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Foreword



Photo credit: WHO/ Rural Damascus

A doctor operating on a baby with light from a mobile telephone.

A girl severely burned in a massive explosion.

Government-controlled or contested areas; urban or rural: contexts vary, but stories converge.

The year 2013 was marked by the unprecedented suffering of the Syrian people, with more than a third of all Syrian families affected by the continuing crisis. The number of people injured and disabled in the conflict continued to rise. Those not directly wounded also suffered the conflict's harsh effects. The disruption of the health system and greatly reduced access to health services, meant that many people were unable to receive essential medicines to treat chronic diseases such as diabetes, cancer or high blood pressure. Almost three quarters of the country's hospitals have been damaged, and almost half of those have ceased to function altogether.

The breakdown of public health programmes was dramatically illustrated by the re-emergence of polio in Syria, which had been polio-free since 1995. With safe water supplies one third of pre-crisis levels, thousands of people have been exposed to diarrhoeal diseases. With deteriorating food security, the population's nutritional status and resilience have declined. The physical and mental health impact of the crisis will be felt for generations to come.

We cannot wait for the conflict to end before addressing the devastation to Syria's health care system.

Only innovation, flexibility and tenacity will allow us to tackle obstacles in a sustained and strategic manner.

Together with its partners, WHO has adopted approaches to ensure immediate results and promote long-term sustainability. These efforts include training local organizations, establishing a network of national NGOs to deliver essential health care, and strengthening disease surveillance at all levels.

WHO's work monitoring and responding to communicable diseases serves to illustrate progress made. WHO has worked closely with diverse stakeholders at community level to enhance disease surveillance. Thanks to these efforts, the Early Warning and Response System (EWARS) is gaining momentum. Over 441 surveillance sites throughout the country are now reporting regularly through EWARS. Almost one third of these sites are in opposition-controlled areas. EWARS covers the entire population: the young and the old, the internally displaced, refugees from neighbouring countries, and local communities. Through EWARS, rapid response teams have managed to avert or contain outbreaks of acute jaundice syndrome, measles, typhoid fever, polio, bloody and acute watery diarrhoea, hepatitis A and brucellosis, potentially saving tens of thousands of lives.

Thanks to the outstanding support of its donors, WHO and its partners have ensured that millions of Syrians received essential health care in 2013. With continuing donor support, we can do more, and do it better. Through targeted public health interventions designed to ensure equitable access by all segments of the population, WHO is serving the Syrian people in both the short and the long term.

Elizabeth Hoff
WHO Country Representative *a.i.*
Syrian Arab Republic



“When the smoke of the conflict dissipates, the international community will discover the extent of the damage to public health, which we will have to deal with for decades to come.”

Dr Ala Alwan - WHO Regional Director for the Eastern Mediterranean

Photo credit: WHO/ Omar Sanadiki/ Al Mouhtahed Hospital/ Damascus

Achievements in 2013

4.6 million people

directly benefited through the distribution of medicines and equipment as well as from health care.

1.5 million people

indirectly benefited through the delivery and distribution of health kits.

1.86 million children

between 6 months and 15 years of age vaccinated against measles, mumps and rubella.

2.2 million children

under 5 years of age vaccinated against polio in all governorates.

Over 2 500 health care workers

trained on the management of communicable and noncommunicable diseases (NCDs), mental health in emergencies, reproductive health and malnutrition, initial clinical management of patients exposed to chemical weapons and health information management.

Over 441 sentinel sites

established throughout Syria, including over 150 sites in opposition-controlled areas after WHO successfully advocated with the Government for the expansion of the Early Warning, Alert and Response System (EWARS) and the distribution of essential medicines and medical supplies in opposition-controlled areas.

Over 70% of health care facilities

throughout the country assessed for damage and functionality.

Development of Syria's Essential Medicines List (EML)

including a Priority List – for 2013, with international and national experts.

7 reported and managed outbreaks

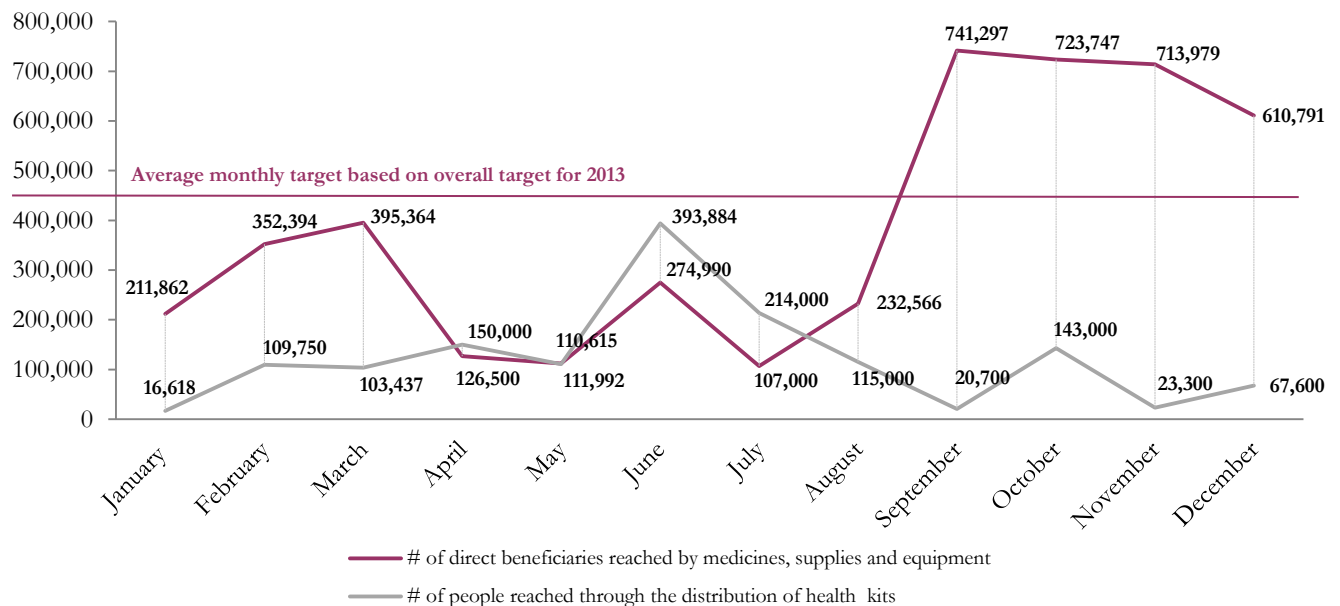
of measles, polio, typhoid fever, bloody diarrhoea, acute diarrhoea (in two different locations) and brucellosis.

9 Health Sector partners

for increased health access and coverage.

Despite serious obstacles in delivering humanitarian aid to contested areas, the medicines and equipment delivered to opposition areas by WHO accounted for almost 15% of all supplies delivered in 2013. A total of 670,400 people directly benefited from these efforts.

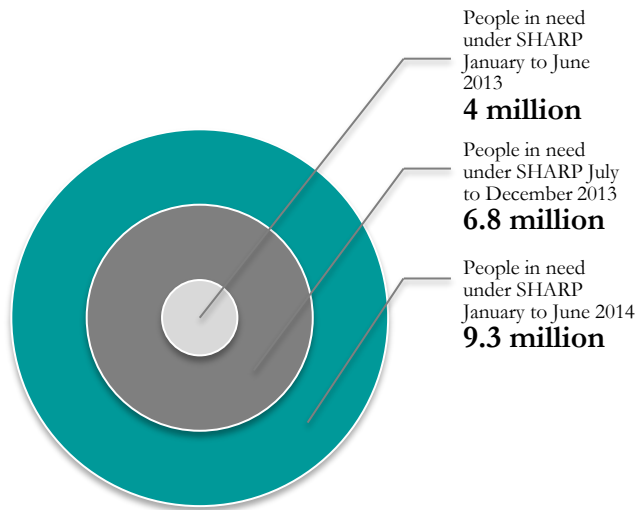
Overview of the number of beneficiaries reached monthly during 2013



The situation in Syria in 2013

1. People in need of humanitarian assistance

The violence in the Syrian Arab Republic steadily escalated during 2013, leading the United Nations' Emergency Relief Coordinator Valerie Amos to describe the situation as "a humanitarian crisis on a scale we have rarely seen"¹. Over the course of the year, the total number of internally displaced people (IDPs) rose from 4.25 million to 5.4 million. The overall number of people in need of humanitarian assistance rose from 4 million to 6.8 million. This number is projected to increase to over 9 million by the beginning of 2014. Since March 2011, more than 100 000 people have been killed and over 575 000 have been injured.



2. Disintegration of the public health system

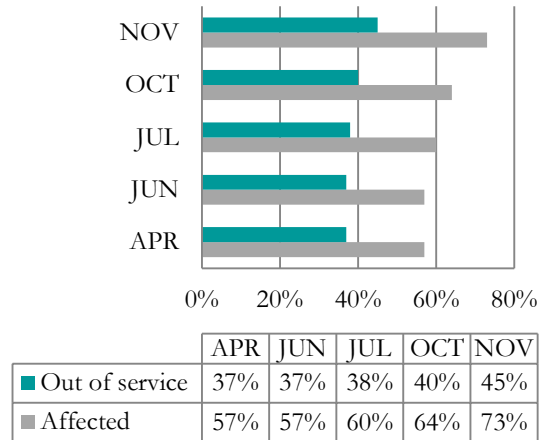
The crisis has disrupted health care services and led to dire shortages of essential medicines, supplies and health care workers, especially those trained in emergency care.

Even when people in need were able to access health services, positive health outcomes were undermined by the effects of protracted stress, suffering and lowered resistance.

By the end of 2013, hospitals and health care facilities had been damaged in 12 of Syria's 14 governorates. The overall percentage of hospitals affected by the crisis rose from 57% to 73%. By December 2013, 45% of these hospitals had ceased to function altogether. Similarly,

¹ United Nations Office for the Coordination of Humanitarian Affairs (OCHA), Under-Secretary-General Valerie Amos, Remarks to the press, Beirut/New York, 6 Sept 2013.

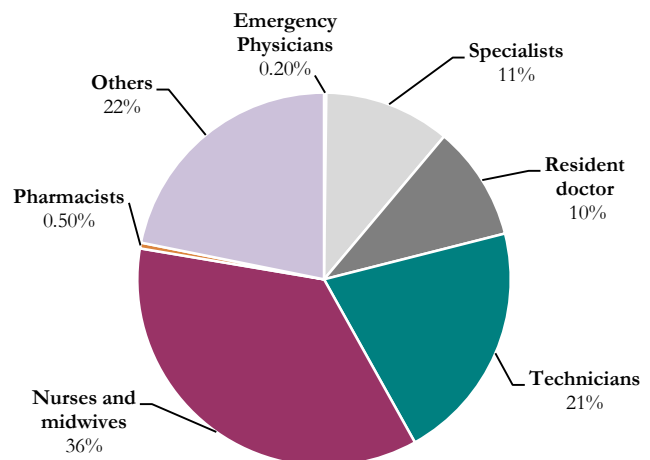
Percentage of hospitals affected and out of service throughout 2013

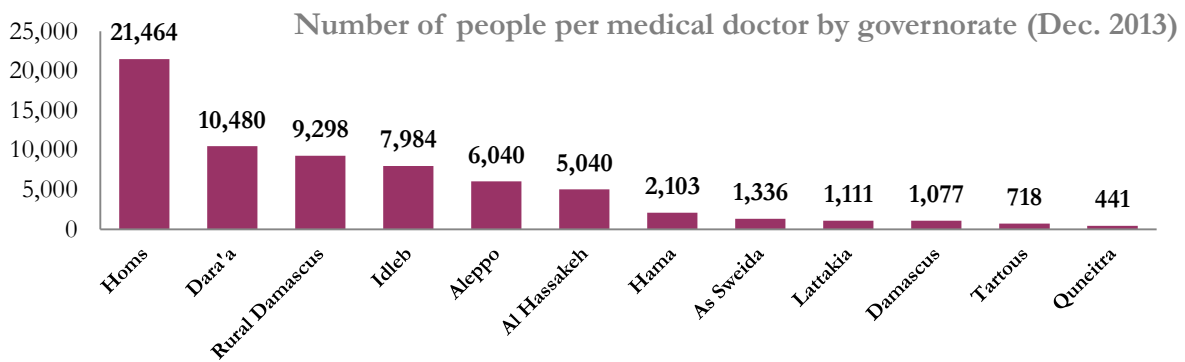


almost one quarter of the country's 1 723 public health care centres were no longer functioning.

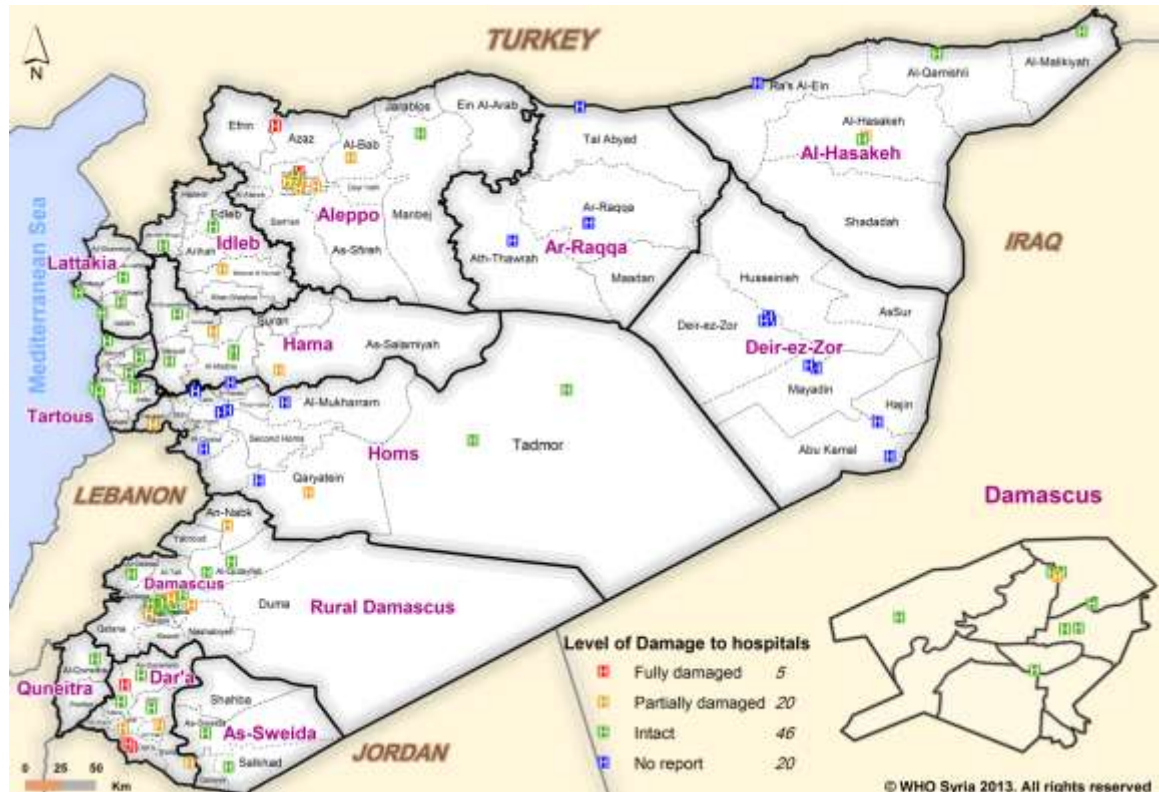
Mortar and artillery attacks, car bombs, hijackings and kidnappings were some of the daily challenges faced by health care workers. Many health professionals left the country, depleting the health workforce in the affected governorates and creating severe shortages in badly-needed health disciplines including trauma care, anaesthesiology and laboratory diagnosis.

Percentage of health staff present in the country by category (Dec. 2013)





Overview of the level of damage to hospitals across Syria

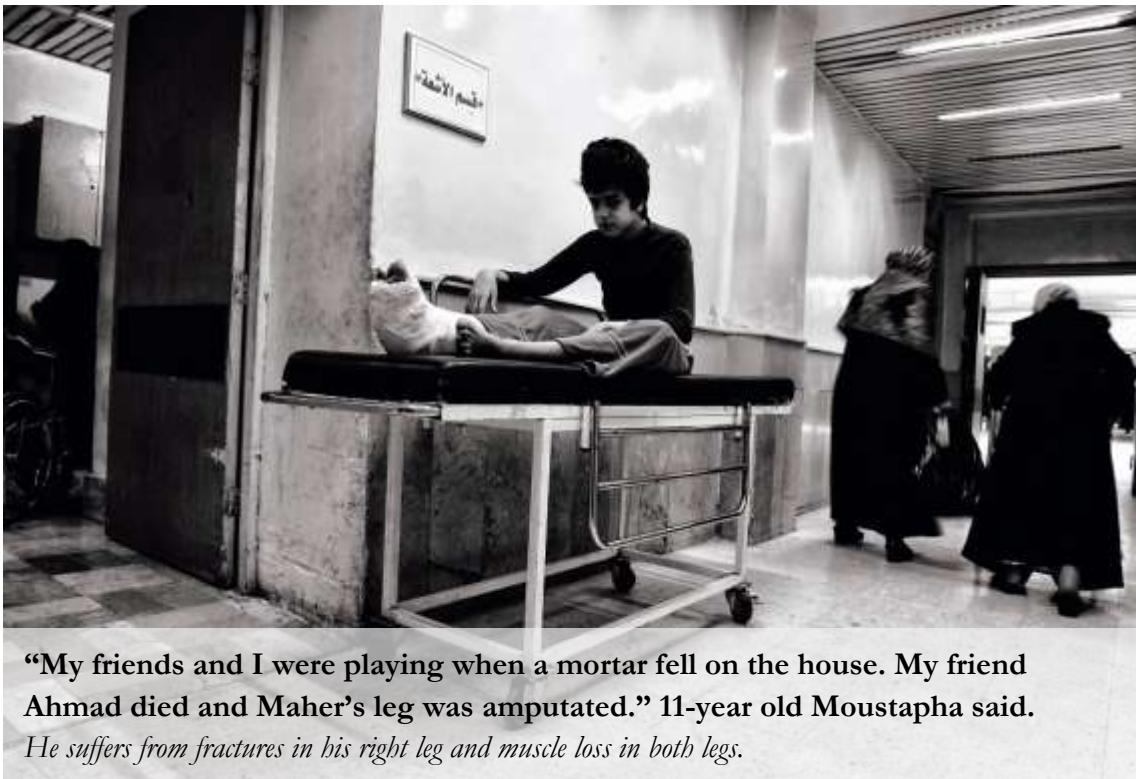


In the northern governorates, there was a notable lack of female staff for reproductive health and sexual and gender-based violence. Hundreds of health care workers were killed or injured. Others were reported kidnapped or missing.

Hospitals were faced with an array of obstacles that severely affected their ability to function, precisely when they were needed more than ever. Lack of fuel and electricity forced many of them to operate at reduced capacity or close altogether. Clean water supplies and proper waste management – both essential to avoid the spread of infectious diseases – were badly disrupted. Critical shortages of essential life-saving medicines and medical supplies left health care facilities unable to meet growing demands.

In pre-crisis Syria, noncommunicable diseases (NCDs) accounted for 77% of all deaths. The rate of complications from NCDs grew considerably in 2013, and inadequate treatment increased the risk of early death. The shortage of medicines to treat NCDs was attributable in part to substantial damage to pharmaceutical plants (before March 2011, 90% of medicines in Syria were produced domestically). This was exacerbated by the side-effects of sanctions for specific medicines²,

² The Ministries of Foreign Affairs, Health and Higher Education have underlined the serious impact of sanctions on the procurement of essential medicines, supplies and spare parts for medical equipment. WHO has invited the Government to submit a formal request to WHO, via the Syrian Permanent Mission in Geneva, for assistance with reimbursable procurement.



“My friends and I were playing when a mortar fell on the house. My friend Ahmad died and Maher’s leg was amputated.” 11-year old Moustapha said.

He suffers from fractures in his right leg and muscle loss in both legs.

“In a bad week we’re seeing up to 100 injured people, but we haven’t been able to treat them adequately because of shortages.”

*Dr
Abdulsalam
Abrash,
Administrative
Director of al-
Amin
Hospital in
Homs*

combined with a breakdown in distribution systems, particularly in heavily affected and/or opposition-controlled areas.

The dramatic devaluation of the Syrian Pound left many people, especially the most vulnerable, unable to pay for health care services. Before the crisis, 51% of the population relied on the private sector, and spent a significant amount on out-of-pocket medicines. The substantial rise (25% - 50%) in the price of medicines that was announced in early 2013 by the pharmacists’ syndicate served to further reduce access to medicines. Prices on the black market rose steeply, leaving medicines beyond the reach of most people, especially in rural areas.

The near-collapse of the national Health Information System (HIS) compromised data collection and led to large gaps in efforts to map the whereabouts of health care providers, as well as patients’ needs.

Many governorates were unable to maintain routine disease surveillance. The worst-affected governorates ceased reporting altogether, greatly increasing the risk of disease epidemics. Vaccination coverage dropped sharply across the country (from 90% before the crisis to 50% in

December 2013), increasing the risk of childhood mortality from vaccine-preventable diseases.

This gradual disintegration of the public health system led to a greater reliance on nongovernmental organizations (NGOs) and charities. However, many NGOs pulled out, citing inadequate funding and security concerns.

3. Worsening conflict: growing health needs

3.1 Trauma care and management

At the beginning of 2013, around 400 000 people required emergency care for trauma-related injuries. Moreover, 50 000 people required surgery, of whom 20 000 needed post-operative hospital care. The number of burn cases was high in 2013, as a result of both the growing violence and domestic fuel accidents. By the end of the year, a total of 575 000 people were reported as having been injured.

Significant damage to the health care referral system meant that many wounded civilians were unable to reach a hospital in time. Some of those who did could not be treated in time due to severe shortages of trauma care specialists and surgeons. This was compounded by a chronic lack of essential medicines including antibiotics,

anaesthetics, serums and intravenous fluids. By the end of the year, over 90% of the country's 520 public ambulances had been damaged, stolen or burned.

A dwindling number of health centres offering basic emergency obstetric care, especially in rural Aleppo, Ar Raqqa, Damascus, Deir-ez-Zor, Quneitra and Tartous, limited women's access to life-saving treatment.

The decreasing quality of safe blood collection, testing, processing, storage and distribution, as well as the insufficient disinfection of dialysis machines, increasingly exposed patients throughout the country to blood-borne diseases such as hepatitis C.

Photo credit: WHO/Omar Sanadiki/ Ibn Al Nafies Hospital/ Damascus



“My sons take care of my medication, but it is hardly available in local markets. Even if they find some, it is tremendously expensive,” 63 year-old Kamal who suffers from deep-vein thrombosis said.

3.2 Primary health care

The high number (6.3 million) of people in need of essential primary health care (PHC) in 2013 was due to many of the factors already described: decreased vaccination coverage, disrupted disease surveillance systems, poor sanitation, and increasing food insecurity.

Reports from children's hospitals and health clinics in Rural Damascus and north-east Syria showed that increasing numbers of children were suffering from moderate and severe acute malnutrition. In Hama, a study of September 2013

showed that 38% of children under five years of age were underweight, 6% were severely wasted, and 19.3% were stunted. According to the Syria Humanitarian Assistance Response Plan (SHARP) for 2013, around 869 500 children under five years of age were thought to need multiple micronutrient supplementation, and another 100 000 were at risk of under-nutrition. Around 300 000 pregnant and lactating women were at risk of micronutrient deficiencies.

3.3. Secondary and tertiary level health care

Approximately 6.8 million people were in need of essential secondary and tertiary level health care. They included 430 000 diabetes patients, of whom 40 000 were insulin-dependent children. Other categories included 5000 patients with renal failure who required regular haemodialysis; over 3500 patients with tuberculosis; 56 000 patients with cardiovascular disease; and 42 000 patients with chronic respiratory disease. There were acute shortages of life-saving medicines to treat all these conditions.

The deteriorating security situation across the country led to more women seeking Caesarean sections rather than natural birth, to avoid the risk of having to travel to health care facilities during the night.

3.4 Communicable diseases

The overcrowded, unsanitary living conditions of many people, combined with the collapse of vaccination and vector control programmes, increased the risk of communicable disease outbreaks. The disruption of Syria's previously well-functioning disease surveillance system resulted in delays detecting disease outbreaks, increasing the risk of their rapid spread.

3.5 Mental Health

A total of 3 million people were reported as requiring psycho-social support or treatment for mental disorders in 2013. The situation was exacerbated by the paucity of hospitals offering mental health care, the lack of mental health professionals, and the scarcity of psychotropic medicines. Based on WHO and internationally accepted projections, it is estimated that approximately 1.9 million people will need treatment for various forms of mental illnesses in 2014.

3.6 Water, sanitation and hygiene

Approximately 2 million people were affected by disrupted water, sanitation and hygiene networks, especially in Rural Damascus, Idlib, Deir-ez-Zor, Homs, Aleppo and Ar Raqqa. Water supply per

capita dropped to one third of pre-crisis levels. Water quality surveillance decreased in most governorates, resulting in a lack of information to guide water quality interventions.

3.7 Health information system (HIS)

Up-to-date health information is vital to guide health interventions and adapt activities to meet evolving needs. The near-total disruption of the HIS badly handicapped health data collection in 2013.

3.8 Rehabilitation and early recovery

Early recovery efforts were difficult to implement, given the continuing, evolving crisis. However, rehabilitation remains a high priority. The most urgent needs include the restoration of operating theatres, burn units and waste management facilities in key hospitals and health care facilities across the country. Rehabilitating public health laboratories is another priority.



Four-year old Fatma was diagnosed with carcinoma (cancer that begins in the epithelial tissues) in mid-2012. She used to receive treatment at Aleppo University Hospital, but the ongoing fighting in the city forced the family to flee their home town and relocate to Jaramana, near Damascus.

“My daughter used to be treated with radioiodine, but the medication is no longer available in Aleppo,” her mother said. “Here in Damascus we regularly go to al-Assad University Hospital but they don’t have the medication either. I don’t know what that means! I just want Fatma to receive her treatment.”

If Fatma does not receive her radioiodine treatment soon, her chances of surviving cancer will be in danger. “I don’t know what I have to do! She is getting worse by the day... I don’t want to lose her,” Fatma’s mother exclaims. “We have not been able to secure her medication for months... The situation is unbearable”.

Thanks to WHO’s intervention, Fatma’s family was able to identify a private source of support and now Fatma benefits from regular treatments.



Photo credit: WHO/Omar Sanadki/ Ibn al Nafees Hospital/ Damascus

Responding to needs: WHO in Syria

WHO's regional strategy for the Syria crisis, falling within the WHO Emergency Response Framework, focuses on five priorities:

1. **Leading and coordinating the health sector**
2. **Providing health information to support the emergency response**
3. **Enhancing access to quality and priority preventive and curative health services**
4. **Strengthening disease surveillance and response**
5. **Providing technical guidance on priority public health issues.**

Using a multi-pronged approach, WHO's strategic interventions in 2013 - complementary to those of its partners - leveraged the Organization's expertise and added value. Interventions were based on needs assessments, and developed for maximum impact and cost-effectiveness while bolstering resilience and building national capacity.

1. **Health sector leadership and coordination**

As the lead UN agency for the health sector, WHO worked with central and local health authorities, other UN agencies, and local and international NGOs and community-based organizations (CBOs) in both government- and opposition-controlled areas. WHO and its partners agreed on joint strategic objectives and work plans, supported by core indicators and unified reporting systems to monitor progress. WHO mapped resources, identified gaps in the health response, and agreed with partners to pool resources and collaborate on joint projects such as the response to the polio outbreak in Syria and neighbouring countries. UN partners included IOM, OCHA, UNDP, UNFPA, UNHCR, UNICEF, UNRWA, ICRC, IFRC, SARC and WHO. NGO partners included IMC and Première Urgence (PU).

The Health Working Group (HWG) -

Emerging health needs were discussed at the HWG's bi-weekly meetings bringing together UN agencies and NGO representatives. Health authorities participated once a month. The HWG reviewed specific requests from the MoH and the MoHE as well as the plans and field reports of each agency for distributing life-saving medicines and supplies through inter-agency convoys. The

EWARS weekly bulletin provided health sector partners with timely information on communicable diseases throughout the country, and helped them plan how to pre-position medicines and supplies in key locations.

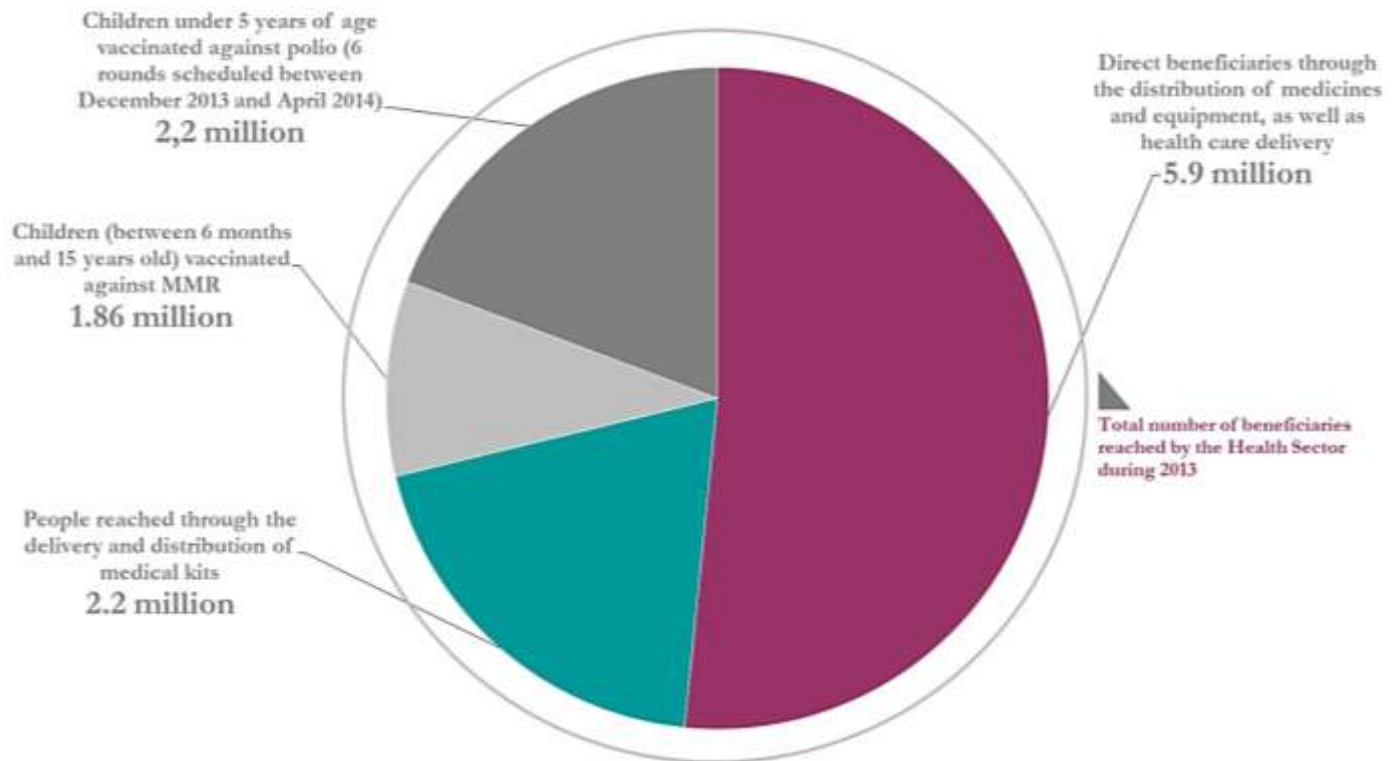
Working with OCHA - WHO revised the "Who Does What, Where and When (4W)" health matrix to allow for more coherence between health activities and those of other sectors. WHO also provided consolidated health information each month to OCHA's 'Dashboard' - a multi-sector monitoring tool that displays the number of beneficiaries reached by each sector. WHO collated information from all health sector partners on damage to the health infrastructure. This information was included in the monthly Humanitarian Bulletin.

Working with local NGOs - WHO worked with networks of local NGOs (36) from 14 governorates of Syria to help them provide PHC and essential secondary level medical care, including trauma care. Through these networks, vulnerable populations that had been difficult to reach were able to access care, sometimes through NGO mobile teams. WHO also established a national network of focal points to monitor activities and assess the health situation in Aleppo, Al-Hassakeh, Ar-Raqqa, Deir-ez-Zor, Dara'a, Idleb, Lattakia, Quneitra, Hama, As Sweida, Rural Damascus and Damascus.

2. **WHO's health information system**

Designing an effective response to a crisis with continuously shifting conflict lines and massive displacements represents one of the greatest challenges for WHO in Syria. Working with the Government, health sector partners, health authorities at governorate level and other UN agencies, WHO's Health Information System (HIS) maps health care needs and service availability, and provides the basis for a comprehensive plan for effective health sector planning and coordination. WHO's Health information system (HIS) maps health care needs and service availability, and provides the basis for comprehensive and effective health sector planning and coordination and more efficient coordination and use of resources. The HIS, backed up by personnel, IT and communication support, includes standardized data collection tools and data processing mechanisms that automatically generate information. These tools have improved strategic decision-making and evidence-based actions, and allowed the health sector to monitor changes, prioritize its response and better allocate

Beneficiaries reached by the health sector across Syria under SHARP 2013



its resources.

Working with health partners, in 2013 WHO conducted quarterly rapid assessments of health facilities. WHO's network of focal points reported on health needs and low and empty stocks of priority medicines. These reports - based on interviews with staff in health facilities and discussions with leaders of local NGOs, CBOs and governorate health authorities - were used to regularly update in-country distribution plans. SARC, ICRC and medical staff of hospitals in Aleppo, Homs and Damascus assessed their capacities for triage and case management. ICRC assessments of trauma care in the two main hospitals in Damascus, as well as in Homs and in Hama, revealed the need to improve supplies and equipment.

HIS results achieved in 2013:

Strengthened management for emergency response - HIS was adapted to strengthen WHO's capacity to respond to emerging situations. A specific tool (Health Resource Availability Mapping System - HeRAMS) was used to identify gaps in the availability of and accessibility to health care resources and services and map them at the health facility level. As a result, 70% of public health facilities were assessed.

Improved information flow between different reporting levels - New data collection mechanisms (e.g., tele-assessments) were introduced to address the shortage of timely information at different reporting levels - from individual health facilities up to the level of the health directorate where accurate information was needed to make strategic decisions. HeRAMS permits tele-assessments from remote areas where accessibility is often a real challenge.

Unified reporting to reinforce the validation and consistency of data - With an increase in the number of reporting facilities, the flow of information and reporting has been streamlined at all levels, and the periodicity of reporting has been standardized (i.e., monthly and quarterly).

Enhanced capacity of national staff - WHO conducted several training workshops to upgrade the skills of more than 50 health staff and statisticians from 12 governorates. Teams of health staff (between two and four persons per governorate) were established and officially approved as emergency cells for HIS reporting. This improved the timeliness and quality of the reported data.



A specific tool (Health Resource Availability Mapping System - HeRAMS) was used to identify gaps in the availability of and accessibility to health care resources and services and map them at the health facility level. As a result, 70% of public health facilities were assessed.

"The ongoing crisis in Syria represents a real challenge to all those involved in providing health services to the people. With the situation changing very rapidly, there was a pressing need for a versatile tool that could identify real-time needs. HeRAMS was suggested by WHO based on its experience with other crises. The implementation results were impressive. HeRAMS has made a difference in HIS development and implementation for better emergency response, as well as improved planning and allocation of resources.

Dr Talal Bakflouni
Planning and International Cooperation Directorate (MoH)

Strengthened coordination and partnership building - WHO worked with its UN and NGO health sector partners to improve the sharing and timely dissemination of information. The interventions of all health partners were mapped by regular Health 4W monitoring. Transparency was reinforced through regular sharing of updates on the impact of the crisis on the public health infrastructure, the functional status of health facilities, and the availability of services and human resources. These efforts enhanced coordination and accountability of the health sector overall and improved its ability to effectively use its resources.

3. Enhancing access to preventive and curative health Services

WHO supported life-saving interventions by providing medicines, supplies and equipment to support trauma management and primary, secondary and tertiary health care services. A total of 6.1 million people benefited from these efforts.

Increasing the availability of essential life-saving medicines - An ongoing lack of essential life-saving medications has greatly affected the capacity of first-responders and trauma care units to perform their work. WHO provided critical support for trauma care (including emergency obstetric care) by procuring and distributing essential medical supplies and life-saving medicines

(anaesthetic agents, antibiotics, IV fluids, albumin, analgesics, anti-pyretics, antidotes, blood products and plasma substitutes and muscle relaxants); medical equipment (defibrillators, ultra-sound machines, oxygen cylinders, portable x-ray machines, ventilators and oxygen generators, anaesthesia machines, ICU beds and operating theatre equipment); and Inter-agency Emergency Health Kits (IEHKs), trauma kits, burn kits and surgical kits.

Effective distribution of medicines - In collaboration with local health authorities, WHO drew up a distribution plan and adapted it to the shifting circumstances of the ongoing crisis. WHO collates information from assessments conducted across the country by its own staff and by other health sector agencies, as well as information provided by partner NGOs and local health authorities. The plan specifies the number of people in need of assistance by governorate/disease and pinpoints which percentage of medicines should go to which hospital, health facility or partner NGO. Since its inception, the distribution plan has proved to be an effective tool for the timely procurement and distribution of medicines, supplies and equipment.



Photo credit: WHO/ Homs

Strengthening the capacity of first-responders

- The steady loss of health professionals across the country called for continuous capacity-building of first-responders. During 2013, a total of 542 health professionals were trained in first aid.

Primary health care (PHC)

Responding to the decrease in vaccination coverage – During 2013, childhood vaccination coverage rates dropped from 70% in January to 50% in December. To counter this decline, WHO met repeatedly with the Syrian Ministry of Foreign Affairs to (i) advocate for more effective outreach and (ii) improve the national vaccination campaign

against polio and measles with 'gap-filling' interventions designed to assist local health authorities in reaching all children in need of vaccination. As a result, an MMR vaccination campaign was conducted in October 2013 that targeted 1 086 218 children between 6 months and 15 years of age.

Strategic collaboration between health sector partners was greatly enhanced during the polio outbreak that was first detected in the Deir-ez-Zor governorate in October 2013. WHO helped develop a multi-country, multi-agency response strategy, with specific micro-plans aimed at vaccinating 23 million children under 5 years of age in the region (of whom 2.2 million were in Syria). In November, 200 vaccinators in Aleppo, Homs and Deir-ez-Zor were trained to administer vaccines and manage their side effects. This enabled them to implement an aggressive house-to-house polio vaccination campaign. Regular supervisory visits conducted by WHO focal points and other health staff in seven heavily affected governorates (Aleppo, Al Hassakeh, Ar Raqqa, Deir-ez-Zor, Homs, Idleb and Lattakia) helped identify gaps in vaccination coverage and develop recommendations for vaccine distribution in settings where security was often unpredictable.

Strengthening the capacity of PHC staff - To improve the quality of PHC and referral services in various governorates. WHO trained health care workers on i) polio outbreak control, including on how to raise awareness (100), polio eradication measures (50), and sample collection (60); ii) severe acute malnutrition (28) and community-based management of acute malnutrition (56 paediatricians); iii) diabetes management (312); and iv) reproductive health (28). By December 2013, 634 health professionals had been trained, improving the quality and quantity of PHC services across the country.

Reaching out to those most in need - In 2013, five mobile clinics were equipped with basic essential medicines, supplies and equipment and donated to three different NGOs identified by the MoH. The mobile clinics improved PHC and referral services for people in the seven most affected governorates (Aleppo, Rural Damascus, Homs, Dara'a, Deir-ez-Zor, Idleb and As-Sweida).

Procuring medicines and supplies - In view of the great lack of essential life-saving medicines and supplies across the country, WHO procured and distributed critically needed medicines, based on the Syrian Essential Medicines List. These included

insulin, cardiovascular medicines, antiepileptics, antibiotics, medicines to treat leishmaniasis (Glucantime), anthelmintic, anti-anaemia medicines, dermatological medicines, and gastrointestinal medicines.

Mental health

WHO's review of the mental health system in Syria revealed there were significant gaps in the availability of mental health and psychosocial support services, as well as a lack of mental health professionals (especially psychiatrists) across the country. In 2013, WHO established and coordinated a forum for active exchange between mental health and psychosocial support professionals from the Government, other UN agencies, and national NGOs.

Representatives from the Syrian MoH, MoHE, Ministry of Education, Ministry of Social Affairs, as well as from UNICEF, UNFPA, IOM, UNHCR, local NGOs, and the Syrian Arab Red Crescent (SARC) attended two workshops in Beirut and Damascus (in October and December respectively) on scaling up mental health and psychosocial support services in Syria. WHO experts with long experience in conflict areas facilitated the workshops and guided participants through the development of 17 recommendations for restructuring the mental health system in Syria.

These recommendations served as a basis for planning and joint decision-making.

1. Raising awareness and strengthening capacities

In crises, people affected by mental disorders often first seek treatment at PHC centres. PHC staff are also the most likely to encounter psycho-social distress in patients seeking treatment for other reasons. WHO organized workshops to raise the awareness of PHC health professionals with regard to mental disorders and psycho-social distress, reduce the stigma associated with these two conditions, and strengthen capacity. Training sessions focused on psycho-social first aid, the principles of psycho-social support, and scaling up mental health support in emergencies.

2. Treatment for people affected by mental disorders

Given the unavailability of psychotropic medicines across the country, patients with common mental disorders suffered daily from worsening symptoms of schizophrenia, depression and anxiety. Throughout 2013, WHO procured and distributed psychotropic medicines in all 14 governorates.

Malnutrition - To respond to an increase in malnutrition, WHO trained 28 health workers in the management of severe acute malnutrition, 56 health professionals in the community-based management of acute malnutrition, and 64

Photo credit: WHO/ Aleppo



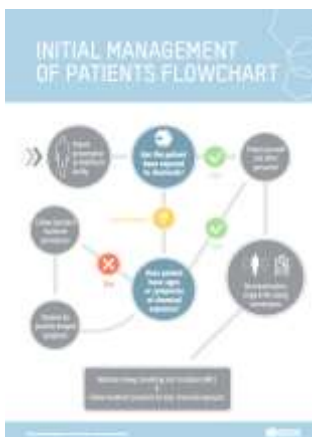
We used to serve 35 000 patients per month but with more people fleeing their homes the number has risen to 90 000. This neighbourhood was inhabited by 50 000 people, now more than 190 000 are living here!” - Medical worker at a health centre in Qudssaya in Rural Damascus.

community workers in the nutritional aspects of emergency care. WHO also provided multi-micronutrient supplementation for 577 500 children under 5 years of age and for 100 350 pregnant and lactating mothers, and supported health authorities in conducting nutrition assessments in IDP shelters.

Essential medical care at the secondary and tertiary levels

In 2013, it was estimated that more than 2 million people were in acute need of secondary and tertiary health care services. The lack of skilled health professionals and absence of policies and procedures for infection control were compounded by shortages of life-saving medicines (e.g., insulin, oxygen, nitrogen gas, anaesthetics, serums and intravenous fluids, antibiotics, and medicines and supplies for renal failure patients). In order to meet the needs of MoH and MoHE hospitals, WHO focused on strengthening the capacity of health staff to provide specialized care.

Emergency obstetric care – WHO conducted a workshop for 28 health care staff to update them on emergency obstetrical services, including postpartum haemorrhage. The workshop also addressed the problem of gender-based violence in the Syrian context.



Strengthening national preparedness and response to chemical attacks - WHO trained 28 medical and 35 non-medical staff of the MoH, MoHE, and national NGOs in three workshops (April, May and June). Accelerated workshops on the same subject were conducted for UN staff in Beirut.

Infection control – WHO conducted a workshop for 37 participants from MoH, MoHE, UNRWA, UNDP, SARC, private sector and NGOs that identified 16 topics for inclusion in an infection control training curriculum. The topics were: (1) definitions and main concepts in infection quality control; (2) epidemics: definitions, outbreak, infection control occurrence; (3) chain of

infection: main components, infections in hospitals, surveillance system, risk factors, orientation of isolation procedures; (4) staff safety: main tasks and responsibilities, vaccination, reporting system, procedures for dealing with infected staff; (5) surveillance system: types of infections, data collection, indicators and methods for analysing data, techniques for surveillance and verification; (6) standard precautions; (7) techniques and practices to reduce infections in hospitals; (8) building and infrastructure; (9) rational use of antibiotics; (10) infection control in high-risk departments; (11) infection control in support departments; (12) quality and patient safety; (13) training of trainers; (14) studies and research and evidence-based medicine; (15) organizational structure: committees, teams, job descriptions with tasks and responsibilities; (16) infection control programmes and activities.

Providing essential medicines, supplies and equipment to support hospitals - In line with the Essential Medicines List, WHO provided secondary and tertiary hospitals with the following medicines and supplies:

- Anaesthesia, pre-operative medicines and surgical supplies were distributed to MoH and MoHE hospitals in Damascus, Rural Damascus (Qutaifa, Nabek) Homs, Aleppo, Lattakia, Tartous, Dara'a and Deir-ez-Zor.
- Insulin, cardiovascular and asthma medicines were distributed in Damascus, Homs, Aleppo, Rural Damascus, Hama, Idleb and Dara'a.
- Specific NCD medicines including immunoglobulin, oxytocin, thyroid hormones and anti-thyroid medicines, respiratory tract medicines, palliative care and anti-cancer medicines were distributed in Damascus, Homs and Aleppo.

Covering gaps for NCDs –WHO worked to fill gaps in the treatment of NCDs by supporting local NGOs. These NGOs played a major role in alleviating health care shortages in the most affected areas. One of WHO's key achievements during 2013 was to provide 26 haemodialysis machines and 53 000 haemodialysis sessions for central and local health authorities and local NGOs in Damascus, Aleppo, Homs, and Lattakia.

4. Disease surveillance and response

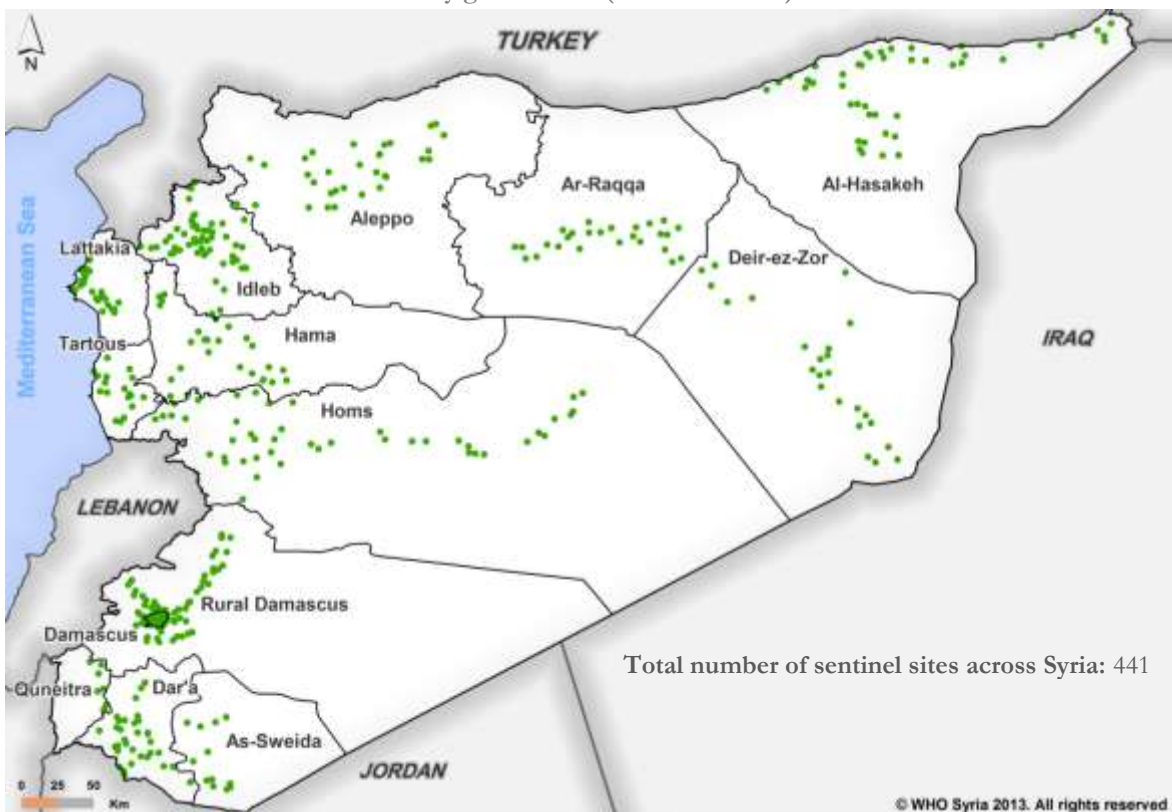
Following the collapse of Syria's routine disease surveillance system, WHO's complementary surveillance system – the EWARS – became the primary mechanism for monitoring the occurrence and geographic distribution of epidemic-prone

diseases such as measles, cholera and bacterial meningitis. At the beginning of 2013, only government-controlled areas were reporting through EWARS, in contravention of the International Health Regulations. After lengthy negotiations with the Syrian Government up to the level of the Prime Minister, in September 2013 WHO secured the Government's agreement to include opposition-controlled areas in the EWARS³. As a result, the number of sentinel sites rose from 97 in January to 441 in December 2013. Just over one third of these sites are in opposition-controlled areas.

positioning of supplies in key areas including Damascus, Deir-ez-Zor and Homs. As a result of these preparedness measures, WHO was able to deploy diarrhoeal disease kits and chlorine tablets to Al Boukamal within 24 hours in October 2013 following reports of a diarrhoeal disease outbreak in the area.

In early 2013, WHO conducted an initial review of 98 sentinel sites, and assessed the types and quantities of medicines needed to respond to disease outbreaks across the country. WHO established a database to facilitate reporting, and donated mobile phones and laptops to EWARS

Distribution of EWARS sentinel sites by governorate (December 2013)



EWARS uses simple data collection tools, and covers priority epidemic-prone diseases that have been selected in consultation with the MOH, based on the epidemiological situation in the country. Reporting formats have recently been enhanced to allow for data disaggregation by gender. Throughout the year, data were collated into weekly epidemiological bulletins that were used to support informed decisions on contingency planning and the strategic pre-

sentinel sites. A total of 792 people were trained on EWARS, disease investigation and response, and the case management of diseases such as brucellosis, leishmaniasis and diarrhoeal diseases.

WHO assessed the status of public health laboratories in Damascus and in governorates, and provided laboratory kits, consumables and equipment to support rapid diagnosis. A total of 190 laboratory technicians were trained in diagnostic techniques.

The quality of EWARS reporting was monitored through the year by means of regular supervisory

³ In opposition-controlled areas, sentinel sites report directly to WHO focal points through private physicians and NGOs.

visits and quality control checklists. In addition, WHO introduced several improvements to EWARS following a formal review of the system. These improvements included tally sheets at sentinel sites, case definition posters and alert threshold definitions.

EWARS has allowed for the rapid detection of and response to hepatitis A, typhoid fever, leishmaniasis, polio and measles across Syria and among Syrian refugees on the Lebanese and Turkish borders. WHO has coordinated the rapid response to these outbreaks – for example, through measles and polio vaccination campaigns - in collaboration with central and local health authorities, SARC and NGO partners. These efforts have potentially saved tens of thousands of lives.

In agreement with the MoH, WHO has agreed on a clear action plan and strategy to strengthen and manage the EWARS in 2014.

Water, sanitation and hygiene

WHO donated chemicals to disinfect drinking water, and jerry cans for storing clean water, to communities in the Governorates of Aleppo, Idleb, Deir-ez-Zor, Dara'a and Rural Damascus. A total of 11 471 000 people benefited from these supplies. WHO also donated six river water treatment units to communities living along the Euphrates River. A local NGO was given responsibility for operating and maintaining the units. The water quality testing laboratories managed by the Ministry of Water Resources were provided with essential supplies. WHO also delivered two medical waste sterilizers to the Paediatric and Al Muwassat hospitals in Damascus, both of which were operating at full capacity, with a turnover of over 1000 patients per day.

A web-based system was designed for reporting and responding to incidents of unsafe drinking water across the country. In 2014, this system will be linked to the EWARS. A total of 450 volunteers will be responsible for reporting the lack of residual chlorine or the presence of bacteriological contamination in specific locations across the country. Another 120 national staff equipped with mobile water quality testing kits will be responsible for investigating and validating these reports. A network of NGOs will assist the national authorities in rapidly tackling confirmed cases of contaminated drinking water.

5. Technical guidance on priority public health issues

Building national capacity

In 2013, WHO supported training initiatives for 2527 health care providers on:

- EWARS (512)⁴ and the EWARS data base (42)
- Polio: raising awareness (100), eradication measures (50) and sample collection (60)
- Case management of diarrhoea (103),
- Surveillance and case management of brucellosis (83)
- Tuberculosis (122)
- Infection control measures (33)
- Severe acute malnutrition (28)
- Community-based management of acute malnutrition (56 paediatricians)
- Diabetes (312)
- Health information (80)
- Reproductive health (28)
- Mental health in emergencies (180) and psychological first aid (75)
- Media training (37)
- First aid (542)
- Chemical hazards (159).

WHO also shared specific guidelines with health sector partners on i) first aid, ii) management of dead bodies, iii) management of chemical injuries, iv) dealing with the mental health of those affected by biological and chemical weapons, and v) countering the polio outbreak.

Cross-cutting issues

Rehabilitation and early recovery

The preparation of a well-designed early recovery plan for the Syrian health system is essential in order to reduce harmful long-term effects, especially on the most vulnerable strata of Syrian society.

A concept note was developed on a National Agenda for the Reconfiguration and Strengthening of the Health System in Post-conflict Syria, comprising the results of field assessments, international best practices, and addressing both early recovery and post-conflict.

⁴ The numbers in brackets refer to the number of participants for each training cycle conducted.

Strengthening due diligence

WHO has established a rigorous monitoring and evaluation framework that includes several data collection tools. WHO is using these tools, and its unified reporting formats, to improve the effectiveness and transparency of its operations and enhance the quality of reporting to the many donors that have generously supported its work in Syria.

Ensuring gender equity in humanitarian interventions

WHO is using the gender marker tool developed by the Inter-Agency Standing Committee to assess whether boys and girls, men and women benefit equally from its planned interventions. These assessments have confirmed that WHO projects implemented in 2013 have equally benefited women/girls and men/boys.

WHO has taken advantage of specific training initiatives such as the workshop on scaling up mental health support in emergencies to raise awareness of the importance of equal access to services for both women and men. WHO has been careful to ensure an equitable gender balance of workshop participants themselves.

Raising awareness of communities

Improving communities' knowledge of health issues enables them to make informed decisions. This is critically important for vaccinations, when parents fail to bring their children to be vaccinated against life-threatening childhood diseases because of false claims regarding vaccine safety. WHO's successful polio vaccination campaigns in Syria were in part due to its work reaching out to communities through religious and other community leaders.

In 2013, 10 000 information leaflets on brucellosis were disseminated across the country. Information on protection in the event of chemical attacks or air-raids was also widely disseminated.



▲ A medical doctor conducts a neurological examination at al-Mouhtahed Hospital in Damascus.

Photo credit: WHO

A new-born is operated on by the light of a mobile phone in Aleppo

Photo credit: WHO/ Aleppo

Challenges and mitigation measures

WHO faced major operational challenges throughout the year. It overcame many of them – partially if not fully - through advocacy, contingency planning, and capacity building.

In the autumn of 2013, WHO's international staff in Syria were evacuated due to the threat of US air strikes – except for the WHO Representative. In spite of this, WHO managed to avoid major disruption to its humanitarian work. WHO's network of national focal points continued to report on health needs and activities across the country. The rapidly evolving situation was assessed daily, and activities were adapted to ensure the safety of WHO staff and assets.

essential medicines and medical supplies for the entire population. These efforts included letters from the United Nations Emergency Relief Coordinator to the Syrian Ministry of Foreign Affairs; letters from WHO's Director-General and the Regional Director to the Syrian MoH and the Syrian Permanent Mission to Geneva; and regional meetings bringing together the Syrian Government, senior WHO officials and UN partners.

Organizing vaccination campaigns targeting millions of children in a country with a highly mobile population, and huge numbers of people in opposition-controlled areas, was another logistic

“We were moving medical supplies to our warehouse in rural Damascus when gunfire was aimed directly at our vehicles. Since then, I feel the weight of the responsibility we have towards the people in need in the country. And despite the many occasions on which the team has faced jeopardy, our commitment has kept us working to support affected populations across the country.” -
Jehad Eibesh, WHO Syria Logistic Team Leader



Photo credit: WHO/ Aleppo

Thanks to its intensive advocacy efforts, by the end of 2013 WHO had managed to reach both government- and opposition-controlled areas. Medical supplies were delivered via international convoys and distributed to local NGOs providing health care services. WHO's network of focal points worked uninterrupted throughout the year to report on health needs, communicable disease alerts and the status of health care facilities. As the lead agency of the health sector, WHO pursued every avenue to advocate for unhindered access to

challenge. Thanks to coordinated advocacy efforts, WHO and UNICEF successfully supported two comprehensive vaccination campaigns that reached 2.2 million children under 5 years of age. They achieved this through establishing mobile clinics and relying on a network of trained health professionals in opposition-controlled areas, coordinated by WHO focal points. In parallel, health information campaigns helped mobilize public awareness and demand.

Measures to mitigate the effects of the sanctions included the identification of alternative medicines that could be imported. A committee of health stakeholders and experts from WHO, MoH, MoHE, and UNICEF met at the beginning of 2013 to develop Syria's Essential Medicines List (EML) budgeted at US\$ 900 million. A subsidiary list of 168 priority medicines was subsequently established, budgeted at US\$ 467 million. The list enhances the effectiveness of WHO's and partners' health operations by enabling the projection and quantification of essential medicine requirements and streamlining procurement.

To mitigate the effects of the dramatic devaluation of the Syrian Pound, local NGOs and CBOs began increasingly providing free health care and medicines. Nonetheless, relatively few health NGOs and CBOs were approved by the MoFA. Those that were allowed to operate were unable to reach restricted areas, and overwhelmed by demand in the areas that remained accessible. WHO supported these NGOs by increasing its procurement, logistic and warehouse capacity, and air-lifting essential supplies. The number of health NGOs supported by WHO rose from eight to 36.

The procurement of medicines, supplies and equipment was delayed by lengthy approval

procedures. Local procurement possibilities were limited. Exchange rates fluctuated sharply. This, combined with a Syrian government decree (repealed in August 2013) that did not allow payment in US\$, led many companies to insist on payment within 48 hours after orders had been placed.

WHO's security arrangements fall under the United Nations Security Management System (UNSMS). The UN has shifted its policy from "when to leave" to "how to stay". The means to continue implementation of programmes in a safe and secure manner are determined by the UN's security management team at country level, with support and advice from security professionals at UN headquarters in New York.

The UN has established criteria that determine the point at which the evacuation of international staff becomes mandatory. The most significant indicator is the serious likelihood that any UN agency will become a direct target or will be collaterally affected. WHO has prepared for this eventuality through training national staff to take over until such time as expatriate staff are able to return. Evacuated staff are also able to oversee operations from a designated alternative office outside the country.



Distribution of medicines (including polio vaccine), non-food items and food baskets in Barzeh - a neighbourhood to the north of Damascus.

Photo credit: WHO



Strategic approach: opportunities for replication

By focusing on fostering strategic partnerships, pursuing innovation, building capacity and ensuring due diligence, WHO in Syria was able to raise over US\$ 74 million to fund its humanitarian interventions in 2013.

The Syrian crisis is widely recognized as particularly challenging for humanitarian implementing partners both politically and practically. WHO has piloted a number of approaches that can be applied to other crises.

Empowering WHO's national staff

Strengthening the capacity of WHO's 37 national staff is a cornerstone of its operational strategy. By allowing these staff to take the lead on initiatives and represent the Organization in important fora, their profile and capacity have been strengthened, reinforcing their ability to take over operations in the event of decreased international presence. National health authorities have recognized WHO's efforts and consider them exemplary.

Collaboration with NGOs

In 2013, WHO's network of 36 health NGO partners provided trauma, primary and secondary level health care to people in need across the country, with a special focus on Aleppo, Homs and Rural Damascus. Around 60 000 people in remote or hard-to-reach areas were able to access health care through NGO mobile teams. Although

this number represents a fraction of the overall number of people in need, these partnerships are crucial in complementing health care services provided by the badly disrupted and overburdened health system.

Strengthening EWARS

EWARS offers an operationally and cost-effective means of enhancing surveillance and response. Its rapid expansion in 2013, achieved with the involvement of NGOs and other health partners, has helped halt the spread of epidemic-prone diseases in both Syria and neighbouring countries, where the risk of disease outbreaks is greatly increased by cross-border movements of highly mobile populations.

Crucially, WHO, as the world's leading health authority, was able to successfully advocate with the Syrian Government for the expansion of EWARS into areas controlled by opposition forces. As a result, by the end of the year, the number of sentinel sites had risen from 98 to 441.

Decentralizing WHO presence

WHO reinforced its implementation capacity by establishing focal points in Aleppo, Al-Hassakeh, Ar Raqqa, Dara'a, Deir-ez-Zor, Idleb, Homs and Lattakia. This allowed it to perform real-time assessments and verify local health needs based on reviews of health facility and NGO records and

interviews with stakeholders. The focal points' reports allowed WHO to accurately identify needs and promptly deploy essential medicines and supplies to where they were needed most. The WHO focal points also monitored the accuracy and timeliness of the distribution of medicines and medical equipment.

WHO established a sub-office and warehouse in Homs, where several other UN agencies have set up operations. Homs was selected because of its strategic location (on the road to the northern governorates) and because of the increasing health needs there due to the intensity of military operations in the area.

Monitoring, evaluation and reporting

WHO has undertaken a number of measures to reinforce monitoring, reporting and financial tracking, and apply lessons from independent assessments with a view to doing more with fewer resources.

WHO has faced a number of programme monitoring challenges. In Al Hassakeh, for instance, the WHO focal point had to cross over into Turkey to send health information to WHO's office in Damascus. In some instances, NGO staff used their own cars to deliver vital medical supplies. WHO is using medical and pharmaceutical students to collect health information and conduct spot-checks of activities implemented by partners. These spot-checks have proved to be highly effective. Using students is part of a broader participatory approach that WHO is promoting.

Photo credit: WHO/ Aleppo

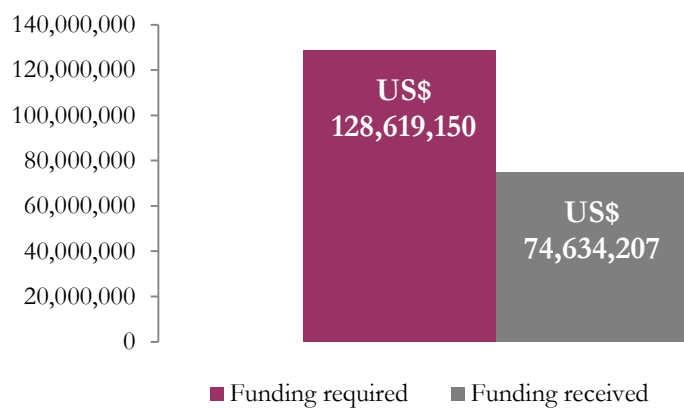


WHO's internal Outcome Monitoring Plan clearly identifies activities, methodologies and timeframes for spot-checks. Other tools such as organizational capacity assessment grids are being used to monitor, evaluate and train partner NGOs.

The above are just some of the examples of WHO's commitment to improving monitoring and maximizing the use of resources. WHO has developed an internal tracking system to map resources and expenditures against approved activities and timelines. This detailed charting of implementation has enabled it to analyse the factors that facilitate or hamper good progress, with a view to systematically improving performance and cost effectiveness. WHO's commitment to transparency, best practice standards of reporting, standardized data collection and analysis, the development of unified reporting formats and regular (formal and informal) reporting to donors has been strongly welcomed by all partners and has served to consolidate collaboration, both internal and external. This focus on expenditure oversight and strong reporting has proved to be a strategic investment.



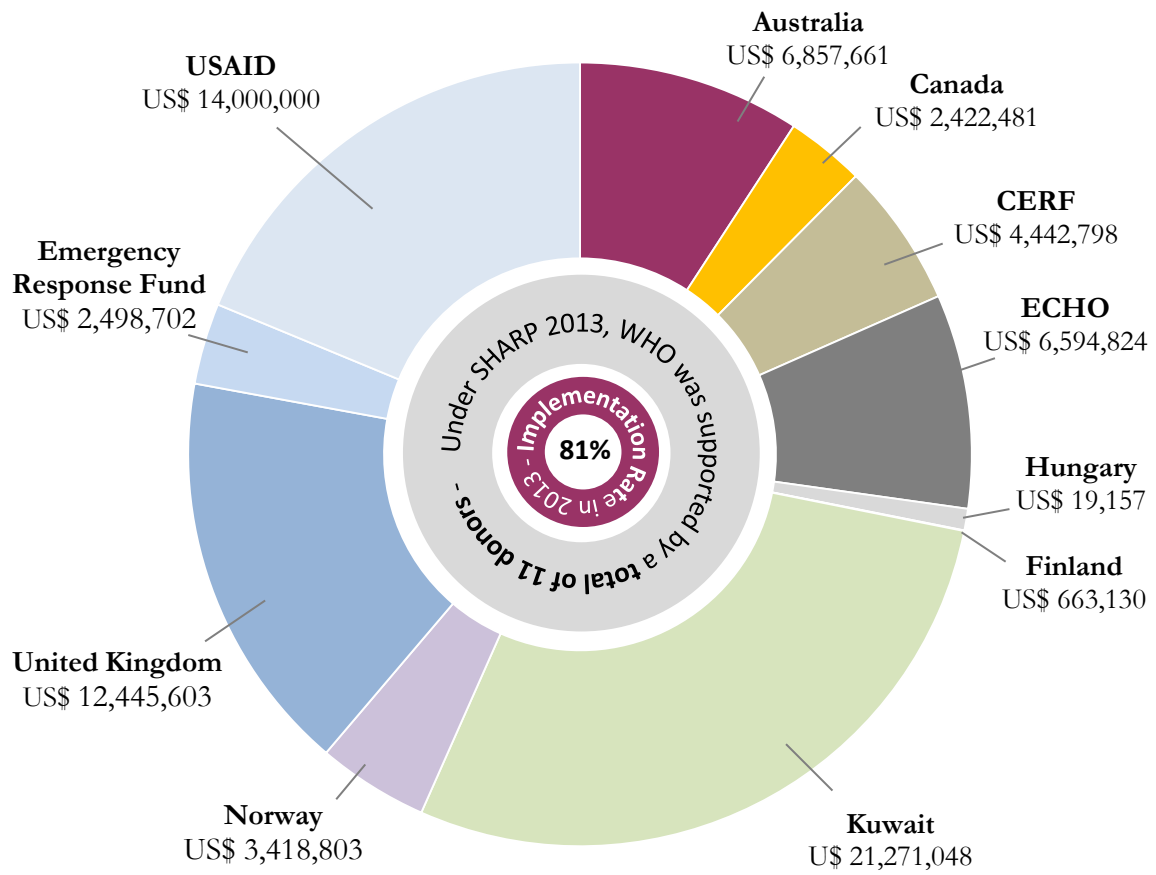
Overview of total funding required and received in 2013



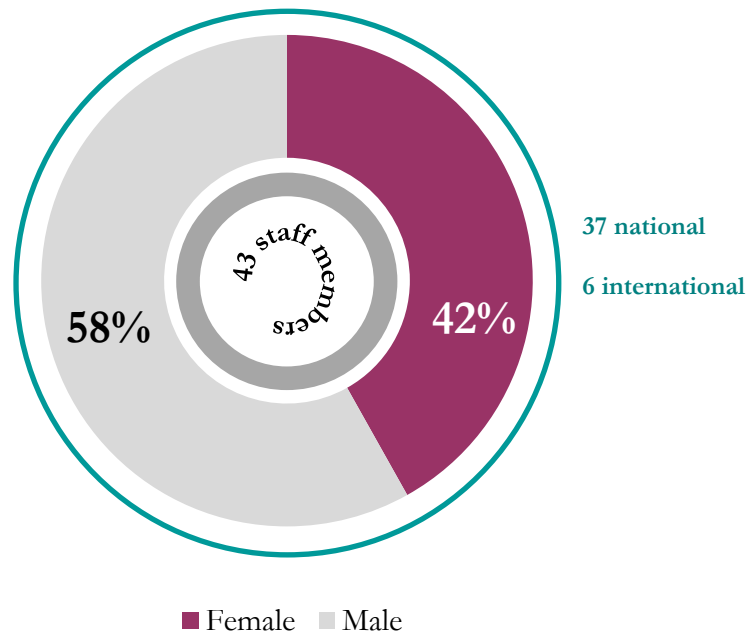
Financial overview 2013

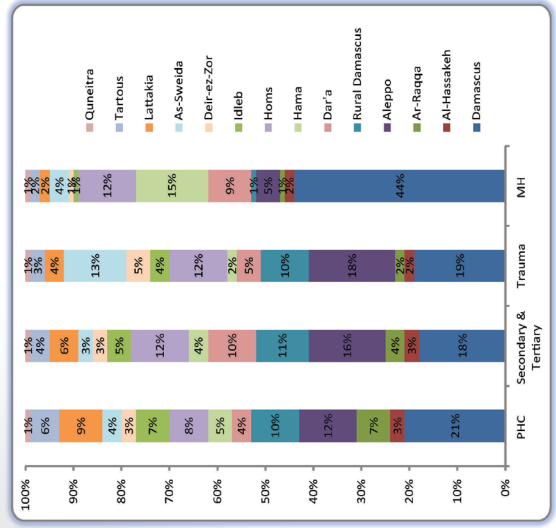
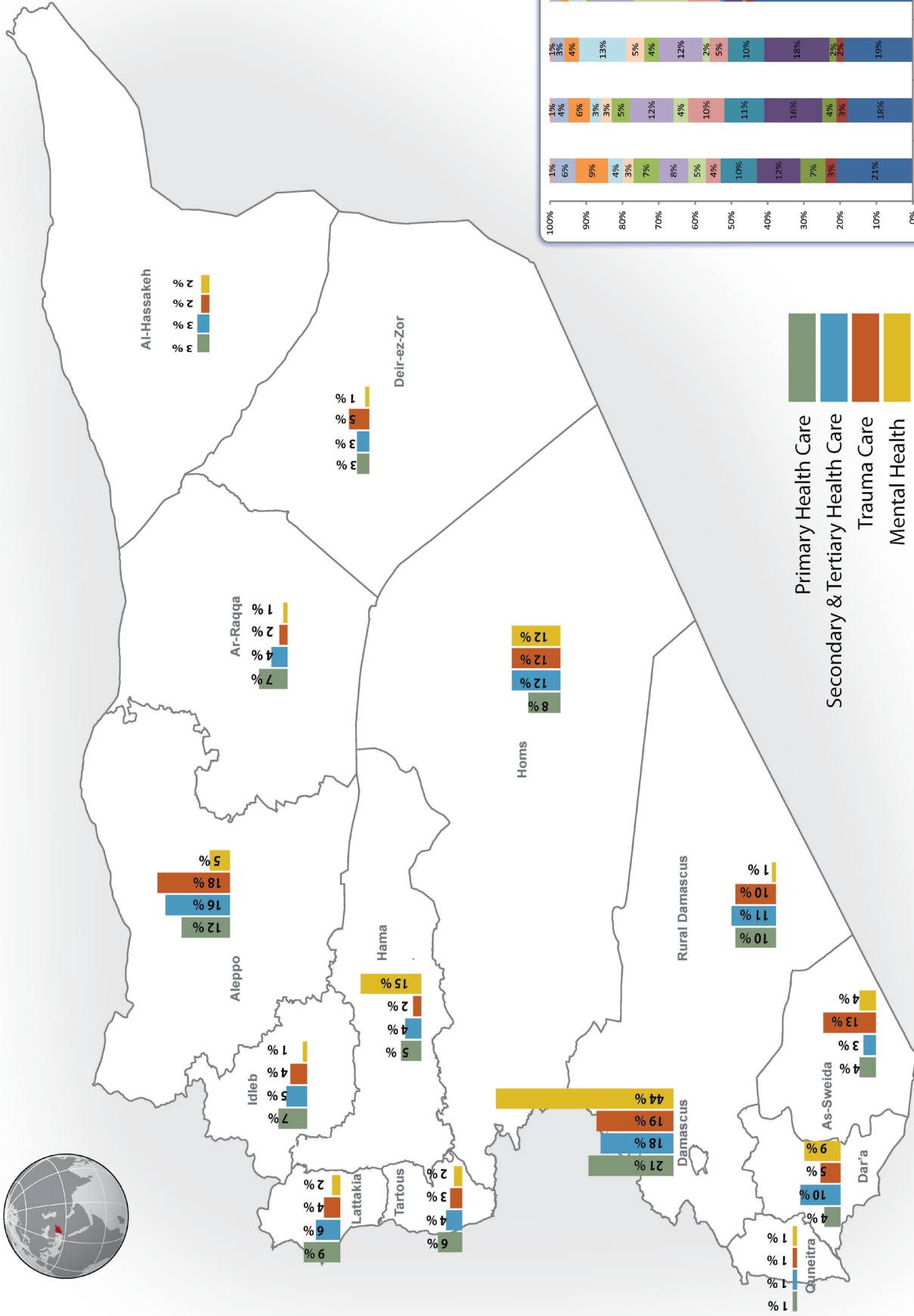


Overview of funding received by donor in 2013



Overview of human resources present in the WHO Syria country office





■ Primary Health Care
■ Secondary & Tertiary Health Care
■ Trauma Care
■ Mental Health



WHO strategic interventions under SHARP 2013

1. Strengthen trauma and referral management

- Deliver medicines, medical supplies, equipment and kits for trauma care;
- Support field-based first aid and transportation;
- Train health staff in emergency medical care and basic trauma surgery;
- Support emergency service and operating theatres in hospital.

Funds required: US\$ 34 481 550

2. Support health information management and coordination

- Develop a systematic approach for managing health information;
- Map available health resources, services, status of facilities, medicines and equipment;
- Map public health risks and partners' capacities and activities at all level;
- Strengthen coordination;
- Strengthen national capacity on HIS management for emergency response;
- Strengthen the operational capacity of the HIS to improve timeliness, completeness and information-flow.

Funds required: US\$ 5 050 000

3. Support delivery of primary health care

- Build capacity to deliver primary health care services;
- Improve access to primary health care services through outreach activities;
- Provide essential medicines for primary health and chronic illness services;
- Support the implementation of medical interventions.

Funds required: US\$ 46 806 600

4. Support delivery of secondary and tertiary health care

- Build capacity to deliver specialized care;
- Provide essential medicines, supplies and equipment to support services;
- Cover gaps in secondary health care for NCDs.

Funds required: US\$ 17,935.000

5. Support mental health services

- Conduct community awareness campaigns;
- Build capacity of health care providers to identify, manage and refer mental health cases;
- Establish a referral mechanism;
- Provide medicines, supplies and equipment;
- Build capacity with regard to and provide psycho-social support.

Funds required: US\$ 5 800 000

6. Strengthen the capacity for health response

- Expand the EWARS to 500 sentinel sites;
- Train health staff from governorates on surveillance;
- Strengthen capacity for response to epidemic-prone diseases;
- Strengthen the laboratory surveillance network;
- Conduct assessment, monitoring and evaluation;
- Preposition essential medicines, medical supplies and equipment.

Funds required: US\$ 9 600 000

7. Rehabilitation and restoration of damaged/ non-functional health facilities in affected areas to full operational capacity

- Rehabilitate partially damaged health facilities in the affected areas in order to provide essential basic health services;
- Provide essential equipment and supplies.

Funds required: US\$ 5 480 000

8. Water, sanitation and hygiene (WASH)

- Supply of water disinfection chemicals and tools/ instruments for provision of safe drinking water;
- Supply of medical waste sterilizers;
- Initiation of the development of a national system for continuous water quality monitoring surveillance.

Funds required: US\$ 2 100 000

WHO has included only the most critical gaps for medicines in the SHARP 2013. The Essential Medicines List estimates the total needs for medicines for the year at US\$ 900 million and the priority list of the most urgently needed life-saving items at US\$ 467 million.

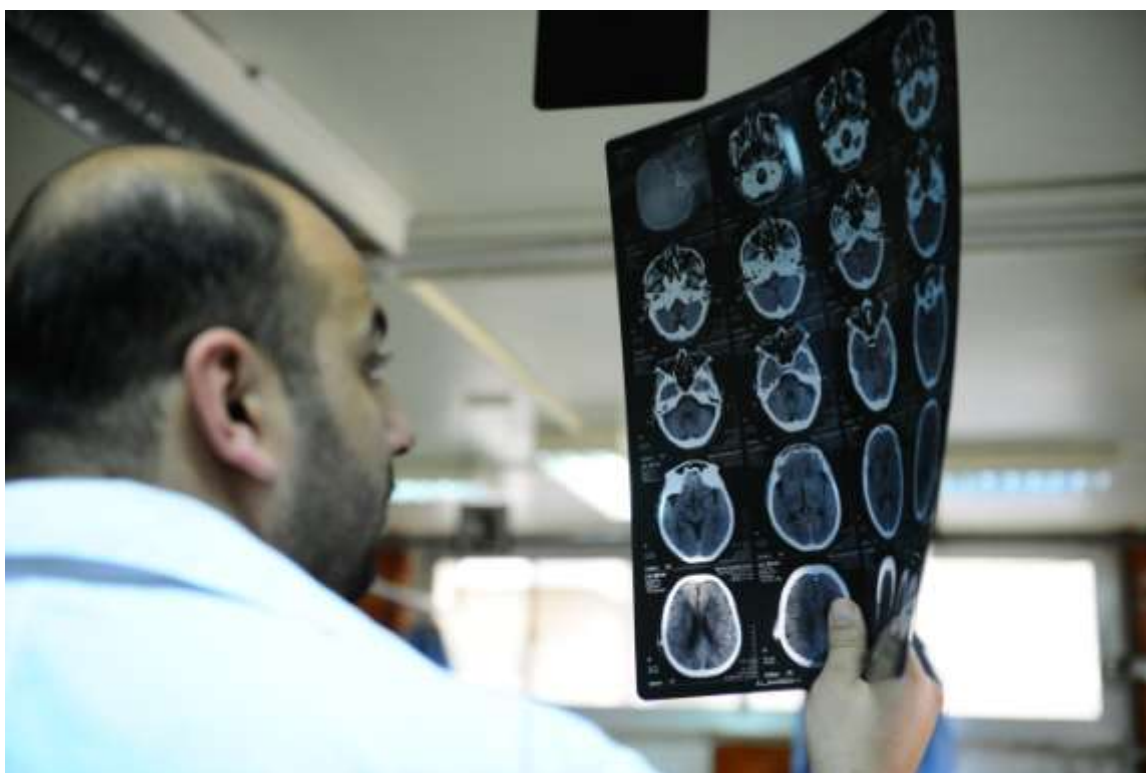
9. Nutrition

- To reduce manifestation of malnutrition in children and pregnant and lactating women affected by the unrest in Syria

Funds required: US\$ 1,850,000

The way forward

Photo credit: WHO/ Omar Samadiki/ Ibn al Nafees Hospital/ Damascus



The United Nations estimates that 9.3 million people will be affected by the crisis in 2014, including 6.4 million IDPs, and 2.8 million who have lost their jobs. **The Health Sector will require US\$ 233,376,172**, with WHO requiring US\$ 178,309,652, in order to continue providing essential health care services to increasingly vulnerable people in need across the Syrian Arab Republic. The Essential Medicines List for 2014 is budgeted at US\$ 450 million.

Building on lessons learned from the approaches adopted in 2013 and interventions undertaken, WHO is pursuing the following strategic areas for 2014:

1. Revitalization of primary health care

services: To improve access to comprehensive primary health care (PHC) services, including reproductive health and vaccinations.

- Funds needed: US\$ 101,898,970
- Implementing agencies: WHO, UNFPA, UNICEF, UNHCR, IOM, PU and IMC

2. Essential medical care at secondary and tertiary level:

To improve access (including of Palestine refugees) to secondary health care services and limited tertiary health care services i.e. for burn victims.

- Funds needed: US\$ 55,514,126
- Implementing agencies: WHO and UNRWA

3. Trauma care:

To strengthen the level of preparedness for and management of trauma, including referral mechanisms, for an increasing number of injuries across the country.

- Funds needed: US\$ 45,495,000
- Implementing agency: WHO

4. Early warning, alert and response system (EWARS):

To prevent, early detect and respond to epidemic prone diseases and contain the current polio epidemic and its spread to other countries/ regions.

- Funds needed: US\$ 16,486,560
- Implementing agency: WHO

5. Mental health:

To strengthen mental health service delivery across Syria.

- Funds needed: US\$ 8,206,900
- Implementing agency: WHO

6. Rehabilitation of health facilities:

To support public and private health infrastructure and services affected by the crisis and enhance revitalization of health services and restoration of health facilities in affected areas.

- Funds needed: US\$ 4,000,000
- Implementing agencies: WHO and UNDP

7. Health information system (HIS):

To further strengthen the HIS for emergency using Health Resources and Services Availability Mapping System (HeRAMS) for regular, timely and accurate collection and dissemination of data.

- Funds needed: US\$ 921,270
- Implementing agency: WHO

8. Coordination:

(i) To strengthen health sector coordination to address the needs of people in need and (ii) to provide improved access of vulnerable populations to a quality basic health care package of services and allow for adequate preparation and response capacities for ongoing and new emergencies.

- Funds needed: US\$ 462,796

- Implementing agency: WHO

9. Tuberculosis and HIV/AIDS:

To strengthen the national Tuberculosis and HIV/AIDS programme.

- Funds needed: US\$ 390,550
- Implementing agency: UNDP.

Health Sector partners will also continue implementing life-saving WASH and Nutrition interventions in 2014:

10. Water, sanitation and hygiene (WASH):

Ensure water, sanitation and hygiene services to the agreed standard with primary purpose of satisfying vital needs, dignity and reduction of public health related risk for population in need in all governorates.

Funds needed: US\$ 115,780,725

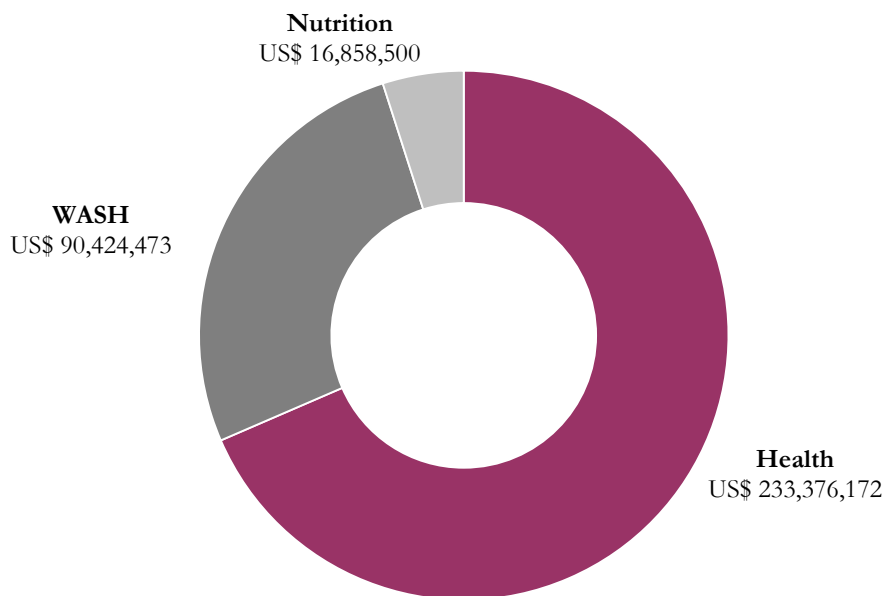
- Implementing agencies: UNICEF, UNFPA, UNDP, WHO, IOM and PU.

11. Nutrition:

Emergency Life Saving Nutrition Services for crisis affected Internally Displaced population in all governorates inside Syria.

- Funds needed: US\$ 16,858,500
- Implementing agencies: UNICEF and WHO.

Health sector partner requirements under SHARP 2014



Acknowledgements

Photo credit: WHO/ Al Boukarnal



The commitment and professionalism of our partner community stand out. We wish to express our sincere appreciation for the collaborative spirit, courage and generosity of so many of you. Without the determination of our NGO counterparts, medicines would not have reached many remote areas. Were it not for the courage of the drivers, UN employees and private individuals ready to risk their lives, the health response in 2013 would not have achieved the results it did. Without the steadfast support of its donors, WHO would have been unable to implement its life-saving humanitarian health interventions. The efforts of health authorities remain crucial in enhancing the

access of all in need to health care services. WHO will continue to build on its frank and transparent dialogue with national authorities in 2014.

WHO's Country Office in Syria also wishes to recognize the invaluable guidance and leadership of WHO's Regional Director for the Eastern Mediterranean, the continuous support of the Director of Programme Management, and the guidance provided by WHO colleagues in headquarters and the Emergency Support Team (EMST) in Amman, Jordan. Most of all, WHO's national staff in Syria, through their creativity, determination and dedication, have set an inspirational example to us all.

Glossary

| | |
|---------------|---|
| CBO | Community-based Organization |
| EMST | Emergency Support Team |
| EML | Essential Medicines List |
| EWARS | Early Warning, Alert and Response System |
| HeRAMS | Health Resources Availability Mapping System |
| HIS | Health Information System |
| ICRC | International Committee of the Red Cross |
| IDP | Internally Displaced Person |
| IEHK | Inter-agency Emergency Health Kit |
| MoH | Ministry of Health |
| MoHE | Ministry of Higher Education |
| NCDs | Noncommunicable Diseases |
| NGO | Nongovernmental Organization |
| OCHA | Office for the Coordination of Humanitarian Affairs |
| PFA | Psychological First Aid |
| PHC | Primary Health Care |
| PSS | Psychosocial Support |
| SARC | Syrian Arab Red Crescent |
| SHARP | Syria Humanitarian Assistance and Response Plan |
| UNFPA | United Nations Population Fund |
| WCO | WHO Country Office |
| WHO | World Health Organization |

