



8,580 Total confirmed cases

4,059 Recoveries

458 Deaths

Source: Syrian Ministry of Health (MoH)

*MoH data does not include areas outside of GoS control



This report is produced by the World Health Organization (WHO) and the Office for the Coordination of Humanitarian Affairs (OCHA), in collaboration with humanitarian partners. The next report will be issued on or around 30 December.

HIGHLIGHTS

- As of 8 December, the Syrian Ministry of Health (MoH) reported 8,580 laboratory-confirmed cases, 458 fatalities, and 4,059 recoveries in Government of Syria (GoS)-controlled areas.
- In northeast Syria (NES), 7,256 confirmed cases of COVID-19 as of 6 December.
- In northwest Syria (NWS), as of 7 December, 17,527 confirmed cases of COVID-19 were reported.

SITUATION OVERVIEW

While current official numbers remain relatively low in GoS-controlled areas, in recent months, the epidemiological situation has rapidly evolved and all factors – including that the vast majority of announced cases have not been linked to exposure/contact with a known case – point to widespread community transmission. November represents the peak of official numbers reported in a single month (2,069), followed by 2,008 cases reported in August.

In GoS-controlled areas of the country, 8,580 laboratory-confirmed cases have been reported by the Syrian MoH as of 8 December. Of these, seven were in Ar-Raqqa; 22 in Deir-Ez-Zor; 35 in Al-Hasakeh; 115 in Quneitra; 473 in Dar'a; 470 in Tartous; 395 in Hama; 515 in As-Sweida; 1,326 in Homs; 965 in Rural Damascus; 886 in Lattakia; 1,516 in Aleppo; and 1,855 in Damascus.

As of 8 December, 239 health care workers (HCW) have tested positive for COVID-19 in GoS-controlled areas. Of these, 12 fatalities have been reported, while 114 cases remain active. Humanitarian actors continue to receive reports that HCWs in some areas do not have sufficient personal protective equipment (PPE). The WHO continues to lead efforts to support the increased distribution of PPE where needed to ensure the protection of HCWs.

In recent weeks, the number of reported cases in schools has sharply increased, with 828 cases to date, more than double of the figures at the start of November (399 cases). This highlights the challenges of preventing transmissions in schools due to overcrowded classrooms, insufficiently qualified teaching personnel, and poor/damaged infrastructure. Of these, 420 were reported to be teachers and other staff, with the highest reported cases in Rural Damascus, Aleppo, and Homs. Both WHO and UNICEF, along with Health and Education sector partners, continue to strengthen COVID-19 preventive actions in schools.

Humanitarian actors have received unverified reports concerning additional possible cases. This is supported by indications that in some areas, healthcare facilities, most recently in November, have been unable to absorb all suspected cases and/or are suspending surgeries, or adapting wards, to accommodate increased COVID-19 patients. While the UN is not in a position to verify or directly link such reports to COVID-19, other unverified reports received further support concerns, including reports on difficulties in obtaining tests, as well as rising number of obituaries, death notices, and burials.

The actual number of cases remains difficult to confirm. This is due to limited testing across Syria with a subsequent prioritized testing strategy used, and, the likelihood that a significant number of asymptomatic and mild cases are going undetected. Contact tracing continues to be a challenge, including in more remote governorates and camps. Furthermore, community stigma and individual reluctance to go to hospitals mean it is likely that a significant number of people with

symptoms are not seeking tests or treatment, or, they are obtaining private services offering home care, negatively impacting the long-term health prospects and survival of a subset of patients with compromised immunity or complications.

In NES (as of 6 December), there have been 7,256 confirmed cases of COVID-19. Of these, 5,984 are currently recorded as active, 1,058 have recovered, and there have been 214 confirmed deaths. Although infection remains widespread, the rate of transmission has slowed somewhat in the second half of November, particularly in areas where a full lockdown was in force. Overall, the number of confirmed cases does not provide an accurate reflection of infection prevalence. The decrease in new cases appears to be a result of multiple factors, including a reduction in testing capacity (due to supply shortages), low surveillance capacity, as well as continued challenges related to case diagnosis and detection.

Furthermore, the combination of partial and full lockdown measures appear to have slowed transmission in some areas. Low levels of case detection are linked to under-reporting due to social stigma, misapplication of the case definition/ clinical screening protocols, and challenges in activating the rapid response teams (RRT). Despite the imposition of lockdown measures during November, there remains limited adherence to basic protective measures such as mask-wearing, and limited enforcement of these measures.

As of 6 December, 667 of the 7,256 confirmed cases of COVID-19 (9 per cent of all cases) were recorded amongst HCWs. Of these, 205 (28 per cent of all cases among health workers) have been recorded in Al-Hasakeh city. Transmission continues to be reported at health facilities across NES. Although transmission among health workers and at health facilities continues to have a detrimental impact on health service continuity, health partners have continued to improve Infection Prevention and Control (IPC) measures/ compliance resulting in a reduction in facility closures and staff infections.

As of 30 November, according to updates provided by 10 NES NGOs, covering 88 health facilities, three health facilities were closed or partially closed, including one in Raqqa (Mahmoudli), one in Al-Hasakeh city, and one in Kobane. A further 13 health facilities were closed or partially closed at some point during November due to infection among staff. This is a reduction from 23 facilities which were closed or partially closed during October. As of 30 November, there were 77 staff in self-isolation/quarantine from nine NGOs, while a further 56 health staff from eight NGOs have been in self-isolation or self-quarantine at some point during November.

A total of 25 confirmed COVID-19 cases have been reported in camps, an increase of just five confirmed cases throughout November. COVID-19 cases have been recorded in the following camps: Al Hol (13); Areesha (4) Mahmoudli (6); and Sereniye (2). Despite the low number of confirmed COVID-19 cases in camps, significant concerns remain around possible community transmission. This is particularly true at the Al Hol internal displaced persons (IDP) camp, where confirmed cases have been recorded in five separate phases, indicating that it may be impossible to contain the virus through isolation and contact tracing alone. These challenges are compounded by the reluctance of people to move to designated camp-level isolation areas if they are considered suspect, an underreporting of symptoms, and a lack of adherence to basic preventative measures (including the use of face masks). As such, health partners in Al Hol are adapting their strategy for responding to the virus. Instead of prioritizing containment – with an emphasis on testing, tracing and isolation - resources will be directed towards increased community surveillance, focusing on the most vulnerable and suspect case, and saving lives amongst the most vulnerable. Health partners are also looking at how to enhance adherence/awareness around basic preventative measures to save lives and suppress transmission.

Throughout November, lockdown measures have been further tightened in NES, building on the partial lockdown measures announced on 30 October and since extended. Stringent restrictions have been implemented across different parts of NES in recent weeks, with three separate full lockdowns initiated in four cities (Ar-Raqqa, Al-Hasakeh, Qamishli and Tabqa) between 26 November and 5 December. Lockdowns were also in place in Derik between 6 and 19 November, and, the Euphrates Province between 15 November and 10 December (with measures temporarily lifted between 26 and 30 November). All essential humanitarian activities are permitted to continue although additional movement permissions procedures have been implemented at the local level, with some level of local variance. Although levels of enforcement vary, the partial lockdowns remain in effect across all areas of NES. On 6 December new measures were put in place until 20 December. While shops, grocery stores, schools, universities and educational facilities are allowed to open, places of worship are closed, except for Fridays and Sundays, and all mass social gatherings are prohibited. Public transportation is allowed to enter/exit NES. Across all areas of NES, schools, universities and kindergartens were closed between 26 November and 5 December. It is understood that education facilities reopened on 6 December.

In NWS (as of 7 December), a total of 17,527 confirmed cases were reported (9,648 from Idleb and 7,879 from Aleppo governorates), including 221 deaths. A total of 8,334 people reportedly recovered. Of all cases, 1,618 (9.23 per cent) were among HCWs, and 747 (4.26 per cent) were identified among community health workers, as well as other staff working in health facilities. A total of 1,596 (9.63 per cent) cases were reported from IDP camps.

Increasing testing capacity continues to be a focus in NWS, particularly in hotspot sub-districts such as Idleb (Idleb), Dana (Idleb), Afrin (Aleppo), Al Bab (Aleppo) and Azaz (Aleppo). In total 60,497 polymerase chain reaction (PCR) tests have been completed, including 31,261 in Aleppo and 29,236 in Idleb governorates, with a test positivity rate of 23.18 per cent.

Currently, three laboratories have been operationalized (Idleb, Jarablus, and Afrin), with a total of four PCR machines (two of which were delivered in September). Daily testing capacity has nearly doubled since October, to an average of over 1,000 tests per day. Procurement of additional testing kits continues, as do efforts to enhance human resources, including through training. An NGO, with the support of WHO, has activated a community-based quarantine centre (CQC) in Idleb, specifically for IDPs living in camps, for those who are not ill but who are believed to have been exposed to COVID 19. These persons, when identified, are usually expected to quarantine in their homes, but due to overcrowded living conditions in camps, this may not always be possible. Partners have also increased outreach activities in and around camps located in areas of underreporting, as identified by the COVID-19 Task Force. One major initiative has been to mobilize community health workers to improve community-based active screening and early detection of suspected and undetected COVID19 cases, prioritizing camps that have reported the highest incidence rates in Idleb.

A strong emphasis is being placed on increasing capacity in hospital settings across NWS, regarding both staff and resources. The COVID-19 Task Force Case Management Group continues to assess the availability of oxygen therapy and beds in community-based treatment centres (CCTC), as well as repurposing beds in hospitals for emergency cases, across NWS.

PREPAREDNESS AND RESPONSE

Hub-level preparedness and response planning

The focus of the Humanitarian Country Team (HCT) in Syria continues to be on reinforcing comprehensive, multi-sectoral preparedness and mitigation measures for COVID-19. The HCT is also oriented to protecting, assisting, and advocating for the most vulnerable, including internally displaced persons (IDPs), refugees, and host communities particularly vulnerable to the pandemic, including by, to the extent possible, working to continue principled programme delivery and the provision of life-saving assistance across the country. The current key priorities in Syria are:

- Improving surveillance capacity and expanding national and sub-national laboratory capacity to test for timely detection;
- Protecting health care workers by training and providing additional PPE;
- Building the capacity of health care workers on IPC and case management protocols;
- Procuring COVID-19 supplies including diagnostics and biomedical equipment;
- Enhancing awareness raising and risk communication; and
- Engaging with the Ministry of Health on their vaccination strategy, including defining priority population groups.

WHO is the lead agency and is working to support the Syrian MoH in enhancing health preparedness and response to COVID-19, following [International Health Regulations \(IHR 2005\)](#). WHO, acting on the eight pillars of the global WHO Strategic Preparedness and Response Plan, continues engaging the Syria MoH and partners. To enhance technical capacity and awareness, including on rational use of PPE, case management, IPC, environmental disinfection, and risk communication; and is focused on procuring and enhancing medical supplies including in laboratory testing and PPE for case management and healthcare facilities. On 31 March, the UN Secretary-General Antonio Guterres launched a report - Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19 - which forms the basis of incorporating socio-economic impacts as the 'ninth pillar' of the response.

As the UN supports national preparedness and response in Syria, the specific country context poses considerable challenges. This includes a fragile health system that is suffering from a lack of personnel and needed infrastructure. There are also limited existing essential equipment, and an insufficient supply of water and sanitation infrastructure. There are significant existing vulnerable populations reliant on humanitarian assistance, and, there are challenges accessing certain areas, due to ongoing hostilities. Due to COVID-19 preventative measures, humanitarian workers are not able to move freely to support and implement humanitarian programmes. There are also challenges in procuring supplies, which are exacerbated by a competition for local supplies, a deteriorating economy, and sanctions. It remains a priority to both increase and decentralize testing, to accommodate more timely diagnosis of more samples from a greater range of geographical locations.

In NES, NGO partners continue to implement and scale-up COVID-19-related activities under all eight of the WHO preparedness and response pillars for COVID-19. During October, the NES Forum issued an updated version of the NES COVID-19 PRP, first issued in April. The plan requests a further US\$ 12.1 million (of total requirement amounting to US\$20.2 million) to implement this plan. While focusing on the next three months, because of possible supply challenges and pipeline breaks anticipated during 2021, requirements have in some cases been calculated over an extended period. Key components of this plan include laboratory testing, case investigation, risk communication and community engagement, case management, and IPC. By the end of November, WHO trained an additional eight technicians in NES, and bought a GeneXpert machine on 2 December, to be established in the Qamishli national hospital for COVID-19 testing.

In NWS, there continues to be a critical funding gap of nearly US \$11 million through to the end of the year across preparedness and response plan (PRP) pillars. There is an urgent need to fill gaps in expanding testing, strengthening surveillance, operating CCTCs, medicines and additional IPC materials across NWS.

ACCESS RESTRICTIONS

Borders and crossing points

As of 2 December, most land borders into Syria remain closed, with some limited exemptions (from Jordan, Turkey, and Lebanon), including commercial and relief shipments, and movement of humanitarian and international organization personnel. Damascus International Airport, as well as Tartous and Lattakia ports, are operational. Starting 15 November, authorities in Jordan introduced additional facilitations for some individuals, including Syrians and Jordanian nationals with Syrian residency to cross into Syria via the Jaber/Nassib border. From 16 August, as in many other countries, the GoS implemented requirements for individuals arriving from official border crossing points with Lebanon, including the presentation of a negative PCR certificate obtained within the past 96 hours at accredited laboratories. The border crossing point between Rukban and Jordan remains closed, curtailing access to the UN-clinic.

In addition, reports indicate internal crossings into the Tal-Abiad and Ras Al-Ain area, across frontlines, remain closed. Restrictions appear to remain in place at Um Jloud in Aleppo; at Awn Dadat, the crossing has been closed since 19 October. Al-Bukamal-Al-Quaem crossing is reported to open for commercial and military movements; Ras Al-Ain border crossing is partially open for humanitarian shipments, voluntary returns, and visits relating to the agricultural harvest. Abu Zandin in Aleppo remains closed, although reports indicate in practice, crossings do occur. Ghazawiyet Afrin and Deir Ballut in Aleppo are open for commercial and humanitarian cargo movement.

The Bab Al-Hawa border into NWS from Turkey, is open for commercial and humanitarian traffic and movement of humanitarian staff. On 12 November, Turkish authorities introduced new restrictions at Bab Al Salama border crossing (Turkey-Aleppo), including limiting NGO staff movement to Tuesdays and Thursdays only, limiting two staff to one vehicle per NGO being granted movement per day, and requirements to register with the crossing's authorities. Internal crossings between Idleb and northern Aleppo remain open to both humanitarian cargo and staff. All internal crossings between NWS and NES remain closed, however, not due to COVID-19 restrictions.

The 12 October announcement by local authorities in NES indicated internal crossings would be open. However, lockdowns from the 26 November impacted internal crossings at Tabqa, Akeirshi, and Abu Assi in Ar-Raqqa. The measures have not impacted Al-Taiha in Aleppo, although early reports indicate some individuals have been prevented from moving to GoS areas.

COVID-19 preventative measures and key access constraints

In GoS-controlled areas, the GoS continues to maintain a widespread easing of preventive measures introduced throughout May, albeit with some ongoing, ad-hoc changes, including the recent suspension of some schools/classrooms where students or teachers had been confirmed to have contracted COVID-19. Otherwise, markets, restaurants, cafes, gyms, parks, theatres, cinemas, and most leisure facilities are open, with mandated precautionary measures, as are mosques and churches. Public and private transportation services have resumed, as have schools, universities, and institutions. While broad-based restrictions are not expected to be re-imposed due to socio-economic impacts, it remains possible the GoS may enforce localized lockdowns.

In NWS, continued hostilities, south of the M4 and around the M5 highways, continued to hinder safe access to highly vulnerable areas by humanitarian workers in support of existing needs and COVID-19. The multiplication of improvised explosive devices (IED), landmines, and unexploded ordinances (UXO) constitute a major threat to civilians and humanitarians and undermines access. Local authorities have implemented sporadic restrictions concerning the closing of and or reductions to crossings allowed at both international and internal borders/crossing points.

In NES, local authorities continue to provide exemptions for humanitarian goods and personnel at the Fishkabour/Semalka informal border crossing, and in other limited cases, including urgent medical cases to cross to Iraq. Throughout November, lockdown measures have been further tightened, building on the partial lockdown measures announced on 30 October and extended every 14-days. This has included a partial curfew in place since 27 October requiring the closure of most shops and restricted trading hours for essential shops, and requirements that restaurants only operate delivery service while mass gatherings are prohibited. Social, educational, and all training/group activities are prohibited, and schools across NES are closed. On top of these measures, more stringent restrictions have also been implemented across different parts of NES in recent weeks. A lockdown was also imposed on Al-Malikeyyeh town from 3 November. All other areas in NES are now in partial lockdown, except for the Kobane and Ein Issa area, where full lockdown is imposed until 10 December, with exemptions between 26-30 November to allow people to purchase food and other essential items. Humanitarian partners remain largely exempt from lockdown restrictions, and all essential humanitarian activities are permitted to continue.



Country-Level Coordination

At the national level, the UN has established a COVID-19 Crisis Coordination Committee (CCC), led by the UN Resident Coordinator and Humanitarian Coordinator (RC/HC) with the WHO Representative for Syria serving as the Incident Manager, to closely engage with the GoS and other stakeholders in the implementation of the multi-sectoral response. The UN RC/HC and WHO Country Representative, along with other UN leadership in-country, continue to engage senior officials on the COVID-19 response, including with the Deputy Minister of Foreign Affairs, the Minister and Deputy Ministers of Health, the Ministry of Social Affairs and Labour, the Ministry of Legal Affairs, and Ministry of Education, as well as the International Committee of the Red Cross (ICRC) and Syrian Arab Red Crescent (SARC).

OCHA Syria continues to engage the Inter-Sector Coordination team in Damascus to coordinate response efforts within Syria. WHO is holding daily meetings in Damascus and weekly Health Sector coordination meetings and operational calls to monitor the implementation of the COVID-19 preparedness response plan (PRP). Weekly operational calls on NES are also ongoing, including enhancing and strengthening preparedness and response efforts at points of entry (PoEs) and in contingency planning for camps.

In addition, sectors, including WASH, Health, Logistics, Protection, Nutrition, Food Security, Shelter, and Non-Food Items (NFIs) continue to undertake national and sub-national level meetings to support coordinated response planning, as well as coordinating with authorities. Key activities have included developing sectoral-specific guidance on risk mitigation, information dissemination among partners, and the development of sector-specific response plans incorporated in the operational response plan.

In NES (as of 1 December), the COVID-19 Task Force continues to meet on a biweekly/monthly basis and to serve as a platform for coordinating work across the eight pillars of the response. The task force updates health partners and sector coordinators on COVID-19 related developments, support engagement with the local authorities, and addresses key cross-cutting issues affecting health partners. The task force also oversees the work of two dedicated sub-task forces for risk communication and community engagement (RCCE), and case management, case investigation, and IPC. The NES Forum and partners continue to engage with local authorities at two levels:

- At the central level, a COVID-19 technical committee continues to function, with weekly meetings convened with the head of the local authority department of health. The technical committee brings together stakeholders, and acts as an advisory body to the department of health; ensures strategic coherence; guides seven local COVID committees; and, advocates on key public health measures.
- Seven local COVID committees have been established across NES (Al-Hasakeh, Qamishli, Deir-Ez-Zor, Tabqa, Ar-Raqqa, Menbij, and Kobane). These committees provide operational leadership at the local level, with a focus on RCCE, case investigation, RRT deployment, and, IPC among health workers and at health facilities. In most areas, COVID committee meetings take place every week.
- At the camp-level, health committees continue to operate across all camps in NES to oversee actions related to COVID-19 prevention and mitigation. The Camp Administration also participate in these bodies. These committees support work under the eight pillars, overseeing key functions including contact tracing, RCCE, and the isolation areas inside the camp. Contingency plans to support the continuity of services have been developed across all camps. These plans specify the activities which can/should be maintained, that have been adapted to mitigate the risk of transmission, and activities which have been suspended to reduce the transmission risk. Considering the recent NES-wide lockdown measures, individual camps have also enforced additional restrictions, particularly impacting protection and education activities as well as group activities. Also, movement in and out of camps has been restricted to emergency cases only. Some relocation activities, such as the relocation of IDPs from collective centres to Serekaniye camp, have been suspended.

In NWS, a quarantine centre is now operational with a 61-bed capacity, and the COVID-19 Task Force is working towards fully activating all linked pillars to isolate asymptomatic cases. This is linked with contact tracing for people living in camps – referral, triage, IPC, and surveillance. The health information system unit, supported by WHO, is working to streamlining real-time information from COVID-19 designated facilities. Standardized reporting is being activated in all COVID-19 isolation hospitals and CCTCs on the DHIS2 information system format (capturing admission, discharge, and death certification data). This allows for the deployment of standardized forms, training the data entry operators, and running a quality check once information is received from the facilities. Key indicators that are being focused on now are occupancy rates, daily new admissions to assess new caseload burden, oxygen support, and, intubation ratios. The forms have been developed and supported by the Health Information System (HIS) project of WHO. The new morbidity and mortality forms will initially start with COVID-19 designated facilities, and it will be scaled for other facilities.

Risk Communication and Community Engagement

The Risk Communication and Community Engagement (RCCE) Group, which aims to inclusively engage communities while communicating critical risk and event information concerning COVID-19, is working closely with WHO and the Syrian MoH. The RCCE Group has developed and widely disseminated a multi-component package, including a toolkit of key messages covering a wide range of issues related to COVID-19, and finalized online training materials in Arabic, and trained several partners.

In response to a reported increase in COVID-19 cases in recent weeks, the RCCE Group has focused on strengthening inter-agency coordination. This to increase coverage and effectiveness of public engagement on the ongoing risks of COVID-19, with interventions emphasizing preventive measures (physical distancing, hand, and respiratory hygiene) and health-seeking behaviours.

While cumulative RCCE efforts to date have reached an estimated 15 million people, survey information and anecdotal evidence suggest the risk perceptions, across Syria, are very low, with a lack of adherence to individual preventive measures observed in some communities. The national public opinion survey on COVID-19, was implemented by the Ministry of Information, with UNICEF and WHO technical support. The survey was conducted with 30 data collectors targeting 6,000 individuals. The results are being analyzed and a report expected at the end of December.

As detailed in previous reports, efforts are ongoing on the development, printing, and distribution of information, education, and communication (IEC) materials. Furthermore, awareness-raising continues on social media, WhatsApp, radio and television channels, and direct community engagement/person-to-person, including during distributions. Other channels, including through the smart card/Takamol application and online quizzes, are also being utilized. Engagement is also ongoing at universities, schools, religious leaders in mosques, and with church networks.

Over the reporting period, the WHO supported three workshops to coincide with World Antibiotics Awareness Week, to promote behavioural change and to address critical issues related to antimicrobials, including in the context of COVID-19. WHO, with UNICEF, further supported a 20-day awareness campaign in Homs and Hama on preventive measures, utilizing ten teams to reach 280,000 people, including school children, in 200 locations across the two governorates. WHO also continued technical support for the MoH COVID-19 dynamic infographic dashboard for Syria, in Arabic and English. UN agencies, specific sectors, and partners continue awareness-raising activities during existing programmes (such as distributions) and/ or as separate initiatives, including through social media campaigns, training, and regional outreach activities.

In NES (as of 30 November), IEC materials have been made available to partners through the dedicated NES Forum COVID-19 google drive folder, and, the dedicated Syria COVID-19 resources dropbox folder. A validated training programme on RCCE key messages has been developed and delivered. Training materials/ tailored training is available to partners upon request. Additional support on reactive messaging or development of IEC on new developments and support to partners provided at bi-weekly sub-task force meeting and upon request.

In late November a group of four NGOs operating in NES released an analysis of the data they had previously published. The report highlighted a continued lack of knowledge around preventative measures related to COVID-19. Almost 60 per cent of respondents mentioned that a barrier to them on taking precautionary measures was a lack of desire to change behavior. This implies a further need for precautionary advocacy. Similarly, in another survey, 42 per cent of respondents reported that they do not have enough information to keep themselves safe. A further, 41 per cent of respondents reported that their community does not believe that protective measures, that have been put in place, will reduce the spread of the virus.

After the lifting of lockdown measures in the summer, reported mask-wearing went from over 50 per cent of the population to around 10 per cent. Along with an analysis of the survey results mentioned above, this indicates that the lockdown measures are contributing to increased trust/acceptance around key protective measures, such as adhering to using personal protective measures. It is possible that the new round of lockdown measures in place, at the time of reporting, could have a comparable impact. However, 93 per cent of households in NES have reported facing at least one barrier to implementing preventative measures, with the most reported barrier being a lack of money. According to the survey, people in NES have also been most affected by the economic impact of COVID-19. Eighty-eight per cent of respondents have experienced a moderate or significant loss of income from COVID-19 restrictions. Finally, stigma remains a concern, with 89 per cent of people surveyed in NES reporting that they believe COVID-19 is causing discrimination against certain groups of people, including healthcare workers and those suspected of having the virus.

In response to the low levels of mask-wearing in NES as well as the reported economic barriers to implementing personal protective measures, the RCCE sub-task force has been coordinating a facemask campaign. The sub-task force is coordinating with Food Security and Livelihoods Cluster partners on the production of cloth masks and linking them with

NGOs and local authorities, to provide the masks at identified priority locations. The aim will be to distribute these masks to vulnerable populations, along with key RCCE messages on face masks, as well as on general COVID-19 key messaging. Thus far, based on an area-based approach, the campaign has provided masks to the Ar-Raqqa Health Council and at primary healthcare facilities in Ar-Raqqa. In the next phase, the campaign will work to provide cloth face masks to all teachers working in Al-Hasakeh, and Deir-Ez-Zor so that schools can establish a mask mandate for teachers as they reopen. Additionally, other implementing agencies in Ar-Raqqa and Kobane will be engaged to expand the provision of face masks to targeted health facilities in these areas.

There has also been a reported lack of adherence to public health measures and organizational SOPs among NGO field-staff. The RCCE sub-task force is working with implementing partners to reemphasize the importance of compliance among field staff to IPC measures. Repeat briefings will be convened for these staff on updated SOPs, to establish accountability among staff and volunteers, ensuring that humanitarians set a positive example.

The key priority over the last month has been to counter the social stigma associated with COVID-19, and the knock-on impact it has on the reporting of symptoms and health-seeking behaviour among symptomatic persons. Stigma among people who are suspected of having COVID-19 is leading to a significant underreporting of cases, which in turn leads to those reluctant to seek support having higher case fatality rates at COVID-19 treatment facilities, reinforcing negative perceptions of seeking treatment. Among recommendations that have been developed to counter stigma, including conducting a barrier analysis, to be better able to assess what is preventing the local community from reporting symptoms (if) they suspect they have COVID-19. It has been reported that harmful rumours have been spread in camp and non-camp settings around the dangers of treatment in public health facilities, COVID-19 treatment facilities, and about COVID-19 itself. To address misinformation RCCE are being requested to enquire about what specific rumours families have heard regarding COVID-19 to track these rumours and provide accurate information in response. This is a part of ongoing efforts to build trust in the health system and to promote reporting of symptoms.

In NWS (as of 29 November), additional responsibilities for community health workers (CHWs) in NWS were identified by the COVID-19 Task Force, that include:

- Improving the community-based active screening and early detection of suspected and undetected COVID-19 cases. CHWs will work in prioritized camps in coordination with the camp management as mobile screening teams.
- Arrangement of the referral process for the identified cases to the correct level of service delivery point, in coordination with the central hotlines, referral desk, and surveillance team.
- Strengthening contact tracing of contacts of confirmed cases and the follow up with cases in self-isolation.
- Improvement of healthcare-seeking behaviour of suspected and confirmed cases through outreach activities. Especially in camps and locations of underreporting of COVID-19, as identified by the EWARN team.

A survey on utilization of COVID-19 CCTCs by the general population, of confirmed COVID-19 cases, and of healthcare workers in NWS is ongoing.

With the support of a partner, WHO has created an animated video version of the “My Hero is You” storybook endorsed by the Inter-Agency Standing Committee, to help children understand COVID-19 in Arabic.

On 14 November, WHO commemorated Diabetes Day, reaching a total of 11,823 beneficiaries through social media, including 8,717 interactions, and 6,070 story views to raise awareness regarding increasing cases of COVID-19 deaths inside NWS, including particular risks posed to those with diabetes and other chronic conditions.



Surveillance, Rapid Response Teams, and Case Investigation

WHO continues to engage closely with the MoH with technical teams meeting daily. With WHO support, the new COVID-19 case definition for Syria has been disseminated, and suspected cases are included as a priority in the early warning alert and response system (EWARS). Currently, 1,360 sentinel sites report cases through the EWARS system across all 14 governorates.

Within Syria, relevant stakeholders have agreed to collect samples through 112 RRT for a referral to the central public health laboratory (CPHL) for testing. During the reporting period, more than 9,000 suspected COVID-19 cases and contacts were investigated within 24 hours of an alert received. Also, WHO supported the transport of 2,072 suspected case specimens to the central laboratories.

In the reporting period, given the additional challenges of the current co-circulation of influenza and COVID-19, WHO supported the activation of influenza surveillance in three sentinel sites in Damascus and Aleppo. Twenty-five surveillance officers were trained, and six laboratory staff were trained in testing samples for influenza and COVID-19.

As outlined in previous reports, RRTs continue to collect and deliver samples to the CPHL or regional laboratories in Aleppo, Homs, and Lattakia with WHO support. As of 27 November, approximately 40,236 samples have been collected from thirteen governorates since mid-March, including 232 samples from Al-Hasakeh, 109 from Deir-Ez-Zor, and 13 from Ar-Raqqa.

In NES (as of 2 December), there have been at least 17,970 samples collected in response to alerts received through one of the three surveillance systems operational in NES to track reports of suspected cases and conduct case investigation. Of these, at least 7,321 samples (not including two samples collected and tested via a mechanism of local authorities in April) have so far been confirmed as positive; 64 cases via the MOH/ EWARS mechanism, 193 cases via the Early Warning, Alert, and Response Network (EWARN) mechanism and 7,064 cases via the mechanism of local authorities).

As of 30 November, 354 swab samples (232 from Al-Hasakeh, 109 from Deir-Ez-Zor, and 13 from Ar-Raqqa) are understood to have been collected and processed via the MoH/ WHO EWARS system. This is an increase from 328 samples as of the end of October. The status and/or results of these tests have not been systematically communicated with relevant entities. It is also possible that the total number of suspect case notifications received, and samples collected by MoH EWARS RRTs could be higher than what has been reported in this COVID-19 Update as MoH does not share this information with local authorities or NES partners. It is understood that 64 of these samples have tested positive (an increase of three from the end of September); 35 from Al-Hasakeh (three deaths), seven from Ar-Raqqa, and 22 from Deir-Ez-Zor (one death). It remains unclear whether these cases are a duplication of positive cases recorded under the mechanism of the local authorities.

There have been 762 tests conducted in NES as of 30 November, in response to alerts received through the EWARN system (an increase from 679 as of the beginning of November). These samples have been transferred to Idleb for testing, with 193 samples testing positive (up from 188 as of the beginning of November): 36 in Ar-Raqqa, 14 in Al-Hasakeh, and 143 in Deir-Ez-Zor. The EWARN team alerts the laboratory of the local authorities whenever suspect cases are identified, with samples subsequently collected via EWARN and local authorities, meaning that the majority of positive cases have also likely been confirmed positive by the local authorities.

As of 1 December, 16,854 samples have been collected and transferred to the laboratory of the local authority in Qamishli (or in a minority of cases, Tall Refaat). This is an increase from 5,039 samples tested as of 3 November. As reported, the number of samples collected has reduced during the second half of November. Testing continues to be lowest in Ar-Raqqa, Menbij, and Deir-Ez-Zor, indicating challenges around surveillance/ case detection and lower levels of awareness among the population around what to do should they develop symptoms.

The centralized hotline mechanism continues to function, supported by the local authorities, Kurdish Red Crescent (KRC), and NGO partners. This hotline (hotline A) is available to the public and can be reached through 4 phone numbers, widely disseminated to the population via media/ social media and through flyers. Individuals with symptoms are encouraged to contact the helpline where they will be asked some basic questions as part of a triage process and, if deemed a suspect case, an RRT will be deployed to collect a sample and conduct a case investigation. A second hotline (hotline B), also part of the Operations Desk (OD) in Qamishli, has now been established to facilitate the referral and hospitalization of cases.

As previously reported, across NES, there are an estimated 25 RRT. As of the beginning of December, refresher RRT training has been completed in all locations excluding Deir-Ez-Zor. Although in recent months coordination around RRT deployments have been strengthened, there remain several challenges impacting the effectiveness of RRTs including i) a lack of mobile RRT capacity, wherein many areas the absence or severe lack of mobile RRTs; ii) lack of clinical assessment of secondary causes, as RRTs only swab cases for whom an alert has been received and processed and not possible additional symptomatic persons in a household; iii) limitations in data-collection, because despite consistently increasing staff numbers, the OD - which oversees hotline A + B and manages COVID-19 case data – the team is overburdened in data-entry requirements.

To address what has been a significant underestimation/underreporting of recoveries (and deaths at home), owing to the lack of dedicated follow-up capacity, as of 1 December a dedicated “Recovery/ Follow-Up Unit” under the OD has been trained. This unit is expected to be functional by the second week of December. It will be responsible for following-up with COVID cases both as part of regular screening and to track/ confirm recoveries (recovered cases being defined as an individual who meets criteria of a minimum of 13-days in self-isolation, with the last 3-days asymptomatic).

In NWS, out of 241 sentinel sites (129 in Aleppo and 112 in Idleb), 235 reported through EWARN the 9-15 November. This constitutes 97.5 per cent completeness and 86.5 per cent timeliness. Eleven EWARN staff members attended the annual EWARN workshop to look at the transitioning from EWARN systems in emergencies to routine surveillance systems.

Points of Entry

WHO has supported screening efforts at points of entry (PoE) by providing PPE, infrared thermometers, barriers, registration forms, and one thermal scanner camera. Among 15 GoS-designated PoEs, seven have now partially opened for international travellers, including airports in Damascus, Aleppo, and Lattakia, and from 15 November, at Nasib crossing in Dar'a for travel from Jordan. WHO has supported assessments of 12 PoEs in Rural Damascus, Homs, Tartous, Aleppo, and Lattakia (with others ongoing); and based on findings, are working to fill identified gaps, including the establishment of six medical points. During the reporting period, the WHO supported two three-day workshops on PoE capacity in Aleppo and Deir-Ez-Zor for 58 participants. WFP, as the Logistics Cluster lead, continues to monitor PoE, including operational status, capacity, new developments, and restrictions. The Food Security Sector continues to liaise with the Logistics Cluster to update partners.

In NES it was announced, on the 12 October, that all PoE would be immediately reopened as per normal (although due to restrictions by authorities on the Kurdistan Region of Iraq (KRI) side, cross-border movements have been limited to 3 days per week). Given the current phase of the epidemic curve in NES, with transmission remaining widespread and largely uncontrolled, the PoE pillar is not considered an immediate priority. However, as transmission levels fall, ensuring adequate screening capacity at PoEs will be critical in avoiding the reimportation of infections.

According to the latest Humanitarian Needs Assessment Programme (HNAP) transit point mapping (as of 1 December), approximately 16,730 people crossed into NES via crossline and cross-border PoEs in the two weeks between 17 and 30 November (i.e. equivalent to 8,115 per week). This represents a reduction in the number of weekly crossings from approximately 15,000 per week as of the second half of October. One factor contributing to a reduction in the number of people crossing is the closure of crossline PoEs in Ar-Raqqa between 26 November - 5 December, as part of the lockdown measures. According to HNAP, between 17 and 30 November, 16,730 individuals (IDPs/returnees, travellers and commercial trucks, humanitarian partners) crossed into NES at crossing points in Ar-Raqqa (14,900 from three PoEs), Menbij (1,530 from two PoEs), Al-Hasakeh (300 from two PoEs). This does not include movements via informal crossing points which are difficult to monitor/ track and in fact, may have increased due to the closure of formal crossing points in Ar-Raqqa.

A monitoring team has been established to assess levels of compliance of the recently developed guidance on 'NES Border Crossing /PoE' and a 'Technical Monitoring System' for PoEs in NES. The NES COVID-19 Task Force is exploring the capacity of partners to provide some limited support. The KRC continues to, at PoEs, distribute brochures to all new arrivals, which contain general information on COVID-19, guidance on self-quarantine, and information on what to do if you develop symptoms (this includes phone numbers to contact the helpline).

Identified gaps continue to persist concerning the infrastructure, supplies, and staffing at PoEs, such as the lack of dedicated medical and isolation caravans and limited furniture, ambulances, medical equipment (including oxygen), PPE, coverage of staffing costs, and capacity-building for staff. Although NES NGOs are not prioritizing support to PoEs, the NES COVID-19 Task Force is coordinating with other stakeholders to ensure these gaps are covered. As of the last week of November, a project had been initiated to upgrade 4 of the busiest POE in NES: Tahya (Menbij), Awn Dadat (Menbij), Tabqa (Ar-Raqqa) and Fishkabour (Al-Hasakeh). These upgrades will provide additional infrastructure (e.g. medical posts and isolation units), supply basis medical equipment/ consumables (including PPE) as well as non-medical equipment (furniture, IT equipment, etc.).

In NWS, almost 199,377 travellers were screened between November 1 – 23 using temperature checks within the seven PoEs, by medical staff of WHO implementing partners. A total of 135 travellers were suspected COVID-19 cases and referred to the associated CCTCs of those PoEs. An additional 1,143 suspected cases were referred to the CCTCs and the referral hospitals from other health facilities inside NWS, through the COVID-19 referral system.

Laboratory

To enhance diagnosis and prioritize increased testing capacity, the WHO continues to support the CPHL in Damascus. Rehabilitation of the CPHL was completed to establish a designated laboratory for COVID-19, two air-conditioners and two refrigerators were procured, two air-conditioners and four refrigerators were fixed, and, the laboratory generator was repaired. On-site training for 42 laboratory technicians has also been completed, including to support the expansion of testing in four regional laboratories in Lattakia, Homs, Aleppo, and Rural Damascus. In the reporting period, the WHO supported training for laboratory technicians working in Al-Hasakeh to support increased laboratory capacity in NES.

WHO has provided testing kits to the MoH since 12 February. To date, WHO has provided a wide range of reagents and supplies needed for conducting approximately 70,000 tests, in addition to five polymerase chain reaction (PCR) machines and two extraction machines, 5,000 waste bags and 21,000 bags for samples, and six months' PPE for staff. WHO has

additional supplies and equipment in the pipeline, including six PCR machines. UNHCR has procured one GeneXpert machine. WHO has reported that at present, both WHO and MoH are facing challenges to obtain some specific supplies, largely due to limited market availability and transportation, which is impacting the capacity to expand testing. WHO continues to work with MoH to ensure the availability of needed supplies.

Following WHO support for training of laboratory technicians and essential supplies, COVID-19 testing continues at the Tishreen University Hospital in Lattakia, Zahi Azraq Hospital in Aleppo, the public health laboratory in Homs, and Jdidet Artuz Health Centre in Rural Damascus. As of 21 November, the MoH reported approximately 64,000 tests have been conducted. As detailed above, increased capacity and decentralization of testing, including NES, continues to be a priority.

In NES (as of 1 December), the most pressing supply gap was for diagnostic consumables, with only 10-14 days stock of some items. In terms of PCR testing kits and RNA extraction kits, current stocks are sufficient for between 15-30 days and 8-16 days respectively based on projections of 500 and 250 tests per day. As previously mentioned, two NGOs are donating a combined 30,000 RNA extraction kits and 35,000 PCR testing kits. Of these, the first 10,000 RNA extraction kits and 15,000 PCR testing kits are ready for delivery pending the necessary export permits from the KRI authorities. A second shipment of the remaining diagnostic supplies is not expected to arrive in NES until mid-January. One NGO is also procuring various consumables for the laboratory, which should arrive in NES during the second half of December. Although local authorities have indicated that they will procure supplies should the laboratory run out, so far, they have been reluctant to cover longer-term supply needs and support increased testing.

The number of tests administered per day has decreased significantly throughout November, from a 7-day rolling average of 260 per day at the end of October to only 130 per day as of 30 November. This falls well short of the target to increase testing to 500 samples per day. Relatedly, the laboratory has reduced operations from an average of almost six days per week during October to under four days per week in November. Although the lack of diagnostic supplies, particularly consumables such as microcentrifuge tubes and filter tips for pipettes, has contributed to a reduction in testing, it cannot alone account for such a drastic reduction in overall levels. In terms of turnaround time, 50 per cent of results are delivered the same day or within one full day of sample collection, with 89 per cent of results delivered within two full days of sample collection.

In line with efforts to increase testing capacity, the local authorities previously committed to conducting a minimum of 500 tests per day, to screen health workers and to test health workers in self-quarantine. Despite these commitments, there have been multiple challenges that have hampered the rollout of this strategy. Supply challenges combined with the lack of an established pipeline to replenish depleted stocks have put a ceiling on the testing capacity. Other challenges include social stigma around getting tested (or being visited by RRTs). A divergence of approach in some areas (e.g. in Ar-Raqqa the local committee of health have instructed health facilities to send suspect cases with mild symptoms home without a test; in Al-Hasakeh District the committee of health has reportedly instructed RRTs not to test under the 40s). The limited compliance among many health facilities (particularly private health facilities) with regards to the official procedures for reporting and referring suspect cases. In practice, this means that RRTs are often not activated in response to alerts, and subsequently, no test is administered.

In NWS, agreements are in place for two additional laboratories to be made operational in Jarablus and Afrin. WHO has procured more than 6,000 swabs and Universal Transport Mediums (UTM) and also, with support from OCHA, the Turkish Red Crescent (TRC) is in the process of procuring 50,000 swabs and Viral Transport Medium (VTM) to support the laboratory activities inside NWS. Another partner has planned to launch two more laboratories in NWS, to donate a PCR machine to the EWARN team to further strengthen and accelerate the lab activities for COVID-19 in NWS and has donated 9,400 COVID-19 swabs and UTMs to EWARN.



Infection Prevention and Control (IPC)

WHO, UNICEF, Health, and WASH partners are working closely with relevant authorities to enhance IPC measures across public spaces, support health facilities, and to integrate measures across humanitarian programmes. Health and WASH actors continue health facility assessments to gauge IPC capacity, with many implementing IPC measures, such as establishing social distance, maintaining cross-ventilation, handwashing, and disinfection, and upgrading triage areas. Similar efforts are ongoing in collective shelters, with Shelter sector partners supporting upgrades in 21 shelters to date.

Within the reporting period, the WHO delivered a further 3,000 PPE to NGO partners, and currently has over five million additional PPE in the pipeline. To date, WHO has delivered more than six million PPE items, including medical masks, N95/FFP2 respirator masks, gloves, reusable heavy-duty aprons, gowns, headcovers, shoe covers, goggles, coveralls, face shields, alcohol hand-rubs, and PPE kits. In addition, over a million PPE have been delivered by health sector partners.

In its capacity as the WASH cluster lead, UNICEF continues to engage with partners to strengthen IPC in healthcare facilities, schools and learning spaces, youth centres, and communities, in addition to regular WASH services. During the

reporting period, in addition to water trucking (see below) and continued operation and maintenance of WASH infrastructure across the country, rehabilitation of WASH facilities were completed at Drikeesh National Hospital in Tartous. Light rehabilitation of WASH systems has also been carried out in 15 quarantine, and isolation facilities, including Al-Hol and Dweir quarantine centres, and over 625,000 items of PPE were provided by UNICEF to partners in November, including to hospitals.

With schools reopening, WASH sector partners, under the 'Implementation Plan of the School Reopening Framework', continued to support the delivery of soap and disinfectants to schools. In the reporting period, ICRC continued the rehabilitation of WASH facilities in 42 schools in Dar'a. In addition, local NGOs in As-Sweida provided over 5,500 masks to students in 39 schools, in addition to provided RCCE materials. In Aleppo and Deir-Ez-Zor, trained teachers delivered COVID-19 preventive measures sessions to students. Additionally, 12,000 soap bars have been provided to schools in Homs, Hama, Tartous, and Lattakia. A partner completed the COVID-19 and WASH-related hygiene behaviour awareness sessions in 13 schools in Eastern Ghouta and distributed child and adolescent kits for 4,357 students.

Training in IPC and the use of PPE also continued. WHO supported four capacity-building workshops for health care workers in Damascus, Aleppo, and Tartous, and a further 50 healthcare workers from NGO partners on IPC/PPE measures in Homs and Aleppo. In addition, to enhance IPC measures for elderly patients, WHO further supported two four-day workshops for 45 healthcare workers, including on elderly care at home in the context of COVID-19, and followed up with two supervisory visits to 11 primary health care centres to ensure appropriate IPC measures.

In NES (as of 3 December), under the joint leadership of the Health and WASH working groups, a second round of the 'IPC in Health Facilities Assessment' has been launched and will aim to be completed by the end of 2020. This is a follow-up to the first round assessment which was launched in April-May and evaluated the capacity of individual health facilities against a range of IPC-related indicators: hygiene promotion, personal hygiene, water provision, sanitation, waste management, staff training/ capacity-building, infrastructure (e.g. isolation/ triage capacity), PPE use, disinfection practices, availability of key equipment and supplies and clinical management/ staff health. The first round of the assessment covered 95 facilities and based on the first round of the assessment; several interventions were launched to enhance IPC capacity at health facilities. As of the end of November, at least 45 health facilities received WASH-related upgrades with support planned for a further 31 facilities. The second round of the assessment will target all facilities assessed under the first round. In addition to NGO-supported facilities, emphasis will be on expanding coverage to all public hospitals in NES and, to the extent possible, other local health authority supported primary healthcare facilities.

Health partners are taking continued steps to reduce transmission among health workers and at health facilities. Recognizing that there appears to be a reduction in the level of transmission at NGO supported health facilities and among NGO employed health workers, suggesting that IPC enhancements can positively impact reducing transmissions, the NES COVID-19 Task Force has proposed that all health facilities in NES take six basic steps to promote greater compliance with IPC measures. These include: that all health facility directors/ managers should sign a declaration agreeing to comply with a basic set of IPC measures; that health workers should always wear face masks in health facilities and disinfect hands when attending patients, and, to wear masks in public to set an example; that all people entering a health facility should wear a face mask (patient or non-patient); that health workers should not go between facilities; and health providers are encouraged to adopt standardized disciplinary measures if these procedures are violated.

To ensure technical coherence across camp-level isolation facilities, several SOPs related to solid waste management, disinfection protocols, and laundry have been developed to support Camp Management, WASH, and Health partners to ensure compliance with basic minimum standards.

In NWS, a total of 151 staff were trained across four CCTCs, supported by WHO implementing partners on IPC. There is a review of COVID-19 case management guidelines underway, specifically on case management admission criteria and on the patient pathway within the hospital and CCTC departments. The IPC and triage guidelines, along with standard operating procedures are being defined specifically for rehabilitation workers to conduct a rapid assessment and facilitate IPC triage.



Case Management

To date, humanitarian partners have been informed by local authorities of 33 identified quarantine facilities and 50 isolation spaces in 13 governorates. At the central level, the MoH has announced 21 isolation centres are currently running, with a cumulative capacity of 1,002 beds, including 826 isolation beds, 176 ICU beds, and 155 ventilators. The 32 quarantine centres are reported to have 5,157 beds. As mentioned in previous reports, information indicates that patients experiencing mild symptoms have been requested by some isolation centres to quarantine at home.

The priority remains on providing support to and reinforcing isolation facilities. Outlined in previous reports, the WHO has delivered 85 tons of medical supplies by road from Damascus to Qamishli in July. As of early October, all 85 tons have

been distributed to 17 hospitals, including 16 in cross-line areas (12 of which were previously supported by the UN through Yaruobiah crossing), two private hospitals serving as referrals for Al-Hol, and two hospitals in areas of GoS control. In the reporting period, the WHO supported the delivery of two ambulances to support the referral system in Aleppo and Idleb. In the reporting period, the WHO supported training for 235 healthcare workers on case management in Homs, Aleppo, Dar'a, Al-Hasakeh, and Quneitra, including on ventilator management.

In NES (as of 1 December) overall levels of hospitalization to COVID-19 dedicated facilities remains extremely low. Based on partial data provided by 9 of the 17 operational COVID-19 facilities, only 9 per cent of available beds were occupied as of 27 November. This increases the concern that people are not receiving the treatment they require, potentially contributing to a significant number of people dying at home. Of 984 admissions recorded by 9 COVID facilities, 265 (27 per cent of admissions) have died. The figures for those that have died, as reported here, are higher than the official confirmed death figures, due to a reporting lag from hospitals on cases, and because some of the deaths were among non-confirmed COVID cases. Of reported deaths at 9 COVID-19 facilities, 37 per cent (95) have died within 24 hours of admission, with well over half dying within 48 hours of admission. The late presentation indicates that patients are often not reporting symptoms until they become severe, or that there are delays in referral, with patients reportedly often visiting multiple health facilities before being admitted to a COVID-19 hospital.

Another factor contributing to low levels of reported hospitalizations is the high number of admissions to non-COVID private hospitals, with limited adherence in some areas to the agreed procedures for the diagnosis and referral of suspect cases. In many cases, health facilities are not alerting the Operational Desk to suspect cases, meaning that samples are not collected for testing, and, instead, a doctor makes a diagnosis through other means. These same facilities are often admitting patients who require hospitalization. Anecdotal information indicates that up to 90 per cent of suspect/confirmed COVID cases which have been hospitalized in Menbij and Kobane have been admitted to non-COVID private facilities. Possible explanations for this are the social stigma around COVID facilities (i.e. associated with high levels of deaths, families are unable to be with their loved ones), financial incentives, and, in some cases, poor quality of care/ limited capacity in COVID-19 facilities.

The number of COVID-19 cases admitted to non-COVID facilities raises concerns around IPC. There is a high risk that vulnerable non-COVID patients could be exposed to the virus, particularly as these facilities lack dedicated staff for treating COVID-19 cases and are often not organized according to basic standards.

Across NES there are 23 COVID-19 facilities, 19 of which will be supported by NGOs. Of these, 17 are at least partially operational as of the beginning of December. Throughout November, five new facilities were activated, including a dedicated maternal facility in Ar-Raqqa, an ICU in Menbij, and other facilities in Deir-Ez-Zor and Tabqa. In total there are an estimated 863 beds planned for moderate-severe cases, of which 571 (66 per cent of planned) are currently available (up from 57 per cent as of the beginning of November). For critical cases, of 111 beds planned there are currently 93 available (84 per cent of planned, up from 77 per cent), although some are without a ventilator. In terms of capacity and coverage, there remain significant gaps, particularly in Deir-Ez-Zor, Qamishli, Menbij, and Tabqa.

In NWS, all planned COVID-19 hospitals are now operational, at partial or full capacity. NWS currently has nine hospitals for case management, with a capacity of 183 intensive care unit (ICU) beds and 640 'step-down' ward beds (exclusively separated for isolation treatment). The target for increasing ventilator capacity has been reached (164 new ventilators have been added) to have adequate capacity to treat critical cases. A total of 29 CCTCs have been activated, with 1,258 beds. Five additional CCTCs are planned in the coming months in Aleppo. Regional health facilities with on-call emergency basic and comprehensive emergency obstetric and newborn care for pregnant women with COVID-19 have been activated.

There has been an increased occupancy rate in intensive care units when compared to normal ward admissions. While on average, the oxygen support requirements seem to be high, cases requiring mechanical ventilation are less than 20 per cent. Occupancy rates in CCTCs are steadily increasing, though the geographic distribution varies in terms of occupancy rates. In total, there are more than 10,000 admissions to date. The concern is on the length of stay and if there is adherence to guidelines for isolation. There have been aggressive advocacy campaigns on social distancing and other mitigation strategies. Those have focused on educating communities in seeking care when presented with symptoms and how to access CCTCs for both primary care management of mild symptoms to alleviate the burden from hospitals and to avoid further spread.

WHO continues to oversee the implementation of mental health and psycho-social support (MHPSS) helplines, supporting the workers at COVID-19 facilities, and COVID-19 patients and their families. During the reporting period, there were a total of 902 psycho-social support (PSS) consultations through the MHPSS helpline. WHO has provided SOPs on MHPSS service provision in CCTCs, including the responsibilities of the psycho-social workers in providing PSS counselling. WHO has been advocating for NGOs who are handling CCTCs to ensure that personal support workers are available to provide PSS counselling services and follow-ups to COVID-19 patients and workers inside CCTCs. WHO has adapted the 'suicide prevention during COVID-19 guidelines' prepared by the IFRC, and which are recommended by the Inter-Agency Standing Committee on MHPSS, and, trained 180 HCW on these guidelines through a four-day online training.

Operational Support and Logistics

The COVID-19 Crisis Coordination Committee is working with partners, particularly the Logistics Cluster, to minimize potential disruption to service delivery and essential humanitarian assistance, including through the Procurement Working Group (PWG) in Damascus which is consolidating UN agency PPE requests to harmonize sourcing.

The Logistics Cluster continues to monitor supply routes and bottlenecks associated with getting supplies into Syria and holding monthly consultations with partners through cluster coordination meetings. It liaises closely with the Whole of Syria Health Cluster, to provide full visibility on the pipeline for COVID-19 related supplies. As the lead agency of the Logistics Cluster WFP is providing access to an air cargo transport service from Damascus to Qamishli. This is in addition to a UNHAS service for air passengers between Damascus and Qamishli.

As previously reported, the WHO has established the Supply Chain Coordination Cell to improve information management and coordination to support strategic guidance, operational decision-making, and overall supply chain monitoring. WHO has also established three consortia to look at buying supplies of PPE, diagnostics, clinical care, respectively. The COVID-19 supply needs from all hubs have been shared with WHO EMRO for compilation and submission to the Global COVID-19 Supply Chain Task Force for consideration, a multi-stakeholder body to coordinate demand, procurement, and allocation of supplies for low- and middle-income countries. WHO, in coordination with the Health Sector, has developed an online COVID-19 Supplies Tracking System to monitor, in real-time, the items procured, distributed, and in the pipeline by health sector partners. The dashboard is updated weekly. Within Syria, distributions and service delivery have been rapidly adapted, and work is ongoing to adapt modalities to decongest distribution sites.

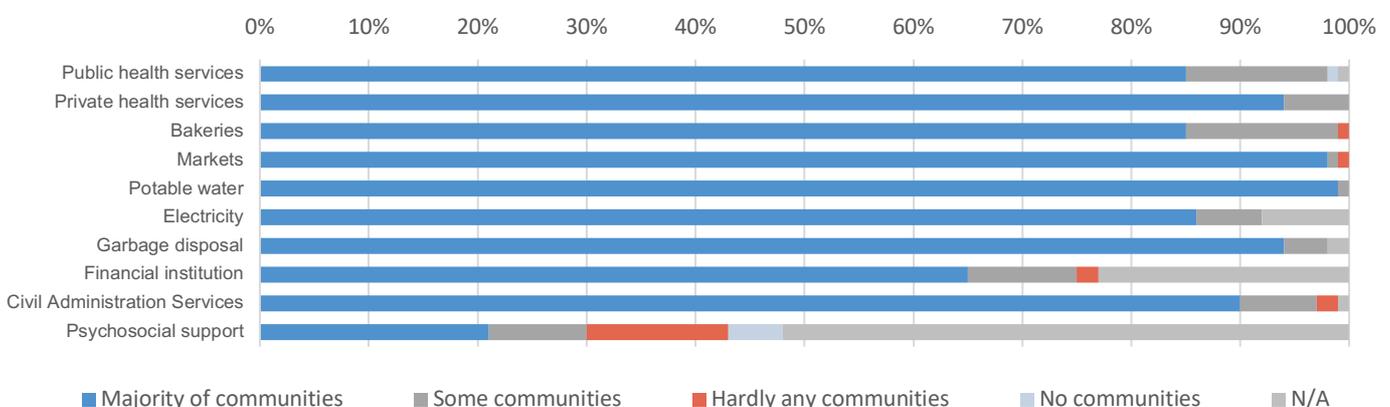
In NES (as of 3 December) NGOs continue to face challenges in importing medical equipment and PPE from suppliers based in Iraq/ KRI and report challenges in exporting COVID-19 related supplies from KRI to NES. Some NGOs have had more success than others in navigating these ambiguities through direct negotiation with authorities or reducing quantities (i.e. dividing into individual shipments). At present at least one shipment of diagnostic supplies is awaiting authorization from the KRI authorities to export. The dedicated COVID-19 supplies shipment tracker is being used to coordinate and better enable an understanding of the specific constraints impacting NES COVID-19 shipments, and, provide clarity on the workaround to the constraints. Information gathered through this tool will also guide subsequent advocacy around supply issues. Whether this is formal advocacy vis-à-vis the authorities in KRI or working with other stakeholders to mobilize alternative supply modalities to mitigate supply challenges NES NGOs are facing.

In NWS, COVID-19 supplies have been distributed to 218 health facilities operated by 24 NGOs to cover identified needs for one month. This distribution includes 614,210 pairs of examination gloves, 5,298 protective goggles, 92,383 N95 masks, 452,090 surgical masks, 8,466 face shields, and 54,827 protective gowns. WHO is working on the COVID-19 supply distribution plan to cover needs for one-month, based on the survey data submitted by partners. The COVID 19 Task Force is also focusing in terms of securing adequate oxygen supply for hospitals and CCTCs (concentrators and refilling cylinders), and there is an ongoing assessment to map existing supply lines for facilities and identify gaps requiring supply support.

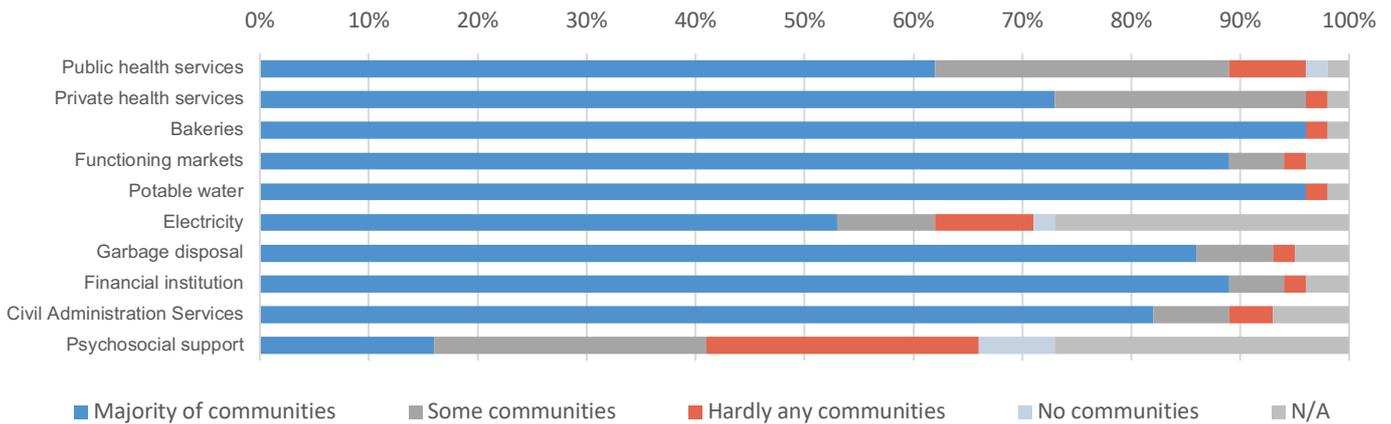
Annexes

STATUS OF BASIC SERVICES (Source: HNAP as of 1 December 2020/Proportion of sub-districts with access to the below services)

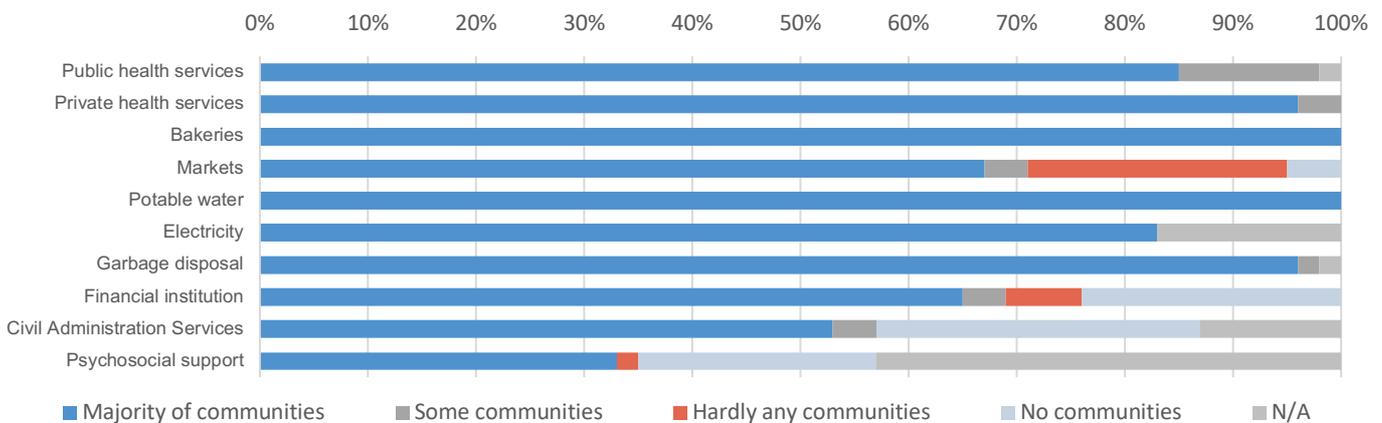
GoS



NSAG



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More Information

- [COVID- 19 General information:](#)
- [COVID-19 Country and Technical Guidance](#)
- [WHO COVID-19 Dashboard](#)
- [IASC COVID-19 Outbreak Readiness and Response \(including protocols\)](#)
- [COVID-19 Advice for the Public](#)
- [Infection prevention and control during health care when novel coronavirus \(nCoV\) infection is suspected](#)
- [Statement on the third meeting of the International Health Regulations \(2005\) Emergency Committee regarding the outbreak of COVID-19](#)
- [How to talk to your child about COVID-19](#)
- [Guidance for Pregnant and Lactating Women](#)
- [Guidance on Rational use of Person Protective Equipment for COVID-19](#)
- [COVID-19 Online Courses](#)
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