Vulnerabilities among VOC settlements in Jordan amid the spread of the COVID-19 outbreak

Introduction

The purpose of this brief is to provide insight on how the vulnerable out-of-reach communities (VOC) in Jordan can be affected by the proliferation of the COVID-19 virus. REACH has been present in Jordan since 2012, supporting humanitarian response on the refugee influx. This brief will use findings from the latest REACH multi-sector needs assessment (MSNA) from March 2020 (not yet published) to understand VOC vulnerabilities in relation to COVID-19. As part of this MSNA, all available households (HHs) were assessed in every identified settlement across the country. In addition, for each settlement field teams conducted two key informant interviews (KII) with individuals knowledgeable about the situation for the population living in the settlement. One KII was conducted with a male member of the settlement, and another with a female member. In total, the MSNA surveyed a total of 2,435 households (HHs) and 653 key informants (KI). The breakdown of the distribution of HHs by nationality and governorate can be seen in Table 1. The sectors found to be more vulnerable to COVID-19 outbreak are migration and livelihoods, food security, health and water, sanitation and hygiene (WASH).

Table 1: Distribution of HHs in VOC settlements by nationality and by governorate[1]

Governorates	Syrian	Pakistani	Egyptian	Palestinian	Yemeni
Mafraq	1,173	7	1	-	-
Irbid	381	23	-	-	-
Balqa	259	29	4	-	1
Karak	212	23	-	-	-
Amman	151	5	-	-	-
Madaba	67	1	-	-	-
Zarqa	52	-	2	-	-
Aqaba	28	-	-	-	-
Jerash	9	-	-	3	-
Ma'an	5	-	-	-	-
Total	**2,237**	**88**	**7**	**3**	**1**

Migration and livelihoods

According to the results of the REACH 2020 MSNA, a vast majority (98%) of HHs reported generating income within the agriculture sector. Based on the MSNA findings, 22% of HHs reported that they intended to move within the next year (n=532), and the highest majority of these (73%) stated that they would be moving in the spring time (March-June). The main reported reason for migration was to seek employment opportunities (92%). On March 21st 2020, the Jordanian government issued a nationwide curfew, which is expected to last at least until the 15th of April 2020.[2] This curfew prohibits any movement between governorates, with public transport being postponed. These restrictions directly affect the migration patterns of HHs, limiting their ability to find new livelihood opportunities and potentially leading to debt increases as well as extreme livelihood coping strategies. Particularly, the governorates that are more vulnerable to these movement restrictions are: Karak, where 220/235 HHs moved at least once within the past one year prior to the assessment, followed by 247/293 HHs in Balqa and 83/100 HHs in Jerash.

[1] Table extracted from REACH MSNA on VOC report, March 2020, unpublished. No VOC settlements were identified in the governorates of Tafileh and Ajloun.
[2] https://jo.usembassy.gov/covid-19-information/

According to the MSNA report, the majority of HHs (80%) reported daily labour to be one of their primary sources of income. The nation-wide curfew prohibits people from leaving their homes except in extreme circumstances.[2] This may prevent HHs from carrying out their income generating activities, if their location of residence is not tied to their labour, although the majority of HHs generate income through agriculture in small farms and their location of labour is linked to their residence. Those who do not live on their farms require a permit to access them, and these are not widely distributed.[3] This barrier to access farms is most prevalent in the governorates of Mafraq and Irbid, where in Irbid there is a full lockdown, and a high number of farmers usually commute to Mafraq from Irbid for work.[3] Even though the majority of HHs live near their farm, restrictions on movement may affect HHs ability to access markets to sell their produce, further affecting their income generating opportunities. Therefore, HH income is expected to decrease and expenditure/debt on basic needs is expected to increase. In addition, increase in health/hygiene expenses amid the COVID-19 outbreak may also increase debt accumulation, which is already wide-spread in VOC (reported by 88%, with an average of 949 JOD). It is important to also note that 53% of HHs reported cash assistance from charities, NGOs or the UN as being one of their main sources of income, and it is crucial that this assistance continues during the COVID-19 outbreak.[4] A significant proportion of non-Syrian HHs (92/99 HHs) are not registered with UNHCR, and therefore are less likely to receive food/cash assistance. Moreover, the movement restrictions across Jordan and its border have jeopardised the continuation of international aid. After the government announced a national emergency, aid organisations suspended or slowed their programmes that were not directly healthcare/sanitation related.[5] Furthermore, several organisations have relocated their funds to emergency pandemic operations.[5] Without additional preparations or support, this strategy could have a negative long-term effect on the sustainability of refugee programmes in Jordan.

Food security

Due to the limitations on movement and the potential barriers to carry out daily labour activities, food insecurity is likely to increase during the COVID-19 outbreak. In the MSNA report, store/market bought food was one of the main reported sources of food for HHs (96%). Although small shops and markets remain open during the nation-wide curfew, the prohibition on public transport and private vehicles will make them harder for some HHs to access regularly, particularly those living in rural and hard-to-reach areas.[2] In addition, most refugees are not economically stable enough to stock supplies during a lockdown.[5] After travel restrictions were announced, an immediate spike in food prices occurred, although the government has tried to ensure price ceilings.[5]

Due to the likely increases in debt, HHs will most likely resort to more extreme coping strategies. It can be assumed that HHs will reduce the frequency of food consumption per week, either because food sources are too far away or in order to save money/resources. Before the start of the COVID-19 crisis, 30% of HHs had borderline or poor Food Consumption Scores (FCS), and this figure is likely to rise. Moreover, according to the MSNA, 54% of HHs reported having a sub-optimal diet (in which five or less food groups are consumed) before the start of COVID-19 outbreak, and this figure is likely to increase as HHs opt for a more restricted diet to save money, or are not able to afford different food groups.[6]

[3] Rapid Food Systems Assessment, Food and Agriculture Organization, March 31, 2020, Jordan
[4] https://www.jordantimes.com/news/local/unhcr-monthly-cash-assistance-refugees-jordan-continues-%E2%80%94-representative
[5] https://reliefweb.int/report/jordan/refugees-risk-jordan-s-response-covid-19
[6] The sub-optimal diet refers to the dietary diversity score (DDS), a global indicator of the quality of food consumption. Dietary diversity is the sum of the number of different foods or food groups consumed by a HH over seven days. DDS categorizes HHs as consuming a "sub-optimal" diet when five or fewer groups are consumed and an "optimal" diet when six or more groups are consumed.

A commonly reported way of maintaining access to food was through borrowing from friends/relatives (42%). Due to the new movement restrictions and increasing unemployment, this coping strategy is predicted to become harder to employ, and instead, relying on less preferred/expensive food is expected to increase. In addition, reducing food consumption is likely to be employed by more HHs because of increased inaccessibility of food due to distance, inability to visit friends/relatives to get food and overall increases in debt.

With the potential increase in food insecurity, livelihood-based coping strategies are more likely to become extreme in order to deal with the shortage of food. Before the COVID-19 outbreak, 85% of HHs were using some form of coping strategy in the light of food shortage (51% stress and 34% crisis – see Table 2 below). This pattern was seen in most of the governorates. It is likely that there will be an increase in coping strategies that do not include social interaction or movement. These may be: spending savings, buying food on credit and reducing essential non-food expenses. Although these are not classified as emergency coping strategies outside of the COVID-19 context, they may become the only means of coping and, therefore, become the most extreme way to survive in a socially restricted setting.

Table 2: Livelihood coping strategies used by HHs over a 30-day period prior to data collection[7]

Livelihood-based Coping Strategies		%
Stress Coping Strategies	Spent savings	15%
	Sold household assets	9%
	Bought food on credit or borrowed money to purchase food	72%
Crisis Coping Strategies	Sold productive assets	4%
	Reduced essential non-food expense (e.g. education/health)	22%
	Sent children to work	12%
Emergency Coping Strategies	Taken jobs that are high risk, illegal and/or socially degrading	0%
	Sent child household members to beg	0.1%
	Sent adult household members to beg	0.1%

Health

Access to healthcare

The main reported healthcare facility accessed by HHs before the COVID-19 outbreak were pharmacies (65%) across all nationalities (except for Egyptians). This figure is likely to increase as pharmacies are widespread and remain open during the curfew, while other popular health-care facilities (public and private) become unattainable due to restrictions on movement or unavailable due to temporary suspension.[2] Healthcare is likely to become more difficult to access during the COVID-19 crisis due to 1) HHs having a lower income and therefore reducing expenses on non-food essentials, as well as accumulating debt for food rather than other non-food essentials such as healthcare, 2) longer distances travelled on foot to healthcare facilities due to prohibition of public transport and private vehicles. In addition, healthcare facilities may become overwhelmed with COVID-19 patients, and therefore make it more difficult to access other types of essential healthcare such as maternity care. Without access to healthcare facilities amid the COVID-19 outbreak, more pregnant women may give birth at home without skilled attendance and essential care, increasing the likelihood of labour, postpartum and post-natal complications.

[7] Table extracted from REACH MSNA on VOCs report, March 2020, unpublished

In addition, the MSNA reported that most VOC settlements (92%) were within a 10-km distance from primary health services. It is important to note that these distances may increase during the COVID-19 outbreak, as it is unclear whether the above MSNA reported distances were that of pharmacies or other health-care services that have become difficult to access during the curfew. Moreover, before the COVID-19 outbreak, the main barrier to access healthcare was the cost (81%). In the MSNA report, 67% of HHs were in debt to cover health expenses. The financial pressure on HHs during the epidemic is likely to exacerbate this problem.

Health problems

Prior to the COVID-19 outbreak, 67% of KIs reported numerous cases of respiratory diseases in VOC settlements. Respiratory diseases were the most prevalent health problem across all governorates. The highest of these cases were in Karak, reported by 60/64 KIs, followed by Zarqa (86/95 KIs), Balqa (74/95 KIs) and Amman (52/74 KIs). HHs in these governorates are particularly vulnerable during the COVID-19 outbreak as respiratory conditions can exacerbate the effects of the virus. In addition to this factor, underlying health conditions, such as chronic illnesses are a risk factor for developing severe cases of disease, thus increasing mortality rates. In the MSNA report, 37% of HHs had at least one member with a chronic condition. Across governorates, Balqa had the highest proportion of HHs with chronically ill individuals (131/293 HHs), followed by Karak (91/235 HHs) and Amman (60/155 HHs).

WASH

Access to water

Not only is water an essential life source, but is also essential in up-keeping adequate hygiene standards needed to prevent the spread of COVID-19. According to the MSNA report, the three governorates that had most difficulties in accessing water were Irbid (130/404 HHs), Mafraq (198/1,181 HHs), and Balqa (68/293 HHs). The reported reasons behind this were: not having enough containers to store water (34%), water being too expensive (33%) and difficulty with transporting water (25%). Access problems, particularly related to costs, are likely to increase, as incomes may decrease in HHs. This can result in HHs not having regular access to water, or drinking unsafe water, which can lead to water-borne diseases and an increased risk of COVID-19 transmission. Governorates most at risk of the latter are Mafraq, where 170/1,181 HHs reported unacceptable drinking water, followed by Balqa (60/293 HHs), and Irbid (50/404 HHs). Before the COVID-19 outbreak, 6% (n=135) of HHs reported they did not have access to drinking water for 5 days or more over the past month prior to the MSNA assessment. The governorates with the highest cases were Mafraq (73/1,181 HHs), Irbid (23/404 HHs), and Balqa (15/293 HHs). Due to a likely increase in water access barriers during the epidemic, more HHs are likely to have days without drinking water, with the most vulnerable to this issue residing in the governorates mentioned above. Drinking unsafe water, staying without water or buying water with debt are the coping mechanisms that are most likely to increase, as the other popular strategy used before the COVID-19 outbreak -borrowing water from family/neighbours- is more difficult to carry out during movement restrictions.

Hygiene

Pit latrines without a slab/platform were the most common type of latrine reported by HHs in the MSNA report (45%). Without a slab/platform, pit latrines pose a higher risk of HHs getting infected with the COVID-19 virus, as there is an increased chance of transmitting faecal-oral transmitted diseases[8], with COVID-19 potentially being one of them[9], but

[8] https://www.open.edu/openlearncreate/mod/oucontent/view.php?id=207&printable=1

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7130192/

still unknown[10]. In addition, 43% of HHs reported using communal toilets, and from these HHs (n=1,061), 13% reported sharing communal toilets with more than 20 individuals, falling outside the SPHERE standard of maximum 20 people per latrine.[11] Crowding in unsanitary environments increases the risk of COVID-19 spread and transmission.

Overall, most HHs (98%) had access to soap. The remaining 2% (n=48) stated that soap was too expensive or that they did not need soap. With the rise in debt, if HHs are not aware of the importance of washing hands to prevent the spread of COVID-19, they may opt to leave soap out of essential spending in order to have more money to buy food/water. Therefore, it is important to provide soap and hygiene awareness to HHs during the COVID-19 outbreak.

Conclusion

This brief has highlighted the sectors that are the most vulnerable to the spread of COVID-19, which is likely to severely effect VOC. Since this population is critically vulnerable due to their lack of infrastructure, such as water and sanitation facilities, humanitarian aid actors are urged to pay particular attention to these communities. Some key conclusions from this brief are:

- Restrictions on migration across governorates significantly prevents VOC HHs from finding income generating opportunities.
- A significant proportion of non-Syrian HHs are not registered with the UNHCR, and therefore may face a higher risk of not receiving food/cash assistance. It is important to include these HHs in service provision.
- HHs in Karak, Zarqa, Balqa, Amman and Aqaba reported having the highest cases of respiratory and/or chronic illnesses, and therefore are at a higher risk of COVID-19 cases developing into severe stages. HHs that reported pit latrines without a slab/platform and communal latrines are at a heightened risk of transmitting and getting the COVID-19 virus.
- Across all governorates, food quality and amount of consumption is likely to decrease, while debt per HH increases, due to the national lockdown preventing livelihood generating activities.
- HHs particularly in Irbid, Mafraq and Balqa reported having difficulties accessing water. Without WASH assistance, their likelihood of COVID-19 infection increases.

[10] https://www.cdc.gov/coronavirus/2019-ncov/php/water.html

[11] The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, 2018.