SYRIAN ARAB REPUBLIC
Preparedness and Response to COVID-19

Monitoring Report no.1

Issued 14 July 2020

This report summarizes progress and gaps for COVID-19 related preparedness and response efforts by humanitarian partners in Syria, as consolidated across all operational hubs.[1] For a general situation update please refer to the fortnightly Joint Response Update by WHO and OCHA (last issued on 5 July 2020)[2].

Situation Update

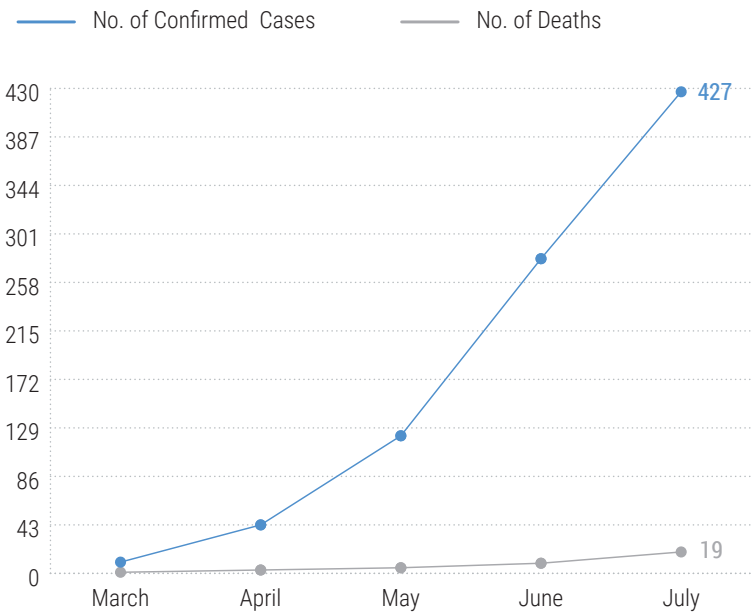
As of 14 July, the Syrian Ministry of Health (MoH) confirmed 417 cases of COVID-19, including 19 deaths and 136 recoveries. An additional six cases have been reported by local authorities in north-east Syria (NES), while to date four cases has been registered in north-west Syria (NWS).

Reported figures represent a sharp increase over the past month and underline why the Syrian population continues to be considered at high risk, particularly when combined with relatively low levels of testing, recent relaxation of precautionary measures, the accelerating spread of COVID-19 in neighbouring countries, reported infections of several health workers, and the debilitated state of the health system. Just over 12,100 tests have been conducted so far across the country[3], in six operational laboratories and one testing site.[4]

The socio-economic impacts of COVID-19, including from mitigation measures such as border closures and movement restrictions which were mainly implemented from March to May, have already affected large segments of the population. COVID-19 mitigation measures have added to the consistent macroeconomic decline of recent years, further spurred by the regional financial crisis in Lebanon. The latter has contributed to a significant depreciation of the Syrian pound (SYP), which reached its lowest informal exchange rate against the US Dollar in early June (SYP 3,200 to US$ 1). As a result, prices of essential goods and services have surged, further impacting a population already struggling to make ends meet.

Confirmed COVID-19 cases

As of 14 July



* The graph above shows all confirmed cases reported by Ministry of Health laboratories in Damascus, Homs, Lattakia and Aleppo in areas controlled by the Government of Syria (GoS) (417 cases), as well as those reported by local authorities in NES (six cases) and NWS (four cases) respectively.

1 The document on "Consolidated Planning and Requirements for COVID-19 Response" summarized response activities across all operational hubs in early May 2020. Associated costs of US$ 384 million are in addition to 2020 HRP requirements (US$ 3.4 billion).

2 Please refer to the fortnightly Syria UNOCHA-WHO COVID-19 Response Update (Response Update No.6, published 19 June), the Syria COVID-19 Update (No.12, published 14 June), and the 14 June Update on Impact of COVID-19 Measures on Access for more detailed information.

3 Approximately 9,331 tests carried out in four testing facilities within Syria in the Central Public Health Laboratory (CPHL) in Damascus and the public health laboratories in Aleppo, Lattakia and Homs Governorates. As of 14 July, at least 293 samples have been collected for testing in NES. 2500 samples were collected in north-west Syria, using polymerase chain reaction (PCR).

4 Testing laboratories and sites are distributed as follows: one Central Public Health Laboratory (CPHL) in Damascus; three public health laboratories in Aleppo, Lattakia and Homs; one testing facility in Idleb; one in Qamishli, currently operating two days a week, and one testing site in Tell Refaat.

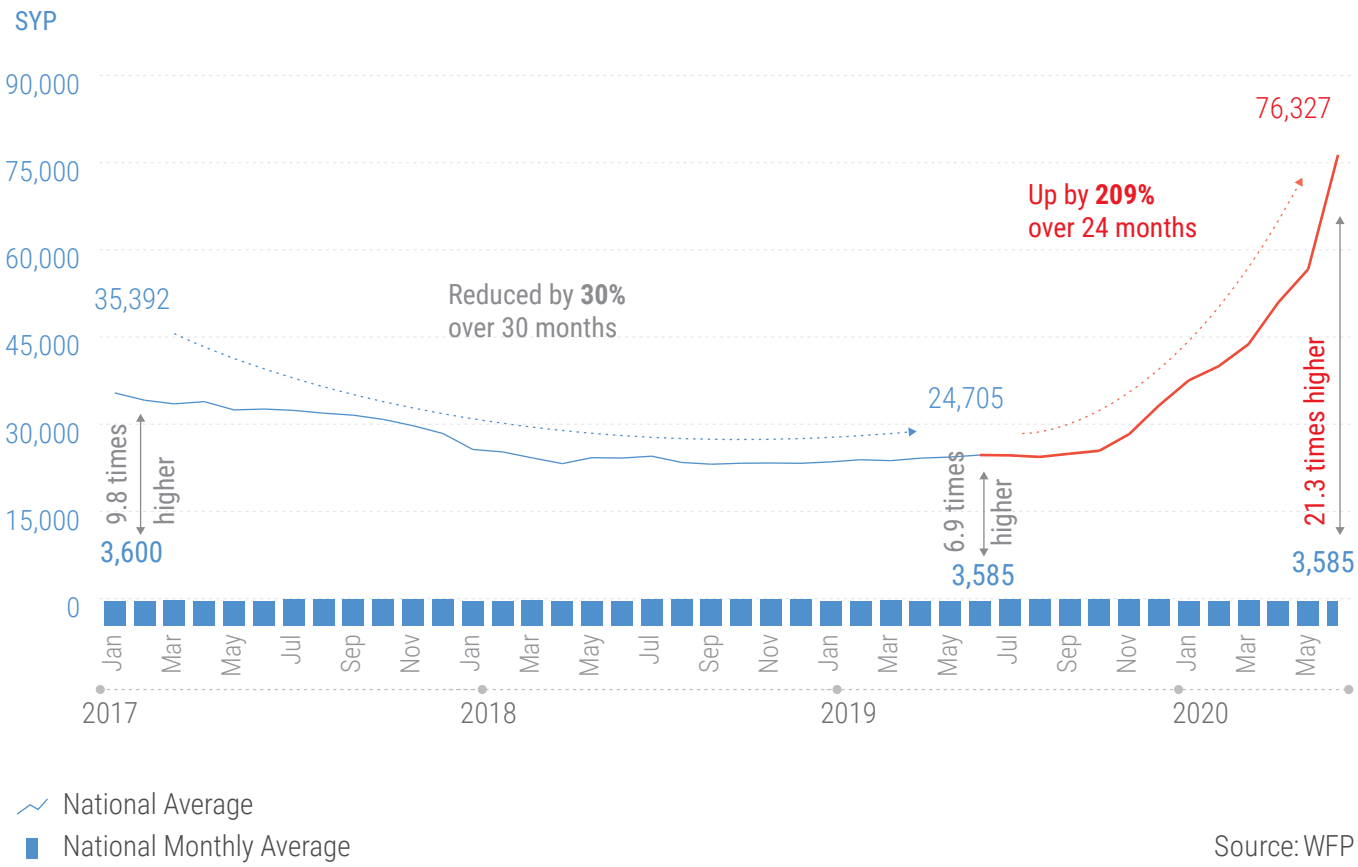
According to the World Food Programme (WFP), the price of an average food basket in early June stood at SYP 76,327, approximately 35 per cent higher when compared to the previous month – and over 200 per cent higher when compared to the same period in 2019. All 14 governorates reported average food basket price increases. Locally produced and procured relief items, notably WASH, sanitation supplies, and medicines, have also been affected by these price hikes, increasing humanitarian response costs and affecting the implementation of key humanitarian activities.

These developments have exacerbated existing humanitarian needs and have placed further stress on a population that has all but exhausted their ability to cope after more than nine years of crisis. According to WFP, 9.3 million people in Syria are considered food insecure as of late May – an increase of 1.4 million people in the past six months alone. Surveillance data shows that acute malnutrition rates have increased in IDP and remote areas, reaching between 22-34%. This is the first time NWS has presented such high rates since the Syria emergency response began. Consultations with reproductive health actors reveal that mothers' access to antenatal care (ANC) and post-natal care (PNC) has declined, with more than 50 percent of mothers not utilizing ANC/PNC services. Chronic malnutrition is rapidly increasing, with rates at 29% compared to 19% last year at the same time. The increased risk and rise of malnutrition, especially among IDPs, requires much more focus on food insecure households with pregnant women and children under the age of 59 months, young mothers, households with low purchasing power, and support on appropriate diets to help fight the risks of COVID-19 along with a scale-up in treatment for acute malnutrition of pregnant and lactating women (PLW) and children 0-59 months.

COVID-19 related restrictions and lockdowns have spurred the further loss of job opportunities, particularly for those reliant on daily wage labor or seasonal work, increasing the likelihood of more people being pushed into food insecurity in the coming months.

Women, children and other vulnerable groups such as persons with disabilities and the elderly are disproportionately affected by the overall deteriorating conditions, including with regard to protection issues and gender-based violence that have reportedly been on the rise in many parts of the country. Under these circumstances, maintaining basic humanitarian services is crucial, particularly as related to health, WASH, nutrition, education and critical protection services as well as comprehensive approaches to address basic household needs, as these have a direct impact on the vulnerability of at-risk populations.

Cost of average food basket



Source: WFP

Access to Services and Assistance

In June, the general relaxation of several COVID-19 preventative measures has continued across the country[5]. The daily curfew has been lifted, as has the travel ban between and within governorates – while localized lock downs have been imposed in two areas in rural Damascus in response to clusters of cases. Markets, restaurants, cafes, gyms, public parks, theatres, cinemas and most leisure facilities are now allowed to open, so long as precautionary COVID-19 measures are adopted. Mosques and churches are also open, including for group prayers, provided physical distancing is observed. Public and private transportation services have also resumed, as have universities and institutions. However, a number of public areas in Aleppo remained closed following the death of a COVID-19 patient on 27 June. Further reports indicate some other recent closure of public buildings due to COVID-19 in various locations, including mosques.

In north-east Syria (NES), the lockdown/ curfew completely ended as of 15 June. This follows significant relaxations of the curfew in previous weeks and limited adherence since the end of April. However, the Executive Council of NES Self-Administration has announced a new decree imposing movement restrictions, which was to enter into force on 13 July, foreseeing the closure of all crossings into NES without exceptions. Humanitarian cases, i.e. people travelling to KRI to seek health treatment and returning to NES are to be quarantined for a period of 14 days, except for humanitarian workers if they undergo quarantine in KRI 48 hours before entering NES. These measures add to cross-border movement restrictions already in place before the pandemic, with humanitarian supplies and goods allowed into NES only once a week. Moreover, funerals of people deceased due to COVID-19 will be halted and social distancing measures will be imposed during large gatherings, such as weddings, consolation tents and places of worship. These measures were to exclude students sitting exams in GoS-controlled areas. It is worth noting in this context that on 9 July, the Water Department of Al-Hasakeh city administration declared a state of emergency due to insufficient water provision from Alouk water station.

For education, here has been a gradual re-opening of schools and learning centers in both NWS and NES. In GoS areas, basic (9th) and high school (12th) exams started in June in GoS areas for 500,000 students, including around 3,000 students who travelled cross-line and from Lebanon to sit their exams.

The within-Syria nutrition response has also been severely hit by the pandemic, with over one million beneficiaries affected by the recent suspension and/or minimization of nutrition services and programs following the introduction of COVID-19 mitigation measures by GoS, mainly affecting mobile nutrition teams (who lack PPE); the provision of community-based services, such as blanket distributions, door-to-door screening, and IYCF counselling (given concerns around overcrowding).

Most land borders into Syria remain closed, with some limited exemptions (from Jordan, Iraq, Turkey and Lebanon), including commercial and relief shipments, and movement of personnel from humanitarian and international organizations. Borders with Lebanon and Jordan remain closed to civilians; humanitarian workers have been able to move between Lebanon and Syria. While a limited number of humanitarian workers have been able to enter Lebanon from Syria. The crossing points with Lebanon have remained open for humanitarian and commercial cargos. International flights remain limited, while Damascus, Aleppo and Qamishli airports are still operating domestic and cargo flights.

The border with Jordan remains completely closed. Access to Rukban from within Syria remains under discussion with the various parties while individual departures are being catered to, notably emergency medical cases. There are still no qualified medical personnel inside the camp and only a few commercial trucks recently managed to reach the camp (five trucks in May).

In north-west Syria (NWS), individual crossings to and from Turkey remain restricted while humanitarian and commercial deliveries are authorized. UN cross-border shipments continue and have in fact increased since early March while commercial trucks (used by most NGOs) were partially impacted. Humanitarian and commercial shipments, and NGO staff movements, continue from Turkey to Syria. Restrictions at the two crossing points of Deir Ballut and Ghazzawiyeh linking Idleb and north Aleppo areas, continue, however creating a limited impact on humanitarian shipments and crossings of staff.

In NES, there have been restrictions on cross-border movements through the Fishkabour-Semelka crossing since early March, and although the border remains officially closed, exemptions have been granted for international humanitarian NGO staff, allowing them to move once a week on Tuesdays. Border crossing for NGO staff in and out of NES is complicated and requires prior approvals, which is a significant change to previous procedures. The first movement back to NES on the 3rd of June allowed the NGOs to bring in 33 international staff (including 15 medical personnel), this was followed by subsequent crossings (7 and 13 staff) from KRI to NES. Now, movements are planned on a weekly basis.

5 Refer to COVID-19 Response Update No. 6 and 14 June Update on Impact of COVID-19 Measures on Access for more details

Funding Status

Consolidated financial requirements for COVID-19 response in Syria are part of the Global Humanitarian Response Plan (GHRP)[6]. US$ 384.2 million are required for the multi-sectoral response to COVID-19, to address both immediate health needs and secondary effects of the crisis. These requirements are in addition to the US$ 3.4 billion required for wider humanitarian programming, as established in the 2020 HRP before the COVID-19 crisis.[7]
As of 14 July, US$ 106.8 million have been received to support the COVID-19 response, covering 28 per cent of total requirements. Most funding has been received by the Health Sector (US$ 32.4 million) and the WASH Sector (US$ 18.6 million). To fully deliver against all sectors targets and ensure a comprehensive response, increased funding is urgently needed to address the health and socio-economic impacts of the crisis.

Funding Status

As of 14 July 2020

SECTOR	REQUIREMENTS (US$)	FUNDING (US$)	SHORTFALL (US$)	FUNDING SHORTFALL	%COVERAGE
Camp Coordination and Camp Management	8.1M	0.5 M	7.6 M		7%
Early Recovery and Livelihoods	20.7M	7.7 M	13 M		37%
Education	27.4M	-	27.4 M		-
Logistics	0.4M	-	0.4 M		-
Food Security and Agriculture	37.8M	0.4 M	37.4 M		1%
Health	158M	32.4 M	125.6 M		21%
Nutrition	10.9M	-	10.9 M		-
Protection	12.8M	4.2 M	8.6 M		33%
Shelter/NFI	33.2M	-	33.2 M		-
WASH	69.9M	18.6 M	51.3 M		27%
Multisector	5.1M	0.1 M	5 M		3%
Multiple Field clusters (shared)	-	42.8 M	-		
Total	384.2M	106.8M			

6 https://reliefweb.int/report/world/global-humanitarian-response-plan-covid-19-april-december-2020-ghrp-may-update-abridged
7 https://fts.unocha.org/appeals/924/summary

Response Progress

An initial set of indicators has been agreed to gauge progress against response targets across all hubs, as well as overall changes in needs and context. Monitoring of the COVID-19 response will be gradually expanded as current monitoring systems are being adjusted. It is to be noted that several response indicators reported against by sectors relate to pre-existing HRP programming which had to be readjusted to address secondary and tertiary effects of COVID-19.

Response progress for the health response specific to COVID-19 covers the period up until early June; indications of response progress by all other sectors cover the period up until the end of April, unless specified otherwise.

Health partners have made significant efforts to scale up capacities and to provide health staff with the required knowledge and equipment to prepare and respond to severe cases. Surveillance and testing capacity remain key bottlenecks in the response. Testing will need to be further increased to ensure cases can be detected in a timely manner and at scale – since the publication of the COVID-19 Consolidated Plan in early May, the daily testing capacity has been raised from 70 to 345[8], well below what is occurring in neighbouring countries. Increasing capacity of rapid response teams and for sample collection also remain priorities to improve case detection. More than 3,600 humanitarian personnel, particularly health care workers, have been trained in infection, prevention and control, and 1,180 health care workers have been trained in case management. Twenty-four (out of 54 planned) isolation centers have been set up at governorate level, equipped with life-saving essentials.[9]

As for other sectors, the Nutrition cluster has so far reached over 34 organizations with workshops on COVID-19 guidance to adapt nutrition programming. These include COVID-19 specific guidance on wasting and simplified treatment protocols to reduce close contact, IYCF continuation, Family Mid-Upper Arm Circumference (MUAC) capacity building, surveillance, and IPC of nutrition field workers. The guidance stipulates programmatic adjustments in the context of COVID-19 and is aimed at mitigating the risk of infection while ensuring continuity of life saving nutrition services. All hubs have developed COVID-19 taskforces to produce plans and support partners with nutrition program adaptations. From next month, the nutrition sector will present data on COVID-19 program adaptation by sub-district level with clear figures per service.

Partners across all hubs and sectors have worked to adjust Standard Operating Procedures (SOP), by integrating risk mitigation measures and communication into their activities, generally enabling distributions and service deliveries to resume after an initial slowdown when mitigation measures were put in place in March and April. Community or group-based activities such as education and protection services have been more seriously impacted by these mitigation measures. However, individual specialized protection, GBV and CP support continued to be provided remotely, with a quick adaptation to the new modality of service provision.

With COVID-19 directly threatening lives, compounding existing humanitarian needs, and placing additional stress on both people and systems, the multi-sectoral response is based on a shared understanding that health system capacity must be strengthened to respond to current and future cases. At the same time, critical humanitarian response and services need to be maintained and scaled-up where necessary to support a further deterioration in the lives of an already vulnerable population. Communication and awareness raising activities will continue to be crucial, as misinformation and rumors, complacency, and lack of risk mitigation behaviors are widely reported across all areas of the country and require continued community engagement efforts.

Response indicators listed below showcase achievements as well as response gaps in this regard. Figures also indicate critical gaps in specialized equipment, including for laboratories and beds for the treatment of severe and moderate cases. In light of market shortages and challenges with local procurement of some COVID-19 supplies, required COVID-19 supplies have been quantified and costed across all operational hubs, with estimated requirements totaling $122 million. Processes have been and are being established in all hubs to meet a portion of this supply demand through the Global Supply Portal for COVID-19.

8 Daily testing capacity varies significantly across Syria, with 250 tests performed on average within Syria, ninety in Turkey and five in NES.
9 Isolation centres are geographically distributed as follows: 14 in areas served by the Syria hub, 4 in Turkey and 6 in NES.

Crisis-Wide Response Progress

SECTOR	INDICATOR	TARGET	REACH				
			TOTAL	SYRIA HUB	TURKEY CROSS-BORDER	NES NGO CROSS-BORDER	REACH VS TARGET
Health Response							
Health	# of Health Care Workers (HCW) trained in IPC	2,300	3,603	2,233	701	669	158%
	# of laboratories established to test COVID-19	17	7	4	1	2[8]	41%
	# of Health Care Workers (HCW) trained in case management of COVID-19 patients	1,175	1,180	634	25	521	100%
	# of isolation centers established at governorate level and equipped with life-saving essentials such as ventilators, oxygenators and monitors	57	24	14	4	6	42%
	# of dedicated beds for COVID-19 critical cases	3,080	182	108	74	-	6%
	# of dedicated beds for COVID-19 moderate cases	1,592	772	423	90	259	48%
	Total daily testing capacity across Syria	2,000	345	250	90	5	17%
Multi-Sectoral Response							
Adjustment of SOPs, Protocols ,Trainings							
SNFI	# of SOPs, guidance notes, protocols and strategies developed by sectors, the ISC and HCT and shared to wider community on COVID-19 preparedness and response, including social protection		6				
CCCM	# of Sites Camp that have Management Systems developed/ supported	993	351				35%
Protection	# of SoPs, training tools, guidance, protocols and strategies developed by protection sector and AoRs related to COVID-19	5	4				80%
Communication and Awareness Raising							
Protection	# of people / interventions reached with (age-appropriate) awareness messages for COVID-19	1.2M	233,095				19%
	# of communities with established hotlines (phone, email and SMS) functioning and/or increased access to timely and accurate information on COVID-19 from credible sources	0	26				

SECTOR	INDICATOR	TARGET	REACH				
			TOTAL	SYRIA HUB	TURKEY CROSS-BORDER	NES NGO CROSS-BORDER	REACH VS TARGET
WASH	# of people reached on COVID-19 through direct messaging on prevention and access to services (excluding mass media)	1.5M	710,813	115,810	91,640	103,363	 47%
Service Delivery							
Protection	# of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic that receive assistance adapted to COVID-19	626,901	16,112				3%
	# of GBV response services provided during COVID-19 crisis to survivors and/or women and girls at risk	276,375	16,672				6%
Shelter	# of people reached with critical Shelter assistance		180				
NFI	# of people reached with critical NFI assistance	252,825	184,672				 73%
CCCM	# of IDP benefited from Community Health Workers and WASH Committees administered by the camp management	1.5 M	214,000				 14%
ERL	# of people enrolled in and benefitting from a social safety net to support the most vulnerable and ensure the inclusion of COVID-19 affected populations in the targeted beneficiary groups	50,000	383				1%
	# of critical livelihoods infrastructure (including through cash-based modalities) rehabilitated as mitigation to the impact of COVID-19 preventive measures	25	1				4%
	# rural and urban entrepreneurs affected by the pandemic preventive measures assisted	200	0				
WASH	# of people reached with critical WASH supplies and services to strengthen Infection Prevention and Control (IPC) measures • # of people reached through expanded water services and operational support to water systems to ensure continuity of safe water supply and enabling handwashing environment	6M	4M	695,930	3.2M	150,641	 67%
	# of people reached with critical WASH supplies and services to strengthen Infection Prevention and Control (IPC) measures • # of people reached through provision, rehabilitation or maintenance of WASH/sanitation facilities in support of social distancing, cleanliness and handwashing	2M	250,551	87,289	57,770	105,492	 13%

SECTOR	INDICATOR	TARGET	REACH				
			TOTAL	SYRIA HUB	TURKEY CROSS-BORDER	NES NGO CROSS-BORDER	REACH VS TARGET
WASH	# of people reached with critical WASH supplies and services to strengthen Infection Prevention and Control (IPC) measures • # of people reached through hygiene items distribution to enable appropriate handwashing and cleanliness	3M	712,916	117,913	0.5M	103,363	 24%
Education	# of children supported with distance/ home-based learning	3.4 M	41,993	6,665	34,925	403	1%
FSS	# of targeted people supported with hygiene kits as part of general food assistance		592,155				

Hub-Level Response

Within Syria, including north-east Syria

Changes in needs and context

While the number of confirmed COVID-19 cases in Syria remains relatively low, cases have increased more than five-fold in the past month – from 50 as of 16 May to 417 as of 14 July – with new clusters emerging following a series of repatriation flights and cross-border commercial movement. The total number of governorates affected is now eight – Damascus, Rural Damascus, Dar'a, As-Sweida, Homs, Lattakia, Hama and Quneitra, although 85 per cent of all cases have been recorded in just two governorates – Damascus (53 per cent) and Rural Damascus (34 per cent). Based on information currently available, 92 per cent of cases are related to contact with confirmed cases and travel. 52 per cent of confirmed cases are among men and 48 per cent among women. The case fatality rate is currently 4%. To date, at least 22 health care workers have been infected with COVID-19.

The GoS continues to maintain a widespread easing of preventive measures introduced throughout May. However, in recent weeks, as additional clusters of reported cases have emerged, lockdowns have been imposed on Ras al-Ma'ara town and Jdaidit al-Fadel town in Rural Damascus. Between 29 April - 13 May, eleven incoming repatriation flights holding some 2,270 Syrian nationals arrived in the country; 78 passengers on these flights were later confirmed as having COVID-19 cases (mainly from Kuwait, UAE and Sudan), prompting the suspension of all such flights. However, on 22 June a repatriation flight brought 250 Syrian students who had been reportedly stranded in India to Damascus. Another repatriation flight for 250 Syrian nationals from India also arrived on 2 July. Up to 1,200 Syrian students are understood to still require repatriation in total. The GoS has reiterated in the reporting period that a "full curfew" remained possible, should factors related to the virus necessitate it.

A number of traders are reported to be experiencing a notable drop in stock levels, with some commodities not available, including vegetable oil and sugar, due to wholesalers waiting for the stability of the informal exchange rate. Shortages of other essential commodities, such as medicine, have also been reported in recent weeks. Many humanitarian partners have reported that the volatility of the informal exchange rate has forced a temporary suspension of local procurement, including vital COVID-19 related materials such as personal protection equipment (PPE), as suppliers have withdrawn tenders.

Some partners have further indicated that as a result of the inflation a redesign of budgets was being considered, and that programme delivery would likely be delayed.

The response within Syria remains focused on enhancing technical capacity and awareness, including on rational use of PPE, case management, infection prevention and control, environmental disinfection, and risk communication; as well as procuring and enhancing integral medical supplies including in laboratory testing and PPE, for case management and healthcare facilities. Among others, the following achievements can be highlighted:

- An estimated 12 million people have been reached by television and radio awareness campaigns, and printed information, education and communication (IEC) materials since March, while more than six million people have been reached through social media;
- Active surveillance activity has been taking place across 125 hospitals, 25 active surveillance teams and 115 personnel;
- 111 rapid response teams have been deployed in 13 governorates with 432 personnel trained in COVID-19 surveillance;
- National laboratory testing capacity for COVID-19 diagnosis has been expanded from one location – Damascus – to four (Damascus, Aleppo, Homs, and Lattakia);
- More than 1.3 million PPE items, including surgical masks, gloves, reusable heavy-duty aprons, gowns, headcovers, alcohol hand-rubs, medical masks, goggles and coveralls, and alcohol hand-rubs have been delivered to the MoH, partners and national hospitals, including in Qamishli, Al-Hasakeh, Menbij, Ar-Raqqa and Tabqa;
- Eighteen ambulances have been specially equipped to support COVID-19 related referrals.

To date, local transmission has only been identified in Damascus and Rural Damascus with other cases clustered in time, geographic locations and/or by common exposure, meaning that there is still time to prepare and respond. However, funding for the response within Syria remains a major concern; the current gap for case management alone is 90 per cent (US $6.5 million) of overall requirements, while only 10 per cent of these supplies (ventilators, oxygenators, intubation etc.) can be procured locally, with local exchange rate fluctuations further complicating the situation. Issues with the quality of PPE available on the local market is a further constraining factor, with it currently extremely difficult to source N95 masks, face shields and goggles. Currently, there is also a gap of $1.1 million for PPE.

North-East Syria (NES) - NGO Response

Changes in needs and context

As of 12 July, local authorities have confirmed a total of six cases of COVID-19 in NES, all from the same cluster in Al-Hasakeh city. Even though the number of suspected and confirmed cases is lower than initially expected, the risk of transmission remains high due to pre-exiting vulnerabilities amongst internally displaced people (IDPs), overcrowded last-resort sites, dense urban centres and limited health system capacity. In addition, since mid-May there has been a significant increase in movements into NES, both via cross-line transit points between GoS and areas outside of Government control or border crossings with the Kurdistan Region of Iraq (KRI), including students traveling from areas outside of Government control to GoS areas to sit their national exams, as well as Syrians returning to NES via border crossings with the Kurdistan Region of Iraq (KRI). Low surveillance capacity and inconsistent application of quarantine and screening procedures compounds these risks, limiting the ability to detect cases early and break-up transmission chains.

Changes in the operating environment

NES NGOs rely on a combination of local procurement, procurement from KRI and international procurement for basic medical items (such as basic PPEs). Local supply chains in NES have been affected by disruptions to cross-border and cross-line commercial activity and the overall economic crisis, while partners also face restrictions on procuring and importing items from KRI, including restricted humanitarian supply movement across the border. Over the past weeks there have been widespread reports of shortages in basic medicines at pharmacies in NES, with over 80 per cent of all pharmaceuticals in NES manufactured within Syria. This has contributed to an increase in prices at both public and private facilities, already contributing to an increase of admissions at 'free' healthcare points, including NGO supported facilities.

Response achievements and gaps

Since March, NES NGOs have conducted COVID-19 risk awareness/ communication activities in at least 30 sub districts out of 35 under the control of SA (i.e. 86 per cent of sub-districts in NES) reaching 51 communities and 20 IDP last resort sites. Core messaging has been delivered across all 71 locations, and tailored messaging has been delivered to 39 locations. Efforts are ongoing to improve overall reporting coverage and enhance joint operational coordination between NES NGOs and UN/NGO partners. The priorities under the Infection Prevention and Control (IPC) pillar include ensuring adherence to minimum IPC standards in health facilities and crowded public spaces. Complementing messaging and outreach activities, IPC-based interventions are also particularly critical in areas where sanitation conditions and hygiene practices are poor. Overall, gaps remain most extensive in informal settlements, informal camps as well as in collective centres outside Al-Hasakeh city. In Deir-Ez-Zor alone, almost 3,000 HHs living in these last resort sites are currently not being covered with any COVID-19 related assistance. A key priority is to finalize initial construction and preparation work for all COVID-19 referral facilities for moderate and severe cases to meet minimum standards. Out of the 103 intensive care unit (ICU) beds for critical cases none are fully operational (only 1 mixed ward, also supporting non-COVID cases, is available to receive patients), while only 309 of 975 beds planned for moderate-severe cases are currently online (with no beds currently available in non-GoS controlled areas Deir-ez-Zor. In addition, the procurement and delivery of critical medical equipment to NES remains a challenge due to a combination of global supply shortages as well as restrictions on the ability of NES NGOs to procure supplies in KRI for export to NES, including, in some cases, the imposition of taxes, levied specifically on items imported by NES NGOs.

North-west Syria- Turkey Cross-Border Response

Changes in need and context

As of 27 June, of samples from patients collected in NWS four samples tested positive, while all other cases tested negative. The COVID-19 taskforce continues to coordinate the application of relevant IPC measures across NWS including Points of Entry (PoEs).

The effects of mitigation measures, coupled with the rapid devaluation of the SYP, continue to exacerbate the humanitarian needs of 4 million people living in the area, including 2.7 million internally displaced. The price of the minimum expenditure basket reached historical highs in May 2020. Reports of gender-based violence and related protection issues are on the rise. Longer-term needs of displaced persons are increasing, and in some cases, are becoming more complex. All civilians, displaced and resident population, living in north-west Syria have been impacted by the economic downturn. Those in displacement may be disproportionately impacted. Humanitarian actors are facing a more complex operational environment and have adapted key activities and procedures to mitigate COVID-19 related risks.

Status of preparedness and response measures

Functional triage across the health facilities is a key activity being coordinated under the taskforce and managed by health partners. The taskforce is monitoring the referral system at health facility level, including the level of treatment required and availability of services and beds, and inter-facility transfer in order to improve coordination across the care continuum. Plans are underway to provide 41 health facilities with PPE material (masks and surgical gloves) for three months. The ventilator capacity will be increased to support three active COVID-19 referral hospitals and two in-planned ones.

The Coronavirus Awareness Team (CAT) is working on an enhanced digital communication strategy. As of 11 June, six health cluster members reported utilizing 345 awareness workers to reach 19,853 beneficiaries with different awareness-raising activities, 459 NGO workers participated in related trainings. Clusters have collaboratively distributed 720,000 food parcels with soap, including 420,000 with COVID-19 stickers, instead of the in-person distribution of brochures.

Response achievements and gaps

There have been some delays in starting operations of COVID-19 Community Based Treatment Centres (CCTC), and only two CCTCs (out of 30 planned) are in place. Information gathering through ad-hoc surveys from different partners at the field level is underway in order to identify gaps in the COVID-19 response effort.

During the initial stages of the pandemic, humanitarian actors had to cease or reduce certain activities to allow them time to identify and implement mitigation measures adapted to the current environment in an effort to keep people in need and humanitarian staff safe - mainly affecting education and protection programming. Major gaps in personal protective equipment (PPE) persist, especially for non-health cluster members, essential to execute regular activities of the clusters in case of an outbreak.