Health care remains underfunded in the Syrian response. Review of funding for health activities in Syria and neighbouring countries is urgently needed to ensure adequate provision of services through the provision of equipment and consumables, capacity building, training, increased inclusion of vulnerable groups and, where necessary and feasible, support for running costs and rehabilitation of health facilities.

After nine years of crisis, there is an alarming prevalence of war-related and other injuries and disabilities. Persons with injuries and disabilities require physical rehabilitation services that offer a continuum of care: starting in the immediate aftermath of an injury or surgery, and continuing to full social and economic integration into society. Moreover, the mental health consequences of war-related violence and trauma-related psychological processes require funding for an urgent expansion of services as part of a long term strategy for mental health and psychosocial support (MHPSS) within the Syrian crisis response.

**Urgent Concerns**

**Health care and health needs**

- Inside Syria, the destruction of hospitals and health care facilities has deprived millions of people of access to basic health care. 41% of the population requires treatment for non-communicable diseases, while 46% of health facilities are not fully functional. (1)
- Gaps in non-emergency care can lead to long-term disabilities, such as when untreated diabetes results in an amputation or when complications at birth lead to cerebral palsy.
- Due to the capacity of explosive weapons to cause mass casualties, hospitals can be overwhelmed by the sudden influx of severely injured patients. This, in combination with e.g. insufficient blood supplies, forces hospital staff to focus all their attention on saving lives by performing surgeries outside of their specialization and by applying aggressive methods, such as amputation, to injuries that could have been treated more conservatively in peacetime. (2)
- A recent study conducted by the Humanitarian Needs Assessment Programme for Syria shows that 27% of Syrians live with a disability, almost double the global average of 15%, and that mobility is the most prevalent functional difficulty. Internally displaced persons (IDPs), who are also more likely to live in high risk living situations, are more likely to live with a disability (29%) than residents (26%) and returnees (27%), as are people above 40 years of age (56% live with a disability). (3)
- In 2018 the funding appeal of the health sector was only covered for 40.5%, while, as of November, only 21.2% of the required funding for health care in Syria 2019 has been covered. (4)

**Vulnerable populations**

- Vulnerabilities associated with gender, age, and disability, have been heightened by the crisis. Child labour, for instance, is on the rise, with roughly 42% of male and 18% of female youth below the legal working age currently participating in the workforce. (5)
- Children under five, adolescent girls and women of reproductive age, persons living with disabilities and people at high risk of complications from chronic diseases, particularly the elderly, remain the most vulnerable population groups in need of health services.
- Pregnant women and neonates who have no access to life-saving obstetric care or essential reproductive health care, and patients with untreated chronic diseases are at risk of death or permanent impairment.
- Children who are not vaccinated face high risks of contracting infectious diseases.

**Mental Health**

- According to the 2018 Syria Arab Republic Humanitarian Response Plan (HRP), one in five Syrians is at risk of developing moderate mental health issues, and one in 30 is at risk of developing severe or acute mental health problems. (6) In 2019, the HRP estimated that just under 1 in 7 Syrians is in need of mental health care.

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2. Humanity & Inclusion, 2019, 'The Waiting List - Addressing the immediate and long-term needs of victims of explosive weapons in Syria'.
6. Syria Resilience Consortium, 2019, 'Hidden, Overlooked and at Risk: the Role of Gender, Age and Disability in Syria'.
health consultations.8

■ A December 2018 PRD-WG and REACH study on access to health care in Northern Syria found that, on average, 20% of IDPs, 14% of returnees and 13% of residents reported high daily feelings of anxiety or depression,8 while, in 2017, the International Medical Corps (IMC) found that more than 50% of the Syrian population suffered from severe emotional disorders. Depression and anxiety were the most common, followed by epilepsy (17%) and psychotic disorders (11%).(10)
■ The available data suggests a high need for mental health support, but comprehensive qualitative and quantitative assessments of psychosocial and mental health needs, coping strategies, and the prevalence of mental health diseases are missing.
■ Before 2011, Syria had just 70 psychiatrists for a population of 22 million, and mental-health services were only available in two cities. After nine years of conflict, and rampant displacement, there is an even bigger lack of specialized psychological, psychiatric and psychotropic services.
■ Non-specialised local staff working in psychosocial support need capacity building through validated curricula and special tools for online training.
■ There is a need to go beyond the Psychological First Aid emergency approach by adapting MHPSS interventions to protracted crisis and other specificities of the Syrian context.
■ There are not enough resources available to offer specialized treatment to children affected by exposure to violence, loss, grief and other traumatizing experiences.


Physical Rehabilitation

■ The protracted crisis has further eroded and overburdened an already inadequate health system that was unable to address injury- and disability-related needs: before the crisis prosthetics and orthotics (P&O) services for civilians were largely unavailable and the number of physical rehabilitation professionals was inadequate to meet the needs. The situation has worsened because many health providers have fled. For example, patients with complex injuries like polytrauma are often seen by medical specialists without having access to rehabilitation services and/or only see a physiotherapist, while physiotherapists are not trained to treat such cases.
■ The deficit in trauma and non-emergency care for war-wounded, including amputees, result in a growing number of long-term disabilities.
■ Although humanitarian actors have stepped in to respond, the health needs exceed their financial capacity and level of access to provide services to all vulnerable populations.
■ In response to the lack of qualified rehabilitation professionals, some aid workers have acquired the technical skills that are essential to the delivery of physical rehabilitation services. If they are unable to continue their work due to changing areas of control, this will result in a loss of human capital that will widen the gap in service delivery to the population.
■ At country level, there is insufficient reliable data to assess the exact scope of the physical rehabilitation needs, conflict-related or not, and prepare for an adequate response.

Recommendations

To parties to the conflict:
■ Encourage local authorities to rapidly register, and generally create an enabling environment for, humanitarian organizations engaged in providing health services, including mental health care, rehabilitation, and prosthetics and orthotics services.

To donors and UN agencies:
■ prioritise funding for the health sector as improved access to and continuity of health care is a priority in Syria.
■ prioritise the inclusion of mental health and psychosocial support in the humanitarian response in Syria and neighbouring countries;
■ provide funding for long-term projects that address the mental health consequences of war-related violence, loss, grief and other trauma-related psychological processes;
■ provide funding for programs that focus on the specific needs of children that were exposed to war-related violence, loss, grief and other trauma-related psychological processes, and on strengthening parenting and caregiving skills in that regard.
■ provide multi-year project funding to prevent gaps or breaks in services for people injured and persons with disabilities, including funding to develop the technical capacity of non-specialised actors to and maintain standards of quality and to strengthen parenting and caregiving skills in this regard.

In relation to physical rehabilitation:
■ encourage links between all actors in charge of the health sector on one side, and international bodies, including INGOs, on the other side, to support the integration of physical rehabilitation as part of a key package of primary health care services;
■ encourage links between all actors in charge of the education sector and international bodies, including INGOs, that are specialised in rehabilitation to update curricula and training packages for physiotherapists in order to meet population needs and facilitate bringing paraprofessionals into a more formalised structure to ensure patient safety.
■ fund more data collection which covers all geographical areas of Syria and analyses barriers and solutions to accessing services, beyond only health care, for persons with injuries and disabilities;
■ add a weighing for disability inclusion when screening project proposals and set expectations for project proposals to demonstrate disability inclusive design, including participatory needs assessments, disability disaggregated data and indicators to measure specific inclusion-related achievements;
■ promote the integration of the needs of persons with disabilities to the response across all sectors, to avoid segregation or patchy access to services.