**DRAFT**

A close up of a logo

Description automatically generatedturkeyhub_transparent.png

***WORKING DOCUMENT***

**COVID-19 Preparedness and Response Plan for Northwest Syria (NWS)**

Gaziantep, Turkey

*(v7.1 draft, 26 March 2020)*

# Purpose of the document

# This document has been developed for the governorates of Northwest Syria to establish a local plan of action to support the districts, sub-districts and communities of Aleppo and Idleb to rapidly accelerate the scaling up of their capacities for the prevention and early detection of, and rapid response to, coronavirus disease 2019 (COVID-19), as required under the International Health Regulations (IHR 2005). This local plan is aligned with the WHO global 2019 novel coronavirus strategic preparedness and response plan, but tailored to the local context.

# Background

## Global situation of COVID-19 outbreak[[1]](#footnote-1)

# Coronaviruses are zoonotic viruses that circulate amongst animals. Some have been identified in humans, causing illness ranging from mild symptoms to severe illness.

# On 31 December 2019, WHO was alerted to several cases of pneumonia of unknown origin in Wuhan City in the Hubei Province of China. One week later, on 7 January 2020, Chinese authorities confirmed that they had identified a new virus as the cause of the pneumonia cluster. The new virus is a coronavirus, belonging to the same family of viruses that cause the common cold, as well as viruses that cause severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome coronavirus (MERS-CoV).

# Since the first cases were reported, WHO has been working with the Chinese authorities and global experts to learn more about the virus, including the source of infection, how it spreads, its severity, the high-risk groups, how best to treat patients and how to control the outbreak. Furthermore, WHO has been working with countries to better prepare for and respond to the situation or an epidemic.

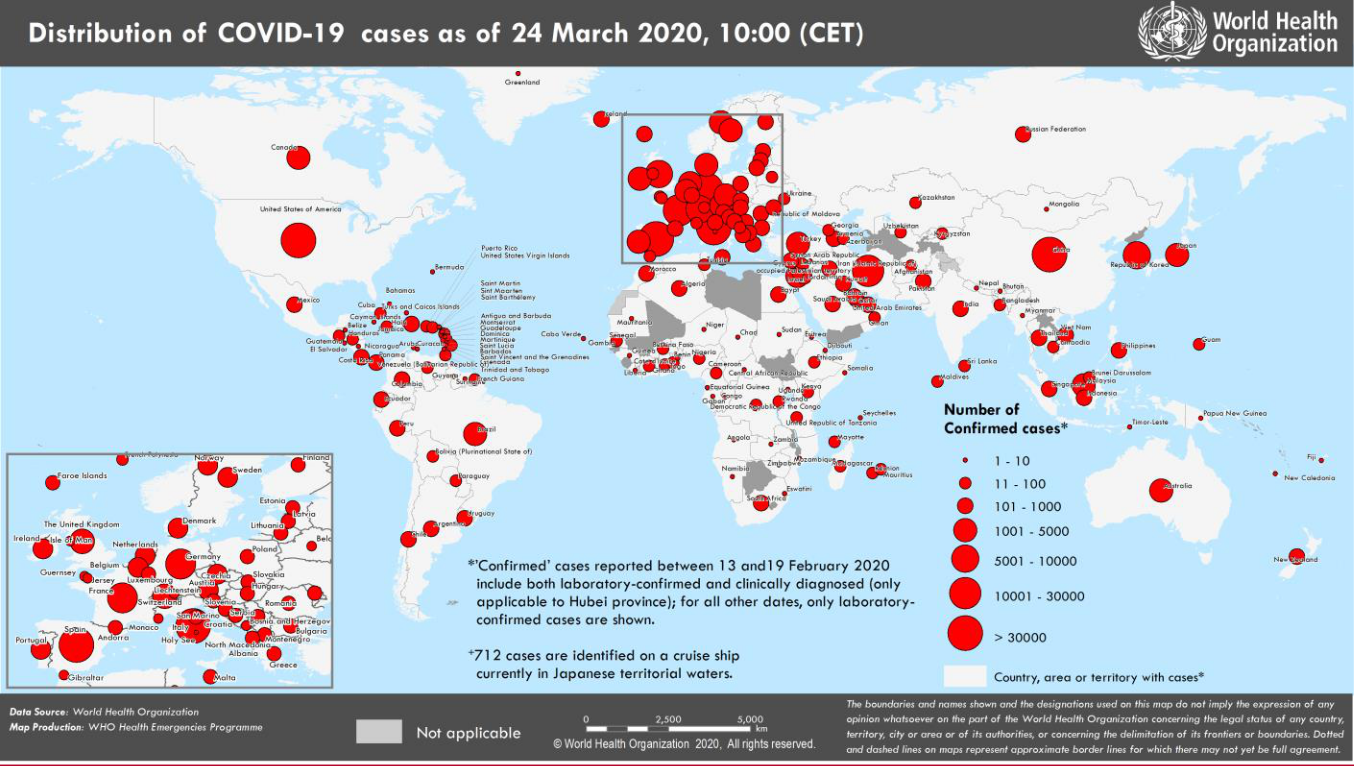
# The number of confirmed cases worldwide has now exceeded 300 000. As of 24 March 2020, a total of 372,757 (laboratory-confirmed) cases of COVID-19, including 16,231 associated deaths (CFR:4.4%), have been reported from 193 countries. The daily number of new confirmed cases in China has been stabilizing since the end of February. However, a continued increase in the number of cases and the affected countries have been observed since the middle of February, and the risk of spread and impact of COVID-19 have become very high at the global level. It took over three months to reach the first 100,000 confirmed cases, only 12 days to reach the next 100,000 and only 4 days to reach the next 100,000. The number of cases in the current pandemic is likely to have been underestimated since the symptoms are similar to seasonal influenza or other acute respiratory infections (ARI), and the figures will rise as testing increases.

## PHEIC declaration1

# The IHR (2005) Emergency Committee on the outbreak of COVID-19 was first convened on 22‒23 January 2020, and subsequently reconvened on 30 January 2020. The WHO Director-General declared the COVID-19 outbreak to be a public health emergency of international concern (PHEIC) after the second meeting. On 11 March 2020, WHO declared COVID-19 a pandemic, pointing to the over 118,000 cases of the coronavirus illness in over 110 countries and territories around the world and the sustained risk of further global spread The Emergency Committee has provided recommendations to WHO, to China, to all countries and to the global community, on measures to control the outbreak. The Committee believes that it is still possible to interrupt the spread of the virus, provided that countries establish strong measures to detect disease early, isolate and treat cases, trace contacts and promote social distancing measures commensurate with risk.

## Regional situation of COVID-19 outbreak[[2]](#footnote-2)

In the Eastern Mediterranean Region (EMR), as of 24 March 2020, 19 countries have been affected by COVID-19 and reported 27,215 confirmed cases with 1,877 deaths. Although the first confirmed case of COVID in the EMR was reported from UAE on 29 of January 2020, Iran has been identified as the most affected country in the region, with 23,097 cases and 1,812 deaths. The concerns about the surge of cases and deaths in the region and increase in the number of travel-related confirmed cases is very high. Further Turkey has reported 1,529 cases in the same timeline, with Syria reporting its first confirmed case this week.

**Figure 1: Countries, territories or areas with reported confirmed cases of COVID-19, 24 March 2020**

## North-western part of Arab Republic of Syria -current situation and risk of COVID-19

In the North-western Syria (NWS), there is ongoing military operation which has escalated significantly since December 2019 as the government forces of the Syrian army advanced towards Idleb governorate.

According to the UN Humanitarian Needs Assessment Programme (HNAP) Monthly Mobility and Needs Monitoring report for February 2020[[3]](#footnote-3), the ongoing violence in north-west Syria has resulted increased the monthly displacement rate nearly 9x since November 2019. In February 754,078 IDP movements were recorded, which was 119% increase from the previous month. Three sub-districts in Idleb and Aleppo currently host 56% of recent IDPs (Dana, Salqin and Azaz). Dana sub-district remains the most impacted by displacement, hosting 33% of this month's IDPs. 51 percent of February IDPs are first-time displaced, demonstrating impact of recent hostilities and expanding frontlines on non-IDP households.

Shelter conditions are of great concern, with 47% in emergency shelter and 15% in sub-standard buildings. To date, limited population movements from North-western Syria (NWS) have been observed in parts of eastern Aleppo. Further, the evolving political and military situation in NWS may trigger further developments within NES as negotiations unfold between parties to the conflict.

As for NWS, there is limited laboratory diagnostic capacity to confirm (as of 24th March 2020). Based on the current epidemiological situation in the region with the rapid spread of cases in neighbouring countries, WHO considers the overall risk for Syria to be very high. Considering the disrupted and fragile health system, the risk of the spread of diseases is high in Aleppo and Idleb governorates. The overall capacity of preparedness and response in Syrian Arab Republic is considered as level 2 out of 5 (based on IHR annual report 2019),[[4]](#footnote-4) where 5 is the highest capacity, which indicates a limited capacity that requires technical and operational support.

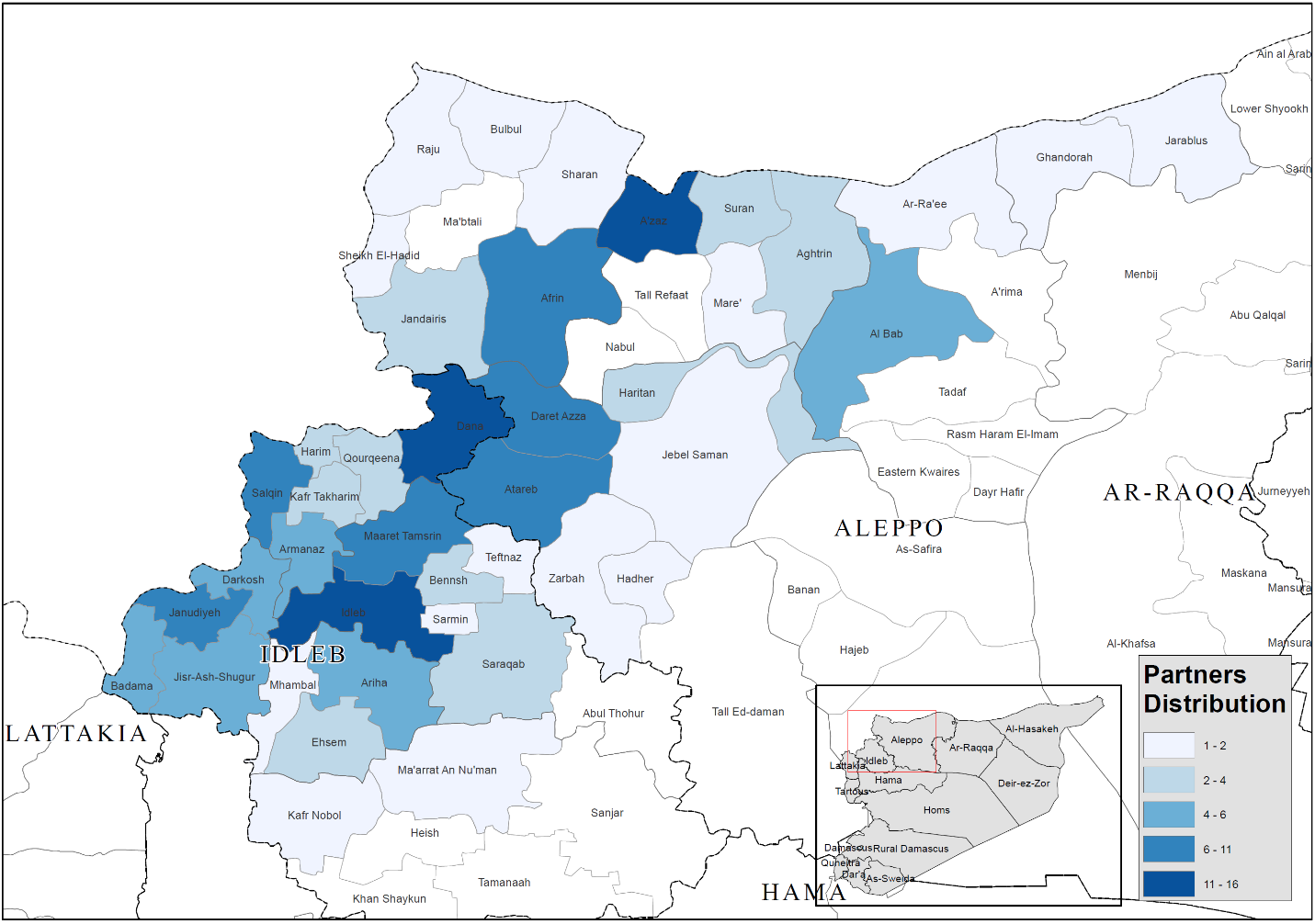
## Health facilities in NWS

As per reports from Health Resources and Availability Monitoring System (HeRAMS) on March 9, 2020, in NWS, out of total 571 health facilities, only 299 are functioning, 239 are non-functioning and 33 have no reports. The functioning are managed and supported by health partners. Among them, 54 (18%) are Hospitals, 125 (42%) are fixed PHCs, 52 (17%) are mobile clinics, 41 (14%) specialized care centres, while 27 (9%) others health facilities (e.g. Ambulance network, Blood Bank, Central Laboratory etc). About 57% of these functioning health facilities are located in Idleb and 40% in Aleppo; while the remaining 3% health facilities are in the North-eastern part of Syria (in Al-Hasakeh, Ar-Raqqa, Deir-ez-Zor governorates). The following table and the map show the distribution of the functioning health facilities in the NW Syria.

**Table 1: Distribution of functioning health facilities in the NWS per facility type**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Governorate** | **Hospital** | **PHC** | **Specialized Care Centre** | **Mobile Clinic** | **Other** | **Total** |
| Idleb | 36 | 69 | 24 | 24 | 17 | 170 |
| Aleppo | 18 | 55 | 17 | 21 | 10 | 121 |
| Al-Hasakeh\* |  | 1 |  | 2 |  | 3 |
| Ar-Raqqa\* |  |  |  | 3 |  | 3 |
| Deir-ez-Zor\* |  |  |  | 2 |  | 2 |
| **Grand Total** | **54** | **125** | **41** | **52** | **27** | **299** |

*\*Governorates belong to the North-eastern part of Syria (Source: HeRAMS, 9 March 2020)*

**Figure 2: Distribution of health facilities among health partners in NWS** (WHO, January 2020)

## IDP Situation

Since 1 December 2019, there are 186,458 families/959,258 individuals displaced in Northwest Syria. While 80% of the total IDP population are children and women, most them are in Dana, Azaz, Maaret Tamsrin, Afrin and Salqin sub-districts. Reportedly 2,721 individuals are seeking shelter, nearly 400,000 of them are displaced to camps, collective centres, and tents. Due to the lack of shelter 23,000 IDP have taken schools as shelter[[5]](#footnote-5).

## Risk of importation of COVID-19

The risk of imported cases in Syria including its North-western territory and further local transmission in the community seems high owing to the following reasons:

1. There has been a surge of cases in neighbouring countries, including those that share borders with Syria, such as Iraq, Lebanon, Jordan and Turkey.
2. As of 25 March, the Syrian Arab Republic News reported that the Health Ministry announced that the four’ case of COVID-19 was detected in Syria to raise the total number to five.[[6]](#footnote-6)
3. There is large and frequent population movement between Syria and Iran, and the government of Syria currently does not put any entry restrictions on Iran. Until this week, there had been direct flights from Iran to Syria. In addition, there is an Iranian military base stationed in Deir-ez-Zor which is a neighbouring governorate of;
4. Several mass gatherings are expected over the next months for the occasion of Ramadan and other Shia holidays, which may trigger an outbreak among the community;
5. Failure to detect suspected cases is likely due to the current disruptive surveillance system, which covers public, NGO supported and/or private health facilities, along with the limited capacity of physicians and health care workers, also due to nonspecific presentations and co-circulation of other respiratory diseases as the ongoing H1N1 outbreak;
6. There is disrupted capacity of contact tracing and case management due to the fragile health system with limited availability of medical equipment and health facilities.
7. Based on the current data, CFR in Iran is 4.4% higher than global CFR.[[7]](#footnote-7)
8. Vulnerable populations reside across the country, such as IDPs in the Northeast and Northwest of Syria who are more susceptible to disease due to limited access to health care and deteriorated living conditions. Also, armed conflicts are ongoing in Northwest Syria, which increase the vulnerability among the population to any infectious disease.

# Preparedness and response plan for COVID-19 in NWS

## Pillar 1: Country‑level coordination, planning, and monitoring

In Gaziantep, WHO have liaised and engaged the international partners and stakeholders to ensure an effective coordination and implementation of the activities related to COVID-19 in the governorates of the NWS. The WHO lead Turkey Health Cluster has already convened coordination meeting with the health cluster partners on 3rd of March 2020 to brief and discuss on the COVID-19 preparedness and response plan for NWS. On the same day, they formed a 14-member Task Force for COVID-19, based in Gaziantep, followed by another Task Force meeting on 10th March 2020 where they identified the relevant partners for relevant activities under 8 pillars and distributed the activities across them. A contact list of Task Force members and the Focal Points for each pillar have been appended in Annex 3 and Annex 4 of this documents. In addition, bilateral meetings between relevant partners under different pillars have taken place in between.

One of the key Health Cluster partners, the Assistance Coordination Unit (ACU) has already translated a few WHO COVID-19 related materials into Arabic for distribution (e.g. “Home care for patients with suspected novel coronavirus (2019-nCoV) infection presenting with mild symptoms and management of contacts Interim guidance 04 February 2020” and “Getting your workplace ready for COVID-19”). A detailed activity plan under the Coordination has been outlined in Annex 1 of the document. With support of OFDA, WHO GZT plans to organize 6 coordination meetings, and conduct a workshop on IHR for all stakeholders in Gaziantep.

The Health Cluster, although with over 120 partners and members, only one third are the final implementing partner the in cross border field operations as of February 2020. The surge call to support the COVID-19 response by international NGOs have been limited by the inability to bring surge human resources as travel ban are been implemented worldwide.

## Pillar 2: Risk communication and community engagement

Risk communication and community engagement (RCCE) is a critical aspect of public health interventions, which is required to raise awareness and avoid the spread of misinformation and panic in the community. Risk communications teams from ACU, UNICEF, WHO Gaziantep with the health cluster implementing partner (UDER) have identified 7 districts (Afrin, Azaz, Albab, Jarablus, Harim, Idleb and Jisr Ash-shugur) with 28 sub-districts to implement the planned activities. There will be at least one focal point in each of those sub-districts (depending on the size of population and density of population in the communities and the accessibility among the communities in the sub – district). Those focal point will be selected from the already existing team-leaders who will be trained by the central team on the specific approach for COVID- 19 response and will be linked with the District Level Officers (DLOs) from Early Warning Alert & Response Network (EWARN) teams to activate the surveillance system and support the rapid response in case there are suspected cases.

The focal points will train the Community Health Workers (CHWs) teams on the specific key health messages to be delivered to the communities during the house hold visits and will explain how to use and distribute the Information, Education and Communication (IEC) materials (which will be developed in this regard). Each focal point will build a network in his / her sub–district to identify a number of influencers from their communities and create WhatsApp group for sharing. The Gaziantep base team will prepare local messages / adopt the existing IEC materials (banner, poster, flyer), print and distribute in NWS. Also, they will identify and train teams for risk communication and behaviour change approach in collaboration with the partners (KPI, C4D etc.).

A COVID-19 Awareness Team was established by local heath NGOs, civil defence, local activists, education actors and with close coordination with the working group of the RCCE to unify community messages, ensure that it is delivered through the appropriate outlets, conduct regular visits to community leaders, and identify spokesmen. The team will collect regular feedback from communities to ensure that messages are relayed and received correctly, and to improve communication strategy according to the community needs and understanding. A central call centre will be established in NW Syria to provide accurate timely information and a detailed communication plan will be implemented.

With funding support of OFDA, WHO Gaziantep plans to conduct coordination meetings with the authorities on risk communication strategy and activities; conduct workshop on risk communication; and develop and disseminate IEC materials and produce audio/visual materials (radio spots/TV spots). The health cluster partner SAMS has developed a video message on community awareness for COVID-19 and posted on the YouTube and UNICEF is working also on 3 comprehensive videos to be shared with all partners to be used in the awareness sessions [[8]](#footnote-8). The detailed activity plan is outlined in the annex.

Furthermore, UNICEF related sectors including Health, Nutrition and WASH will engage in the RCCE plan as follows

1. **UNICEF NWS COVID-2019 RCCE RESPONSE**

The UNICEF response is aligned with the 2020 WHO global Strategic Response Plan (SRP), the 2020 UNICEF COVID-2019 Humanitarian Action for Children appeal and the COVID-19 preparedness and response plan for Northwest Syria (NWS). UNICEF is targeting up to 800,000 people with preparedness and/or response activities, with the aim of **limiting human-to-human transmission and protecting individuals from exposure to COVID-19**. The UNICEF preparedness and response activities are presented below in line with pillars 2 and 7 of the WHO NWS response plan (the following are examples per sector and not exhaustive):

1. **COVID-2019 RESPONSE RCCE STRATEGY**

The response plan focuses on the immediate measures that must be undertaken to ensure preparedness and response actions to address the COVID-2019 pandemic while sustaining the ongoing humanitarian operations and life-saving programmes responding to needs in Northwest Syria (NWS) pre-dating this new emergency. The plan builds on the WHO-led preparedness and Response Plan for NWS and aims to expand the significant investments which have been made over the past years in supporting health systems, previous outbreaks or health response, and draw on strong risk communication networks, especially for the most vulnerable communities or those in camp settings.

UNICEF will therefore focus its response on contributing to the containment of the spread of the COVID-19 epidemic, decreasing morbidity and mortality and decreasing the deterioration of human assets and rights.

In view of the rapid spread of COVID-19, UNICEF-Gaziantep jointly with partners has developed this RCCE plan for northwest Syria to ensure proper risk communication and community engagement measures in both the governorates in Northwest Syria. UNICEF Gaziantep plan is well aligned with OCIVD-19 with UNICEF-WHO's global 2019 novel coronavirus strategic preparedness and response plan and tailored to the Northwest Syrian context.

**The purpose of the RCCE plan:**

The main purpose of this plan to establish a reliable communication channel and ensure proper need-based risk communication and community engagement measures to deal with COVID-19 communication gaps and challenges in Northwest Syria. There following reasons for the special RCCE plan that:

* The population inside Northwest Syria depends heavily on the informal information system.
* Population residing nearby Syrian army posts is prone to shock, and there is a possibility that a large section of the population may not get proper information related to COVID-19.
* A large section of the population has inadequate access to the right information and essential social services in their areas.
* They have limited capacities and opportunities to cope and adapt challenges and miscommunication around COVID-19 and.
* Limited or no access to the right information system for the COVID-19.

1. **Target Group:**
   * School going Children
   * Women and Girls
   * Person with disability
   * People living in the bordering area with Syria
   * People living in IDPs
   * 3.5 million Arabic speaking Syrian people living inside Turkey.
2. **Strength**:

* Years of experience in a conflict situation, specifically risk communication and community engagement.
* UNICEF partners with the most trusted and reachable service provider inside Northern west Syria.
* Excellent resources and capacity to implement large and complex Communication for Development (C4D) interventions, as they were successfully done during cVDPV2 outbreak and response between 2017-2019.
* Strong networking & partnerships with approximately 1951-Schools/Colleges, 2034-Mosque, and approx. 69-Community Based Organizations on the ground.

1. **Call for action**:

* Under the UNICEF umbrella, there is a separate need for the formation of the task force committee for Risk Communication and Community Engagement and the appointment of one focal person from each partner's agency.
* The RCCE unit inside the UNICEF Gaziantep office has been established.
* Separate strategy for the tele and digital risk communication and community engagement, e.g.:
  + creation of social media (Facebook, Twitter, etc.) page for Northwest Syria either by UNICEF of by the partners.
  + COVID-19 hotline number for both the governorate separately.
  + Promotion of digital IEC.
  + Online training and learning resources for the field staff and volunteers working inside Northwest Syria.
  + Use of What's app as a digital communication tool for community engagement and community ownership in the program.
* Preparation and rollout of a comprehensive Risk Communication and Community Engagement plan for COVID-19.
* The RCCE plan needs to sync with the operational and supply plan.
* Strengthening of information management system for COVID-19.

**IV. Networking and Partnerships**:

* **Partners** – Resource mapping of all the partners with their expected support in RCCE response for COVID-19.
  + Appointment of governorate and sub-district level RCCE focal person
  + The Governorate level coordinator will form what's app group for all the sub-district focal person for RCCE.
  + Each focal person will supervise the community mobilizers of its organisation.
  + Community mobilizer will identify key personality in his/her assigned area and form a What's app group for the day to day interaction and information sharing and also work as a myth buster in his/her designated areas.
* **Education system** - Involvement of the education system as they are going online and its best to aligned with them to use their online platform for disseminating our risk communication and community engagement initiative for COVID-19
* **Internet Service Providers** – these no established internet service providers inside Northwest Syria and people relying on the local internet service providers. There are few actions needed for the:
  + Listing of all internet service providers by the partners.
  + Explore the opportunity of partnering with the local internet service providers by our partners on the ground to involve them in our RCCE approach.

**V. Training and Capacity building**:

* All the focal person of RCCE will get online orientation by the partner agency.
* Online learning materials and resources for the focal person and community mobilizers.
* An online repository for communication resources.

**VI. Coordination and Information sharing:**

* Weekly Coordination call with all the RCCE taskforce members.
* Weekly coordination call with Turkey country office specifically on how our RCCE materials and initiative can reach to the 3.5 million Arabic speaking Syrian refugees inside Turkey.
* Weekly skype call with RO and WHO

**VII. Monitoring and Evaluation**:

* Weekly reporting on RCCE intervention for COVID-19
* Sub-district wise RCCE plan for COVID-19 interventions.
* IEC microplanning at the sub-district level (template will be shared by RCCE unit – Gaziantep).
* Documentation of best practices and success stories.

**VIII. Supply:**

* In consultation with Health, Nutrition, WASH, Education, Child protection, and partners assess the requirement of the print and digital IEC materials, Hygiene kits, Schools kits, and other essential logistic supplies.
* Printing and distribution of IEC materials, Hygiene kits, school kits, and other logistics support.
* Daily/weekly updates and feedback sharing on the IEC and logistic supply and further requirements.

**IX. e-initiatives:**

* Introduction of app-based Communication booklet for the Social mobilization activities and reporting.
* In consultation with Health, Nutrition, WASH, Education, Child protection, and partners, assess the requirement of the print and digital IEC materials, Hygiene kits, Schools kits, and other essential logistic supplies.
* Printing and distribution of COVID-19 IEC materials, procurements of Hygiene kits, school kits.



1. **RCCE activities by thematic areas :**
2. ***Risk Communication and Community Engagement is strengthened to ensure women, children and their families know how to prevent COVID-19 and are encouraged to seek assistance.***
   1. ***Health***

* UNICEF supported social mobilization network (health workers and social mobilizers) is present in all 15 sub-districts of NWS. UNICEF partners are also supporting 46 PHCs and 17 rapid response teams in NWS.
* 35,000 one pager leaflets, 5000 Posters for PHCs and 5000 one pager stickers (IEC Material) printed and being shared at PHCs, and additional 13,000 one pagers and 29,000 leaflets will be printed inside NWS by health partners.
* Community health workers will display posters at PHCs and will distribute leaflets to people who are coming to seek health services at PHCs.
  1. ***Nutrition***
* Provide orientation and visual material on prevention of transmission of COVID-19 to staff at nutrition sites and RRTs in collaboration with health partners.
* In view of ensuring adequate nutrition care and feeding for infants and young children, especially for those who cannot be breastfed and vulnerable children, strengthen dissemination of key facts and recommendations for appropriate infant and young child feeding across all nutrition sites (OTP: (Outpatient Therapeutic Programme) and MBA: (Mother Baby Areas) - also in the Health Centre,) through training to staff in addition to development and extensive dissemination of visual material.
  1. ***WASH***
* Training in collaboration with Health and Nutrition section of community mobilizers and hygiene promoters on preventive aspects of COVID-19
* Installation of additional handwashing facilities and increase quantity of soap
* Increase the number of handwashing points including water tanks to be installed as necessary.
* Provision of additional quantities of soap for households, health facilities, schools and child-friendly spaces.
* Increase quantity of domestic water supply and strengthen drinking water safety
* Increase per capita water supply from 25 to 30 litre to enhance water availability for handwashing
* Enhance water quality monitoring to ensure requisite 0.2mg/l free residual chlorine (FRC) at household level
* Increase chlorine supplements at service points such as at households, water truckers, and water stations
* Increase Handwashing/Hygiene Promotion
* Handwashing Promotion among all adults and children, communicating risks of COVID 19 and handwashing and social distancing
* Handwashing promotion will be undertaken at household/family level only or communicated through loudspeaker channels (specific guidance note available – no large crowd gatherings for hygiene promotion).
* Provision of IEC Materials
* Development of IEC material in collaboration with the Health and Nutrition sections using specialised C4D service
* Use UNICEF posters in communities and camps at water stations, water distribution points and handwashing facilities and all other visible locations
* Distribution of UNICEF leaflets alongside Hygiene kits
  1. ***Child Protection:***
* Building on the structure of child protection teams on the ground and protection focal points at district levels, conduct **targeted** outreach awareness (home to home+ online delivery) to particularly most vulnerable families and children presenting protection concerns, consideration to those severe cases who were already on child protection case management and new ones, ensuring delivery of accurate information **on how to prevent and seek assistance** as well as messages on positive coping mechanisms to caregivers and how to provide a sense of normalcy and comfort to children in stressful circumstances.
* **Develop and broadcast messaging** and information on 2019-nCoV through social media, and other channels including targeted messaging for key stakeholders and at-risk groups based on community risk perceptions (including children, parents/care givers, pregnant women, health providers etc.); including **how to prevent and seek assistance** as well **as prevention of stigma to affected families and their children.** 
  1. ***Education***
* Provide UNICEF Communication Package includes IE material related to COVID 19 with UNCEF Education partners.
* Provide awareness on prevention of corona virus infection to 868 teachers and education personnel.
* Raise awareness of 16,800 children in schools

**ACTIONS TAKEN TO DATE**

In Gaziantep, UNICEF led RCCE including WHO, ACU and partners ensuring smooth implementation of the activities related to COVID-19 in the governorates of the NWS. UNICEF is a member of a 14-member Task Force for COVID-19, created by WHO and based in Gaziantep, which has already identified the relevant partners for relevant activities under 8 pillars and distributed the preparedness and response activities across them.

Risk communication and community engagement is a critical aspect of public health intervention in the country, which is required to raise awareness and avoid the spread of misinformation and panic in the community. Risk communications team led by the UNICEF that comprise WHO GZT and ACU have identified 7 districts (Afrin, Azaz, Albab, Jarablus, Harim, Idleb and Jisr Ash-shugur) with 28 sub-districts (**number of sub-districts and focal person are subject to change**) to implement the planned activities for COVMID-19 by using UNCIEF’s locally developed CIVID-19 communication packages. There will be at least 1 focal point in each of those sub-districts (depending on the size of population and density of population in the communities and the accessibility among the communities in the sub – district). Those focal point will be selected from the already existing team-leaders who will be trained by the central team on the specific approach for COVID 19 response and will be linked with the DLOs (District level officers). The focal points will train the CHWs teams on the specific key health messages to be delivered to the communities during the household visits and will explain how to use and distribute the IEC materials (which will be developed in this regard). Each focal point will build a network in his / her sub–district to identify a number of influencers from their communities and create WhatsApp group for sharing information and facilitate organizing events of groups such like gathering in mosque after Algoma pray or in schools. The group sessions will be delivered by the focal points and the community leaders in the sub – district level. The GZT team will prepare local messages / adopt the existing IEC materials (banner, poster, flyer), print and distribute in NWS. Also, they will identify and train teams for risk communication and behaviour change approach in collaboration with the partners (KPI, C4D etc.).

UNICEF led collation (WHO, ACU, and Partners) for the RCCE to conduct coordination meetings with the authorities on risk communication strategy and activities; conduct workshop on risk communication; conduct awareness campaigns for youth on COVID-19; and develop and disseminate IEC materials and produce audio/visual materials (radio spots/TV spots). UNICEF have already developed COVID- Communication package that includes.

* Five Animated videos
* Posters
* Banners
* Pamphlets
* Stickers

UNCIEF has already sent first lot of IEC:

* 35000 posters
* 5000 posters
* 5000 stickers
* 5 Video on COVID-19 one video is already circulated and four videos are under review.

UNICEF jointly with partners are assessing fresh need for the IEC materials and communication intervention and will do assessment on regular basis to ensure proper availability of communication materials. UNICEF led RCCE has also started social media promotion and using UNICEF communication package for Social media e.g., Facebook, What’s app promotion. We have also planned for the school education, and community awareness on the hygiene practices.

**RCCE plan and timeline**:



## Pillar 3: Surveillance, rapid response teams, and case investigation

ACU has already translated the WHO COVID-19 surveillance guidelines into Arabic and disseminated to NWS and disseminated the standard case definitions, case investigation and follow up for active surveillance to all governorates, district and sub-district level in the Northern Syria. The case definitions are based on the global surveillance guidelines by WHO and as a living body and will be regularly updated.

They are also preparing an Acute Respiratory Infection (ARI) bulletin which is under development and it will include COVID-19 in it. The EWARN system has been revised for alert verification, investigation and sample collection. The current Rapid Response Teams (RRT) must be modified or to establish new COVID-19 oriented RRTs in the NWS to further strengthened the case investigation in order to initiate the response activities.

WHO will support the ACU to enhance their existing EWARN-based respiratory disease surveillance systems, and coordinate with the polio team for incorporating the community event-based surveillance for COVID-19. In addition, WHO is to collaborate with NGOs in NES and NWS to early detection of cases and investigation through existing network (EWARN) to covering the surveillance. With support of OFDA, WHO Gaziantep office plans to support 2 meetings for surveillance officers in the field; conduct two trainings on case detection/investigation on contact tracing; six workshops on community based surveillance (EWAR) at camp level. WHO will also support transportation cost for trainings inside Turkey, as well as communication cost for local health partners.

## Pillar 4: Point of Entry (PoE) readiness & strengthening

The risk of imported cases in North-western territory and further local transmission in the community seems high. On March 22nd, the SAR Ministry announced that the first case of Coronavirus (COVID-19) was registered in Syria to a woman who had come from abroad.

Furthermore, due to a surge of cases in neighbouring countries, including cross line, and cross the border with Turkey, limited surveillance system, shortage of health care workers, and inadequate capacity of health authorities to launch contact tracing and limited availability of medical equipment and health facilities.

**Status of PoEs:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Point of Entry | Type of crossing | Location (Gov – District) | Current situation / functionality | Anticipated movement (High/ low) |
| Bab Alhawa | Cross- border | Idleb – Aldana – Sarmada - Bab Alhawa | Measures from Turkish side in place | Mild |
| Bab Alsalameh | Cross- border | Aleppo – Azaz – Sijo - Bab Alsalameh | Measures from Turkish side in place | Low |
| Jarablus | Cross- border | Aleppo – Jarablus - Jarablus | Measures from Turkish side in place | Low |
| Tell abyad | Cross- border | Aleppo - Afrin – Jindires - Hamamat | Measures from Turkish side in place | Low |
| Hamamat | Cross- border | Raqqa - Tell Abiad - Tell Abiad - Tell Abiad | Measures from Turkish side in place | High |
| Menbij -Jarablus | Cross- line | Aleppo – Menbij – Menbij - Dadat | No measures / Need to Update |  |
| Albab – abo zendin | Cross- line | Aleppo – Albab – Albab – Abo Alzinden | No measures / Need to Update |  |
| Tell Abyad-Ain Issa | Cross- line | Raqqa - Tell Abiad – Ain Issa | No measures / Need to Update | Low |
| Daret Ezza-Afrin | Cross- line | Aleppo - Jabal Sem`an - Daret Ezza - Algazawiya | IDA has started temperature screening activities | High |
| Atmeh-Afrin | Cross- line | Idleb – Aldana – Atmeh - Der Ballout | SRD has started temperature screening activities | high |
| Hama-Idleb | Cross- line | Hama or Idleb not determined yet | No measures / Need to Update |  |

Readiness:

IDA has started to screen traveller’s temperature in Daret Ezza-Afrin PoE, through a team of 2 nurses. Suspected cases are directed to one of the two designated hospitals (Azaz Hospital, Rai Hospital) after coordinating with Hatay Health Directorate (Turkish health authorities).

SRD has started to screen traveller’s temperature in Atmeh-Afrin PoE, through a team of 2 CHWs. Suspected cases are isolated in a tent then directed to nearby health facilities for physical examination then if the health service provider decide that the case need a referral, then it will be coordinated with Hatay Health Directorate (Turkish health authorities).

Strengthening:

The PoEs surveillance and Infection Prevention and Control (IPC) measures be will be established through identification of screening area at the entrance of each POE, equipped with basic equipment included temperatures devices - thermal scanner cameras, poster, banner, PPE, IPC supplies and dated case definition and screening questionnaires and line-listing forms.

Primarily, all the identified nurses/ paramedics for screening area will be trained and briefed on the concept of screening based on COVID-19 updated case definition, maintaining of IPC standard precaution measure in accordance to IPC COVID-19 guideline and standard operation procedures. In addition, the triage team will be trained on patient screening questionnaires and line-listing.

Operationally, the surveillance and screening areas will be led by POE coordinator, overall be responsible on coordination, management and monitoring and evaluation the implementation progress and day to day activities, while screening area run by the technical team consist of one nurse/8hr-shift responsible for travellers’ temperature check, assessment general medical condition as per screening questionnaire, provide counselling for suspected case and initiate communication with Medical Doctor on call and coordination with COVID-19 referral network as per required. Further each PoEs has surveillance focal person, responsible for data collection, verification based on the screening questionnaires and contact tracing and follow-up within 14 days, while IPC worker, one cleaner will be responsible of decontamination, maintaining cleaning of the environment and waste management. More details on human resources are in table below:

Human resources required for PoE, screening area- COVID 19

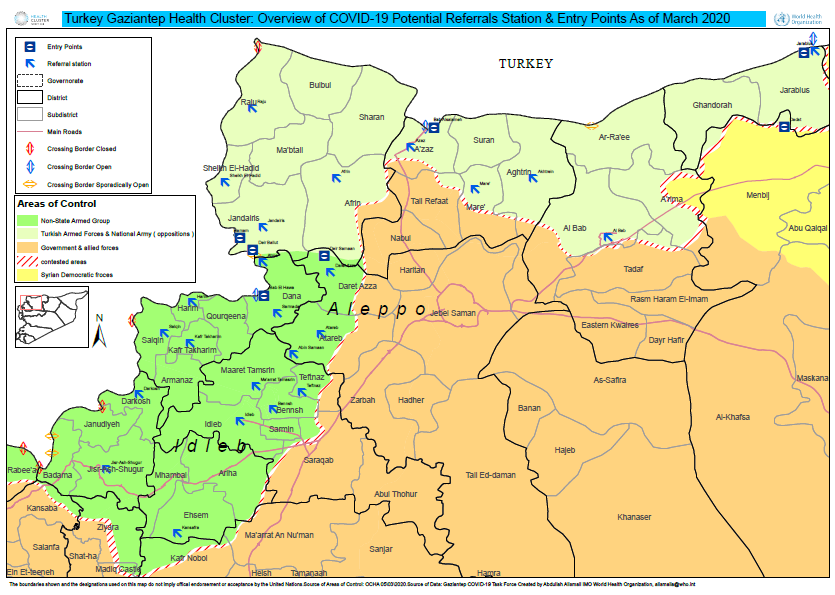
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Item | Per shift | 2 shifts | # PoE | total |
| Nurse | 2 | 4 | 9 | 36 |
| Driver | 1 | 1 | 9 | 9 |
| Focal point | 1 | 2 | 9 | 18 |
| Vehicle | 1 | 1 | 9 | 9 |
| Tent | 2 | 2 | 10 | 20 |
| Screening equip. | 1 | 1 | 9 | 9 |
| Surveillance team | 1 | 2 | 9 | 18 |
| Health worker | 2 | 2 | 9 | 36 |
| Doctor on call | 1 | 2 | 9 | 9 |

|  |  |
| --- | --- |
| Item /position | TOR |
| Nurse | Screening travellers’ temp, isolate suspected cases, organize referrals. |
| Driver | Transport suspected cases to referral facilities, decontaminate vehicle |
| Focal point | Over all supervision and coordination |
| Surveillance team | Data collection, reporting |
| Health worker | IPC measurements, distribution of IEC materials |
| Doctor on call | Stand-by for approval of case-referral |

PoE Framework

|  |  |  |  |
| --- | --- | --- | --- |
| Task | Responsible person | Target | Total |
| Activate the PoE surveillance at the PoE | Local authority/ local partner | All PoEs | 9 |
| Ensure coordination between different sectors at PoE and a mechanism of information sharing | WHO/ local partner | All PoEs Focal point | 18 |
| Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill passenger(s) | WHO/ relevant local partners | All PoEs health workers | 36 |
| Provide technical guidance and guidance documents at the PoE | WHO/ relevant local partners | All PoEs | 9 |
| Ensure the availability of staff and provide necessary equipment at the PoE (e.g. thermal scanner, electronic thermometers) | Relevant partner | All PoEs | 9 |
| Endorse COVID-19 an entry screening Questionnaire | WHO/ relevant local partners | All PoEs | 9 |
| Endorsement of referral network data collection tool and referral card | WHO/ referral partner | passengers | ---- |
| Develop and print banners for entry screening (#?) | WHO/ referral partner | 4\ PoEs | 36 |
| Develop and print IEC materials available to provide to the travellers (e.g. brochures, flyers etc.) | WHO/ UNICEF/ referral partner | 1000\ PoE | 9000 |
| Establish the monitoring of PoE surveillance | EWARN | 2\ PoE | 18 |
| Tents 16 sqm for (PoE) | Check with partners | 2 tents/ PoE/ 10 PoE | 20 |

**Figure 3: DRAFT Overview of potential Referral Stations and PoEs**



**Initial list of referral system stations:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Location | Area | Governorate | District | sub district | community |
| 1 | W. Aleppo | Aleppo | Jebel Saman | Atareb | Abin Samaan |
| 2 | W. Aleppo | Aleppo | Jebel Saman | Atareb | Atareb |
| 3 | Idleb | Idleb | Harim | Dana | Atmeh |
| 4 | Idleb | Idleb | Idleb | Bennsh | Bennsh |
| 5 | W. Aleppo | Aleppo | Jebel Saman | Daret Azza | Daret Azza |
| 6 | Idleb | Idleb | Jisr-Ash-Shugur | Darkosh | Darkosh |
| 7 | Idleb | Idleb | Harim | Harim | Harim |
| 8 | Idleb | Idleb | Idleb | Idleb | Idleb city |
| 9 | Idleb | Idleb | Jisr-Ash-Shugur | Jisr-Ash-Shugur | Jisr-Ash-Shugur |
| 10 | Idleb | Idleb | Harim | Kafr Takharim | Kafr Takharim |
| 11 | Idleb | Idleb | Ariha | Ehsem | Kansafra |
| 12 | Idleb | Idleb | Idleb | Maaret Tamsrin | Ma'arrat Tamasrin |
| 13 | Idleb | Idleb | Harim | Salqin | Salqin |
| 14 | Idleb | Idleb | Harim | Dana | Sarmada |
| 15 | Idleb | Idleb | Idleb | Teftnaz | Teftnaz |
| 16 | Euphrates Shield | Aleppo | A'zaz | A'zaz | Azaz |
| 17 | Euphrates Shield | Aleppo | A'zaz | Aghtrin | Akhtrein |
| 18 | Euphrates Shield | Aleppo | Albab | Albab | Albab |
| 19 | Euphrates Shield | Aleppo | Jarablus | Jarablus | Jarablus |
| 20 | Euphrates Shield | Aleppo | Azaz | Maree | Maree |
| 21 | Afrin District | Aleppo | Afrin | Afrin | Afrin |
| 22 | Afrin District | Aleppo | A'zaz | Mare' | Mare' |
| 23 | Afrin District | Aleppo | Afrin | Jandairis | Jandairis |
| 24 | Afrin District | Aleppo | Afrin | Sheikh El-Hadid | Sheikh El-Hadid |
| 25 | Afrin District | Aleppo | Afrin | Raju | Raju |

SOPs (to be developed further and linked with IPC pillar/ overall referral pathway):

1. PoE authorities to stagger the arrival of travellers into categories: aid-workers, trade etc. with tracing information available and IDPs so that the flow is maintained for the screening of travellers in a coordinated manner.
2. Dedicated section for initial screening, where symptomatic travellers would be isolated and moved to designated isolation section/ tent (SOPs to handle to be made available).
3. Though the travellers will be directed to the designated screening counters as per categorization, in case any traveller presents him/ herself at any other counter, the PoE staff would direct him/ her to the designated counter.
4. After screening, the remaining asymptomatic travellers will be allowed to move to the designated process for clearance for advisory (as per recommended measures for self-management).
5. Suspected travellers would be moved to the isolation tent and subsequently would be referred as per referral protocol.
6. The escort team would escort suspected travellers to the dedicated transport.
7. The symptomatic travellers shall be quarantined and managed as per laid down case management guidelines (at receiving facility).
8. Each vehicle needs to decontaminate after every trip

## Pillar 5: Laboratories

With support of OFDA, WHO GZT support sample collection and shipping as needed; conduct workshops on sample collection and referral; workshops on IPC and laboratory diagnosis for COVID-19 to strengthen the lab capacity of the partners. Also, they will support procuring laboratory sample collection swabs and medium, setting up stablishing the laboratory for coronavirus (rehabilitation of CPHL, fixing laboratory devices and equipment); procure PPEs.

## Pillar 6: Case management

Hospitals and other healthcare facilities are considered play a critical role in responses to emergencies, such as communicable disease epidemics. Therefore, an entry point for the case management is required to reinforce and establish triage system at all level of health care services include health facilities and established home based (quarantine) and case management Isolation based on the case definition below:

1. **Case Definition**:

* **Suspect case A**. Patient with severe acute respiratory infection (fever, cough, and requiring admission to hospital), AND with no other etiology that fully explains the clinical presentation AND a history of travel to or residence in China during the 14 days prior to symptom onset, or any other country with confirmed COVID-19 cases.

OR

* **Suspect case B**. Patient with any acute respiratory illness AND at least one of the following during the 14 days prior to symptom onset: a) contact with a confirmed or probable case of COVID-19 cases infection, or b) worked in or attended a health care facility where patients with confirmed or probable COVID-19 cases acute respiratory disease patients were being treated.
* **Probable case Probable case**: A suspect case for whom testing for COVID-19 cases is inconclusive1 or is tested positive using a pan-coronavirus assay and without laboratory evidence of other respiratory pathogens.
* **Confirmed case A** person with laboratory confirmation of COVID-19 cases infection, irrespective of clinical signs and symptoms.

1. Definition of contact

A contact is a person that is involved in any of the following:

* Providing direct care without proper personal protective equipment (PPE) 2 for COVID-19 patients
* Staying in the same close environment of a COVID-19 patient (including workplace, classroom, household, gatherings).
* Traveling together near (1 m) with a COVID-19 patient in any kind of conveyance within a 14‐day period after the onset of symptoms in the case under consideration.

# Reinforcement of Triage System:

As initial step to prevent or limit transmissions in healthcare setting, the triage system will be established at **all health facilities in northwest Syria. This will be through** identification of triage station (Approximately two separated buildings/or tents) at the entrance of each health facilities, equipped with basic equipment included temperatures devices, IPC supplies and dated case definition and screening questionnaires and line- list. Primarily, all the identified triage team will be trained and briefed on the concept of triage, case definition, IPC procedures, day to day monitoring IPC activities to ensure precaution measure in accordance IPC- COVID-19 guideline and standard operation procedures. In addition, the triage team will be trained on patient screening questionnaires and line- list. Operationally, the triage station will be under health facility management, run by on call doctor, 2 nurses, one IPC worker, one cleaner and guard trained staff.

The screening area will be the entry point, in which under strict IPC precaution measures, the patient will be checked based on the patient screen questionnaires. Patients who do not fit the case definition will be allowed to enter the health facility, while the suspected cases matching the case definition will be referred to observation areas for further medical assessment by trained physician. Highly suspected case will be counselled by the physician, provide argent need care and advised for home self- isolation or/and to be referred to the community based- Isolation for further investigation and provision of supportive therapy, while the suspected cases with severe symptoms and underline medical condition be referred immediately to nearby Isolation - case management- Centre.

**Figure 4: Triage patient flow**

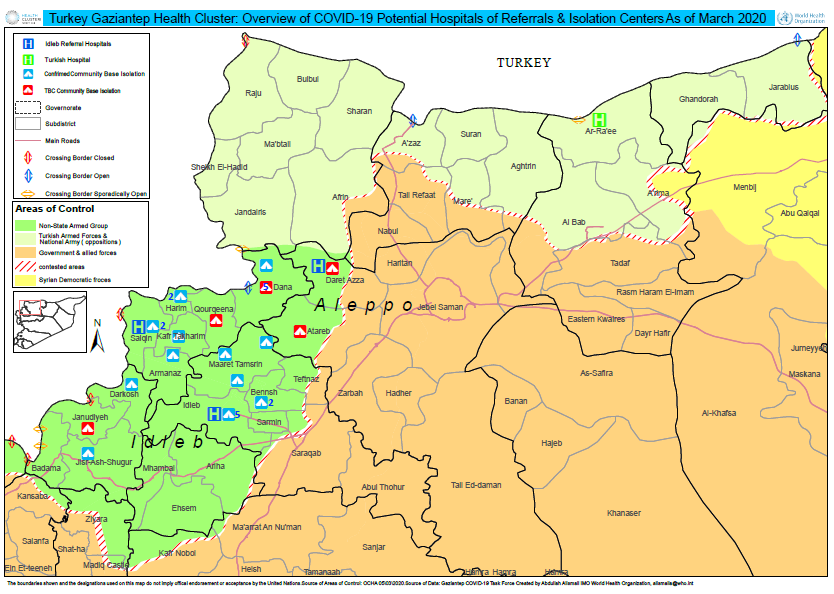


# Activities/output

* Identification of triage station staff include on call doctor, 2 nurses, one IPC worker, one cleaner and guard Trained staff
* Facilitate IPC – COVID- 19 training of trainees (ToT) targeted the IPC core team (HF manager senior nurses and paramedics) at triage and health facilities. The training will focus on staff and patient safety, basic IPC precaution measures, hand, respiratory and environment hygiene, waste management and case scenario on handling and applying IPC measure for COVID-19 andrecognition of patients with mild/severe acute respiratory infection associated with COVID-19 infection based on case definition.
* Trained core team will conduct roll out IPC- COVID-19 training targeted all health facility will facilitate roll- out
* Training Triage medical team on COVID 19 case definition and screening questionnaire
* **Reinforcement of infection prevention and control activities** (IPC basic training, identify of IPC team day to day to monitor and assess activities and ensure IPC measures and supplies in place. Please find details activities workplan
* Provision of supportive therapy, patient health education (Hand and respiratory hygiene and environmental cleaning and limitation on movement) and provision of protective and hygiene supplies

# Work plan and needs

|  |  |  |  |
| --- | --- | --- | --- |
| Task | Responsible person | Target | Total |
| Identify HF IPC core team | Partner and HF manager | All HFs | 210 |
| IPC – COVID training | WHO/SRD | 3 staff/HF/180 HF | 540 |
| Roll-out IPC – COVID training | HF IPC core team | All HFs | 1750 |
| Distribution of IPC poster | WHO/ SRD |  |  |
| Provision of IPC kit | Partner/ HF manager | 5 kits/HF/ for 180HF/ 3 months | 2,7000 |
| Define /Recruitment CHW to be attached to designated health facilities | Health Partner in coordination with WHO | 2 CHW/HF/ for 180HF aimed at 3 months | 360 |
| Health Education messages and | CHW | 3 session/180HF/day | 540 |
| distribution of IEC materials | CHW | 20IEC/3session/day/30day for 180HF | 234,000 |
| IPC M&E Reporting and feedback | All HFs | All HFs | 180 |

**Figure 5: DRAFT Health Cluster Referral Hospitals** 

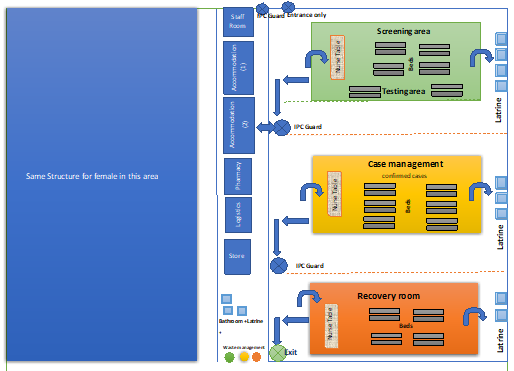
# Home care for patients / establishment of Community- Based Isolation (CBI)

Home care may have considered for those presenting with mild illness, hospitalization may not be required unless there is concern about rapid deterioration. However due the current overcrowded living condition and protentional inefficient housing space for self-isolation in the camps and host communities, propose to establish community based Isolation, which will offer   **separate and restrict the movement of the suspected/ confirm COVID-19 infection with mild symptoms and without underlying chronic condition (lung, heart, renal failure or immunocompromising condition).** The community- based Isolation I will run by trained health personnel community health worker and IPC worker and other supportive staff to basic health care services.

The community based- Isolation will start with capacity 30 beds distributed in the following section

1. **observation areas** with capacity of 15 beds defined for highly suspected cases/ contact developed symptoms and undergoing laboratory confirmation testing and provision of basic supportive therapy, HE and maintaining premise hand and respiratory hygiene.
2. **Isolation and case management areas** with capacity of 10 beds, run by medical (1 MD, 2-3 nurses per shift) to provide medical assessment and supportive therapy for confirm COVID-19 infection with mild symptoms and without underlying chronic condition
3. **recovery areas**; capacity of 5 bed run by on call doctor and 1 nurse/8hrs shift to provide final assessment and preparation for discharge cases.

**Figure 6: Blueprint of Community Based Isolation Centre**



# Hospital based - Isolation and Case management

Basically, there is not isolation centres in entire northwest. In discussion with health partners identified three hospital care with intensive care units in Idleb, Salqin and Daret Azza to be modified and re-established as isolation COVID-19 case manage Centre; while Turkish health authorities identified two hospitals in Euphrates Shield including WATAN supported hospital in A’zzaz and Gabanbeg Hospital in Jarablus district. Primarily the Isolation Centre will provide hospital specialized intensive care unit level 11 care services for highly suspected/ **confirm COVID-19** infection patient with **severe symptoms and with underlying chronic condition (lung, heart, renal failure or immunocompromising condition**. Thus, the Centre will consist of three sections which includes;

# Observation areas:

Is an entry point for the Isolation unit, the suspected/confirm cases will be re assessed based on the patient screen questionnaires, evaluate the medical condition of patient and initiate required investigation and supportive/ associated medication treatment. We anticipated the facility has capacity to initiate sample collection, transportation and diagnostic testing for COVID- 19. t. Patient not fit the case definition will be allowed to enter the health facility, while the suspected cases matching the case definition will be referred to observation areas for further medical assessment by trained physician

# Medical ward

Provide inpatient case management (patient assessment, monitoring, routine lab investigation, x-ray and provide supportive therapy and treatment of co related NCD, cross infection for **confirm COVID-19** infection with **severe symptoms with underlying chronic condition and no organ impairment.**  The initiate phase; the medical ward will have capacity of 10 beds, run by on call senior specialized physicians and the 1 medical doctor, 2-3 nurses, 3 IPC workers, per 8hrs shift for 24/7.

# Intensive care unit:

Is an organized unit will provide care to critically severe COVID-19 patient with organ impairment or complication form which recovery is generally possible ill patients that requires intensive and specialized medical and nursing care, an enhanced capacity for monitoring, and multiple modalities of physiologic organ support to sustain life during a period of life-threatening organ system insufficiency. The unit will consist of 10 ICU beds, equipped with essential accessories include oxygen, ventilator, monitors and essential laboratory services and will be led by specialized trained ICU physician charge for case manage in accordance to guideline and protocol and the nursing team will comprise of 3 ICU technicians, 3 nurses per 8hrs shifts for 24/7.

# Recovery area:

Is an area with 5 bed capacity Managed by Case management physicians and 1 nurse/8hrs shift to provide final assessment and preparation for patient discharge and follow-up.

# Referral and patient transportation services

The case management including health facilities triage station, community- based isolation and the Isolation Centre will be link with the current referral network, through selection of specific ambulances to provides mean of transportation services of mild/ severe emergency cases to COVID-19 designated Centres. Moreover, the ambulance services will support intra-referral between case management Centres. The ambulance staff will be trained on IPC- COVID-19, reinforce IPC precaution measures at all defined ambulances and provide required equipment and supplies. Details of the referral pathway and central call Centre will be share with all link case management will be shared with all health providers.

# Medicines and medical supplies

|  |  |  |
| --- | --- | --- |
| Items | Quantity |  |
| ICU modified kit (1000cases/3months) | 15 | Mersin in process to be transport to NWS |
| Basic IEHK | 10 | Warehouse inside Syria |
| Fluid kit (5,000) | 1 | ACU warehouse |
| PPE (chemical EPRP) | 2,000 | In hospital stock can be remobilized to Isolation centres, plus additional in warehouse inside Syria |
| PPE | 1,200 | Pipeline |

# MHPSS

Mental health and psychosocial aspects of the COVID-19 pandemic should be considered a cross-cutting issue amongst all sectors and emergency pillars involved in the COVID-19 response. IASC-MHPSS stated that addressing MHPSS considerations will be key to stopping transmission and preventing the risk of long-term repercussions on the population’s well-being. Clear coordination mechanisms and integration of MHPSS technical expertise are critical as part of response strategy - provision of hope, safety, empathy, social connectedness and self- and community efficacy should be embedded across every intervention. Local actors need to be supported with both accurate knowledge and facts about COVID-19 as well as MHPSS skills. People with mental health, substance abuse or psychosocial disabilities need continued/uninterrupted access to care and support during this outbreak; and that MHPSS responses must be grounded in the context, to evolve and adapt to the needs of each population over the course of the outbreak.

## Pillar 7: Infection prevention and control

The infection prevention and control (IPC) measures in health-care settings are of central importance to the safety of patients, health-care workers and the environment, and to the management of communicable disease threats to the global and local community. Currently, the WHO supporting and reinforcing the IPC program in approximately 65 health facilities.

As IPC COVID-19 response strategy the WHO will encompass its IPC activities to the all health facility setting, through building capacity, structuring IPC core team provision of technical supervision and IPC supplies. Thus, the WHO will Facilitate IPC – COVID-19 training of trainees (ToT) targeted 900 medical and non- medical personnel, who will have considered as IPC core team including HF manager senior nurses and paramedics and CHW working at health facility setting. The training will focus on staff and patient safety, basic IPC precaution measures, hand, respiratory and environment hygiene, waste management and case scenario on handling and applying IPC measure for COVID-19 and recognition of patients with mild/severe acute respiratory infection associated with COVID-19 infection based on case definition. Moreover, the existing WHO IPC program will provide technical support to community-based- isolation and Isolation Centre. In addition, more than 2,700 IPC kit need it in order to reinforce the IPC – COVID-19 at 180 planned triage stations.

## Pillar 8: Operational support and logistics

WHO Health Cluster Team mapping of partners and activities ongoing.

WHO Gaziantep is in direct contact with WHO Dubai logistics hub at the International Humanitarian City Warehouses to coordinate supplies and deliveries.

Besides having beyond a health cluster non-health plan coordinated by OCHA, will laisses with logistics cluster and CCCM for an integrated response at community at camp level.

Meetings are ongoing with health cluster observers and Turkish health authorities in areas of the NWS as are managing the cross-border activities.

Inter-Cluster coordination and coordination with UNICEF, Shelter and NFIs on going for gap filling.

Please find below the list to tents request:

|  |  |  |
| --- | --- | --- |
| Activities | Specifics | Total need estimates\* |
| Triage station for 190 HFs | Two Tents (4x6m) for each HF X 190 HFs NWS | 380 tents |
|  |  |  |
| Community based Isolation Centres (CBIC) | 6 rubhall tents (6X16m) for each 28 CBI | 100 tents |
| 7 tents (4x4m) for each 28 CBIC staff and supported activities | 196 tents |
|  |  |  |
| Point of Entry (POE) | 2 tents for each PoE X 10 POEs | 20 tents |

\*Budget estimates will factor support/ aid from other partners and may not reflect the total need

# Annexes

## **Annex 1: PRP activities and timeline**

Legend:

|  |  |
| --- | --- |
| Status | Colour code |
| Completed |  |
| On-going |  |
| Planning Stage |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PILLARS** | **March** | | | | | **April** | | | | **May** | | | | |
| W1 | W2 | W3 | W4 | W5 | W1 | W2 | W3 | W4 | W1 | W2 | W3 | W4 | W5 |
| **1. Coordination, planning and monitoring** | | | | | | | | | | | | | | |
| * 1. COVID-19 Health Cluster Task Force Established Brief Health Cluster on COVID-19, and ensure timely sharing of information between partners |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Organize regular coordination / Task Force meetings to engage the key partners to develop an operational plan with estimated resource requirements for COVID‑19 preparedness and response (twice a week, every Tuesday and Thursday) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Prepare a list of trained health staff from NWS covering different functions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Select measurable indicators for monitoring of planned COVID activities (Following the WHO recommended indicators adopting for NWS) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Send the technical guidance documents (in Arabic) to all governorate and district level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct a one-day training workshop to brief on IHR (all stakeholders meeting) in Gaziantep |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **2. Risk communication** | | | | | | | | | | | | | | |
| * 1. Risk communication was established by WHO/UNICEF and cluster partners * A local Corona Awareness Team was established by local health NGOs, civil defence, education actors, and other social establishments |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Implement risk-communication and community engagement plan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A. Review of current communication channels |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Review of targeted community leaders to be engaged (mosques, educators, local councils,) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Provide paid advertisements through local internet providers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D. Provide internet connection in camps and shelters to limit community movements |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| E. Provide communication hotlines to health facilities and isolation centres |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| F. Establish a central hotline to provide information and receive questions (including on MHPSS) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| G. Establish sub district reporting networks to identify suspect cases and report to EWARN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| H. UDER is establishing community survey to assess current awareness and collect feedback through two-way communication. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Identify a media spokesperson(s) at central level and develop regular talking points – completed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Identify focal points (FP) from 28 sub-districts of 7 districts of Aleppo and Idleb and conduct 6 training sessions for FPs followed by 50 in-house training for 1000 CHWs * Risk communication team to further elaborate the activities * ToT to be planned for district level people in GZT (20 sub-district FPs for TOT) – planned next week * The activities to be broken down here as sub activities including the cascade of trainings estimated budget |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Identify 2,500 community influencers through sub-district focal points and create WhatsApp groups for sharing information, 539,000 individual sessions. – planned   (Note: the activity will cover half of the districts and the rest will be covered by other methods e.g. social media) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop local messages, print flyers, brochures and posters and disseminate to the HFs, local establishments, and community during households’ visits and collective shelter sessions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Produce audio-visual materials and use PSA and air through local radio and TV and social media * UNICEF developed 3 videos * NGOs developed several videos * Develop 4 video recordings per month to provide public update |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Provide protective equipment to CHWs FPs, and community influencers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Provide liquid soap to awareness teams to distribute during sessions. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.10 Provide orientation (including on IYCF-E) and visual material on prevention of transmission of COVID-19 to partner staff and communities through nutrition sites and RRTs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.11 Development and provision of IEC material on increased hand washing/hygiene promotion |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.12. Production of IEC materials (hard copies and online) on MHPSS intervention against COVID-19- Contract with a partner NGO for 3 months |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.13. Scaling-up the MHPSS Helpline and be it specific on COVID-19 and specific for individuals in the communities for 6 months |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.14. MHPSS Helpline for humanitarian aid workers in Southern Turkey (access in English-Turkish and Arabic) (Gaziantep, Kilis, and Hatay) for 6 months |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.15. Training of community leaders, imams, youth leaders, women’s group on PFA and Self Care plus MHPSS on COVID-19 (target 1,000) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.16 Training of WASH workers, camp coordination workers, food security workers on PFA and Self Care, plus MHPSS on COVID-19 (target: 1,000) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.17 1 day-Training of CHWs on MHPSS Intervention to fight COVID-19, Self-Care and Parenting Skills (Target: 1,000)  Note: WHO trained already CHWs on PFA. Needs 1 day training of Self Care and Parenting Skills to fight COVID-19 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.18 One day workshop for MHPSS workers on review of MHPSS-COVID-19 and Parenting skills on COVID-19 (Target: 200) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2.19 Creating messages on preventive measures specific for elderly, NCD patients, PWDS, cancer, Thalassemia and patients on dialysis. To be available in hard copies and in social media. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **3. Surveillance, RRTs and case investigation** | | | | | | | | | | | | | | |
| * 1. A COVID-19 Surveillance WG established lead by ACU/EWARN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Translate into Arabic and distribute standard case definitions, case investigation to all governorate, district and sub-district level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct 1 refreshers TOT on surveillance and response of Flu + COVID-19 for 26 district level officer (DLOs) via Skype |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct trainings on surveillance and response of Flu + COVID for 200 EWARN staff that includes FLOs, RRT and lab employees at district and sub-district level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct cascade of 220 training sessions on surveillance and response of Flu + COVID for 5,500 NGO staff (TBC) inside Syria |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Enhance the existing ILI and SARI surveillance and activate the active case finding and event-based surveillance (EBS) for COVID-19 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Monitor and report the disease trends with appropriate data analysis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Activate the RRT and undertake case-based reporting to WHO within 24 hours under IHR (2005) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Activate / establish community based surveillance (CBS) in the camps / community using the polio community network |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct 2 meetings for surveillance officers at the governorate level |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **4. Point of Entry readiness & strengthening** | | | | | | | | | | | | | | |
| * 1. WG lead by local Health authorities & cluster |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Activate the PoE surveillance at the Turkey borders gates and crosslines check points |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Ensure coordination between different sectors at PoE and a mechanism of information sharing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Disseminate latest disease information, standard operating procedures, equip and train staff in appropriate actions to manage ill travellers(s) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Provide technical guidance and guidance documents at the PoE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Ensure the availability of staff and provide necessary equipment at the PoE (e.g. thermal scanner, electronic thermometers) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop an entry screening protocol |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop and print traveller referral card |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop and print banners for entry screening |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop and print IEC materials to provide to the travellers (e.g. brochures, flyers etc) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Screen the travellers at the PoE   Based on the agreed-on protocol of PoE after discussing with the Turkish / Syrian local authorities (as applicable)  (Note: There are number of unofficial / illegal PoEs between Turkey and Syria. Needs to discuss with local authorities) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Allocate / rental ambulances / vehicles for transport suspected cases to referral hospitals |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **5. Laboratory** | | | | | | | | | | | | | | |
| * 1. Activate lab in Idleb & Jarablus (tbc) to resume testing for ILI & SARI cases ASAP by providing required lab supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Share the guideline of laboratory testing, testing protocol and list of referral laboratories |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Develop a mechanism with GZT Public Health lab to support testing for COVID-19 samples from NS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Procure 1 PCR machine, 6,000 units of tests by PCR, 6,000 extraction units and 5,000 sample collection swabs COVID-19, PPEs and 2,000 pieces of universal transport medium |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Support HFs / laboratories with collection of samples and shipping them up to the reference lab |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Arrange training of 3 ACU central level staff on COVID-19 lab methods in Ankara reference laboratory |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Arrange refresher’s training on laboratory diagnosis of influenza in Ankara laboratory for 4 ACU central staff |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. Case management | | | | | | | | | | | | | | |
| * 1. Provide COVID case management guidelines to all HFs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Ensure availability of stocks of medicines for supportive treatment |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Identify 3 isolation rooms and equip with ventilators, oxygen concentrators, ambu-bag |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Rehabilitate the ICU in 15 health facilities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Procure medical equipment /supplies (3 portable x-ray, 3 oxygen concentrators, 30 ventilator) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct training workshop on case management and IPC for HCWs (2-3days) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. 2 days training on PFA and Self Care plus improving mental-well-being on COPVID-19 for Frontline Health Workers, Team Leaders- Target: 300 aid workers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. MHPSS Helpline specific for COVID-19 patients and their families, plus frontline health care workers- Contract with 1 partner NGOs for 6 months (3 teams to be created) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6.9. Training for specific health workers, hospital helpers, and key MHPSS workers on Bereavement and Mourning of demised COVIOD-19 patients and to their families  \*will be activated at a later stage |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6.10. Providing strategies in providing incentives, recognitions for frontline health workers and paramedics, including patients to help maintain their high motivation.  \*to be discussed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6.11. Adding MHPSS workers into the human resources at 6.3 (numbers will be discussed)  \*to be discussed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **7. Infection control and prevention** | | | | | | | | | | | | | | |
| * 1. Review the existing IPC capacity, WASH services (esp. hand hygiene stations) and existing stock of PPE (surgical masks, surgical masks, gloves, disposable gown, googles) etc |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct ToT on IPC COVID-19 for 897 staff work at 299 functioning health facilities in NWS (from last week of March) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Conduct ToT on IPC for XX ACU CLOs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Procure medical supplies (X hygiene kits, X disinfectants) and X PPE for X HFs / laboratories |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Ensure availability of IPC guidance at the HFs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Ensure a mechanism of rapid notification of cases to IPC teams |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Establish 3 Quarantine centres each for 3 months |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Provision of all required supplies at PHCs to support in handling COVID 19 suspected cases until cases are referred to nearby health facilities. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Installation of additional handwashing facilities and increase quantity of soap available * Ensure Water Quality Standards are met * Increase available Water Quantity |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. **Operational support and logistic** | | | | | | | | | | | | | | |
| * 1. Map/checklist of available resources and supply systems by conducting an inventory review of supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Review stocks for medical and other essential supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. Review procurement processes for medical and other essential supplies |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

## 

## **Annex 2: Estimated budget for COVID-19 PRP activities in NWS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pillar** | **Unit cost** | **Number of training/meeting** | **Total cost ($)** |
| **1. Country-level coordination** | | | |
| 1.1. Organize coordination / Task Force meetings to engage the key partners to develop an operational preparedness and response for COVID‑19 and regular follow up meetings (Once a week initially) | 200 | 20 | 4,000 |
| 1.2. Conduct a one-day training workshop on IHR (all stakeholders meeting) in Gaziantep | 5,000 | 1 | 5,000 |
| 1.3 Surge COVID-19 Task Force Staff (2 staff X 3 months each) | 10,000 | 6 | 60,000 |
| **Sub total** | | | **69,000** |
| **2. Risk communication** | | | |
| * 1. Risk communication was established by WHO/UNICEF and cluster partners * A local COVID-19 Awareness Team was established by local health NGOs, civil defence, education actors, and other social establishments | 5000 | 3 | 15,000 |
| 2.2 Implement risk-communication and community engagement plan:   1. Review of current communication channels 2. Review of targeted community leaders to be engaged (mosques, educators, local councils,) 3. Provide paid advertisements through local internet providers 4. Provide internet connection in camps and shelters to limit community movements 5. Provide communication hotlines to health facilities and isolation centres 6. Establish a central hotline to provide information and receive questions 7. Establish sub-district reporting networks to identify suspect cases and report to EWARN 8. UDER is establishing community survey to assess current awareness and collect feedback through two-way communication. | -  -  18,000  105,000  7,464  15,000  6,000  - |  | 151,464 |
| 2.4. Identify focal points (FP) from 28 sub-districts of 7 districts of Aleppo and Idleb and conduct 6 training sessions for FPs followed by 50 in-house training for 1,000 CHWs   * Risk communication team to further elaborate the activities * ToT to be planned for district level people in GZT (20 sub-district FPs for TOT) * The activities to be broken down here as sub activities including the cascade of trainings estimated budget |  |  | 1,410,000 |
| 2.5 Identify 2,500 community influencers through sub-district focal points and create WhatsApp groups for sharing information, 539,000 individual sessions.  (Note: the activity will cover half of the districts and the rest will be covered by other methods e.g. social media) |  |  | 1,500,000 |
| 2.6 Develop local messages, print flyers and posters and disseminate to the HFs, local establishments, and community during households’ visits and collective shelter session |  |  | 124,000 |
| 2.8 Provide protective equipment to CHWs FPs, and community influencers |  |  | (from IPC budget) |
| 2.10 Provide orientation (including on IYCF-E) and visual material on prevention of transmission of COVID-19 to partner staff and communities through nutrition sites and RRTs |  |  | 410,000 |
| 2.11 Development and provision of IEC material on increased hand washing/hygiene promotion |  |  | 100,000 |
| 2.12. Production of IEC materials (hard copies and online) on MHPSS intervention against COVID-19- Contract with a partner NGO for 3 months |  |  | 20,000 |
| 2.13. Scaling-up the MHPSS Helpline and be it specific on COVID-19 and specific for individuals in the communities for 6 months |  |  | 60,000 |
| 2.14. MHPSS Helpline for humanitarian aid workers in Southern Turkey (access in English-Turkish and Arabic) (Gaziantep, Kilis, and Hatay) for 6 months |  |  | 30,000 |
| 2.15. Training of community leaders, imams, youth leaders, women’s group on PFA and Self Care plus MHPSS on COVID-19 (target 1,000) |  |  | 140,000 |
| 2.16 Training of WASH workers, camp coordination workers, food security workers on PFA and Self Care, plus MHPSS on COVID-19 (target: 1,000) |  |  | 140,000 |
| 2.17 1 day-Training of CHWs on MHPSS Intervention to fight COVID-19, Self-Care and Parenting Skills (Target: 1,000)  Note: WHO trained already CHWs on PFA. Needs 1 day training of Self Care and Parenting Skills to fight COVID-19 |  |  | 70,000 |
| 2.18 One day workshop for MHPSS workers on review of MHPSS-COVID-19 and Parenting skills on COVID-19 (Target: 200) |  |  | 21,000 |
| 2.19 Creating messages on preventive measures specific for elderly, NCD patients, PWDS, cancer, Thalassemia and patients on dialysis. To be available in hard copies and in social media. |  |  | 20,000 |
| **Sub total** | | | **4,211,464** |
| **3. Surveillance** | | | |
| 3.2 Conduct 1 TOT on surveillance and response of Flu + COVID-19 for 26 district level officer (DLOs) via Skype | 0 | 1 | 0 |
| 3.4. Conduct trainings on surveillance and response of Flu + COVID for 200 EWARN staff that includes FLOs, RRT and lab employees at district and sub-district level | 5,500 | 1 | 5,500 |
| 3.5. Conduct cascade of 220 training sessions on surveillance and response of Flu + COVID for 5,500 NGO staff inside Syria | 253 | 200 | 55,660 |
| 3.6. Enhance the existing ILI and SARI surveillance and activate the active case search for COVID-19 | 2,000 | 1 | 2,000 |
| 3.7. Monitor and report the disease trends with appropriate data analysis | 3,000 | 1 | 3,000 |
| 3.8. Activate the RRT and undertake case-based reporting, contact tracing, follow up and share data with WHO within 24 hours as per IHR 2005 | 3,000 | 1 | 3,000 |
| 3.9. Activate / establish community based surveillance (CBS) in the camps / community using the community network | 3,000 | 6 | 18,000 |
| 3.10. Conduct meetings for surveillance officers at the governorate | 600 | 2 | 1,200 |
| Transportation cost | 5,000 | 1 | 5,000 |
| ICT/communication cost (SIM card, increase the thresholds of call) for MOH/DOH | 5,000 | 1 | 5,000 |
| **Sub total** | | | **98,360** |
| **4. Point of Entry (includes partner proposal and resources from other sources)** | | | |
| 4.11. Equipment for decontamination/ rental ambulances / vehicles for transport suspected cases to referral hospitals | 1,000 | 60 | 177,000 |
| 4.12. Procure equipment for entry measurement (thermal scanner cameras, poster, banner) | 100,000 | 1 | 100,000 |
| EMS team/ HR personnel (Field Project Coordinator (Medical doctor) (NWS), Location supervisor Nurse (NW Syria), Location Cleaner (NWS), Paramedics (NWS), Ambulances drivers, Data entry (NWS) – including partner operating costs/ IHD) |  |  | 328,350 |
| Supplies, Commodities, Materials (including associated transportation, freight, storage and distribution costs) |  |  | 98,200 |
| Training for Paramedics, cleaners and other staff BOQ 2 |  |  | 15,725 |
| **Sub total** | | | **719,275** |
| **5. Laboratory** | | | |
| 5.1. Activate lab in Idleb lab to resume testing for ILI & SARI cases ASAP by providing required lab supplies | 4,000 | 1 | 4000 |
| 5.2. Share the guideline of laboratory testing, testing protocol and list of referral laboratories | 500 | 1 | 500 |
| 5.3. Develop a mechanism with GZT Public Health lab to support testing for COVID-19 samples from NS | 500 | 1 | 500 |
| 5.4. Procure 1 PCR machine, 6,000 units of tests by PCR, 6,000 extraction units and 5,000 sample collection swabs COVID-19, X…. PPEs and 2,000 pieces of universal transport medium | 100,000 | 1 | 100,000 |
| 5.5. Support HFs / laboratories with collection of samples and shipping them up to the reference lab | 50,000 | 1 | 50,000 |
| 5.6. Arrange training of 3 ACU central level staff on COVID lab methods in Ankara reference lab | 1,000 | 3 | 3,000 |
| 5.7. Arrange refresher’s training on laboratory diagnosis of influenza in Ankara lab for 4 ACU central staff | 1,000 | 4 | 4,000 |
| To Support PCR lab in Jarablus (TBC) - ACU |  |  | 200,000 |
| **Sub total** | | | **362,000** |
| **6. Case management** | | | |
| 6.3. Support HR cost for 6 hospital isolations with ICU capacity for 5 months.   * Three SAMS supported hospitals (Adlib Central Hospital in Idleb city, Alamal Hospital in Daret Ezza and Salqin Hospital in Salqin) * SIMRO internal medicines in Idleb city, while two hospitals in Euphrates Shield including WATAN supported hospital in A’zzaz and Gabanbeg Hospital in Jarablus district.   Hospital capacity of 70 beds (30 medical ward bed, 30 ICU beds and 10 recovery beds): | 100,000 | 6 | 3,000,000 |
| 6.4. Conduct COVID- 19 case management and IPC targeted 552 medical and non-medical staff at the 6 hospital Isolations | 2,000 | 12 | 24,000 |
| 6.5. Rehabilitation and logistic supporting cost for 6 hospitals | 100,000 | 6 | 600,000 |
| 6.6. Procure medicines and medical renewable supplies (15 NCD for the Secondary kits, IEHK supplementary medicines and renewable supplies kits and Lab consumable supplies) for duration of 6 months | 200,000 | 6 | 1,200,000 |
| 6.7 Procure medical equipment /supplies (33 portable x-ray, 33 oxygen concentrators, 60 ventilator) | 1,500,000 | 6 | 9,000,000 |
| 6.8. 2 days training on PFA and Self Care plus improving mental-well-being on COPVID-19 for Frontline Health Workers, Team Leaders- Target: 300 aid workers |  |  | 70,000 |
| 6.9. MHPSS Helpline specific for COVID-19 patients and their families, plus frontline health care workers- Contract with 1 partner NGOs for 6 months (3 teams to be created) |  |  | 70,000 |
| 6.10. Training for specific health workers, hospital helpers, and key MHPSS workers on Bereavement and Mourning of demised COVIOD-19 patients and to their families  \*will be activated at a later stage |  |  |  |
| 6.11. Providing strategies in providing incentives, recognitions for frontline health workers and paramedics, including patients to help maintain their high motivation.  \*to be discussed |  |  |  |
| 6.12. Adding MHPSS workers into the human resources at 6.3 (numbers will be discussed)  \*to be discussed |  |  |  |
| **Sub total** | | | **13,964,000** |
| **7. Infection control and prevention** | | | |
| 7.2. Conduct IPC- COVID and triage system ToT training targeted 540 IPC team at 180 fixed HFs in NWS at Health facilities NWS   * First round is ongoing target 540 health worker at 180 fixed HFs, while the second round will target 119 non-fixed and specialized Centres | 1,425 | 54 | 77,000 |
| 7.3. Conduct IPC training for 600 IPCs workers at working at 6 Hospitals Isolation and 30 Community based Isolation | 2,000 | 10 | 20,000 |
| 7.4. Procurement of IPC supplies (hygiene, PPE disinfectants) for functioning health facilities include, 54 Hospitals, 125 (PHCs, 52 mobile clinics, 41 specialized care centres, while 27) others health facilities (e.g. Ambulance network, Blood Bank, Central Laboratory etc) and PPEs, for HRH across all cadres |  |  | 900,000 |
| 7.7. Establish 28 CBIC in highest cluster population in Idleb and Aleppo sub district and two in Afrin district. (This include HR, medicines and IPC supplies, Logistic, WASH and infrastructures) | 350,000 | 30 | 10,500,000 |
| 7.8 Isolation tents for identified fixed facilities, PoE and CBIC (600 no’s) | 700 |  | 420,000 |
| * 1. Provision of all required supplies at PHCs to support in handling COVID 19 suspected cases until cases are referred to nearby health facilities. |  |  | 500,000 |
| 7.10 Installation of additional handwashing facilities and increase quantity of soap available   * + Ensure Water Quality Standards are met   + Increase available Water Quantity   + Provide hand-washing (soaps, solution) |  |  | 1,600,000 |
| **Sub total** | | | **14,017,800** |

|  |  |
| --- | --- |
| **Grand Total** | **33,441,899** |

\*Budget estimates are factored for the short-term (though few capital inputs will carry-over for consequent periods)

## **Annex 3: COVID-19 Task Force Members for NWS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***#*** | ***Name*** | ***Email*** | ***Organization*** | ***Title*** |
| 1 | Dr Abdulhakim Ramadan | [abdulhakim.r@ihd-sy.org](mailto:abdulhakim.r@ihd-sy.org) | IHD | Public Health Coordinator |
| 2 | Amer Heluani | [referral.syr@gmail.com](mailto:referral.syr@gmail.com) | Referral System | Referral System Coordinator |
| 3 | Naser AlMhawish | [naser.m@acu-sy.org](mailto:naser.m@acu-sy.org) | ACU | Surveillance Coordinator |
| 4 | Yasir Elferruh | [yasir.f@acu-sy.org](mailto:yasir.f@acu-sy.org) | ACU | EWARN |
| 5 | Mustafa ABIDOĞLU | [m.abboud@simro.ngo](mailto:m.abboud@simro.ngo) | SIMRO | PM |
| 6 | Mohammad Aleisa | [maleisa@sams-usa.net](mailto:maleisa@sams-usa.net) | SAMS | Senior Health Officer |
| 7 | Abdulkarim | [kar90iem@hotmail.com](mailto:kar90iem@hotmail.com%20) | MRFS |  |
| 8 | Hussein Assaf | [hussein.assaf@ri.org](mailto:hussein.assaf@ri.org) | Relief International | Health Manager |
| 9 | Zakariya Alhamad | [Zakaria.alahmad@ri.org](mailto:Zakaria.alahmad@ri.org) | Relief International | Healthcare Coordinator |
| 10 | Yasser Najeeb | [yaser.n@sig-sy.org](mailto:yaser.n@sig-sy.org) | SIG | Director for Programs. |
| 11 | Sikander Tayyab Khan | [stayyabkhan@unicef.org](mailto:stayyabkhan@unicef.org) | UNICEF | C4D Officer |
| 12 | Mustafa Haj Omar | [m.omar@qcharity.org.tr](mailto:m.omar@qcharity.org.tr) | Qatar Charity | Health Officer |
| 13 | Badrul Munir Sohel | [sohel@who.int](mailto:sohel@who.int) | WHO | EWARN Officer |
| 14 | Dr Jorge Martinez | [martinezj@who.int](mailto:martinezj@who.int) | WHO | Health Cluster Coordinator |

## **Annex 4: COVID-19 Focal Points for Area of Work**

|  |  |  |
| --- | --- | --- |
| **Area of work per PRP pillars** | **Focal point** | **Partners (needs to be updated)** |
| 1. **Coordination, planning and monitoring** | * Dr Jorge Martinez * Dr Vinod Varma WHO | Health cluster partners, ACU, WHO, Turkish health Authorities, Syrian Local Health Authorities |
| 1. **Risk communication and community engagement** | * Dr Hani Alashawi, WHO * Mr Sikander, UNICEF | ACU, UDER, Violet, UNICEF, SIG, Orient, Syrian local health authorities, Civil Defence, WHO, CHW Network, Nutrition cluster, WASH cluster |
| 1. **Surveillance** | * Dr Naser and Dr Yasir, ACU * Dr Sohel, WHO | * ACU * WHO |
| 1. **Points of entry (PoE)** | * Dr Abdulhakim Ramadan, IHD * WHO | Turkish Syrian Task Force, Syrian Local Health Authority, IOM, Bahar, SRD, |
| 1. **Laboratories** | * Dr Redwan, ACU * Dr Sohel, WHO | * ACU * WHO * Turkish Ministry of Health |
| 1. **Infection prevention and control** | * Dr Idris, WHO * Dr Hussein, RI | * WHO * Health Cluster * UNICEF |
| 1. **Case management** | * Dr Idris, WHO * Dr Mohammad, SAMS | * Task Force, WHO, SAMS, SRD, RI, Referral network, Civil Defence |
| 1. **Operational support and logistic** | * Dr Jorge, WHO * Dr Abdul Hakim Ramadan, IHD | * Shelter & NFI cluster, WHO pharmacy, CCCM cluster, UNICEF, SRD, Referral Network, Civil Defence, |

## **Annex 5: COVID-19 Resources**

* **WHO global:** <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/>
* **EMRO**: <http://www.emro.who.int/health-topics/corona-virus/index.html>
* **EURO**: <https://euro.sharefile.com/share/view/s992aba8b6b24ea89/foa80836-9448-4801-8cc5-2c2400db3a72>
* **IPC**: <https://openwho.org/courses/COVID-19-IPC-EN>
* **Video** **gallery**: <http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/multimedia/video-gallery>
* **International** **traffic in regards to COVID-19**: <https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak>
* **Turkey** **MoH**: <https://www.seyahatsagligi.gov.tr/Site/koronavirus>
* **Gaziantep** **HeRAMS**: <https://app.powerbi.com/view?r=eyJrIjoiOTMzY2FiYWItMDIwMS00YjlkLTg1YmItYTY4YmFlYTJkYTc5IiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9>

**COVID-19 partners’ platform**: <https://covid-19-response.org/>

* **Critical preparedness, readiness and response actions for COVID-19**: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/critical-preparedness-readiness-and-response-actions-for-covid-19>
* **COVID-19: Operational Planning Guidelines and COVID-19 Partners Platform to support country preparedness and response**: <https://openwho.org/courses/UNCT-COVID19-preparedness-and-response-EN>
  + **Responding to community spread of COVID-19, Interim guidance , 7 March**: <https://www.who.int/docs/default-source/coronaviruse/20200307-responding-to-covid-19-communitytransmission-final.pdf?sfvrsn=ec5fa30a_5>

1. Coronavirus disease 2019 (COVID-19) strategic preparedness and response plan: Accelerating readiness in the Eastern Mediterranean Region and World Health Organization. Coronavirus disease 2019 (COVID-19) Situation Report 64 [↑](#footnote-ref-1)
2. World Health Organization. WHO Eastern Mediterranean Regional Office Public COVID-19 Dashboard [↑](#footnote-ref-2)
3. Humanitarian Needs Assessment Programme, Syrian Arab Republic (North-West Syria), February 2020 [↑](#footnote-ref-3)
4. <https://www.saglik.gov.tr/TR,64383/koronavirus-alacagimiz-tedbirlerden-guclu-degildir.html> [↑](#footnote-ref-4)
5. Snapshot of IDPs in North West Syria 8 March 2020, CCCM Syria Cross-Border Info [↑](#footnote-ref-5)
6. <https://www.sana.sy/en/?p=188847> [↑](#footnote-ref-6)
7. World Health Organization. Islamic Republic of Iran, Coronavirus Disease 2019, 1 March 2020 [↑](#footnote-ref-7)
8. <https://www.youtube.com/watch?v=pS2zrBiSMUM&list=PL906Y6OrlAXhD5BtqRWANKrbGHqpFA1hB&index=23> [↑](#footnote-ref-8)