2023	**People in Need** **15.3M**	**People targeted** **11.5M**	**Requirements (US$)** **$548M**	**Partners** **80**	**Projects** **95**
2022	**People in Need** **12.2M**	**People targeted** **7.98M**	**Requirements (US$)** **$583M**	**Partners** **70**	**Projects** **85**

Two-year response strategy and priorities

The evolving complexity of Syria's ongoing humanitarian crisis in terms of emerging epidemics and outbreaks including the current cholera outbreak, combined with a worsening economic situation, deteriorating security situations in northern parts, and environmental pressures, are further stretching, and disrupting the country's already weak and fragile health system.

For 2023, the health sector will prioritize the below response strategies to provide life-saving health services to 15.25 million people in need, including those most at risk due to poor physical and/or mental health, as well as limited access to basic health care services.

- Expand and increase access to quality lifesaving and life-sustaining coordinated, equitable and quality humanitarian health services across all levels of care – community, primary, secondary, and tertiary. This will include emergency trauma and surgical services, and non-communicable diseases (NCDs) which are estimated to account for 45 percent of all mortality in Syria[1], reproductive and maternal health, child health – including immunization and nutrition services, mental health, diagnostic services, and specialized care for persons with disability, those with communicable and non-communicable diseases, and children with severe acute malnutrition with medical complications.

- Strengthen the health sector's capacity to prepare for, detect, and deliver a timely response to disease outbreaks, including cholera and other waterborne diseases (WBD), meningitis, measles, leishmaniosis, and COVID-19. Enhancing lab/diagnostic capacities and surveillance is critical to ensure improved timely detection, rapid response, and case management. Protecting the health of marginalized populations is prioritized for risk awareness and communicable diseases response including cholera and COVID-19 vaccination. Partners will increase activities that improve infection prevention and control (IPC) in healthcare facilities, in close collaboration with WASH and other sectors. A multi-hazards preparedness and response plan will be developed to respond to different multi-sectoral threats such as climate changes (drought, severe weather conditions), conflict, and epidemics/ pandemics including cholera, WBD, measles, leishmaniosis, and respiratory infections.

- Strengthen emergency preparedness and response capacity and restore damaged and non-functional health facilities (HFs) to **mainstream** early recovery in Syria's health response, address health inequity, and ensure access for marginalized and vulnerable populations. Further expansion of essential health services packages in all areas of primary and secondary care coupled with pre-service and in-service training of health care workers must be complemented with strengthened supply chain management and health information systems and bolstered by linkages with communities through outreach efforts such as community health workers, mobile medical units, and ambulance services.

[1] WHO, 2016.

The sector will aim to tackle and mitigate response challenges, including resource limitations and implementation capacities, through local community engagement and partnerships to ensure an inclusive, whole-of-society approach to health system recovery, inter-sectoral collaboration, integrated programming, and proactive engagement with humanitarian donors and other relevant stakeholders.

Cross-Sectoral Coordination

The health sector will work closely with related sectors to ensure the provision of integrated, equitable, and quality services to 15.25 million people in need of health services, particularly vulnerable, hard-to-reach, and marginalized communities (SPO 3.3). Close coordination with other sectors such as WASH, nutrition, food security, CCCM, protection, and GBV will be essential to ensuring the health system responds to disease outbreaks and the diverse needs of patients, particularly pregnant and lactating women, children under 5 and displaced people living in camps and camp-like settings (SPO 1.2 / 2.2). This will include the clinical management of rape, MHPSS, and integrated nutrition services – screening, treatment, IYCF (infant and young children feeding) awareness, nutrition supplies distribution, referral, and management of moderate and severe acute malnutrition with medical complications. Addressing maternal anemia in pregnant and lactating women will also be coordinated with the nutrition sector.

The multi-sectoral response will be prioritized to support the ongoing cholera outbreak response operations. The health sector is highly interdependent and relies on functional electricity, water, and road networks, as well as fuel supplies, for proper functioning. Integrated health and WASH interventions will be prioritized not only for effective WASH in HFs, but also to contain the ongoing cholera outbreak, and effective address water-borne diseases and other needs posed by the water crisis. Furthermore, multi-sectoral integrated risk communication and community engagement (RCCE) interventions will focus on awareness, infection prevention, and health-seeking behavior at the community and facility levels.

Finally, the health sector will be further coordinating with the Early Recovery and Livelihood (ERL) to make sure health system resilience actions are incorporated into the overall response strategies and activities.

Quality Programming

Through enhancing access, improving quality, and delivery of integrated essential health services package, the health sector will prioritize responding to the needs of the most vulnerable groups including 2.2 million children under 5 years, 4.2 million women of reproductive age (15 – 49 years), 700,000 older persons (age 60 and above), 5.3 million displaced persons –including refugees, IDPs and returnees, 2.7 million persons living with disabilities, and those with chronic disease. The health sector will contextualize and adopt all relevant guidelines, standards, and tools and support their dissemination and use in the context of Syria's health response. The health sector will also support building workforce capacity building to deliver quality health services response interventions.

Health sector partners will further prioritize sub-districts with the highest health severity scale ratings (3 and above), dense urban settings, and areas with lower/ limited functional health facilities, as well as last resort sites including camps and camp-like settings. An inclusive, integrated approach to health services delivery, including enhanced community engagement, will be used to cater to populations with specific response needs such as youth and younger persons, older people, and those with non-communicable diseases (NCDs), and people with mental health concerns and those with disabilities.

Delivery Modalities:

An all-modalities approach will be used to reach all people in need of humanitarian health services. Integrated mobile medical teams will be used to deliver services to newly displaced, rural, or access-constrained populations with no access to static health facilities. Camps and collective shelters rely on a variety of interventions – such as nearby health facilities, mobile health, or dedicated facilities within the site – depending on population size and movement restrictions. During hostilities, and particularly when HFs are affected and/or closed, health partners often relocate health services, personnel, and resources to areas closer to the affected people including IDPs. Community outreach mechanisms will also be used to boost health access, RCCE efforts, and integration of core health and nutrition services.
Health partners will support the operation of ambulances to move and refer patients between healthcare levels to ensure that people with emergency illnesses receive timely care. Furthermore, the health sector will ensure that essential medicines and supplies are made available to maintain the functionality of primary and secondary care health facilities, as well as support immunization services for IDPs, host communities, migrants, and refugees.

In areas where public health facilities are partially or non-functional, the health sector will collaborate with private care providers to ensure access to critical care for vulnerable patients – particularly for obstetrical services, surgical and trauma services, and treatment of complications from severe acute malnutrition. To increase access to childhood vaccines and primary health services, light Rehabilitation of Primary Health Care Centers will be undertaken based on multidimensional prioritization undertaken to reduce the burden of zero-dose children for the DPT1 vaccine. Finally, static, and mobile COVID-19 and routine vaccination teams will be expanded to increase vaccination coverage across Syria.

To accomplish this, the health sector will also strengthen inter-sectoral coordination, capacity building of both health partners and the health workforce, and advocate for increased funding for health response.

AAP and Community engagement:

As part of early recovery efforts and building resilient primary healthcare systems in Syria, communities will be empowered and engaged to strengthen linkages between healthcare facilities utilizing the community health workers. Enhancing community engagement will give them a voice and will make health systems accountable to communities. Furthermore, periodic assessments, ongoing monitoring by informatics agencies[2], rumor tracking, and community feedback mechanisms will support the health sector in understanding communities' perceptions of health services and their concerns about threats to health, including vaccine-preventable diseases, and COVID-19.

Messages will be adapted into local languages and those of the main migrant and refugee populations. The health sector will also implement training workshops on AAP, including community engagement through public health and community-based networks, media, schools and universities, and national and local authorities. Finally, all HRP health projects will be required to elaborate on how communities will be engaged throughout the project cycle.

Monitoring

The health sector response performance monitoring will be done in accordance with regional and global guidelines and standards. Existing health information management systems that record service delivery

[2] Such as REACH and HNAP

indicators such as medical consultations, reproductive health indicators, and routine immunization; information and findings from health sector partners' periodic assessments and surveys; EWARS/N and HeRAMS[3] data will be used to assess the sector's performance outputs and outcomes against targets that are set in the log frame on a monthly and quarterly basis[4].

Specific cholera response indicators will be included in the response monitoring tool, which will assess progress against the targets of the cholera response. In addition, the health sector will continue to monitor the COVID-19 response indicators including vaccination coverage, case management capacity, IPC, and training.

These reports will capture sex and age disaggregation for key service delivery indicators and monitor delivery against the health sector severity scale to ensure close alignment between the delivery of assistance and populations in greatest need. Third-party monitoring by some of the sector partners will also be used as part of monitoring mechanisms.

Cost of Response

Based on 2023 projects submissions, the health sector will prioritize projects addressing the specific needs of vulnerable groups, targeting areas of highest severity of needs, and containing a credible budget that reflects both the capacity of the submitting partner as well as realistic funding expectations based upon financial projections and operational realities for 2023. Prioritization is given to integrated, multi-sectoral projects that foster response to epidemics and early recovery activities.

High costs are driven by the difficult operating environment including Inflation, logistical barriers and insecurities that impede the delivery and maintenance of medical equipment, supplies, and medications, many of which require specific handling and environmental conditions. Insecurity, combined with an overall shortage of qualified medical providers, increases recruitment and retention costs. In many areas, the most feasible modality is mobile services, significantly increasing operating costs due to the requirement for vehicles and fuel.

The health response envelope supports a multi-layer response: community engagement, early warning, health security measures, clinical care, and specialized services with integrated MHPSS, GBV services, and physical rehabilitation. Vetting of projects will consider the appropriateness and completeness of the projects' package of services to meet needs against an average cost per direct beneficiary, as well as how well the partner addressed gender and disability inclusion, and protection issues. Partners will integrate Prevention of Sexual Exploitation and Abuse (PSEA) into response programming and will ensure accountability to affected populations and monitor and evaluate its implementation.

Finally, the ongoing cholera outbreak response operation – including oral cholera vaccine (OCV) campaign roll-out, increasing COVID-19 vaccination coverage, multi-sectoral programming, and the ongoing cross-border and crossline assistance are likely to increase overall funding requirements to sustain current service levels.

Breakdown of people in need and targeted for 2023

	BY POPULATION GROUP				BY SEX		BY AGE				DISABILITY
	IDPs	RESIDENTS	RETURNEES	PALESTINIAN REF.	FEMALE	MALE	YOUNG CHILDREN (<5)	CHILDREN (5-17)	ADULTS (18-59)	Elderly (>59)	PEOPLE WITH DISABILITIES

[3] Health Resources and Services Availability Monitoring System

[4] The majority of health service indicators are reported to Whole of Syria on a monthly basis.

In Need	5,272,583	9,930,292	48,108	N/A	7,672,188	7,578,794	2,229,759	4,581,878	7,730,592	708,753	2,672,017	
Target	4,294,302	7,175,821	29,645	N/A	5,759,638	5,740,130	1,712,524	3,487,502	5,792,392	507,350	2,046,706	

Target Figures (2023)

Governorate	PiN	Target
Damascus	1,363,888	1,022,916
Aleppo	2,759,832	1,884,952
Rural Damascus	2,377,857	1,774,250
Homs	676,370	338,947
Hama	910,681	605,932
Lattakia	789,917	570,096
Idleb	2,572,943	2,307,462
Al-Hasakeh	1,044,836	923,791
Deir-ez-Zor	894,407	742,816
Tartous	333,252	166,626
Ar-Raqqa	681,963	627,713
Dar'a	653,784	433,293
As-Sweida	131,404	65,702
Quneitra	59,850	35,272
Total	**15,250,983**	**11,499,768**