To continue its response to the acute health needs of the estimated 6.8 million people affected by the crisis, including IDPs, until the end of the year, WHO requires additional funding support of US$ 56 million.

Current situation

The adverse impact of the crisis on the most vulnerable people continues to increase, heightened by the impaired Syrian health system. Even where those in need can access health services, positive health outcomes are undermined by psychological stress factors, hygiene constraints, suboptimal nutrition and, importantly, a lack of medicines, supplies and equipment.

With 115,000 lives lost and over 575,000 persons injured since March 2011, projections are that these figures will continue to increase during the next 12 months (750,000 injured in the beginning of 2014).

In June 2013, 6.8 million individuals were estimated to be affected by the current crisis [OCHA], but this number has continued to rise steadily and is expected to reach 8.2 million people by the end of September 2013. Of these, 3 million (36.6%) are children.

While in June 2013 4.25 million individuals were estimated to be internally displaced persons (IDPs), the number has been rising progressively in the past six months, reaching 5.4 million at the end of September 2013. With the intensification of the Syrian conflict, numbers are expected to reach 6.4 million by the beginning of 2014.

The situation is exacerbated by a disrupted health system: as of June 2013, 60% of public hospitals had been affected, out of which 22% were damaged and 38% are out of service. Lack of fuel and electricity has forced many hospitals to operate in very challenging conditions, with patients paying the cost as numbers seeking medical services grows. As of June 2013, more than 70% of health centres in Ar Raqq, Deir-ez-Zor and Homs have been damaged or are out of service. 92% of ambulances have been affected, impacting referrals.

The number of primary health care centres currently out of service increased by 4% in the past three months (most of this increment was registered in Homs – from 16% to 46%). Out of a total of 1724 primary health care centres across the country, 38% have been affected, of which 31 (2%) have been damaged, 24% are out of service and 12% are closed due to lack of safety.

With the substantial damage to pharmaceutical plants, local production of medicines has been reduced by 65 – 70%. Prior to March 2011, 90% of medicines in the Syrian Arab Republic were locally produced.

The health workforce has been significantly reduced as many health professionals have fled the country [80,000 doctors outside and an estimated 37,000 still inside the Syrian Arab Republic]. Affected governorates are now lacking qualified medical expertise particularly for trauma, anaesthesia and specialized laboratory personnel. In the northern

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1 Source: UNICEF
governorates, female staff for reproductive health and sexual and gender-based violence is limited. For those health workers that have remained, it is difficult and dangerous to report to duty due to the current hostilities. In the public system, 193 health workers are reported to have been directly affected (68 killed, 104 injured and 21 kidnapped) [WHO].

In 2011, non-communicable diseases (NCD) were the leading cause of morbidity and mortality in the Syrian Arab Republic (77% of deaths). The most common NCDs observed in the past six months include hypertension (30.2% of the population in 2010), diabetes (12.8% of the population in 2013), cancer, epilepsy, asthma, obesity (39% of the population in 2010) and kidney failure. With medicines being expensive and not available to large segments of the population, the health impact of these diseases has greatly augmented.

There is also an increased risk of mortality from vaccine-preventable diseases (7000 cases of measles reported in northern Syria by Médecins Sans Frontières), especially amongst children, was registered in the past six months. The risk of not containing these diseases extends beyond the Syrian population within the Syrian Arab Republic to those in neighbouring countries, as well as the hosting communities.

Due to overcrowded living conditions (especially of IDPs) and diminished availability of water supply per capita, which has decreased to one third over the past six months of pre-crisis levels [an average of 50 – 70 people share one toilet now] and resulted in poor hygiene conditions, individuals are increasingly exposed to outbreaks of communicable diseases.

As a result of the worsening of the conflict, increased trauma and psychological distress was noted among the population. Based on studies conducted in Libya, Algeria and Gaza, it is expected that half of the total population will require psycho-social support in the coming months.

Challenges
Access affects patients, health workers and the operational capacity of support services, included the life-saving ones provided by WHO. Patients across the country are facing reduced access to essential medical services, resulting in increased morbidity and mortality, particularly in heavily affected areas. It is hoped that the recent Statement by the President of the Security Council (S/PRST/2013/15) will facilitate broader access. On the basis of this, a three-month plan is being prepared for humanitarian support, including for health to hard-to-reach areas.

Despite the constrained access in the third quarter, coupled with the reduced number of international staff present in the country (the WHO Country Office is now supported by only three international staff in the country), WHO has managed to continue implementing essential interventions and the WHO focal persons are still operating from their locations across the country to report on health needs, as well as on low and empty stocks of priority medicines based on interviews with staff in health facilities, discussions with leaders of local NGOs and community based organizations (CBOs), and members of the health authorities in the respective governorates. The situation on the ground shifts very quickly and is being assessed on a daily basis in order to adapt implementation of activities accordingly and to closely monitor the security of staff.

Lack of access for humanitarian aid - Permission to access opposition-controlled areas requires negotiation, including for urgently needed, life-saving support. The lengthy procedures have at times hampered the timeliness of deliveries, but thanks to persistent advocacy at the many levels of the Organization and with the supporting voice from donor countries, WHO managed during 2013 to reach both government- and opposition- controlled areas not only via international convoys, but also via direct delivery, including through NGOs.

Expanding vaccination into hard-to-reach areas - essential for permitting broader coverage, of critical importance in this context of high population mobility - has also been challenging. In spite thereof, WHO and UNICEF successfully supported health authorities in completing two campaigns that encompassed also the more remote areas.

Side-effects of Sanctions – Ministry of Foreign Affairs, Ministry of Health and Ministry of Higher Education have underlined the serious impact of sanctions on procurement of essential medicines, supplies and spare parts for maintenance of equipment. For example, a United States pharmaceutical company might be ready to supply blood safety kits, but the restrictions on transfer of funds hamper procurement. According to the Ministry of Health and the Ministry of Higher Education, since 2010 several contracts with foreign suppliers have not been observed in line with predetermined timelines, and goods and services were consequently not delivered. WHO has invited the Government to submit a formal request to WHO via the Syrian mission in Geneva for assistance with reimbursable procurement.

Mitigation measures have included, for example, the identification of alternative medicines that can be imported, but side-effects of sanctions remain one of the principal challenges to medical aid provision in the Syrian Arab Republic.
The dramatic devaluation (particularly in the past six months) of the Syrian Pound has affected the ability of the population to pay for health services, especially amongst the most vulnerable groups (IDPs and families in hard-to-reach areas). The significant rise in the price of medicines (25 - 50%) that was announced in July 2013 by the pharmacist syndicate is also of great concern to the Health Sector partners. As a result of this situation, today the same patients who were able to cover their medical fees in 2010 are progressively becoming dependent on subsidized services. Medicine prices on the black market have risen steeply and are not available to the majority of the population, especially in the rural areas where the communities are traditionally economically worse off than in the cities.

Local NGOs and CBOs providing health support, are having to increasingly provide free-of-charge services and medication, overwhelmed with requests of support. There is a limited number of NGOs and CBOs with experience in health that have been approved by Ministry of Foreign Affairs. Those that are operational are also affected by the reduced humanitarian space.

Other operational challenges
Procurement of medicines, supplies and equipment has proven to be complicated because of many constraints, both at local and international level. Repetitive requisitions within a very limited amount of time has meant that several purchase orders have had to be submitted for the same item several times in a row, causing a delay in the procurement process, as well as preventing WHO from obtaining the best price available. Special approvals took a long time to be granted and fluctuations in the exchange rate represented a significant constraint with procurement on the local market. Until August 2013 a Syrian Government decree which did not permit payment in US dollars, led many companies to require payment within 48 hours after the order had been placed.

Importantly, the delivery of medicines and medical equipment procured in the third quarter have not yet all been delivered and are expected only to arrive in the fourth quarter or even the first quarter 2014 due to exceptionally long lead times.

Security - Sporadic fighting, indirect fires such as mortar and artillery attacks, daily car bombs in the cities, and the increased hijacking and kidnapping incidents constitute challenges on the ground as we remain committed to delivering humanitarian aid to those in need, even with the reduced. Areas accessible for humanitarian activities continue to shrink as a consequence of the conflict. Humanitarian workers are risking their lives on a daily basis trying to assess needs and to deliver medicines, medical supplies, food and non-food items.

WHO response in the Syrian Arab Republic
Goal: To reduce morbidity and mortality in the Syrian population.

The WHO regional strategy for the Syrian Arab Republic crisis, falling within the WHO Emergency Response Framework, has been developed around the following five primary functions:

1. Provide leadership and coordination of the health sector response, together with health authorities;
2. Provide timely information on health trends, health systems impacts, health needs and priorities, and response;
3. Increase access to quality and priority preventive and curative health services;
4. Facilitate early detection and rapid response to infectious disease outbreaks and other public health threats;
5. Provide technical advice and assistance on priority public health issues.

Using a multi-pronged approach, WHO’s strategic interventions, complementary to those of its partners, leveraging the Organization’s expertise and value-added, aim to reduce morbidity and mortality of the Syrian population, especially the most vulnerable groups, including women and children. The interventions focus on the most affected government- and opposition-controlled areas, as reflected in the health sector strategy outlined in the 2013 Syria Humanitarian Assistance Response Plan (SHARP) and the WHO Country Work Plan for the Syrian Arab Republic. Activities are based on needs assessments and developed for maximum impact and cost effectiveness.

To reinforce implementation capacity and reach, WHO has decentralized its presence from Damascus and has at present national focal persons in Aleppo, Al-Hassakeh, Al Raqqa, Dara’a, Deir-ez-Zor, Idlib, Homs and Lattakia. Due to the restricted availability of health workers, the challenge to identify qualified staff in particular for Dara’a remains.

Between January and September 2013, WHO reached 2 119 122 direct beneficiaries through distribution of medicines and equipment, as well as health care delivery; 1 559 150 direct beneficiaries through delivery and distribution of kits; 1 086 218 children (between six months and 15 years old) through MMR and measles vaccination campaigns, as well as 758 257 children under the age of five through a polio vaccination campaign.
During the third quarter, WHO operations were focused along the axes of intervention set out below:

**Targeted life-saving interventions:**

**Trauma and Primary Health (PHC) Care** - WHO continued to provide health assistance to vulnerable populations by delivering critical support in trauma management and PHC services, particularly with regard to procurement and supply of medical kits, medical equipment and essential medicines (i.e. anaesthesia, antibiotics, insulin, cardiovascular disease medicines, haemodialysis consumables, cancer and reproductive health supplies).

As of September 2013, 23,510 direct beneficiaries were reached in Lattakia by supplying health authorities with medical supplies and interventions, Interagency Emergency Health Kits (IEHK), Supplementary and Basic Units for 42,100 direct beneficiaries, in addition to a surgical instrument module and three defibrillators. In Damascus, health authorities received medicines and medical supplies that supported 117,415 direct beneficiaries, including the Al Afia Fund, which provides dialysis sessions to treat more than 125 people on a long-term basis [2.5 sessions per week]. In Dara’a, WHO provided health authorities and the Syrian Arab Red Crescent (SARC) with medical interventions for 23,956 beneficiaries and IEHK Supplementary and Basic Unit kits for 300,000 direct beneficiaries. In Deir-ez-Zor, WHO provided the Islamic Charity Organization (operating in the Aicha Charity Hospital in Albuqamal) with oxygen cylinders, defibrillators, ultra-sound imaging machines, a generator, medicines and IV fluids, permitting the treatment of 13,000 patients for three months.

WHO supported the UN mission to investigate the Syrian chemical weapons incidents via technical equipment, medicines and medical supplies, as well as staff. Further, critical gaps were mapped and technical information on chemical exposure was published. Guidance in English and Arabic on protection from aerial attacks was also disseminated. WHO continued to advocate for access for patients, health workers and medical supplies to enable health response. Moreover, guidance on clinical case management for chemical weapons exposure was finalized and disseminated.

The newly established Burns Unit at al-Mouwassat Hospital in Damascus was supported with six intensive care units (ICU) beds and two ICU ventilators, in addition to medicines and medical supplies to cover for 14,850 beneficiaries.

In light of the decrease in the vaccination coverage, placing large vulnerable populations at risk (not least in hard-to-reach areas), a vaccination campaign was conducted in Al Hassakah governorate (Jabal Abdel Aziz) in response to the increased number of measles cases reported.

**Securing a needs-based approach**

**Assessments** - Between June and September 2013, WHO conducted assessments in 21 hospitals in the 7 most heavily affected governorates of the country through the crucial support of WHO focal persons operating from the targeted governorates and 36 partner NGOs and local health authorities across the Syrian Arab Republic. Information gathered at field level was assessed at central level in Damascus by the Programme Implementation Unit at WHO Syria and cross-checked with requests put forward by the Ministry of Health.

In parallel, several on-spot assessments were conducted by WHO staff while accompanying inter-agency convoys to Homs [Al Qussair and Hesya towns in rural Aleppo] (June 2013 and August 2013), Aleppo (July 2013), Hama (September 2013) and Dara’a (September 2013), which were crucial in identifying (i) life-saving medicines, supplies and equipment needs of five hospitals, (ii) overall damage that was caused by clashes taking place in the area and (iii) to exchange with medical staff on availability of health services and overall health challenges faced by the local population.

Other assessments conducted in between June and September 2013 were:

- Desk reviews for disease profiling and trends;
- Expert assessments (EWARS, WASH, Mapping of needs and coverage);
- Quarterly rapid assessment of health facilities;
- Real time assessments (Aleppo, Al-Hassakeh, Ar-Raqqaa, Deir-ez-Zor, Dara’a, Idlib, Rural Damascus, Damascus, Homs and Hama);
- Assessment reports on triage and proper case management;
- Trauma care assessments in the two main hospitals in Damascus, the main one in Homs and likewise in Hama on availability of supplies and equipment.

**Contingency Planning**
A Winterization Plan was developed and shared with Health Sector partners. The plan includes the procurement of influenza vaccines for high risk groups in IDP shelters.

Medicines to respond to severe acute respiratory infections, water-borne and other diseases (i.e. lice and scabies), and other diseases related to overcrowding conditions during winter time and indoor air pollution were procured and prepositioned in WHO warehouses in key locations for prompt dispatch in case needed in accordance with the detailed Logistics Plan that had been elaborated.

Due to the volatile security situation in the Syrian Arab Republic, the distribution/ pre-positioning locations for medicines and supplies had, however, to be modified in order to allow for safe and strategic storage. A warehouse was rented in Deir-ez-Zor and medicines/supplies were shipped there. In addition, kits and medicines were prepositioned in warehouses in Aleppo, Al Raqqa, Idleb and Lattakia.

Disease monitoring, surveillance and reporting

In September 2013, the mapping of existing sentinel surveillance sites and laboratories was successfully completed, as were capacity assessments of the sites in terms of information and communications technology, Human Resources, logistics, etc. To permit monitoring and to prompt timely and effective response, the disease Early Warning and Response System (EWARS) plays a central role. Following lengthy negotiations with Ministry of Health and Ministry of Foreign Affairs, up to the Prime Minister level, urging facilitation in line with International Health Regulations, an official agreement was reached in September 2013 to include reporting sites also from north and north-eastern governorates into the WHO EWARS (reporting directly to WHO focal points through private physicians and NGO service providers). As a result, today 278 sentinel sites are operational and the number is expected to reach 350 by the end of 2013.

Recent data received from some opposition-controlled areas are indicating an increased number of measles and diarrhoeal cases. Investigation and response activities were undertaken when necessary in such areas, such as (i) collection and testing of stool samples to investigate cholera and shigellosis (August 2013), (ii) shipment of diarrheal kits (August 2013) to respond to the increased number cases reported from Alshadada and Margada in Al Hassakah and (iii) collection and shipping of blood samples of measles cases to be tested in the reference laboratory in Damascus (July 2013).

Essential medicines for epidemic-prone diseases were procured and pre-positioned in different governorates. There is a need to review and update estimated costing against which programmes are budgeted given that when procuring against the Essential Medicines List (EML), the prices have been substantially higher than those indicated in the list. To permit more accurate planning and budgeting, WHO will be convening the stakeholders, who developed the EML in the fourth quarter.

Laboratories were also directly strengthened through the procurement of kits, equipment and consumables which enable better performance in detecting epidemic-prone diseases.

A first participatory review of the EWARS was conducted and finalized recently in collaboration with Ministry of Health professionals to identify ways to further strengthen the system. Based on the recommendations, a detailed Work Plan is being developed to improve the performance of the system including the quality of the weekly reported data. Furthermore, a EWARS monitoring and evaluation plan was developed to measure the impact of the system, with a set of indicators linked to the Country Office’s Implementation Plan for 2013-2014. The findings are also being used as an important tool by a large spectrum of health sector partners for planning and situation oversight.

WHO is sharing lessons learned to promote a coherent, mutually reinforcing approach for the neighbouring countries. WHO’s Emergency support team (EmST) in Amman is serving to engage stakeholders for disease control in Jordan, Iraq, Lebanon, Egypt and Turkey, also in coordination with the Centre for Disease Control and Response (CDC) staff in Turkey, to leverage synergies and promote streamlined approaches and activities, including via regular video and telephone discussions at the various technical levels.

Strengthening human resources was recognized as fundamental in allowing for smooth implementation of trainings and information flow between field and central level, as well as coordination between health sector partners. One national Programme Officer and one national EWARS Programme Assistant were hired to strengthen the team of EWARS professionals. These new staff members have significantly reinforced the capacity of WHO for timely (i) solving of administrative issues linked to training events, (ii) data entry for EWARS reports coming from focal points, (iii) uploading all relevant documents on the WHO GSM, etc. iv) negotiation with partners and v) drafting of critical guidelines for program functionality (which can be forward on demand). Due to the temporary reduction of
international staff in the Syrian Arab Republic, the recruitment of an international Communication Officer had to be put on hold and will be re-initiated once the restrictions on staffing will be lifted.

**Capacity-building**

In 2013, WHO supported numerous trainings on:

- EWARS (403 participants),
- EWARS data base (42 participants),
- Diarrhoea case management (103 participants),
- Surveillance and case management of brucellosis (83 participants),
- Tuberculosis (104 participants),
- Severe Acute Malnutrition (28 participants),
- Community-based management of acute malnutrition (56 paediatricians),
- Diabetes management (50 participants),
- Health information management (80 participants),
- Scaling up Mental Health support in emergencies (26 participants),
- First Aid (133 participants) [for UN staff].

Efforts were made to involve different kinds of health care providers present in the country.

**Strengthening due diligence**

During the third quarter, WHO undertook a number of measures to reinforce due diligence, in terms of monitoring, reporting, internal tracking of finances and in applying lessons from independent assessments to retain a critical perspective with a view to doing more with resources.

**Monitoring and evaluation**

Methods for monitoring progress of interventions being implemented by partners on the ground and for expanding partnerships continue to effectivize operations. This has sometimes proven difficult, particularly for Al Hassakeh, where the WHO focal point has to cross over into Turkey to send the information. Relying on up-to-date information, thanks to the regular health facility-based functionality assessments, and good coordination with health partners, activities may be modified to permit them to remain targeted and effective as circumstances evolve.

In order to effectively monitor and evaluate the implementation of the WHO the Syrian Arab Republic programme, a Monitoring and Evaluation Plan is being applied, based on the revised SHARP 2013 and embedded in the WHO Country Office 2013 Implementation Plan. It helps in monitoring progress against expected impact, as well as to report publicly on delivery at the following levels:

a) Level 1: Overall achievement of WHO health outcomes;

b) Level 2: Achievement of specific objectives within the Syrian Arab Republic [as per SHARP];

c) Level 3: Operational Effectiveness of the WHO Country Office (especially in terms of timeliness, accessibility and coverage);

d) Level 4: Organizational Effectiveness of the WHO Country Office (with focus on financial, human resources, procurement, security and coordination effectiveness).

Due to the restricted access to heavily affected areas, posing a challenge to programme implementation, innovative approaches for monitoring and evaluation have been put in place where necessary.

Methods used to monitor and evaluate WHO activities: Focal points report on health needs, as well as on low and empty stocks of priority medicines based on interviews with staff in health facilities, discussions with leaders of local NGOs and CBOs, and members of the health authorities in the respective governorates. Based on the focal persons’ reports, kits and essential medicines have been shipped directly to the identified hospitals and health centres. The WHO focal points also monitor the accuracy and timeliness of the distribution of medicines and medical equipment.

Assessments include supervisory visits to and tele-assessments of targeted sites. Data collection by medical and pharmaceutical students (21) on a monthly basis for monitoring and evaluation activities in their respective governorate is on-going. Spot-checks conducted by focal points have also proven effective, especially to assess the impact of activities implemented by partner NGOs. Using students is part of a broader participation approach that WHO is promoting.
An internal ‘Outcome Monitoring Plan’ was developed which clearly identifies activities, methodologies and timeframe for spot-checks. More participatory tools, such as the ‘Organizational Capacity Assessment’ grids, are being used to monitor and evaluate capacities of partner NGOs and provide capacity-building in a strategic way.

The Health Management Information Systems (HMIS) in the Syrian Arab Republic, as in any other country, are established to assist in the management and planning of health programmes which in turn ensure delivery of care. This is achieved by dissemination of vital information to the various players in the sector, through i.e. the compilation and dissemination of the 4W (who does what where and when) matrix for the Syrian Arab Republic. The ‘Dashboard’ – a multi-sector product that portrays the number of beneficiaries reached by each sector – is shared on a monthly basis with OCHA. WHO also contributes to the Humanitarian Bulletin which is then shared with all health sector partners. Information in regards to the health infrastructure damages are collected and shared with the sector on monthly basis through detailed maps.

The WHO supply tracking system, categorized by governorate, end user and beneficiaries reached, monitors the distribution and provision of kits, medicines and supplies to implementing partners, namely, MOH, MOHE, and local NGOs.

WHO receives monthly reports from the contracted NGOs detailing consultations/treatments provided, as well as health kits and medicines delivered in the geographical areas where the NGOs are present. Reporting follows WHO-developed formats with defined diseases, disaggregated by gender and age. Additionally, some of the WHO support to NGOs involves in-kind assistance, i.e. direct provision of kits and medicines. In-kind assistance is monitored initially through delivery reports and is later verified with number of beneficiaries reached per the specific items provided.

An Administrative Officer was hired to strengthen real-time oversight of expenditures. An internal tracking system was developed for resources and expenditures against agreed-upon activities and timelines. This detailed charting of implementation will permit analysis of factors facilitating good progress (and those hampering them) with a view to systematically improving performance and cost effectiveness.

Through the standardization of data collection and analysis, as well as the development of unified reporting formats, the WHO Country Office further improved transparency of operations vis-à-vis its multiple donors. The decentralized approach of the WHO Country Office in implementing activities and collecting feedback from the field necessitated the development of a strong framework for guidance in data consolidation and analysis based on best practices collated in the past six months.

### Distribution of funds per country 2012-2013

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### Percentage of funding by donor 2012-2013

- USAID: 30%
- UNICEF: 20%
- UNFPA: 15%
- UNRWA: 10%
- UNHCR: 10%
- OCHA: 5%
- WHO: 5%

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**Planned WHO responses October 2013 and beyond**

The specific figures included below relate to interventions for October-December 2013 as articulated in detail in the SHARP and further delineated in the WHO Country Work plan (forward).

The total financial needs of the health sector in the Syrian Arab Republic for January - December 2013 amounts to US$ 177 274 711 of which WHO has requested US$ 128 619 150. To-date the funding gap for WHO is US$ 56 million.

1. Strengthen trauma and referral management

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Details available upon request
Beneficiaries: 470 000 for trauma-related injuries and 50 000 for surgical assistance and 20 000 post-operative hospital care patients in Damascus, Dar’a, Homs and Deir-ez-Zor

- Delivery of trauma medical supplies and kits for primary and secondary health care; medicines
- 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.

**Cost:** US$ 34 481 550  
**Funding gap:** US$ 15 215 369

2. **Support health information management and coordination**  
**Beneficiaries:** 6.8 million people

- Develop 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 regular coordination.

**Cost:** US$ 5 050 000  
**Funding gap:** US$ 3 967 300

3. **Support delivery of primary health care**  
**Beneficiaries:** 6.8 million people including vulnerable groups

- 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 implementation of medical intervention.

**Cost:** US$ 46 806 600  
**Funding gap:** US$ 25 898 072

4. **Support delivery of secondary and tertiary health care**  
**Beneficiaries:** Approximately 6.8 million people including:  
430 000 diabetes patient out of which 40 000 are insulin dependent children  
5000 haemodialysis patients  
3572 tuberculosis patients  
56 000 cardiovascular patients  
42 000 chronic respiratory patients

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

**Cost:** US$ 17 935 000  
**Funding gap:** US$ 5 803 887

5. **Support mental health services**  
**Beneficiaries:** Approximately 3 million affected people

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

**Cost:** US$ 5 800 000  
**Funding gap:** US$ 2 405 098

6. **Strengthen the capacity for health response**  
**Beneficiaries:** the entire population

- Expand the EWARS to 350 sentinel sites;
- Training staff from governorates on surveillance;
- Strengthening capacity for response to epidemic-prone diseases;
- Strengthening the laboratory surveillance network;
- Conduct assessment, monitoring and evaluation;

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3 A miscalculation appeared in the second quarter Donor Update. It has been corrected here.
• Preposition essential medicines, medical supplies and equipment.

**Cost:** US$ 9 600 000  
**Funding gap:** US$ 2 240 095

7. Rehabilitation and restoration of damaged/ non-functional health facilities in affected areas to full operational capacity  
**Beneficiaries:** Entire population  
• To rehabilitate partly damaged health facilities in the affected areas in order to provide essential basic health services;  
• Provide essential equipment and supplies.  
**Cost:** US$ 5 480 000  
**Funding gap:** US$ 0

8. Water, Sanitation and Hygiene: Restoration of water supply, sanitation, solid waste, hygiene and drainage services in healthcare facilities and hospitals  
**Beneficiaries:** 2 000 000 Out of service hospitals in Aleppo 3; Rural Damascus 2; Homs 3; Hama 1; Id lib 1; Lattakia 1; Ar-Raqq 1; Deir-ez-Zor 2; Total: 14 (Approximately 1 500 000 people)  
Out of service health centres in Damascus 13; Aleppo 15; Homs 11; Lattakia 5; Deir-ez-Zor 11; Quneitra 12 Total: 67 (Approximately 500 000 people)  
• Support construction/repair work for water supply, water storage tanks, sanitation;  
• Facilities, in health facilities;  
• Construction for medical waste incinerator;  
• Training of health staff on healthcare waste management;  
• System in place of continuous water monitoring in certain areas and health facilities with identified problems.  
**Cost:** US$ 2 100 000  
**Funding surplus:** US$ 2,183,814

WHO has included only the most critical gaps for medicines in the SHARP. The Essential Medicine 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. WHO has demonstrated the ability to effectively respond to the increasing health needs of the Syrian population including addressing the severe shortage of medicines and medical supplies across the country. The health sector reached 75% of the targeted beneficiaries in its response in 2012.

**Early Recovery**

Beyond the needs for emergency humanitarian response articulated in the SHARP are those related to complementary more medium-term approaches, such as early recovery planning. A concept note to develop a National Agenda for the Reconfiguration and Strengthening of the Health System in Post-conflict Syria, which will comprise findings of assessments conducted in the field, as well as international best practices and recommendations, addressing both the early recovery and post-conflict phases has been developed.

Ideally, the Health Sector National Agenda will comprise of the implementation of a basic package of health services, accessible, acceptable and affordable by the whole of the Syrian population. Three overarching factors will potentially impact the rehabilitation of the health system: universal coverage, building capacities/ re-distribution of human resources and infrastructure rehabilitation. Experience from the Balkans and Libya has demonstrated that early recovery activities cannot start soon enough as duly diligent preparedness.

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Footnote:  
1 In agreement with WASH and health sector partners, it was decided to allocate an increased amount to the WHO WASH intervention area (for urgent water quality testing and repair of water sanitation in health facilities).