Syria AWD/Cholera Response Plan

September 2022

Contents

1. Situation Overview

1.1 Background

Syria remains a complex humanitarian and protracted emergency characterized by over ten years of ongoing hostilities and the resulting long-term consequences, including widespread destruction of civilian infrastructure, degradation of basic services, explosive ordnance contamination, and the largest number of internally displaced people (IDPs) worldwide, all of which is further

compounded by an ever-worsening economic situation. In 2022, 14.6 million people remain in need of humanitarian assistance, an increase of 1.2 million from 2021[1].

Climatic-induced and human-caused shocks affecting natural resources, particularly water, continue to intensify and exacerbate the humanitarian situation[2]. Insufficient and poorly distributed rainfall, severe drought conditions combined with low water levels in the Euphrates River, regular and sustained cut-off of Alouk water station, and damaged water infrastructure have not only reduced access to safe water for drinking and domestic use for millions of Syrians but also triggered substantial harvest and income losses.

On September 10, 2022, the Ministry of Health (MOH) announced a cholera outbreak in Aleppo governorate with 15 laboratory confirmed cases reported between August 25 and September 9, 2022. Activities under this plan seek to address the immediate needs stemming from this outbreak and highlight response priorities across all areas of the response[3] and key sectors involved. This plan initially focuses on the Health, Water Sanitation and Hygiene (WASH), and Risk Communication and Community Engagement (RCCE) responses for an initial period of 90 days. The activities detailed in this plan are also within the programmatic scope of the 2022-2023 Humanitarian Response Plan (HRP).

In line with planning parameters outlined further below and through activities laid out in this plan, some of which are referenced under the 2022-2023 HRP, Health partners aim to assist up to 137,000 of the 162,000 people estimated at risk to be affected by Acute Watery Diarrhea (AWD)/Cholera. In addition, WASH partners aim to assist up to 5 million of the 8 million people estimated to be in need of WASH assistance to control and prevent further spread of the outbreak. The overall requirements for this three-month plan amount to $34.2m

1.2 Epidemiological Overview

Between 25 August and 23 September 2022, a total of 5,973 suspected cases have been reported in 9 of the 14 governorates in Syria. Most of the cases were reported from Deir-ez-Zor (3,331 cases, 55.76 %), Aleppo (1,336 cases, 22.36%), Ar-Raqqa (753 cases, 12.6%) and Al-Hasakeh (465 cases, 7.78%). Cases have also been reported in IDP camps and sites. A total of 36

[1] Syria Humanitarian Needs Overview 2022, https://reliefweb.int/report/syrian-arab-republic/2022-humanitarian-needs-overview-syrian-arab-republic-february-2022

[2] See the Response Plan to the Water Crisis in Syria, August 2022 https://reliefweb.int/report/syrian-arab-republic/critical-response-and-funding-requirements-response-water-crisis-syria-august-2022

[3] The term 'response modalities' refers to following three: 'Syria Humanitarian Country Team (HCT) Coordinated Response' to designate humanitarian assistance delivered from areas controlled by the Government of Syria, including to Northeast Syria; 'Syria Cross-Border Humanitarian Liaison Group (HLG) Coordinated Response' to designate humanitarian assistance delivered cross-border from Türkiye, including that provided by UN as authorized by UN Security Council resolutions 2449 (2018), 2504 (2020), 2533 (2020), 2585 (2021), and 2642 (2022) or from areas of Northwest Syria controlled by non-state armed groups; 'Northeast Syria (NES) NGO Forum Coordinated Response' to designate humanitarian assistance delivered by NGOs crossborder from Iraq or from areas of Northeast Syria controlled by local authorities.

associated deaths were reported (20 from Aleppo, and 12 from Deir-ez-Zor and 3 in Ar-Raqqa, 1 in Al-Hasakeh reported by MoH) during this period.

During the same period, a total of 228 stool samples were cultured, and 98 samples tested positive for Vibrio Cholera, serotype Ogawa (15 from Aleppo, 58 in Deir-ez-Zor and 25 from Ar-Raqqa). Out of a total of 787 stool specimens tested with Rapid Diagnostic Tests (RDTs), 364 (46%) tested positive (180 in Aleppo, 100 in Deir-ez-Zor, 38 in Al-Hasakeh, and 27 from Ar-Raqqa).

Figure 1: Distribution of suspected and confirmed cholera cases, as of 23 September 2022

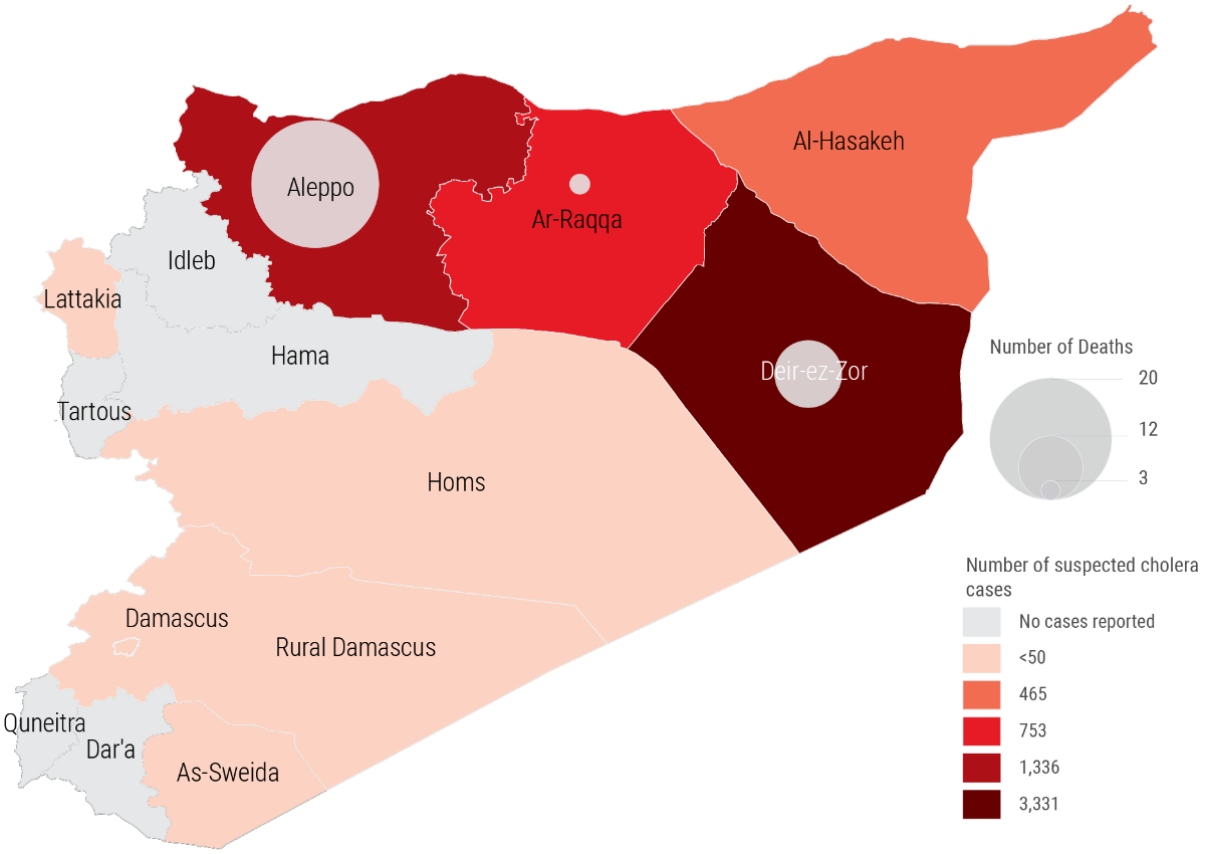
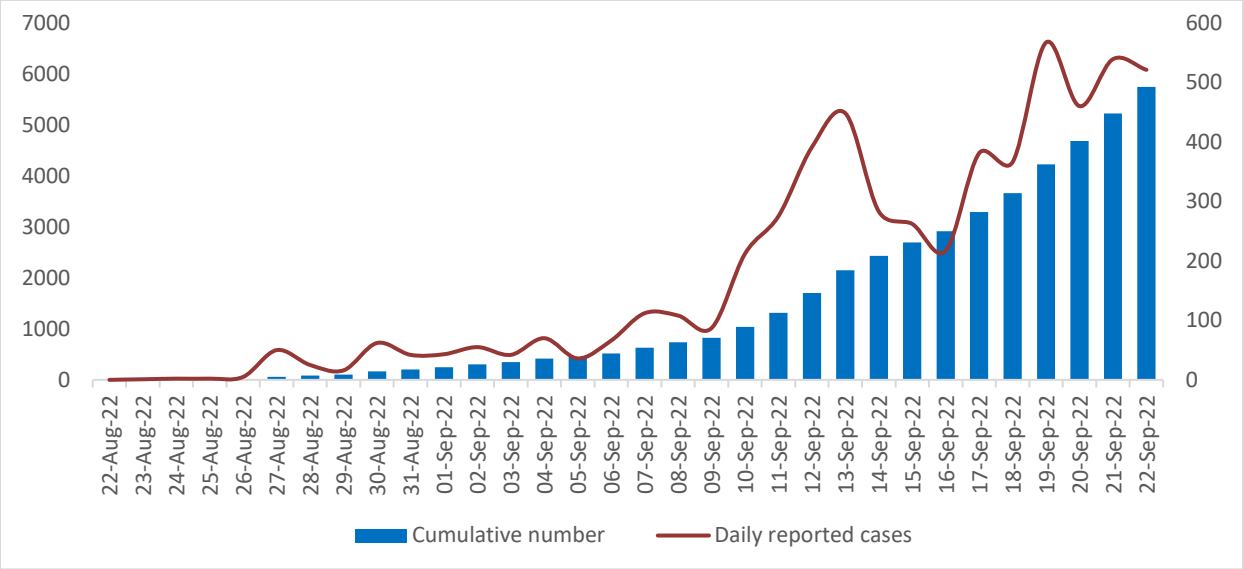


Figure 2: Distribution of suspected cholera cases by date of onset, as of 23 September 2022



Females are slightly more affected than males (52% versus 48% respectively) in Syria. All age groups are affected with 34.8% of the cases below the age of 10 years old.

Figure 3: Distribution of suspected cholera cases by sex, as of 23 September 2022

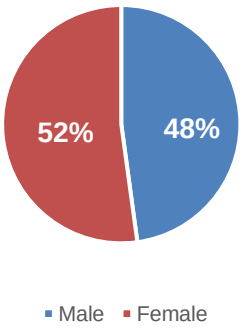
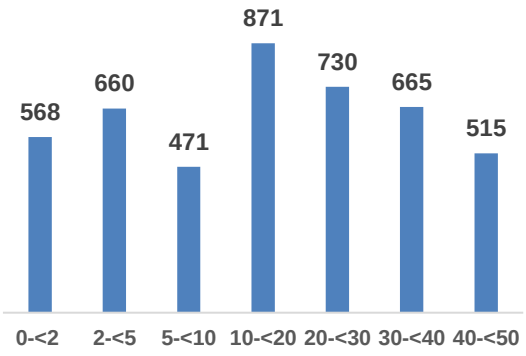


Figure 4: Distribution of suspected cholera cases by age group, as of 23 September



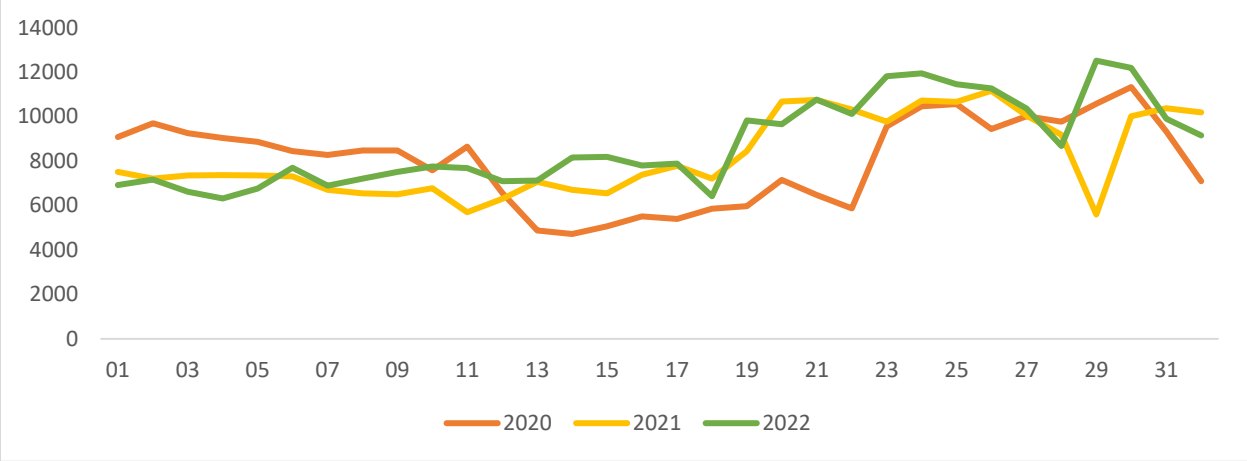
Cholera has previously been reported in Syria by the MOH, including the 1993 outbreak during which 10,917 cases were reported in all governorates, making it the highest number of cases ever reported in country[4]. Further outbreaks were declared in 1996, 2008, and 2009 where 130, 48, and 342 confirmed cases were reported respectively.

Since the start of 2022, AWD cases have accounted for 36.6% of EWARS alerts. The chart below provides an overview of the monthly trend for AWD between 2020 and 2022. Cases of AWD

[4]http://www.emro.who.int/images/stories/syria/Epidemic_preparedness_cholera_plan_of_Syria.1_November_2015.pdf?ua=1

during the summer of 2022 have increased between 7- 9% during the same period compared with 2021 and 2022.

Figure 5: Trends in reported AWD cases reported between 2020 - 2022



In 2022, the overall incidence rate of AWD at the national level is 22.1 per 1,000 population. Incident rates by governorate between 2020-2022 are detailed in the table below. Risks of diarrhea have increased across several governorates due to reduced access to clean water resulting from the limited capacity of existing water systems, low water levels along the Euphrates River, and low levels of rainfall leading to drought conditions in several areas and poor sanitation systems The situation has been further aggravated by the impact of the COVID-19 outbreak in Syria, alongside the broader humanitarian situation and deterioration of the economy with increasing prices of food and basic needs.

Figure 6: Incidence rates of AWD by governorate between 2020-2022

Governorate	2020	2021	2022
Aleppo	14.2	14.2	14.9
Al-Hasakeh	37.6	53.8	48.6
Ar-Raqqa	24.4	25.1	22.1
As-Sweida	7.3	5.7	4.7
Damascus	18.2	12.5	11.5
Daraa	15.6	12.9	14.9
Deir-ez-Zor	79	75.8	126.4
Hama	11.3	9.3	8.6
Homs	6.6	5.7	7.4
Idleb	28.5	32.9	38.8
Lattakia	20.1	7.3	23.2
Quneitra	57.5	53.9	43.1
Rural Damascus	10.4	8.4	6.3
Tartous	15.2	15.4	18.8
Grand Total	**20.7**	**21.1**	**21.3**

2. Operational Context

The operational context in Syria is further outlined in the 2022 Syria Humanitarian Needs Overview[5] .

2.1 Health

Ten years of conflict, socioeconomic downturn, continued displacement, and multiple other hazards including disease outbreaks, have put significant pressure on a fragmented health system in Syria. The already fragile health system is overstretched with additional strain from the COVID-19 pandemic. Nearly a quarter of all hospitals and one third of all primary health care centres remain non-functional and unable to respond to the growing health needs. The essential health service infrastructure requires extensive maintenance and rehabilitation to provide a minimum level of service delivery. There is a chronic shortage of health care staff driven by displacement, death or injury. Sub-optimal living conditions and limited access to basic services, particularly in overburdened communities and camps/sites with internally displaced persons, have increased the risk of exposure to disease outbreaks.

2.2 WASH

In Syria, nearly two-thirds of water treatment plants, half of all pumping stations and one-third of water towers have been damaged as a result of the conflict. Water networks are unable to provide full water quantities to the population due to the lack of stable power supply, the high cost of diesel to operate the power generating systems and fixed budgets, and the prolonged drought. Faced with acute shortages in safe, public drinking water, vulnerable households must increasingly rely on costly water supplied by private vendors who truck potentially unsafe water to neighborhoods and communities. Consequently, nearly half of people rely on alternative and often unsafe water sources to meet or complement their water needs (vis-à-vis 34% in mid-2021). In addition, at least 70 per cent of the discharged sewage is untreated and at least half of the sewage system is not functional. When access to water is limited, hygiene practices are poor, and adequate sanitation is not available, the risk of disease outbreaks increases.

2.3 Challenges and gaps

Challenges and gaps in the following areas are expected to have an impact on the overall response to the AWD/cholera outbreak:

- Low community awareness of cholera prevention measures.
- Severe funding gaps in the health sector that have led to reduced availability of basic life-saving health services.

[5] https://reliefweb.int/report/syrian-arab-republic/2022-humanitarian-needs-overview-syrian-arab-republic-february-2022

- Limited existing capacity within the health system to care for and treat AWD/cholera cases with low knowledge and skill levels among health workers and only 54% of primary healthcare centers and 58% of hospitals functional as of June 2022.
- Fragmented surveillance system, including the use of different reporting systems and approaches to information sharing across and within response areas, and limited capacity to engage in active case finding to quickly identify and response to suspect cases.
- Limited availability of laboratory capacity to culture tests.
- Limited global supply of oral cholera vaccines due to multiple ongoing outbreaks, potentially limiting the number of doses and supplies available to Syria.
- Challenging access to safe water, leading to the use of infected (untreated) drinking water from the Euphrates River[6], due to limited wastewater treatment and sewage discharge into water sources, use of other unsafe water sources, and crop irrigation with contaminated water leading to food contamination. In the Northeast, regular water cuts from Alouk water station contribute to critical shortages in Al-Hasakeh governorate and surrounding areas, affecting over 460,000 people..
- Limited availability of electricity, creating bottlenecks for water production and distribution
- Decreased access to improved sanitation facilities at household levels due to damaged sanitation infrastructure in both urban and rural areas.
- Funding gaps for WASH activities, and in particular for sanitation.
- Lack of expertise and knowledge within the WASH sector on cholera preparedness, prevention, and response.
- Shortages in cholera supplies, including medicines and WASH supplies, as well as challenges with the importation, local procurement, and rapid dispatch.

3. Risk Assessment

Considering the current situation, outbreak epidemiology, geographic expansion and response capacity, the overall risk assessed to be very high at the national level, due to:

1. Outbreak affecting densely populated areas across 9 governorates and cases detected in IDP camps.
2. Limited accessibility of the general population, including in some IDP camps and sites, to safe drinking water and WASH facilities.
3. Presence of more than 6.9 million internally displaced people in Syria[7].
4. Limited accessibility of the population to adequate health care.
5. Limited surveillance capacity and the ability to detect and confirm cases by culture.
6. Limited availability of supplies and lack of expertise in cholera response among the main actors.
7. Limited accessibility to some areas due to hostilities and/or security concerns.

[6] Wastewater from communities located along the Euphrates River bank is released directly and untreated into the Euphrates, which is the sole source of fresh water for Deir ez Zor and Raqqa.
[7] 2022 Humanitarian Needs Overview: Syrian Arab Republic

4. Planning Assumptions

Caseload projections

The following parameters have been developed using an estimated baseline to facilitate the planning process and estimate operational requirements across partners to respond to the outbreak. To calculate an estimated caseload, the following assumptions were used as a worst-case scenario:

- Rural, open settings: 0.5% attack rate
- Open, urban settings and closed settings (e.g., refugee and IDP camps/sites): 1% attack rate

Furthermore, approximately 25-30% of cases will develop severe dehydration, 30-40% with some signs of dehydration, and 30-40% will experience no dehydration. All patients with severe hydration and up to half of mild cases are expected to require a hospital bed for at least one night. While the average length of hospital stay for some patients with severe dehydration is two days, the length of stay will vary based on ease of access to care and other medical complications.

Considering the above assumptions, and in light of current available information, the total estimated caseload for the outbreak is 161,529, of which the health response will target 100% of severe cases and 80% of mild cases. As described in the table below, the total number of cases targeted in this plan by the health response is 137,300.

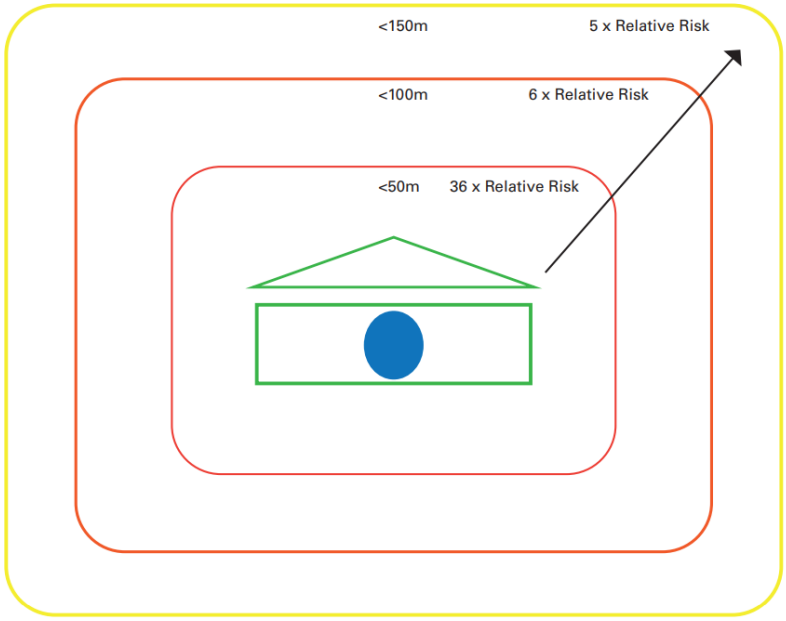
	Severe Cases (25% of total)	Mild-moderate Cases (75% of total)	Total Estimated Caseload
Estimated Caseload	40,382	121,147	161,529
Target	**40,382**	**96,918**	**137,300**

WASH Planning Assumptions

With respect to the WASH response, the number of affected people has been calculated considering that close contacts (in time and space) of a cholera case have a much higher risk of being infected (see graph below). Therefore, per each suspected case, at least 50 to 100 people are at risk (average 5 people/household per 10 to 20 families according with population density and rural/urban setting). For the projected number of 161,529 cases, at least 8 million people are considered at risk (using the 50 multiplier factors – most conservative).

Out of those 8 million people, 5 million are targeted by the WASH response under this plan.

Figure 7: Infection risk and time/space[8]



Those living within 50 meters of a confirmed case are at risk of becoming a case within the first 3 days.

Relative risk remains high but decreases with distance and time::

- *6x relative risk within 51-100m (within first 3 days)*
- *5x relative risk within 101-150m (within first 3 days)*
- *>2x the relative risk within 150m (after 23 days)*

The planning parameters outlined above will be kept under review and will be adjusted to reflect the evolved needs of the outbreak over the coming weeks and months.

5. Response Framework

Goal

Reduce avoidable morbidity and mortality due to AWD/cholera, reduce transmission of the disease in affected areas, and prevent/minimize the risk of introduction of the outbreak to other high-risk areas.

Objectives

- **Objective 1 (Leadership and Coordination)** – Maintain effective and integrated coordination and leadership for the AWD/cholera response.
- **Objective 2 (Disease Surveillance)** – Enhance timely detection, confirmation, and investigation of AWD/cholera alerts to support rapid implementation and prioritization of response activities.
- **Objective 3 (Laboratory)** – Strengthen laboratory capacity for the rapid diagnosis of cholera cases in support of timely and effective epidemiological investigations and response activities.

[8] https://www.unicef.org/media/73121/file/UNICEF-WASH-Global-Review-Rapid-Response-Teams.pdf

- **Objective 4 (Case Management and IPC)** – Increase access to treatment for suspected cholera patients and strengthen the capacity to manage cases at all levels through the implementation of standard management protocols for reducing morbidity due to cholera and enhancing infection prevention and control practices in treatment facilities.
- **Objective 5 (Oral Cholera Vaccination)** – Implement oral cholera vaccination campaigns as a supplementary response and control measure in areas identified as hot spots through data collected by surveillance teams to prevent and respond to cholera outbreaks.
- **Objective 6 (WASH)** – Ensure appropriate lifesaving WASH prevention and response measures to control the spread of AWD/cholera, with special attention to the at-risk populations and improving IPC interventions at health facilities.
- **Objective 7 (RCCE)** – Strengthen risk communication and community engagement and provide key messages to vulnerable communities for AWD/cholera prevention and response through reliable channels of communication and community feedback.
- **Objective 8 (Operations Research and Knowledge Management)** – Generate knowledge to improve implementation of preparedness and response interventions, and to document lessons learned during the cholera response.
- **Objective 9 (Logistics, Equipment and Supplies)** – Ensure procurement, delivery, management, and coordination of essential health and critical WASH supplies to sustain preparedness and response activities.

Activities

OBJECTIVE 1 - Maintain effective and integrated coordination and leadership for the AWD/cholera response

Leadership and Coordination - Key Activities:

- Strengthen health sector coordination at all levels through the activation of a WoS IMS to ensure a comprehensive, well-coordinated and timely response to the AWD/cholera outbreak.
- Convene regular joint WASH/Health cluster/AWD/cholera task force meetings to review the overall situation and coordinate response activities.
- Ensure the production and sharing of timely information products, including maps and situation reports to enable identification of needs and gaps, understand partner presence, and support advocacy activities.
- Collectively engage in monitoring, including through supervision visits, of the response and update strategic and operational plans based on the evolving needs for the AWD/cholera outbreak.
- Mobilize financial and human resources to enable the implementation of AWD/cholera preparedness and response activities.
- Form technical working groups for the following pillars: RCCE; surveillance, laboratory, and case management; WASH; Oral Cholera Vaccination (OCV - if approved for use in targeted settings); and supplies and logistics.

OBJECTIVE 2 – Enhance timely detection, confirmation, and investigation of AWD/cholera alerts to support rapid implementation and prioritization of response activities

Disease Surveillance - Key Activities:

- Conduct daily case data collection, compilation, analysis, and dissemination through regular epidemiological bulletins, sitreps and other information products
- Share all de-identified daily line-listing data across field-level IMS teams/Task Forces for targeted rapid response at community level.
- Map the current surveillance systems in country, including their coverage, electronic platforms, and performance to identify critical gaps and needs
- Review, update, disseminate and circulate protocols, case definitions, and other technical material for AWD/cholera surveillance.
- In collaboration with WASH, health logistics, and RCCE, support operational deployment of integrated multisector rapid response teams to validate, investigate and respond to AWD/cholera reports.
- Conduct training of surveillance and response officers, at both governorate and district levels, on case identification and reporting mechanisms, community case-finding, sample collection and transport, and emergency WASH activities.
- Deploy Community health workers to detect and report alerts in communities.
- Update the rapid risk assessment and conduct a periodic risk assessment for AWD/cholera using available epidemiological information.
- Conduct integrated surveillance for AWD/cholera and nutrition in sentinel sites and at the community level, and provide regular reports on SAM / MAM, as well as for pregnant women admitted to health facilitiess and treatment centres in risk areas.
- Establish or expand sentinel surveillance and community event monitoring sites in all high-risk governorates and districts

OBJECTIVE 3 – Strengthen laboratory capacity for the rapid diagnosis of cholera cases in support of timely and effective epidemiological investigations and response activities

Laboratory - Key Activities:

- Conduct an assessment of laboratory capacity, including on gaps in human resources and training needs.
- Strengthen human resource capacities for laboratory testing through the development and delivery of training to new and existing staff.
- Provide laboratory reagents and supplies for the diagnosis of pathogens causing AWD/cholera.
- Establish a laboratory information management system linked to the district health information system (DHIS) and the national disease surveillance system.
- Review and update laboratory protocols for the diagnosis of different strains of V. cholerae.
- Procurement and distribution of required lab items, equipment, and reagents, including RDTs, transport media, and antibiotic sensitivity tests.

- Provide support and operational costs for collecting and transporting samples to central laboratories, in accordance with the adopted operating procedures.
- Conduct capacity-building training for field staff on the use of RDT and sample collection procedures.
- Provide kits, equipment, and sample bags for water quality and food testing at field level.

OBJECTIVE 4 – Increase access to treatment for suspected cholera patients and strengthen the capacity to manage cases at all levels through the implementation of standard management protocols for reducing morbidity due to cholera and enhancing infection prevention and control practices in treatment facilities

Case Management and IPC - Key Activities:

- Establish and manage cholera treatment centers (CTCs), cholera treatment units (CTUs) and oral rehydration points (ORPs).
- Provide technical guidelines and operating procedures for treatment centers, including on the management of different forms of AWD and complicated cases.
- Support training of health workers at treatment centers on case management, including the correct identification of patients, early treatment and transfer where appropriate, and the management of children with both malnutrition and AWD/cholera.
- Establish a referral system for severe AWD/cholera cases at healthcare facilities and ORPs to higher-level treatment facilities, including for severe cases of malnutrition.
- Establish a data management system in CTCs/CTUs for the timely collection and submission of case and admission/hospitalization data, while also ensuring links to the existing health management information system (HMIS).
- Confirm the susceptibility/resistance of available antibiotics and ensure the use of effective antibiotics for severe cases.
- Provide support for the implementation of comprehensive infection prevention and control measures at treatment facilities, including solid waste management, water chlorination, disposal of contaminated water, and the safe management of dead bodies.

OBJECTIVE 5 – Implement oral cholera vaccination campaigns as a supplementary response and control measure in areas identified as hot spots through data collected by surveillance teams to prevent and respond to cholera outbreaks

Oral Cholera Vaccination - Key Activities:

- Advocate with authorities for the use of OCV in targeted settings and develop contingency plans for the implementation of preventive/reactive cholera vaccination campaigns in identified areas.
- Submit requests to the Global task Force for Cholera Control for a preventive campaign, or ICG for a reactive campaign, and procure the required quantities of OCV doses.
- Conduct two rounds of OCV campaigns, with a minimum of 14 days apart, in the highest risk governorates/districts for persons above 1 year of age.
- Ensure RCCE activities are implemented early and are integrated with cholera vaccination activities.

- Implement enhanced surveillance activities in governorates/districts where OCV has been implemented.

OBJECTIVE 6 – Ensure appropriate lifesaving WASH prevention and response measures to control the spread of AWD/cholera, with special attention to the at-risk populations and improving IPC interventions at health facilities

WASH - Key Activities:

- Reinforce sectoral and intersectoral coordination at all levels for WASH activities.
- Support the training of key actors on WASH AWD/cholera response and prevention.
- In collaboration with Health and RCCE, support the deployment of integrated multisector rapid response teams to enable a timely response to reports of AWD/cholera.
- Support systematic and relevant water quality indicator monitoring and reporting in high-risk areas and healthcare facilities.
- Ensure access and the use of safe drinking water to at-risk populations at water collection points, households, and healthcare facilities.
- Ensure safe excreta disposal in at risk IDP camps/sites and other high-risk areas.
- Provide a basic WASH emergency package to schools affected by AWD/cholera and in high-risk areas.
- Provide and distribute essential WASH supplies to affected and at-risk population (example: cholera kits to affected households and neighbours, soap in at risk IDP camps/sites)
- Implement emergency solid waste management action in at high-risk areas.
- Provide support to the infection prevention and control measures at treatment facilities, in coordination with the health partners (including in nutrition treatment facilities based on needs)
- Conduct capacity building activities with WASH focal points and staff working at treatment centers and healthcare facilities on WASH interventions during cholera outbreaks.

OBJECTIVE 7 – Strengthen risk communication and community engagement and provide key messages to vulnerable communities for AWD/cholera prevention and response through reliable channels of communication and community feedback

RCCE - Key Activities:

- Develop a strategy and action plan for RCCE in consultation with MOH, NGOs and UN agencies.
- Conduct a knowledge, attitude, and practices (KAP) survey at family and community levels on cholera prevention and response.
- Conduct capacity building interventions with 974 MOH health educators and health promotion teams, 850 Ministry of Education (MOE) health education teams and volunteers, and NGOs at national and governorate level.
- Engage with communities to raise awareness and promote hygiene practices and cholera prevention in schools.

- Produce and disseminate cholera job aids and guidelines to support knowledge and skill application among frontline workers.
- Through partner agreements, work with NGOs to deliver RCCE interventions aimed at educating, engaging, and encouraging communities to adhere to cholera prevention practices.
- Support national RCCE coordination, monitoring and documentation of best practices.
- Develop and disseminate print and social media communication and community engagement products.
- Provide support to OCV activities (SBCC costs and logistics).

OBJECTIVE 8 – Generate knowledge to improve implementation of preparedness and response interventions, and to document lessons learned during the cholera response

Operations Research and Knowledge Management - Key Activities:

- Develop an operational research agenda for the outbreak of AWD/cholera.
- Conduct community studies to identify gaps in the AWD/cholera prevention and control measures.
- Conduct studies to identify other pathogens implicated in causing AWD outbreaks.
- Conduct impact studies to measure the effectiveness of different response activities implemented.

OBJECTIVE 9 – Ensure procurement, delivery, management, and coordination of essential health and critical WASH supplies to sustain preparedness and response activities

Logistics, Equipment, and Supplies - Key Activities:

- Procure and preposition cholera kits, laboratory supplies, chlorine, hygiene kits, and other critical supplies to support AWD/cholera response.
- Provide CTCs/CTUs and ORPs with supplies and equipment for AWD/cholera testing (RDTs), infection prevention and control, and treatment, including for severe cases at the appropriate level of care.
- Provide operations, logistics and communication support for RRTs and other community response teams.
- Monitor supply and equipment inventory and stock status across the AWD/cholera response.
- Map available storage capacities and develop a contingency plan for logistics and critical supplies.

6. Monitoring, Reporting and Evaluation

Access to timely and accurate information is vital for all partners involved in the response to prioritize and direct resources and activities to where they will be the most effective. Work will continue to ensure all partners involved in the response are provided with accurate and up to date

information regarding the progress of the outbreak response, service availability, utilization, and outcomes to help direct and support prioritization of resources and activities.

A list of key performance indicators for monitoring progress against the strategic response plan is included in Annex 1. In addition, detailed operational planning is ongoing at the field level, including the development and use of indicators for closely monitoring progress within the priority areas of response.

7. Funding Requirements by Strategic Objective/Response Pillar (USD)

Strategic Objectives/Response Pillar	Syria HCT	Syria Cross-Border HLG	NES NGO Forum	Total
1. Leadership and Coordination	672,500	50,000	120,000	842,500
2. Disease Surveillance	993,043	1,000,000	150,000	2,143,043
3. Laboratory Diagnostics	90,000	400,000	40,000	530,000
4. Case Management and IPC	1,630,788	3,080,000	120,000	4,830,788
5. Oral Cholera Vaccine	*If agreed/approved, funding will be provided through existing mechanisms for OCV*			
6. Water, Sanitation, and Hygiene	7,255,980	3,725,000	4,163,900	15,144,880
7. Risk Communication and Community Engagement	2,300,726	320,000	500,000	3,120,726
8. Operational Research and Knowledge Management	54,464	100,000	35,000	189,464
9. Logistics, Equipment, and Supplies	6,507,295	740,000	1,200,000	8,447,295
Total	19,504,796	9,415,000	6,328,900	35,248,696

8. Coordination Mechanisms

The response to the outbreak will leverage existing coordination mechanisms and capacity under the Whole of Syria (WoS) approach[9], including established AWD/cholera Task Forces in the various response modalities.

9. Annex

9.1 Key Performance Indicators

Indicators	Target	Responsibility	Frequency
Pillar 1: Leadership and Coordination			
Number of multisectoral coordination meetings with tracking of deliverables against agreed TOR	12	Health and WASH cluster	Weekly
Number of multisectoral situation reports on the AWD/cholera outbreak	12	Health and WASH cluster	Weekly
Pillar 2: Disease Surveillance			
Proportion of health facilities submitting timely and complete surveillance reports	100%	WHO	Weekly
Proportion of cholera signals verified within 48 hours of detection	90%	WHO	Weekly
Pillar 3: Laboratory Diagnostics			
Proportion of targeted labs (existing and planned) fully capacitated	90%	WHO	Weekly
Proportion of targeted labs (existing and planned) with standard operating procedures in place for cholera testing	100%	WHO	Weekly
Pillar 4: Case Management and IPC			
Proportion of CTCs/CTUs/ORPs fully operational	100%	WHO/UNICEF	Weekly
Bed occupancy	<100%	WHO/UNICEF	Weekly
Case fatality ratio at governorate level	<1%	WHO/UNICEF	Weekly
The proportion of CTCs fully equipped for the management of severe cases	100%	WHO/UNICEF	Weekly
Pillar 5: Oral Cholera Vaccine			
OCV administrative coverage in targeted hotspots	95%	WHO	Weekly
Pillar 6: Water, Sanitation, and Hygiene			
Estimated # of women, men, boys, and girls with improved access to water supplies services as a result of repair, rehabilitation, and operational support to water systems- including water trucking	100%	WASH cluster	Weekly
Estimated # of women, men, boys, and girls with improved access to sanitation services through support to sanitation systems (including latrines),	100%	WASH cluster	Weekly

[9] Including on Protection of Sexual Exploitation and Abuse (PSEA). PSEA efforts in the Syria operation are supported through a WoS PSEA network, enhancing strategic decision-making at WoS level and operational support at the response area level through joint implementation of international PSEA commitments, technical and operational support, training, awareness raising materials, SEA complaint referral and follow-up, and PSEA mainstreaming.

including sewage networks, wastewater treatment plants- including desludging			
# Of women, men, boys, and girls with improved access to humanitarian lifesaving emergency WASH facilities and services, and with improved hygienic behavior and practices	100%	WASH cluster	Weekly
# Of women, men, boys, and girls who received essential WASH NFIs- Hygiene Kits	100%	WASH cluster	Weekly
Pillar 7: Risk communication and Community Engagement			
Number of people reached through messaging on prevention and access to services	100%	UNICEF	Weekly
Number of people participating in engagement actions for social behavioral change	100%	UNICEF	Weekly
Pillar 8: Operational Research and Knowledge Management			
Operational research agenda for AWD/cholera developed	100%	WHO/UNICEF	Quarterly
Pillar 9: Logistics, Equipment, and Supplies			
Core pipeline of medicines and supplies (WASH/Health) established and monitored weekly	100%	Health and WASH cluster	Weekly
Proportion of targeted facilities reporting equipment and supply stockouts	0%	Health and WASH cluster	Weekly