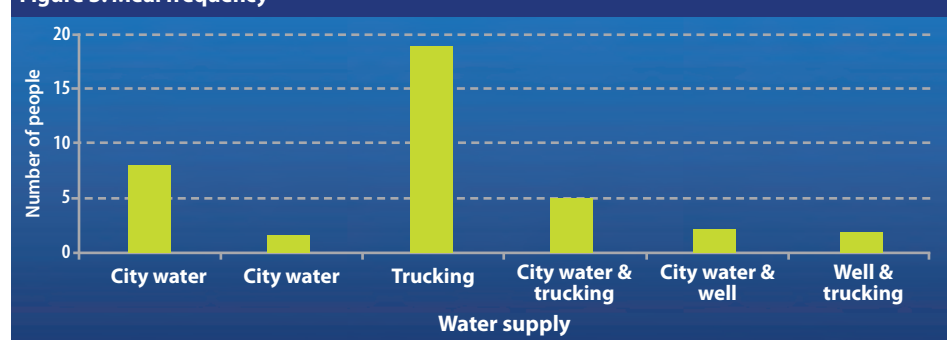
At the outset, there was some resistance from the doctors and nurses to follow the MSF nutrition protocols. As these staff members had limited or no experience with malnutrition, there was a belief that the patient was sick due to other reasons, and therefore only needed interventions such as intravenous fluids and antibiotics. But with training, we were able to change this to a certain extent.

All issues related to breastfeeding and relactation were a challenge, in particular:

- Given the culture of using infant formula, knowledge of breastfeeding among staff and patients was very low. Some mothers had not breastfed at all or had stopped two or three months ago, although their children were still under the age of 6 months. In this age group, the options for therapeutic feeding include breastmilk, therapeutic milk and infant formula. Relactation is a difficult process, even with experienced health professionals providing advice and support, and mothers who are committed to the process. As exclusive breastfeeding was not a common practice amongst most women and the staff, there was limited drive to persist with relactation.

- When these children reached their target weights and were ready for discharge, the problem presented that many of the mothers had not yet

Figure 3: Meal frequency



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 sufficient to train staff fully on breastfeeding promotion, and remote support to breastfeeding was a challenge as locally there was virtually no experienced person on the ground. Predominantly male staff were unable to give breastfeeding support, as only female staff are able to discuss and assist patients with breastfeeding. Most of the female staff had never breastfed before. Also midwives had minimal experience teaching patients about breastfeeding.

- Although many breastfeeding videos were available, as well as pamphlets/books, due to cultural considerations, these materials were deemed too sensitive to use with patients in the programme although some were useful to train the national staff. A training plan was developed with the help of an experienced Save the Children staff but the security situation prevented implementation.

The supply of therapeutic foods and items was problematic. It was difficult for agencies to access international supplies of these foods and agencies were unable to procure comparable nutritional supplies locally. There was a rupture in the supply of F100 milk in January, 2014 so that MSF was required to purchase infant formula locally as an interim measure to use in therapeutic feeding programmes.

Finally, the defaulter rate of the therapeutic feeding programme was high (30% to 50% of the exits) both for the inpatient and outpatient programmes. Some of the reasons for default are not unusual for a feeding programme; these included the fact that some of the patients were IDPs, and their families were moving to another location and that sometimes the caregiver was unable to stay with the patient in the hospital, due to other responsibilities at home. However, what was reported most commonly with regards to patient default was that the parents did not understand or value the care being provided to their children. Due to a lack of understanding of malnutrition, there was distrust that therapeutic milk would be sufficient to support these patients. Also, once patients under 6 months were transferred from the ITFC to the ATFC and no longer were being given therapeutic milk or infant formula, mothers questioned the need to come weekly for weight and physical assessment.

Discussion

Despite difficulties in active case finding and screening, the number of acutely malnourished was higher than expected. The initial assessment and the surveillance did not indicate the importance of malnutrition in the Syrian IDP and host community. This can be partly explained by the large proportion of infants younger than 6 months amongst admissions, as these generally are excluded from screening and community assessment.

Reasons for acute malnutrition in infants appear to be a low rate of breastfeeding, lack of clean water, lack of resources to buy infant formula milk and physical exhaustion of the mother. Treatment of malnourished infants works in the short term, but after discharge from the inpatient ward, a dilemma arises. MSF did not supply infant formula for use at home, but the families would face the same difficulties with feeding their babies as an alternative referral or support system was lacking. MSF actively lobbied other agencies for such support but none was forthcoming. Overall MSF recognised the importance of breastfeeding in these circumstances and organised breastfeeding promotion and individual support as much as possible given the challenging circumstances.

Despite concerns about the general food security, this did not manifest itself in the nutritional state of older children or the general population. However, it was quite visible in very young age groups, who need high quality foods, including a source of milk or other foods of animal origin.

As food security and dietary diversity is low and there are no signs of improvement, MSF

considered blanket selective feeding for all children, as well as improving hospital food and lobbying for more food aid and humanitarian support. However two major constraints hampered implementation of these activities. Tal-Abyad is situated in a rebel controlled area in the north of Syria. This meant denial of regular cross-line support through UN coordinated food aid or nutritional support as this needed government permission. Importation of foods by MSF was not straightforward either. Furthermore, a significant security event involving MSF staff meant that expatriate staff were physically withdrawn from Syria in February 2014; this meant that new programme elements, like the roll out of breastfeeding promotion and support, could not be properly implemented.

Conclusions and recommendations

The Syrian context is relatively new for MSF, therefore we would like to share some lessons learned. In the immediate term, to address the needs and challenges we have identified, we consider that:

There is an urgent need for unrestricted access to people in need throughout Syria and unhindered cross border activities.

- Nutrition assessment and surveillance systems should include infants younger than 6 months, and be alert to potential changes in the under one year age group.
- There is an urgent need to supply infant formula to babies whose mothers have not been breastfeeding and therefore have a limited or lack of milk supply, and who are unable to afford or find infant formula for their babies.
- Medical professionals should be trained on breastfeeding to help educate pregnant women and to provide skilled support to establish breastfeeding and overcome difficulties. There is a need to explore the use of medications to assist women in increasing their milk supply. Strengthened individual support should be complemented by a breastfeeding community awareness campaign focusing on the need to breastfeed exclusively for the first 6 months of age, targeting not only mothers but their families and the community.
- Management of acute malnutrition (likely requiring training), vaccination and targeting the top three illnesses should be integrated into normal paediatric health care structures.
- Blanket selective feeding programmes providing high quality foods to young children and PLW and better quality general food distributions could prevent further deterioration of the nutritional status.

The MSF programme in Tal Abyad has been closed since May 2014; leaving very few agencies addressing malnutrition in Northern Syria. There is an urgent need for others to secure access and step up their nutrition support activities in Northern Syria.

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MUAC measurement in an infant

Anon, Northern Syria, 2014

Coordinating the response to the Syria crisis: the southern Turkey cross border experience

This views piece was developed by the ENN based on eight key informant interviews with donors, UN agencies and INGOs carried out during an ENN visit to southern Turkey in early April 2014, subsequent follow-up by email and meetings with OCHA Geneva and the Global Nutrition Cluster in June 2014. All contributors have seen various drafts but requested to be anonymous.

Note that this views piece reflects the experiences up to April 2014 (with some updates related to UN Resolutions). Other developments in the coordination mechanisms may have taken place since this time.

Background

The onset of the conflict in Syria, which resulted in the establishment of government and opposition controlled areas (the latter are predominantly in northern Syria), has meant that to date (April 2014), the humanitarian response has largely been administered through two separate and uncoordinated programming approaches¹. Firstly, humanitarian agencies based in the Syrian capital Damascus, work through the consent of the Syrian Government and with the Syrian Arab Red Crescent (SARC). Secondly, agencies administering services into northern Syria do so largely through programming planned and coordinated from southern Turkey. This is referred to as the cross border programme² and was initiated in the early months of the crisis by a number of diaspora Syrian based agencies and international non-governmental organisations (INGOs) with support from a small number of humanitarian donors. The coordination experience from the cross-border programme has highlighted a number of lessons learnt and challenges for the humanitarian sector. Coordination and planning for nutrition programming, in particular, appears to have been a casualty of some of these challenges. This is the main focus of this views piece.

Coordination in the absence of a cluster mechanism

Within Syria, the Damascus based UN agencies opted for sectoral coordination with UN cluster lead agencies working with a government co-lead. For nutrition, UNICEF as the cluster lead agency has been 'double hatting' providing technical input, as well as a crucial coordination role. In the opposition controlled areas of Syria however, there has not been any official UN co-ordination presence. In southern Turkey, the national and INGOs involved in the cross border programme established a coordination mechanism known as the NGO Forum, which shared information as best it could between operational agencies (largely INGOs). A joint rapid assessment mission into northern Syria (JRAM) carried out in January 2013 was an NGO Forum led initiative. The formation of the Assistance Co-ordination Unit (ACU)³ in November 2012

brought another prominent player in cross-border programming and it was hoped that this structure would take on operational coordination. However, a number of internal challenges prevented ACU from taking on this role. In addition, OCHA arrived in southern Turkey in February 2013 with a mandate to promote coordination of information management and needs assessments of the cross border programme. This engagement led gradually to the establishment of IASC⁴-like coordination mechanisms. The efficacy of this mechanism was challenged by the lack of cluster activation in Syria at that time, the constraints faced by UN agencies for their direct involvement in a response that was clearly opposed by the Syrian Government, as well as a lack of buy-in by INGOs to coordination by a UN agency (OCHA) that was not itself operational in the cross-border programme. Despite these challenges, there was an increased call for more coordination, in particular between programming from Syria and programming across the southern borders of Turkey into northern Syria.

To date (April 2014), UN agencies present in southern Turkey have largely (with some exceptions and to varying degrees) had to operate an information 'firewall' system between their cross border coordination work and their operations based in Damascus. There were two main reasons for this. The first was the risk of the Syrian Government finding out about UN cross-border activities from southern Turkey, which could jeopardise their work in Government controlled areas of Syria, i.e. the Syrian Government may place restrictions on UN agencies working both sides of the divide or even stop their activities altogether. The second was the potential risk to programming activities and staff involved in the cross-border programme if information was shared with Damascus based programming staff and government counterparts⁵.

The UN therefore effectively adopted an 'indirect support' modus operandi for southern Turkey. OCHA in coordination with global cluster lead UN agencies, INGOs and donors, set up working groups for each sector. Most of

these working groups were co-chaired between INGOs and UN agencies or cluster representatives (without cluster activation) and the majority of them had dedicated coordinators, funded by donors, to chair and steer the group's work. The working groups replaced the NGO Forum and provided a far more effective space for technical coordination within sectors – especially around information sharing and certain elements of operational coordination. The membership of the working groups was extended to cover a wider range of partners, including Turkish and Syrian NGOs which fed into a broader coordination architecture, including an inter-sector working group, as well as a strategic, decision-making body with key representatives of the humanitarian community to provide overall leadership for the response.

However, major challenges remain due to the absence of an official mandate for stronger UN operational involvement⁶. As a result, UN agencies provide support and guidance on humanitarian standards, training and planning of humanitarian programmes in support of NGO operations. WFP, in particular, has managed to use its regional hub in the capital of Jordan, Amman, as a forum for information sharing, thus overcoming to some extent the firewalling constraint⁷. According to many stakeholders in-

¹ See later for updates in this regard with respect to UN Resolution 2165.

² At the time of writing, programming across other borders, such as from Iraq and Jordan, existed but at much smaller scale and are not covered in this views piece.

³ Created in November under the initial leadership of Suhair al-Atassi, a vice president of the National Coalition for Syrian Revolutionary and Opposition Forces

⁴ Inter Agency Standing Committee

⁵ Some INGOs have also adopted a similar approach, i.e. basing themselves in Damascus and not implementing cross-border programming.

⁶ This situation has changed since the adoption of Resolution 2165, later in this article and footnote 9.

⁷ Subsequent and further actions by WFP to coordinate and align cross border and cross line operations following Resolution 2165 are shared in an article in this 48th edition of Field Exchange. Of particular note, all WFP operations in Syria, whether cross border or cross line, are now planned from Damascus.

interviewed during the course of the ENN visit, this has resulted in better 'gap' analysis by WFP, its implementing partners and the food security sector in general. The lack of operational involvement of the UN in southern Turkey for the cross border programme has meant that implementing agencies do not have access to financing mechanisms such as the Emergency Response Fund (ERF) or stocks of non-food items (NFI) and medicines. Furthermore, the absence of the cluster mechanism has also meant that there is no agency identified in the role as provider of last resort – a key feature of the IASC cluster mechanism and important to ensure accountability to both beneficiaries and to donors.

There are ongoing tensions for many agencies working on cross-border programming who believe that OCHA and the UN agencies could have operated more effectively. One view is that OCHA interpreted its role as one of reporting information rather than coordinating the meaningful assessment and analysis of information and the mapping of key gaps to ensure more equitable access to food and non-food assistance. An opposite view from within the UN family is that the refusal of many INGOs to share information with the UN has made it impossible to do meaningful assessments and analysis. Whilst NGOs have been advocating for better coordination, there have been sensitivities and dynamics with OCHA that have continued to constrain strengthened coordination. To some degree, personality clashes have been a part of this problem yet other sectors, notably education, food security and child protection have done well, highlighting that sectoral coordination with concomitant donor support can lead to enhanced coordination even in the most challenging situations. This, however, has not been the experience thus far with the nutrition sector.

The 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 border⁸. As a result, there have been examples of duplication of aid where the so called cross-line programme into northern Syria has been implemented in areas where NGOs operating from southern Turkey have already worked. In addition, there are also concerns that areas exist where both the cross-line and cross border programme have not reached areas in need.

The passing of UN Resolution 2139 in February 2014 raised expectations about greater freedom to share information amongst all stakeholders, as well as opening up more border crossing points from southern Turkey. However development in this regard needed the subsequent Resolution 2165⁹ – considered a "breakthrough in efforts to get aid to Syrians in need"¹⁰ – with the first UN convoy which crossed into Syria from Turkey through the Bab al-Salam border crossing on 24th July 2014. Food, shelter materials,

household items and water and sanitation supplies for approximately 26,000 people in Aleppo and Idleb Governorates were transported. The Syrian authorities were notified and more convoys anticipated. Nonetheless, at the time of interviewing (April 2014) there was still considerable mistrust between INGOs working in southern Turkey and the UN agencies. Although INGOs and donors understood why the UN agencies have operated in the way they have, there is constructive criticism about how they could have combined the maintenance of their 'safe' position in Damascus whilst working more effectively with agencies in southern Turkey. This has been referred to as the 'anonymisation of the response' and links to a widespread view that the UN agencies could have reached out more to INGOs, found better ways to share information (perhaps using the WFP regional hub model) and also connected more fully with Syrian NGOs working cross border. Syrian agencies are increasingly becoming involved in the working groups but this greater engagement has been a slow process. There is also a strong view amongst the donors and INGOs interviewed that as the UN is non-operational, their legitimacy for coordination is intrinsically diminished and that the UN should have been clearer from the start about what they could, or could not do. INGOs and donors have therefore been lobbying to have an INGO co-chair on the inter-sectoral working group in order to strengthen operational coordination. However, OCHA have been unable to grant this request as this arrangement would not be in line with IASC guidelines.

Nutrition sector coordination and leadership

Many actors working in southern Turkey are of the view that there has been an absence of leadership around nutrition programming and coordination. This has meant that there has been a lack of thorough sectoral analysis of the main nutrition problems faced within Syria and amongst the refugees. Added to this has been the limitation of the global benchmark for defining a nutrition emergency, which requires high or increasing levels of GAM for funding to be activated. In essence, donors wanted to see a higher GAM before agreeing to a dedicated nutrition working group and programme of funding. Whilst there are examples of low GAM and nutrition cluster activation in emergencies such as Haiti and the Philippines, the donor focus in the Syrian crisis has been largely confined to other sectors such as WASH (water, sanitation and hygiene) and child protection. There is no doubt that the Syrian crisis has lacked a well-articulated and coherent analysis of nutrition risk and needs and this has constrained the level of attention to the sector.

Between September 12th and 20th 2013, the GNC undertook a scoping mission to "assess the nutrition context and potential nutrition information-sharing mechanisms within the humanitarian response for northern Syria". It was undertaken by a two person team – one member of the GNC Rapid Response Team (RRT) and a nutritionist seconded from an

INGO. It was prompted by a lack of information and data about 'nutrition in emergencies' programming in northern Syria and by concerns regarding lack of understanding regarding infant and young child feeding (IYCF) in this context. It identified that coordination on nutrition needed to be enhanced, with particular emphasis on IYCF. Suggestions were made regarding potential coordination structures and systems. Subsequently, from mid December 2013 to mid-Feb 2014, a GNC RRT member (hosted by an INGO) was deployed "to provide coordination, technical and information management support" on nutrition to the cross-border Turkey based operation. Whilst inroads in raising the profile and engagement on nutrition between agencies was reported,¹¹ the profile of nutrition remained hugely constrained and was essentially short lived given the short term nature of the deployment. The mission placed considerable emphasis on IYCF (particularly breastfeeding support) as a priority issue for response and the need for a nutrition survey to establish whether acute malnutrition was a problem. Many stakeholders disagreed with these recommendations and also felt that the three month period should have resulted in more robust nutrition data and analysis to inform programming.

The absence of nutrition data in northern Syria has been a constant anxiety for implementing agencies that are aware of high levels of food insecurity and lack of access to health care and clean water for many internally displaced people and in the besieged areas. A nutrition sub-group has recently been set up as part of the health working group for the cross-border programme and is working to provide the analysis and programming recommendations needed for the nutrition sector. However, there are very few agencies involved directly in nutrition programming and added to this, the absence of a UN agency presence in the nutrition sub group has reduced the level of authority typically needed to influence donor financing allocations and their response.

A question is raised as to how, in a 'level 3' emergency, which is in its fourth year, there is not a standalone nutrition sector working group in southern Turkey with a lead agency providing credible assessment and analysis of the overall nutrition situation. There is also a related question as to why the GNC was not enabled to sustain a presence in southern Turkey in order to provide coordination for nutrition analysis and operational planning for the cross border programme.

⁸ See footnote 7

⁹ Resolution 2165, unanimously adopted by Council members on 14 July, authorised the United Nations and our partners to use routes across four additional border crossings with Turkey, Jordan and Iraq. The resolution also authorised the establishment of a monitoring mechanism to confirm the humanitarian nature of supplies brought through those crossings points. Available at: <http://unscr.com/en/resolutions/2165>

¹⁰ Under-secretary-general for humanitarian affairs/emergency relief coordinator Valerie Amos, executive director of the WFP Ertharin Cousin and Executive Director of UNICEF Anthony Lake, Statement on Security Council Resolution 2165 on humanitarian access in Syria.

¹¹ GNC End of Mission Report (Feb, 2014)