



World Health
Organization

Eastern Mediterranean Region

Country Cooperation Strategy for WHO and Syrian Arab Republic 2022-2025




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Acronyms and abbreviations

CCS	Country Cooperation Strategy
EWARS	Early Warning, Alert and Response System
GDP	Gross domestic product
GPW13	WHO's Thirteenth General Programme of Work
HeRAMS	Health Resources and Service Availability Monitoring System
IDPs	Internally displaced persons
NCDs	Noncommunicable diseases
SDGs	Sustainable Development Goals
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization
PHC	Primary health care



Signature page

The signing of the Country Cooperation Strategy 2022–2025 reaffirms the strength of the relationship between the World Health Organization (WHO), as part of the wider United Nations system, and the Government of the Syrian Arab Republic.

It underscores the commitment to work together toward agreed priorities for greater impact and relevance to the people of the Syrian Arab Republic as envisioned by the national targets set for the achievement of the Sustainable Development Goals.

The strategy further advances WHO's long history of support to, and alignment with, national development priorities and adds a stronger emphasis on coherence and coordination from all levels of the Organization with the Syrian Arab Republic.



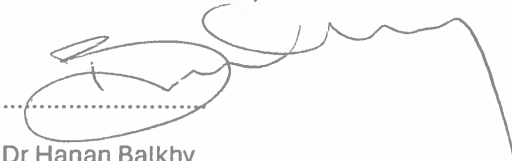
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1. Introduction

WHO's Country Cooperation Strategy (CCS) defines the Organization's medium-term vision for working in and with a particular country (1). The CCS, developed in the context of global and national health priorities, examines the overall health situation in a country, including the state of the health sector, socioeconomic status and the major health determinants. It identifies the major health priorities and challenges and frames WHO's support over the next four to six years; however, due to the complex situation in the Syrian Arab Republic, this CCS covers only three years. The CCS does not preclude other ad hoc technical support for prevailing and emerging situations in response to specific requests from the Government.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning, as well as to improve WHO's collaboration with Member States to achieve the triple billion goals of *WHO's Thirteenth Global Programme of Work 2019–2023* (GPW13, extended to 2025), and the targets of the Sustainable Development Goals (SDGs).

The previous CCS (2008–2013) focused on sustaining the country's decades-long impressive achievements and health gains, further building country capacities to timely address the epidemiological transition from communicable to noncommunicable diseases, and achieving the Millennium Development Goals. However, due to the crisis beginning in 2011 and its devastating consequences, the focus of WHO support shifted to providing humanitarian assistance, based on identified needs (2). Considering the improved security situation in most of the country, the WHO Country Office and the Ministry of Health developed this new WHO CCS to achieve the goals of the National Strategic Plan 2030 (Syria 2030) (3), in line with the United Nations Strategic Framework 2022–2024 that was signed in June 2022.

The present CCS sets out WHO's strategic framework for collaboration with the Syrian Arab Republic, from June 2022 until June 2025, in light of the 12 years of crisis that have had a devastating impact on the health sector and infrastructure of basic services. The current situation is at the worst level since the beginning of the crisis in 2011, with unprecedented levels of food insecurity, deterioration of health indicators, high levels of internal and external displacement and insecurity in some parts of the country in areas beyond government control. The crisis has left much basic infrastructure, including health facilities, damaged or destroyed. A large percentage of health professionals have left the country; those who remain are overworked and need further training and capacity-building. The COVID-19 epidemic has caused further deterioration of health services imposing daunting challenges in the fight to save lives and livelihoods. Due to the continuing sanctions and dwindling donor support, the health sector faces overwhelming challenges in maintaining humanitarian assistance to a majority of people, as well as availing the strategic opportunities of relative calm in most governorates in transitioning from humanitarian assistance to recovery and rebuilding a responsive, resilient health system. There is also the immense challenge of building trust and establishing cooperation with individuals, families and communities who remain in the country, as well as those who have started returning to their country of origin. These individuals can play a role as agents of change and take an active role in the process of rebuilding the health system and ensuring basic services, including food security, shelter, education, and water and sanitation in order to create a conducive political and social environment. The question is not when to start but how to overcome challenges of recovery and build back a better health system.

The CCS mission team comprised senior staff from the Ministry of Health led by His Excellency the Minister of Health, the WHO Representative to the Syrian Arab Republic and staff from the WHO Country Office, Regional Office for the Eastern Mediterranean and headquarters. The WHO Country Office, with support from the Ministry of Health and the WHO Regional Office, discussed and prepared the assessment of the health situation and challenges in the country, in line with the Common Country Assessment, National Health Plan 2030, United Nations Strategic Framework 2022–2024 and GPW13. As part of this process, a series of interviews with key informants were carried out, and meetings were conducted with officials from concerned ministries and institutions, representatives of United Nations agencies, as well as key potential internal and external partners. An extensive review of available published and unpublished documents and publications was also conducted. *The Country Cooperation Strategy for WHO and Syrian Arab Republic 2022–2025* carefully considers the current and projected issues during its transition from continued humanitarian assistance to recovery, resilience and development. The consolidation of health policies and strategies and health system strengthening, based on the strengthening of primary health care (PHC), aims to contribute to the achievement of national and global development and health goals and the targets of the SDGs.

2. WHO/Syrian Arab Republic collaboration

WHO's collaboration with the Syrian Arab Republic extends over many decades, starting in 1948. This collaboration has played an important role in national health development with the main aim of achieving the highest level of health for all. Over the years, collaboration has extended to cover disease control, PHC, human resource development, family planning, Expanded Programme on Immunization interventions, environmental health and healthy lifestyles, and many other health initiatives.

WHO collaboration has been at the forefront of emergency health relief and development in the Syrian Arab Republic during the last 12 years. WHO has demonstrated strong leadership and established strong working relationships with national partners. The Organization is well regarded by United Nations partners and nongovernmental organizations and has a successful working model of collaboration with key partners.¹



Staff from the Ministry of Health and WHO discuss joint priority public health programmes

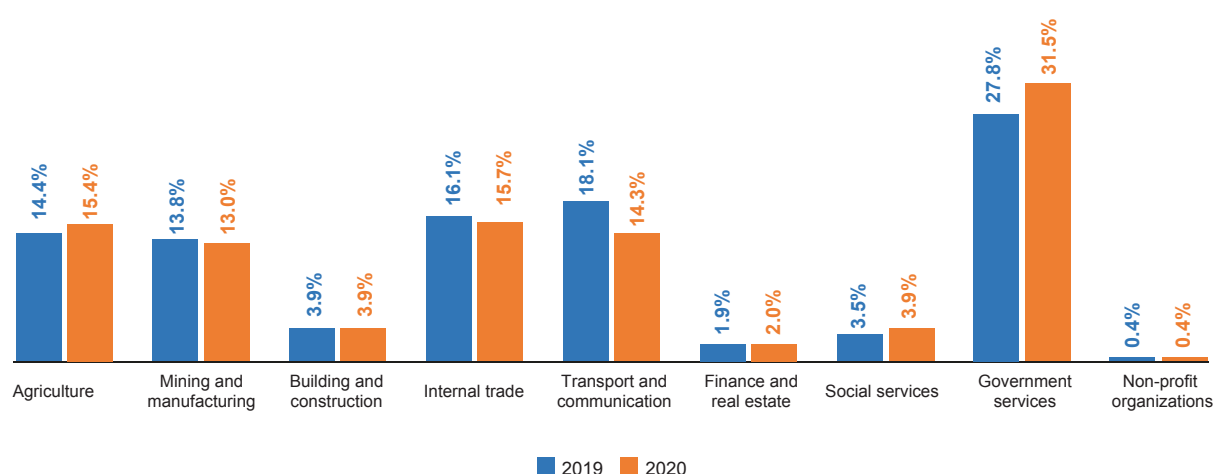
¹ Country functional review for the Syrian Arab Republic. Cairo: WHO Regional Office for the Eastern Mediterranean Region; unpublished data, 2019.

3. Health and development situation

3.1 Political, macroeconomic, and social context

The macroeconomic situation in the Syrian Arab Republic has resulted from a number of internal and external interrelated factors. Multiple key factors led to the undermining of the national economy, namely: the 12-year crisis; the currency exchange crisis recently linked to the situation in Lebanon; exponentially increasing inflation rates; the impact of the arbitrary unilateral sanctions against the Syrian Arab Republic; the COVID-19-impacted global economic downgrade and the slow recovery from the epidemic and its related repercussions.

Syrian Arab Republic's current economic situation has been entrenched by the 12-year crisis and the destruction of its capitalist base (i.e. human, social, natural, material, economic and political) that is ultimately linked to the capacity to produce and provide services. According to the Socio-Economic Impact Assessment of the COVID-19 pandemic in Syrian Arab Republic 2021, gross domestic product (GDP) for 2020 is distributed as shown in Fig. 1. In total, the service sector constitutes over 70% of GDP, which is based on government services, transport and communications, with contributions from internal trade, finance, insurance and real estate sectors. This increases the sensitivity of the Syrian economy to security and political shocks and poses a threat to the sustainability of economic growth.



Source: Syria 2021 Socio-Economic Impact Assessment, United Nations Development Programme (4)

Fig. 1. Sectoral composition of real GDP 2019–2020

Post-pandemic lockdown measures curbed the expected momentum of growth across all sectors and effectively reversed their positive performance in 2019. The hardest hit sectors were those most affected by lockdown measures, while government services, agriculture and non-profit sectors achieved positive growth rates (4).

In the context of this unprecedented situation, it is impossible to ignore increasing food insecurity and poverty during the war, which provided further health challenges for Syrians. The number of food-insecure people rose from 7.9 million in 2019 to 12.4 million people by the end of 2020; a 56% increase. Moreover, in 2021 there were 13.4 million people in the country needing various forms of humanitarian assistance – with six million in extreme need – an increase of 21% over 2020 (4).

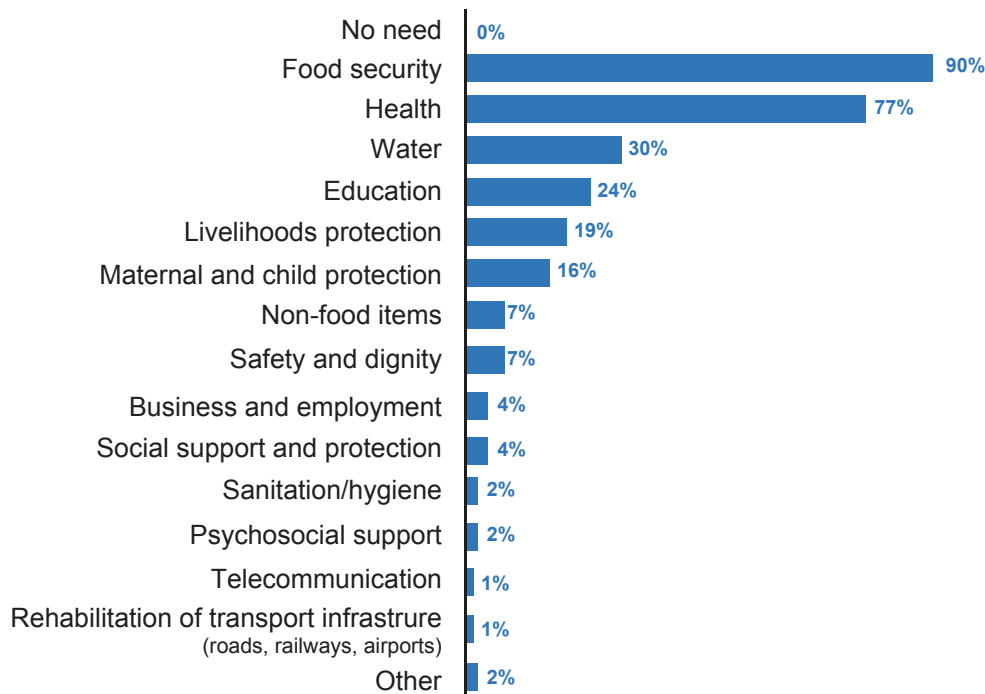
As a result of the flight of Syrian families from non-Government-controlled areas, displaced families – even if they return to their normal residence – have been exposed to food insecurity, as the number of internally displaced Syrians reached 2 913 495 people at the end of 2021, and 2 914 689 in September 2022.¹

In 2019, the Government developed Syria 2030 (national development plan), which outlines a vision for reconstruction and sustainable development, reflecting commitment to recovery and resilience to achieve the SDGs. This vision describes four overlapping phases of reconstruction: relief, recovery, an upward phase, and a sustainable development phase, across four interrelated pillars:

- Institutional building and strengthening integrity
- Infrastructure development and renovation
- (Balanced and sustainable) growth and development
- Social and human development (educational and cultural).

If fully implemented, Syrian Arab Republic's 2030 agenda will be a positive step towards the recovery and stability needed for development. Short-term priorities include taking action to address the challenges of food security, economic and social reintegration, improving basic services (i.e. electricity, water, health, education, housing and social protection) and building basic livelihoods.

All households surveyed in Syria's 2021 Socio-Economic Impact Assessment expressed some kind of outstanding recovery need, with 90% of households indicating that food security was the most important need, followed by health care (77%), then water (30%) (Fig. 2).



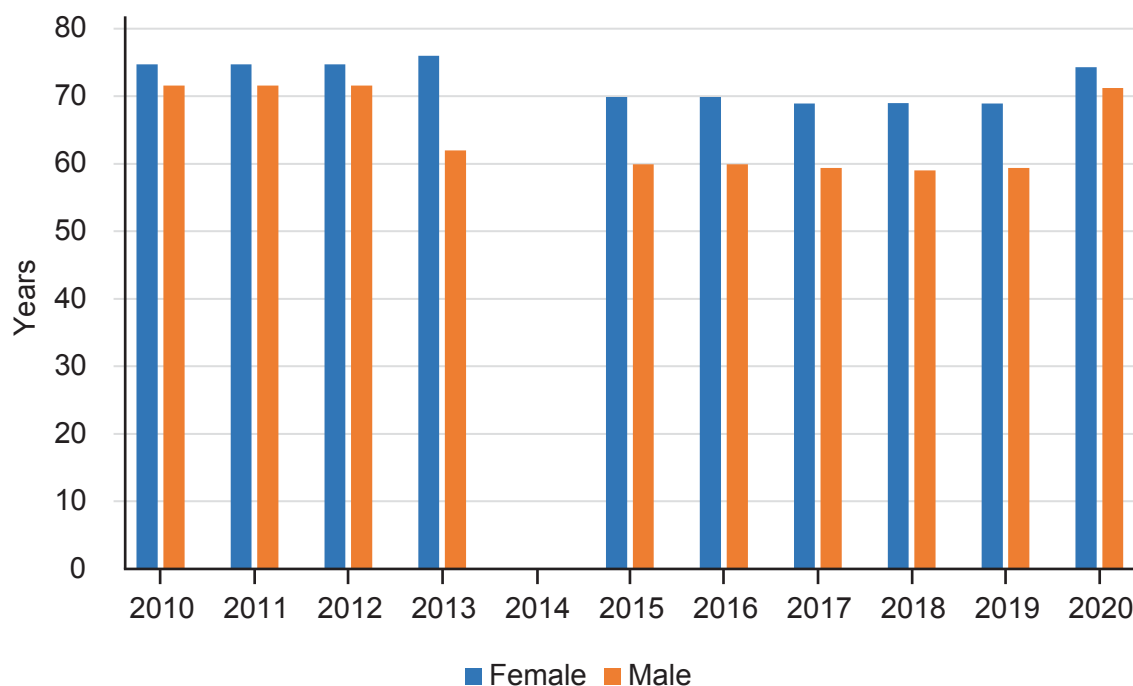
Source: Syria 2021 Socio-Economic Impact Assessment, United Nations Development Programme (4)

Fig. 2. Households' top recovery needs

¹ According to data from the Ministry of Local Administration and Environment/Higher Relief Committee, 2022.

3.2 Health status of the population

The protracted crisis has had a devastating impact on the health of the population. Reported life expectancy, which was 74.7 years for women and 71.6 years for men in 2011, dropped significantly by 2015, to 69.9 for women and 59.9 for men (5) have reached pre-crisis levels again (Fig. 3), within country differences, particularly among the most hard-to-reach areas, are not well documented.



Source: Ministry of Health

Fig. 3. Life expectancy in the Syrian Arab Republic, 2010–2020

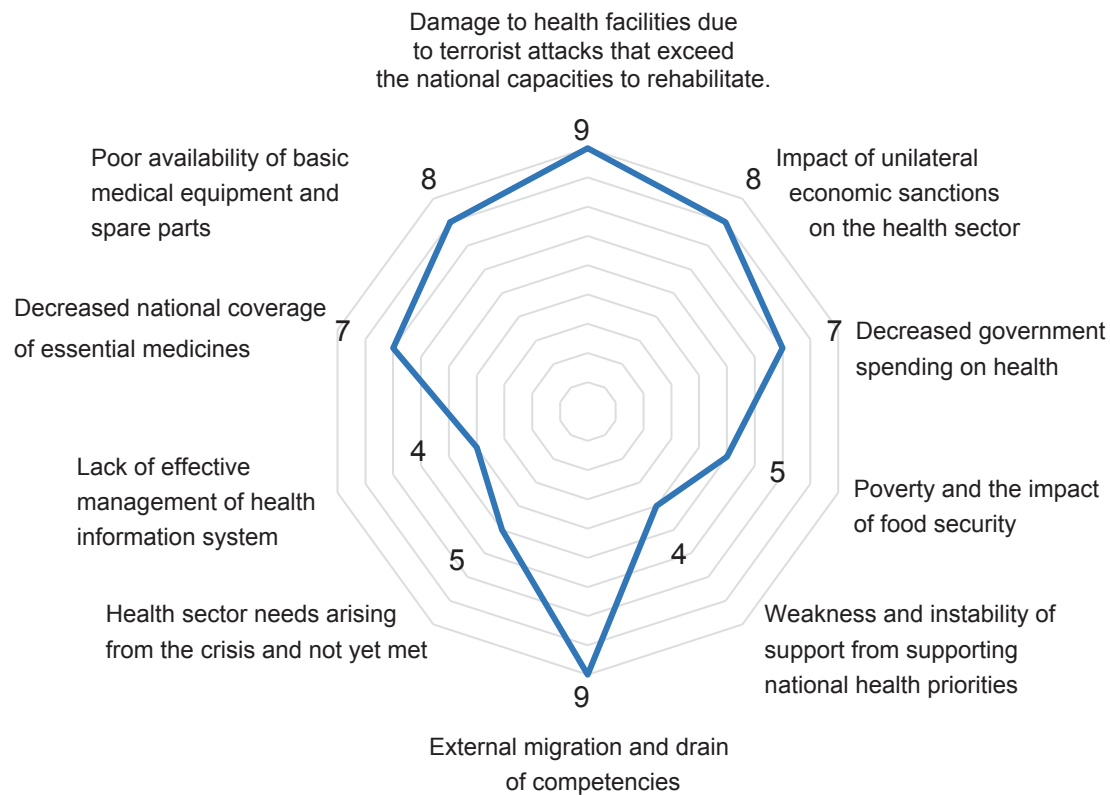
A child mortality survey using the verbal autopsy method, covering the period from 1 November 2017 to 31 October 2018, was carried out in 2019 by the Ministry of Health on 75 385 families distributed over all governorates in the country. The number of live births reported for the period covered was 14 499. The under-5 mortality rate in this study was 23.7 per 1000 live births (343 deaths among 14 499 live births).¹

The total number of deaths was 172 cases distributed to 1000 live births, 100 cases among children under one year, and 72 cases among children from one year to five years; thus the neonatal mortality rate in this study is estimated at 11.8 per 1000 live births, the infant mortality rate at 18.7 per 1000 live births, and the child mortality rate estimated at 5 per 1000 live births. The highest mortality rate for children under 5 during the first half of 2022 was in the Hama governorate (23.9%), followed by Tartous (13.1%), Homs (12.8%), and Daraa and Deir Ezzor (12%), respectively.

Although the crisis led to a deterioration in the population's health, the latest data indicate signs of improvement, but more evidence is needed to better understand the disparities in the country. Public health measures can then focus on the most vulnerable groups and ensure that no one is left behind.

¹ Under-five mortality survey. Ministry of Health of the Syrian Arab Republic, 2019.

Fig. 4 shows the main factors that contributed to the negative impact on health in the country as per an analysis carried out by the Ministry of Health.



Source: Ministry of Health

Fig. 4. Factors contributing to negative impacts on health as per Ministry of Health analysis, 2022

3.2.1 Noncommunicable diseases

According to Ministry of Health data, noncommunicable diseases (NCDs) have been the leading cause of death over the past 10 years, peaking at 654.2 deaths per 100 000 inhabitants in 2018–2019. A large number of deaths were also attributed to injuries: up to 442.7 deaths per 100 000 inhabitants during the same period of time (6).

Fig. 5 shows the most common morbidities in 2020. Cardiovascular disease was the leading cause of morbidity. Fig. 6 shows the most common causes of morbidity in 2019, in which the top three causes of morbidity are cardiovascular, other and gastrointestinal disease.

Fig. 7 shows age-standardized cause of death per 100 000 population in the Syrian Arab Republic in 2013–2020.

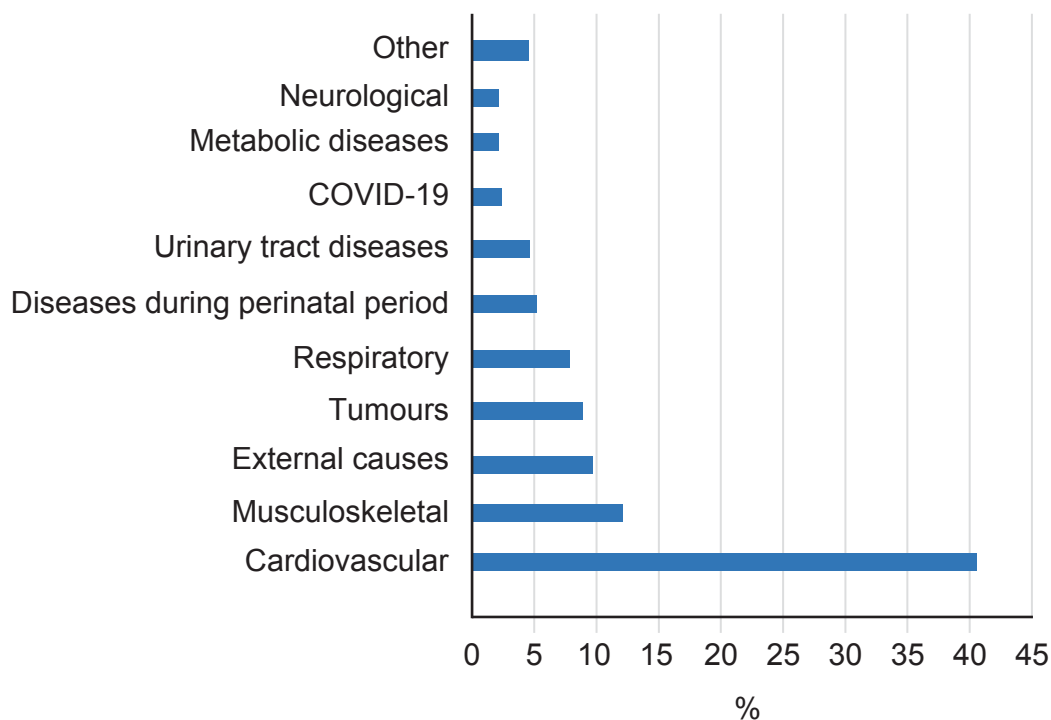
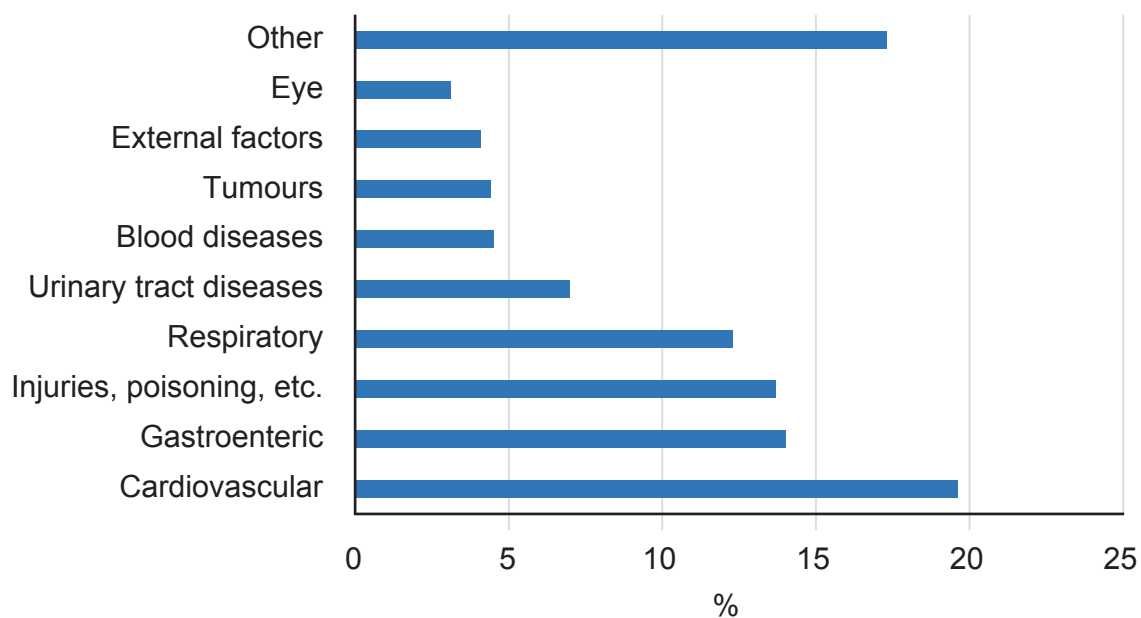
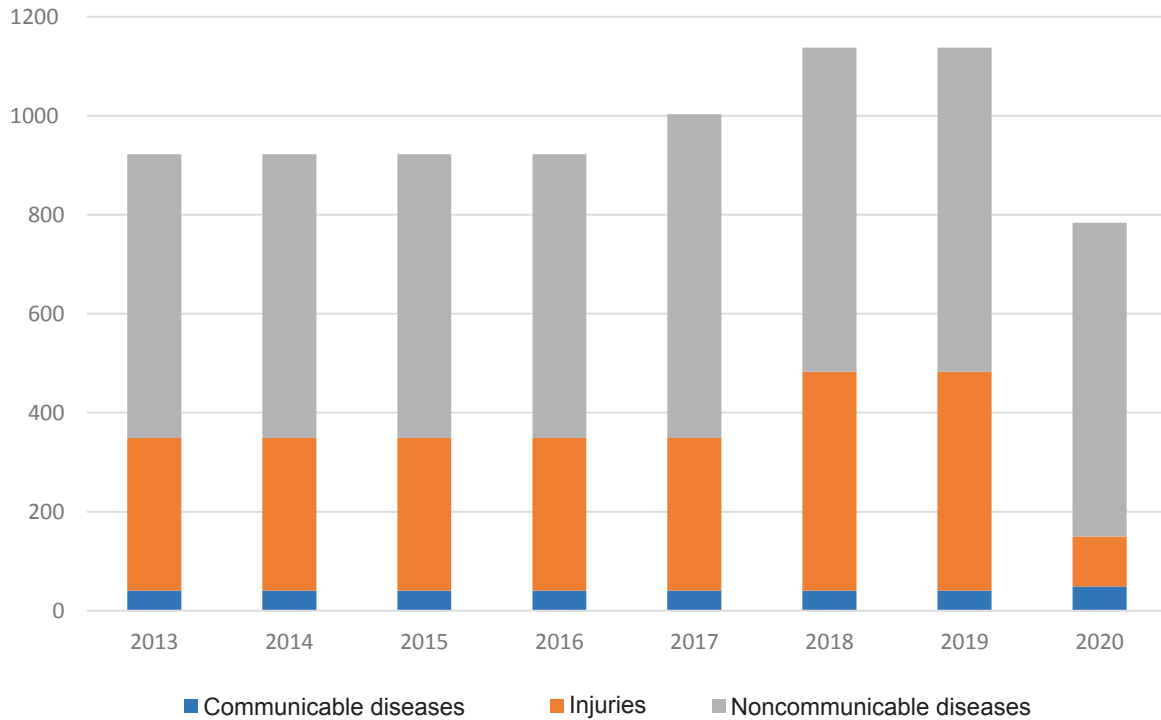


Fig. 5. Most common causes of morbidity, 2020



Source: Ministry of Health

Fig. 6. Most common causes of morbidity, 2019



Source: Eastern Mediterranean Regional Health Observatory

Fig. 7. Age-standardized cause of death per 100 000 population, Syrian Arab Republic, 2013–2020

3.2.2 Communicable diseases

The war in Syrian Arab Republic created conditions for the outbreak and spread of infectious and communicable diseases with the interruption of immunization activities, destruction of health infrastructure and migration of health care workers. Mass population movement to refugee camps created environmental conditions for the outbreak of communicable diseases, such as tuberculosis (TB), leishmaniasis, poliomyelitis, measles, hepatitis and other communicable diseases.

According to Ministry of Health data, the polio outbreak in 2013, nearly 20 years after polio had been successfully eliminated in the country, demonstrates how war can dramatically affect a population and its public health infrastructure (7). Another example is measles, as in pre-2011, the country had a robust immunization programme evidenced by low measles incidence (<1 measles cases reported per 1 000 000 population); during the crisis the incidence rate exceeded 30 cases per 1 000 000 population in some years, according to Ministry of Health data.¹

The Ministry of Health conducts active TB surveillance and reporting in line with WHO guidelines. The Ministry of Health conducted a survey of all prisons in the country and mobile clinics serve remote areas and communities in Deir Ezzor, Aleppo and Rural Damascus. Directly Observed therapy treatment is not always available due to the destruction of health facilities, thus limiting access to medicines and health services (8). According to the national TB annual report for 2021, most reported cases of TB were from the Aleppo governorate.

¹ Ministry of Health unpublished data.

Multidrug-resistant TB is also increasing. In 2021, 17 cases were detected by the national TB programme; however, this number is lower than the estimated 40 cases probably due to underreporting from hard-to-reach areas.¹

The Syrian Arab Republic is malaria-free and has a low prevalence of HIV (8).

Other communicable diseases, including acute diarrhoea, leishmaniasis, hepatitis, vaccine-preventable diseases and typhoid, have also been reported through the Early Warning and Response System (EWARS).¹ In the Syrian Arab Republic there has been an increase in the number of typhoid fever cases. Rates of cutaneous leishmaniasis, which is endemic in most governorates including Aleppo, central Syria, northwest and north east have been rising sharply since 2011 (9).

Another hidden consequence of the Syrian crisis is the rise of antibiotic resistant bacteria. Studies conducted in 2012 show increasing rates of antimicrobial resistance among all the species studied and an increasing burden of resistant Gram-negative infections and methicillin-resistant *Staphylococcus aureus* (MRSA). Major probable drivers include the misprescription and overprescription of antibiotics (10).

3.2.3 Reproductive, maternal, newborn and child health

Reproductive, maternal, newborn and child health are often the worst affected during conflict and emergencies. According to data for 2020 from the Ministry of Health, the under-five mortality rate was 23.7 per 1000 live births; WHO reported infant and under-five mortality rates as 18.8 (11) and 24 per 1000 live births (12), respectively, which are lower than the global average of 28.2 and 37.7 deaths per 1000 live births, respectively (13).

In 2018, the acute malnutrition rate among women of reproductive age was estimated at 4%. In 2021, acute malnutrition among children was 1.5%, severe acute malnutrition (wasting) rate was 0.4% and stunting was 5.2%. The malnutrition rate among pregnant women was 6.9%, reaching 7.8% among breastfeeding women. Data indicated nutritional deprivation among children of three years or younger, making them prone to delayed physical and mental development.



¹ EWARS monthly bulletins (<https://reliefweb.int/>).

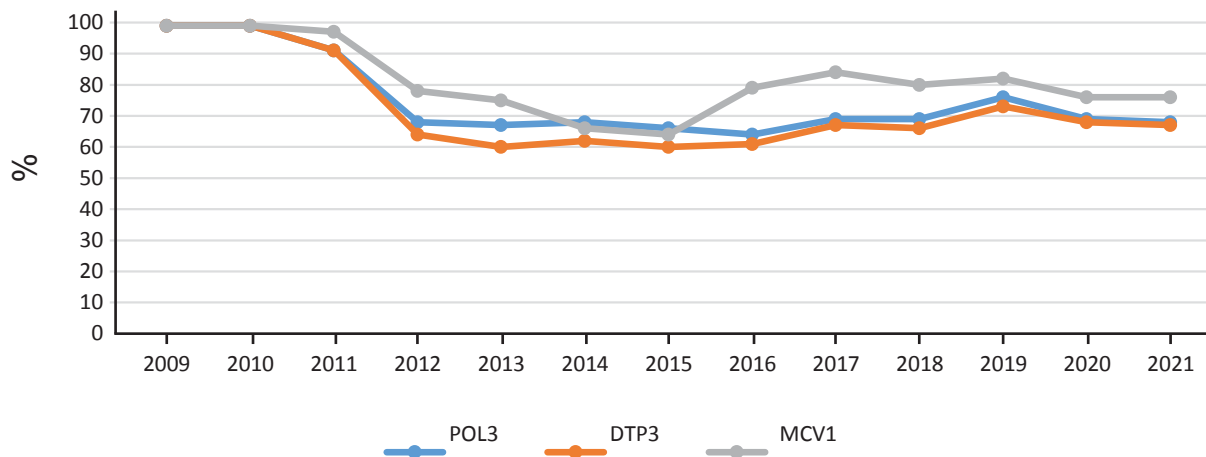
Although access to severe acute malnutrition services rose to 7% in the first quarter of 2021, as compared to the same quarter in 2020, children under five require immediate treatment for severe acute malnutrition, without which it could be life threatening.

According to Ministry of Health data, nearly 42% of children aged 6 to 23 months have anaemia, which has a negative impact on child mortality, as well as cognitive and physical development (14).

Limited exclusive breastfeeding and inappropriate infant feeding practices are ongoing concerns with continuing socioeconomic impact and food insecurity resulting from the crisis. Investing in multisectoral actions to improve availability, accessibility, affordability and consumption of safe and nutritious complementary food and prioritizing varied household diets have been identified as key nutrition strategies moving forward (14).

Major efforts to improve child health are being made through national vaccination campaigns and the creation of mobile teams. These efforts include containment of polio outbreaks over the last decade, as Syrian Arab Republic had previously been classified as one of 10 high-risk countries for polio in the Eastern Mediterranean Region. Public health laboratories have played an instrumental role in conducting surveillance of vaccine-preventable diseases, noting that the polio laboratory is a regionally accredited laboratory.

Destruction of the health infrastructure and a sharp decline in the availability of trained technical staff has reduced vaccination coverage (Fig. 8) and led to outbreaks of vaccine-preventable diseases, including polio (2013 and 2017) and measles (2017 and 2018). Approximately 986 immunization centres are functioning in Syrian Arab Republic out of a total of 1280 centres. Targets of the vaccination programme are set in line with certain vaccination criteria.



Source: Ministry of Health

Fig. 8. Immunization coverage, Syrian Arab Republic, 2009–2021

Women's health has suffered during the crisis, which has included sexual and gender-based violence, menstrual irregularity, unintended pregnancies and preterm births. Exposure to war-related events has also been linked to maternal post-traumatic stress and general psychological distress both directly and indirectly through daily stressors (15). Married women under the age of 18 account for 23% of pregnant women. Early marriages are a cause for concern due to limited access to prenatal and postnatal health care but also due to its social impact. The National Gender Equality Plan highlighted the problem of early marriage.

4. Health system and services

4.1 Challenges

Due to 12 years of crisis, destruction, sanctions, the outbreak of COVID-19 and its effects on lives and livelihoods, the health sector is facing considerable and complex challenges.

Within the post-war context, donor fatigue, financial challenges and lack of data create key challenges to improving access to quality health services. The challenges include:

- strengthening the primary health care model;
- overcoming the shortage of human resources;
- rebuilding infrastructure; training and deploying human resources;
- overcoming recurring shortages of essential medicines and supplies; and
- addressing the current macroeconomic situation and the budget deficit (16).

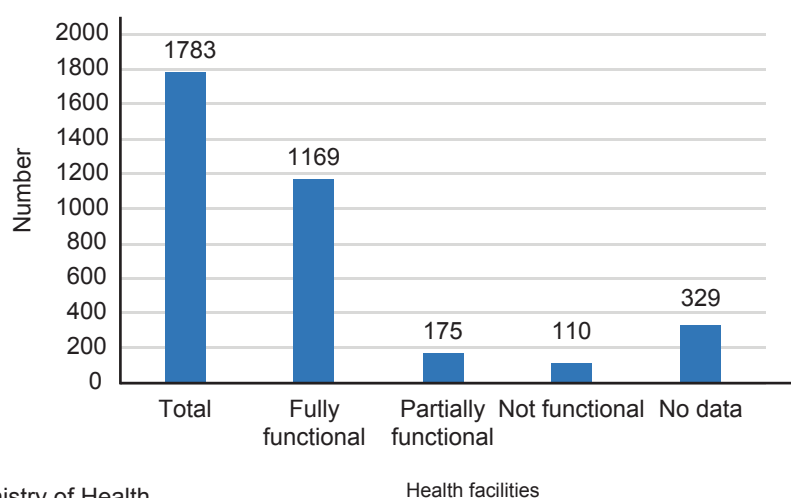
The health system needs to address and focus not only on strengthening the health care system for the population as a whole but on interventions targeting specific population groups, such as returnees, internally displaced persons (IDPs) and refugees to achieve national and global targets.

Attacks on health care disrupt humanitarian operations and compromise access to health care. Nearly 300 attacks on health care were reported in the past four years causing nearly 200 deaths and more than 400 injuries (17). These attacks impacted the health infrastructure, including health facilities, transportation, warehouses and health personnel and patients.

The total cost of damage by attacks on health care to Ministry of Health hospitals and centres in 2021 was estimated to be about 400 billion Syrian pounds across governorates. This estimate does not include facilities outside of Government control, namely in both Idlib and Raqqa. Fig. 9 shows the status of health facilities in 2021.

In 2021, an estimated 46% of hospitals were fully functional across the Syrian Arab Republic; 23% were partially functional and 29% completely out of service (18).

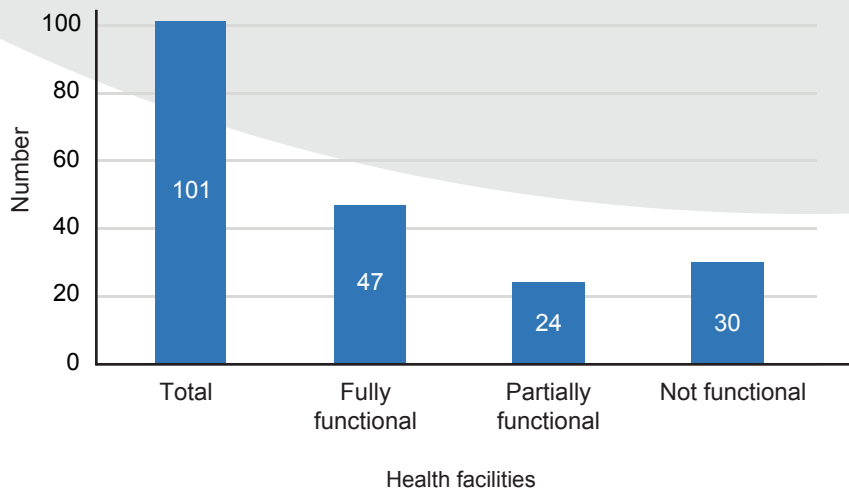
In 2021, only 65% of the total number of health centres were fully operational, there were no data on about 18%, and 15% were affected to varying extents (Fig. 10). The damage to health infrastructure does not include the irreparable loss of life of medical and health staff.



Source: Ministry of Health

Health facilities

Fig. 9. Status of Ministry of Health-affiliated health centres, 2021



Source: Ministry of Health

Fig. 10. Damage to Ministry of Health hospitals, 2021

Considering the various degrees of damage to, and destruction of, hospitals in different governorates, levels of donor funding and the modest resources allocated to annual fiscal plans, a significant infrastructure rehabilitation funding gap is evident among the different governorates. A doubling of efforts will be needed to regain developmental equilibrium in the health infrastructure across the country.

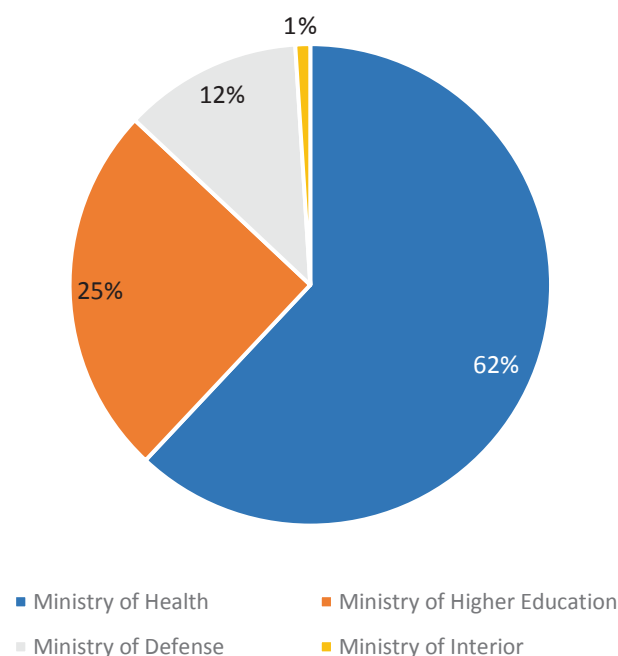
Physical damage only reflects a small number of the effects of the crisis on the health sector, it does not capture the many direct inputs to the provision of health care service, including machinery, tools and other medical supplies. Moreover, direct destruction of infrastructure in other sectors, including transportation, energy and water, further cripple access to health care and service delivery, including maintenance of critical medicines supply chains and referral networks. Sanctions have also had a significant impact on the manufacturing sector, particularly essential medicines production facilities. This impact has been most severe in sectors that export, require a substantial share of imported inputs, or were closely linked to external partners (18).

4.1.1 Service delivery

Sanctions have significantly affected the health sector, by linking the provision of any development or reconstruction assistance to political conditions, imposing a unilateral trade embargo, and imposing unilateral coercive measures whose effects extend to a third country other than the Syrian state (supply, export, sale, banks, companies, people). For example, about 89 European and American medical companies exited the local market, according to Ministry of Health data for 2019.

There have also been direct negative effects on the provision of pharmaceutical supplies necessary for treatment protocols, especially through foreign companies' withdrawal of privileges granted to 58 Syrian pharmaceutical companies, in addition to banning the import of effective and auxiliary raw materials, and some packaging materials not manufactured locally, such as vials and ampoules, and reference materials used to examine the quality and purity of medicines. This also applies to a large number of specific medications, such as for cancer and kidney transplantation, which were imported from European companies who stopped supplying these medications.

The health system is primarily the responsibility of the Ministry of Health. The Ministry is the main provider of PHC, but other medical services, including secondary and tertiary care, are also supported by other major ministries, including that of Higher Education, Defence, Interior and Social Affairs and Labour. For example, in 2019, of the 520 hospitals and 33 850 hospital beds in the country, 129 were public hospitals managed by the Ministries of Health (100), Defence (14), Education (13), and police sectors (2) (Fig. 11) and the remaining were managed by the private sector.



Source: Ministry of Health

Fig. 11. Distribution of hospital beds in the public sector, 2021

The health system is relatively decentralized and focuses on offering PHC services at three levels: village, district and provincial. Patient accessibility to health facilities varies by region; for example, more than 15% of facilities in Aleppo, Al-Raqqa, Dar’a and Quneitra are hard to access or inaccessible. Damaged facilities, frequent power cuts, severe shortages of generators and fuel hamper the functionality of health facilities.

The Government provides low-cost, almost free services to all citizens; which themselves are not provided by the private sector and health professionals are practising in both sectors. However, further efforts are needed to reduce waiting times and promote the role of public hospitals (including by increasing media attention). The private health sector plays an important role in delivering health care, in part due to the omnipresent “dual practice” – due to income differences. In 2021, 60% of hospital beds were in the public sector even though private providers have increased by 41% since the economy was opened up in 2005. This is especially true in large urban areas such as Damascus, Aleppo, Tartus and Lattakia.

Nongovernmental organizations have played a critical role in filling service delivery gaps. Local nongovernmental organizations are strategically positioned within communities to maximize the use of locally available resources and contribute to improving the health and well-being of the population, especially for people requiring humanitarian health assistance.

The strategic plan for engagement with health-related nongovernmental organizations outlines the framework for the delivery of basic essential health care to Syrians complementing the governmental health system.¹

The provision of integrated comprehensive health services addressing prevention, management and rehabilitation based on primary health care is the service delivery priority. These services are based on the principles of integrated services, social protection, efficiency, coverage and quality. Although facing some operational challenges in its roll-out, the costed essential health service package developed by WHO and humanitarian health partners could serve as the basis for establishing an essential and emergency health care package for the country that includes trauma, primary health care, reproductive and child health, nutrition services, management of chronic illness and mental health and the various war-incurred disabilities.



WHO-supported Al-Afia Fund Association providing essential health services in Hama.

4.1.2 Health workforce

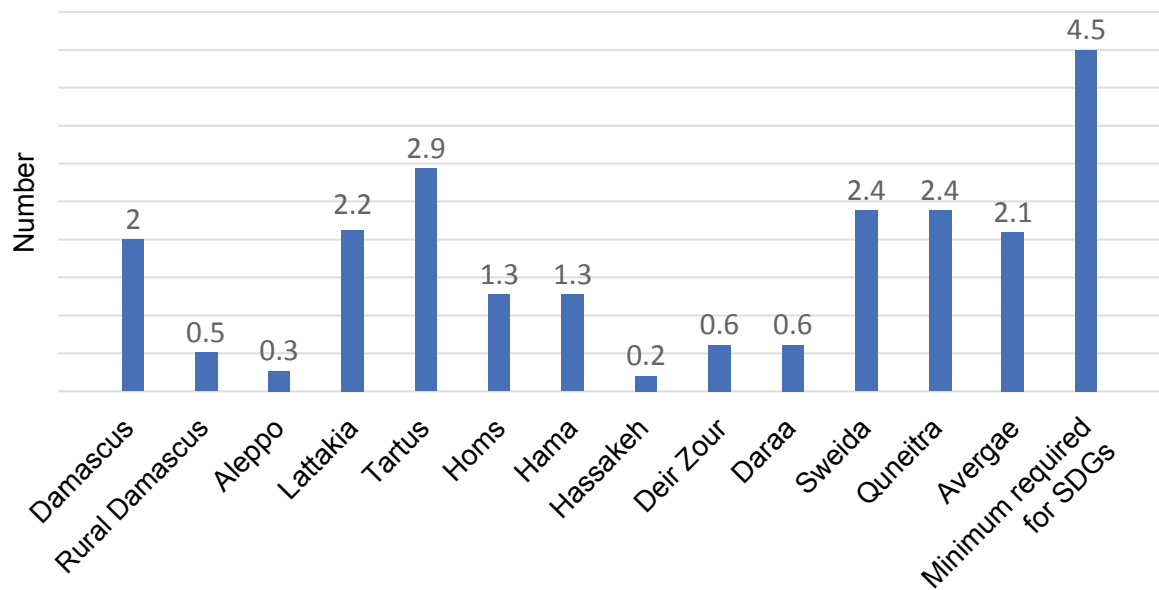
Targeting of health facilities and medical personnel has led to provider “flight” and a hollowing out of the entire health system. Data on the number of physicians, nurses and other health workers who fled are limited, but efforts are ongoing to map the size of the workforce exodus and the location. The health workforce is markedly smaller in number than prior to the crisis with unequal distribution across governorates. In fact, more than 50% of health care workers were estimated to have left the country during the crisis according to a WHO report on the labour market 2021–2022.²

Attacks on health services, outmigration, challenging working conditions and dysfunctionality of health facilities (e.g. frequent stockouts and lack of essential medicines), in addition to the reduced purchase power of incomes along high inflation rates are some of the reasons for health workforce attrition.

Figs. 12–14 show the density of key health workers (doctors, nurses, midwives) per thousand people distributed in the governorates for the year 2021 compared to the minimum required to achieve the SDGs: in Ministry of Health hospitals and its independent hospital bodies (Fig. 12); in Ministry of Health-affiliated health centres (Fig. 13); and for registered health workers (Fig. 14). There is clear disparity between governorates and failure to achieve the targets required to meet the SDGs, especially in the eastern governorates of Aleppo, Rural Damascus and Daraa, while Tartous and Latakia achieve relatively higher levels.

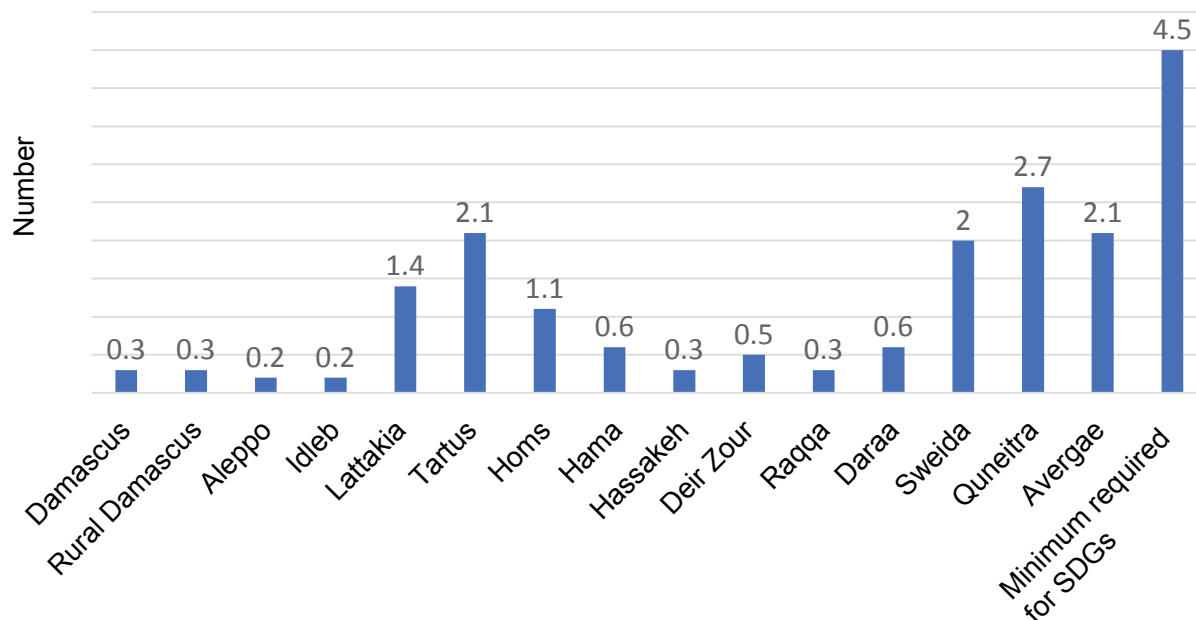
¹ Syrian Arab Republic health NGOs revised strategic plan for engagement in the early recovery phase of the health system, 2020–2024. Cairo: WHO Regional Office for the Eastern Mediterranean; unpublished 2019.

² COVID-19 Operational response plan within Syria. Syria’s United Nations Country Team, 2020.



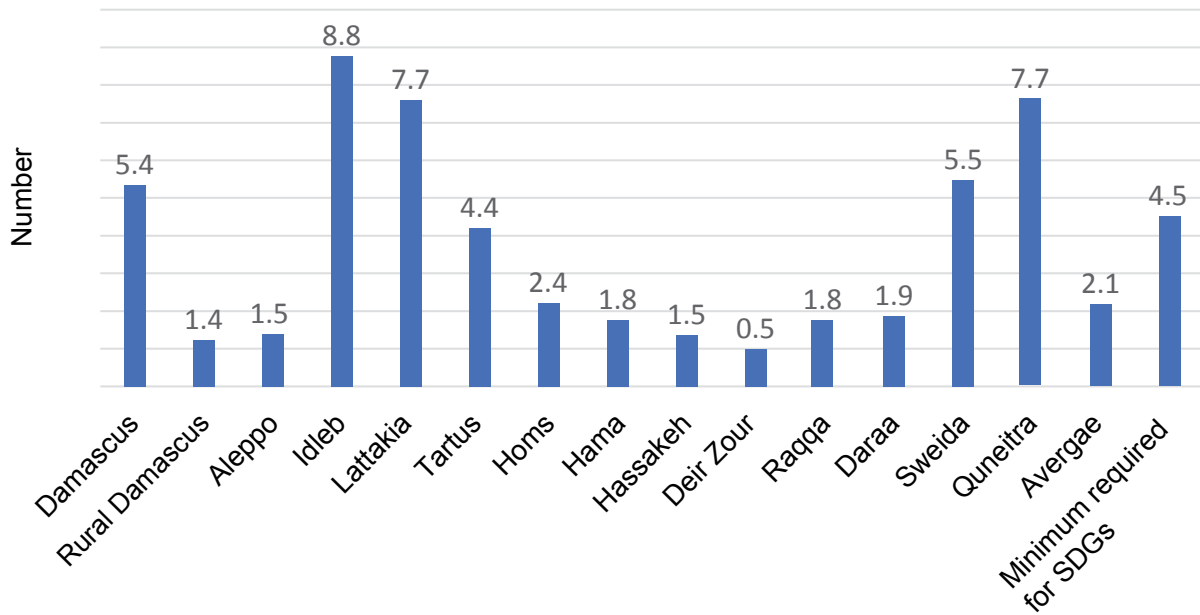
Source: Ministry of Health, 2021

Fig. 12. Density of key health workers (doctors, nurses, midwives) in Ministry of Health hospitals and its independent hospital bodies per 1000 people



Source: Ministry of Health, 2021

Fig. 13. Density of key health workers (doctors, nurses, midwives) in Ministry of Health-affiliated health centres per 1000 people



Source: Ministry of Health, 2021

Fig. 14. Density of registered key health workers (doctors, nurses, midwives) per 1000 people

The Syrian Arab Republic has seven public universities with faculties of medicine: Damascus University, University of Aleppo, Al-Baath University (Homs), Al-Furat University (Deir Ez-Zor), Hama University, Tartous University and Tishreen University (Latakia). However, due to the shortage of qualified health personnel and increased demand on services, individual nongovernmental organizations, in cooperation with international nongovernmental organizations and universities, have often offered BSc and MSc training initiatives to address existing gaps. Such initiatives include academic training, postgraduate training, short courses, continuous medical education, and competency-based training, targeting doctors and other health professionals. Multiple training and education opportunities have been afforded to address operational needs of nongovernmental organizations and the health and humanitarian needs of the population.

The shortage of qualified human resources poses a major challenge towards early recovery. Thus, developing a human resource strategy to attract the appropriate mix of health personnel and retain them is a priority for the Ministry of Health

4.1.3 Health information system

Since the onset of the crisis, the health information system has been adapting to new emerging needs with the help of various stakeholders in the health sector, including national and international institutions, as well as the donor community. This fragmented system includes:

- Primary and secondary health care information system (routine statistics)
- Health resources and service availability monitoring system (HeRAMS) embedded in the
- District health information system 2 (DHIS2)
- Civil registration and vital statistics embedded in DHIS2
- EWARS
- Cancer registry
- GLAAS global analysis and assessment of sanitation and drinking-water..

In spite of implementation of EWARS in 2012 and HeRAMs in 2014, data collected by the Ministry of Health in various health facilities at all levels may not be accurate due to under reporting. Irregular reporting, limited supervision and monitoring, insufficient training and minimal digitalization are some of the key challenges to ensuring the accuracy of data and statistics needed for decision making at the national level, due to the need to provide all health facilities with IT equipment and uninterrupted electricity to ensure continuity of services. Nearly 90% of health facilities use a paper-based register for patients which is entered digitally and then checked for accuracy.¹ Prior to the crisis, the disease surveillance system routinely gathered information on 27 diseases through a network of public and private health facilities. This system was interrupted by the crisis and has now been replaced by EWARS; a syndromic, indicator-based surveillance system for emergency settings. EWARS and HeRAMs have been particularly useful during the pandemic in improving the quality of data. However, greater efforts are needed to strengthen the early warning system and more broadly to improve the availability of reliable data on trauma and injuries and the prevalence of NCDs and other priority diseases, as well as to estimate population figures at national, governorate and district levels to better understand and respond to population movements (19).

Civil registration and vital statistics are overseen by the Ministry of Interior. Pre-crisis, the coverage of birth registration was 98% while the coverage for death registration was only 75%, according to Ministry of Health data (20). The war has resulted in the closure and destruction of many civil registry offices. New births, marriages, divorces and deaths are often not entered into official records, leaving internally displaced persons (IDPs) without documents to prove these events took place (21). Improving coordination and collaboration among stakeholders, contributing to the production of health indicators, expanding the utilization of the International Classification of Diseases and birth and death registry, promoting the establishment of national electronic records and strengthening the database for basic health indicators identified by the Ministry of Health are the priority areas of work for 2022–2025.

4.1.4 Health technologies and pharmaceuticals

Prior to the crisis, the pharmaceutical sector was considered among the most successful sectors in the country, covering approximately 93% of local market needs in 2011 (22). Total pharmaceutical expenditure in 2010 was 29 785 million Syrian pounds (US\$ 621 million), accounting for 1.11% of GDP and 35.96% of total health expenditure.² In addition, pharmaceutical exports had reached the markets of 44 countries worldwide, according to the Ministry of Health.

The destruction of facilities, shortage of imported raw materials, economic sanctions and unfavourable exchange rates has resulted in a near collapse of this sector. Although by 2021, new investments had resulted in as many as 99 licensed factories, the ongoing crisis and economic sanctions meant that only 73 were functioning at full capacity in the same year. Moreover, this had an impact on essential medicines, supplies and vaccine procurement. To bridge this gap, international nongovernmental organizations, nongovernmental organizations and United Nations agencies are supporting the procurement of pharmaceuticals.

¹ Service Availability and Readiness Assessment. Damascus, WHO, 2018.

² Pharmaceutical country profile, 2021. Damascus, Ministry of Health of Syrian Arab Republic, 2011.

Annual expenditure on pharmaceuticals is around US\$ 22 per capita, almost all of which is paid through out-of-pocket payments, according to the Ministry of Health. In response to prices going up by 50%, the Ministry issued pricing regulations in 2021 and 2022 to ease the burden on families.¹ A recent and updated list of all registered medicines and the registration requirements and procedures has been compiled by the Ministry of Health. These new procedures, as well as processes for drug inspection and licensing, aim to make regulatory processes more transparent in line with ISO 9001:2015, to which all pharmaceutical directorates are now certified. Table 1 shows the key indicators of the pharmaceutical sector, and how these have changed over the years.

Table 1. Key indicators of the pharmaceutical sector, 2000–2021

Key indicators of the pharmaceutical sector		2000	2010	2014	2017	2020	2021
Number of locally manufactured varieties of the medicine		2903	6895	6904	7824	9788	10418
Number of pharmaceutical factories	Licensed	54	70	76	86	97	99
	Functional					72	73
Percentage of coverage with local medicines		87%	91%	80%	83%	90%	90%
Number of countries to which Syrian medicine is exported		–	53	4	13	15	17

Source: Ministry of Health

The national drug local coverage index expresses the proportion of licensed medicines that have been approved to be added to the national medicines list, but it does not reflect the actual availability of pharmaceuticals in the local market owing to disrupted production, sanctions, funding and shipping challenges and high production costs.

A local coverage index of national medicines should be developed based on realistic criteria, in cooperation with all concerned authorities. It would be useful, for example, to issue contracts with private pharmaceutical companies for the manufacture of certain medicines to meet the needs of the local market and the emerging requirements of the Ministry of Health, or for pharmaceutical companies to produce specific products to increase joint investment, and also consider the establishment other mechanisms for possible solutions.

The key priority moving forward is to improve access to medicines and vaccines through supporting local production, establishing a functional logistic information management system, and filling priority gaps for essential medicines, lifesaving medical equipment and supplies and spare parts needed for the provision of maintenance of services and the functionality of machines (19).

4.1.5 Health care financing

The Government provides free health care to all its citizens, with a ceiling applied to charges made by private providers. The right to UHC is guaranteed by the Syrian Constitution. The country introduced a Structural Adjustment Programme that was formalized in the 10th Five-Year Plan (2006–2010). Changes made to the health sector and the labour market include the piloting of health insurance schemes to replace free universal charging of fees for health services in public hospitals.

¹ Pharmaceutical country profile, 2021. Damascus, Ministry of Health of Syrian Arab Republic, 2011.

The state of health financing in the country is difficult to ascertain because of the lack of reliable national health accounts and a hospital expenditure management system, meaning that health economic tools are used for cost analysis, for example to calculate the cost of beds and surgeries and the economic burden of NCDs.

In 2013, the latest year available in the WHO Regional Health Observatory, current health expenditure was US\$ 66 per capita and 53.7% was out of pocket. Only 4.5% of general government expenditure was spent on health, one of the lowest rates in the Region. It is likely that with the ongoing crisis, out-of-pocket health expenditure will increase and also use of the private health care sector. Improving the efficiency of available resources, increasing domestic financing for health and advancing UHC through health insurance schemes are key areas of work for the next three years identified by the Ministry of Health.

4.1.6 Health governance

The Ministry of Health plays a leading role in health development through the formulation of a national vision, strategic health planning and management. It provides the necessary health care services, in partnership with the private sector, to guarantee health and social security to all citizens. Overall coordination, management and provision of services falls to the Ministry. However, the actual system operates through several ministries (the Ministries of Higher Education and Scientific Research, Defence, and the Interior); some are better resourced than others. The responsibilities of the Ministry of Health are mainly in the areas of policy and strategy in the health sector, which are generally set by the Government as part of the mandate of the Ministry and affiliated facilities, alongside other ministries, all of which provide health care finance and management.

Gender equality and equity were key principles in government plans. The Government is currently updating its Gender Equality Plan, which includes the specific health goal: to promote equal access to gender sensitive and high-quality health care services for women. The Ministry, in collaboration with WHO, is examining policy coherence to ensure gender mainstreaming in the health system.

The Government's priority is to develop a mechanism to improve the efficiency of strategic planning within the health sector and to strengthen the regulatory framework of the health sector, including the decentralization process and the development of standards for the performance of health institutions and clinical practices. Syrian Arab Republic, with the support of WHO, is actively building a solid foundation to create the tools, facilities and procedures necessary to strengthen implementation of the International Health Regulations (IHR 2005) and maintain national and international health security.



4.2 Health development priorities

The 12-year crisis and waves of displacement have placed a great strain on the country's health system; millions of people suffer from limited access to essential health care services. Suboptimal living conditions and lack of basic services, especially in overburdened communities and camps for displaced persons, increase vulnerability to outbreaks of epidemic-prone diseases among the population.

The priority is to maintain emergency health care assistance as outlined in the relevant strategic plans and work towards reconstruction and recovery. Continuing efforts to prevent and control COVID-19, improving progress in reproductive and maternal and child health, minimizing public health risks to communicable diseases and increasing focus on the prevention and management of noncommunicable/chronic diseases will be priorities in the years to come.

Assessing the functionality and responsiveness of the public health system, as well as the burden of disease, is essential to build a resilient system capable of managing emergencies and addressing disease outbreaks or the emergence of new diseases. This will require strengthening the health information system and enhancing electronic disease surveillance for the early detection and a timely response to emerging and re-emerging public health threats.

A responsive public health and health system during the recovery phase must be able to provide services to all in need, including returnees, IDPs and refugees, and focus on all six building blocks of the health system.

Thus, developing a plan to improve health financing mechanisms and increase domestic health financing is a key step towards achieving UHC for the Syrian population, and rehabilitating non-functional and semi-functional health facilities. Developing an essential package of health services and improving coverage of the quality of basic health care services requires building human resource capacity and

ensuring a needs-based sustainable supply of medicines and diagnostics. Improving health planning, management, resource allocation and finance is key to reconstruction and recovery efforts.

Addressing the health needs of the population requires engagement of a multitude of partners to address the determinants of health and promote health and well-being. Consideration should be given to establishing a multisectoral, multi-ministerial coordination mechanism among all key stakeholders, including nongovernmental organizations, for this purpose. Creating coordinated common platforms among various stakeholders, including the Government and development partners, would facilitate coordinated planning and decision-making, enhance support and aid health system strengthening in line with Syria 2030 and the United Nations Strategic Framework 2022–2024.



5. Partnership environment

The Government works in coordination with all international organizations and humanitarian actors in relief activities in Syrian Arab Republic to deliver health services to civilians in hard-to-reach areas and in host communities receiving displaced people from the affected areas. Examples include providing vaccines to children, various health services for pregnant women, emergency care and the establishment of shelters that provide integrated social health services.

Civil society is increasingly being engaged to promote health. In 2021, the Ministry of Health granted the necessary technical approvals to 45 nongovernmental organizations to implement 67 projects in the health sector at a total cost of US\$ 10 289 088 (25 722 720 000 Syrian pounds) according to data from the Ministry of Health.

Since the crisis began in 2011, the United Nations development system has supported the country through two frameworks: the United Nations Humanitarian Response Plan and the United Nations Strategic Framework. The Humanitarian Response Plan describes the strategic and funding requirements for United Nations agencies, funds, programmes, the Syria Arab Red Crescent and humanitarian international and national nongovernmental organizations to address humanitarian needs in the country.

The three strategic objectives are to save lives and alleviate suffering, enhance protection and increase resilience. Projects focus on sub-districts with the highest level of need severity. The priorities identified for the health sector include ensuring access to quality, life-saving and life-sustaining health services, including timely referral and continuity of care; enhancing early warning surveillance systems for timely response; strengthening COVID-19 preparedness and response, and laying the groundwork for a more resilient health system (2).

In this context and as of January 2022, the Syria Health Cluster consisted of 112 partners (one national authority, nine United Nations agencies, 13 international nongovernmental organizations, 87 national nongovernmental organizations, eight observers and four donors) operating through seven subnational sectoral coordination groups (Aleppo, Homs, Hama, Idleb, Lattakia, Qamishli and Deir-ez-Zor) and six sub-sector working groups (reproductive health, mental health, risk communication and community engagement for COVID-19, trauma and physical rehabilitation, early recovery and incident management) (23). WHO plays a critical and lead role in supporting the health cluster. The COVID-19 response helped improve coordination within the health sector, as well as providing opportunities for joint assessments to better plan, respond, monitor and evaluate the response.



Polio vaccination campaign in Deir-Ez-Zor.

A United Nations Common Country Assessment was carried out by the United Nations Country Team in 2021.¹ The assessment highlighted how the deterioration of the health system and the COVID-19 pandemic had had a negative impact on the population’s health, with the socioeconomic impact of the pandemic aggravating the situation further. It emphasized the limited access to reproductive health and gender-based violence services, particularly for women and adolescent girls.²

The United Nations Strategic Framework 2022–2024 responds to the recommendations of the Common Country Assessment through four programme pillars aligned to Syria 2030:

- Availability and access to basic and social services
- Sustainable socioeconomic recovery
- Enabling environment for a resilient return
- People’s resilience and institutional responsiveness.

The collective outcomes of the two frameworks are similar to the humanitarian-development-peace nexus approach for coherent joint planning and implementation. The outcomes of the Humanitarian Response Plan were included in the United Nations Strategic Framework and related outcomes and key activities, ensuring joint, solid planning and implementation. The emerging experience in the Syrian Arab Republic provides opportunities for implementing this approach more broadly, building on existing public institutions and capacities.

5.1 National partners

Through the past 12 years of crisis, partnerships with national and international nongovernmental organizations gradually expanded from service delivery in the areas of capacity-building and support to the implementation of national legislation – framed by the highest standards of due diligence and risk management to ensure a principled delivery of United Nations support. These consolidated relationships allowed for the flexibility to work together, even at the inception of the COVID-19 pandemic, to adjust and repurpose United Nations programme delivery, maintaining the best possible level of reach to beneficiaries, while respecting the preventive and mitigating measures of COVID-19. On the other hand, work with the private sector and the broader civil society organizations faced additional challenges due to the economic impact of COVID-19 and associated restrictive measures.



A WHO-supported mobile team in Rural Hama.

¹ The United Nations Country Team includes 16 resident entities and offices (Food and Agriculture Organization of the United Nations; United Nations Office for the Coordination of Humanitarian Affairs; Office of the Special Envoy; The United Nations Disengagement Observer Force; United Nations Development Programme; United Nations Department of Safety and Security; United Nations Population Fund; United Nations Human Settlements Programme; United Nations High Commissioner for Refugees; United Nations Mine Action Service; United Nations Office for Project Services; United Nations Relief and Works Agency for Palestine Refugees in the Near East; United Nations Truce Supervision Organization; World Food Programme and World Health Organization) and 7 non-resident entities (United Nations Economic and Social Commission for Western Asia; International Fund for Agricultural Development; International Labour Organization; Office of the United Nations High Commissioner for Human Rights; United Nations Environment Programme; United Nations Educational, Scientific and Cultural Organization; United Nations Industrial Development Organization; United Nations Office on Drugs and Crime) (<https://syria.un.org/en/about/about-the-un>, accessed 13 February 2024).

² United Nations Syria Country Team Report prepared in accordance with paragraph 15(B) of resolution 5/1 of the Human Rights Council for the Third Universal Periodic Review of the Syrian Arab Republic.

5.2 Financial needs and donor support

The impact of underfunding in 2022 is dire. The Health Cluster will have to downsize and limit their services. For example, of the 1622 currently functional health facilities, 80% providing antenatal care and noncommunicable disease services and 42% providing mental health services may have to downsize or limit their services. Ten million treatment courses distributed through WHO will not reach vulnerable populations and 80 nongovernmental organizations/partners, a key network in providing humanitarian assistance, may be deprived of WHO support. The drastic reduction of services for every US\$ 1 million not received means a marked reduction in key services, such as half a million children not being vaccinated, or 400 000 trauma consultations unsupported with 15 000 people suffering from long-term disability, according to WHO (23).

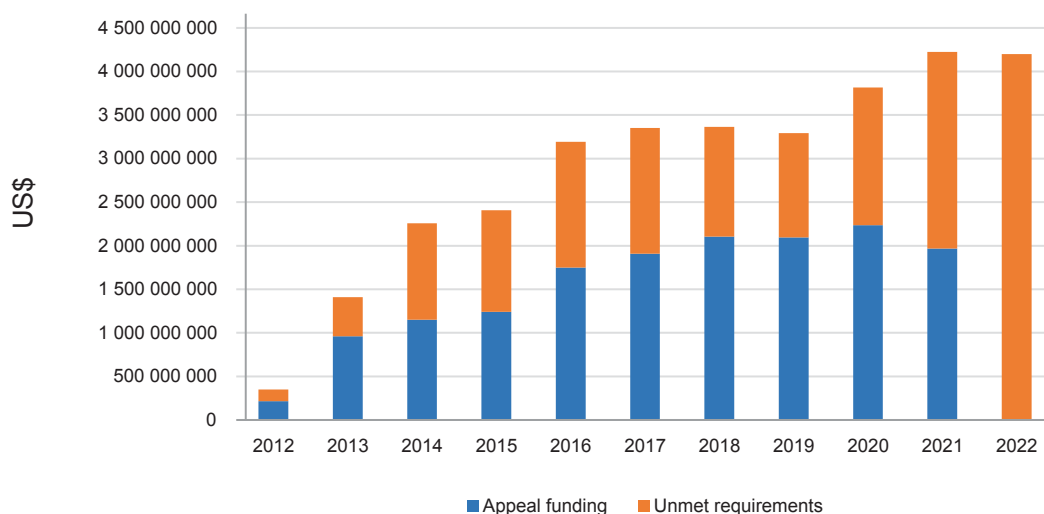
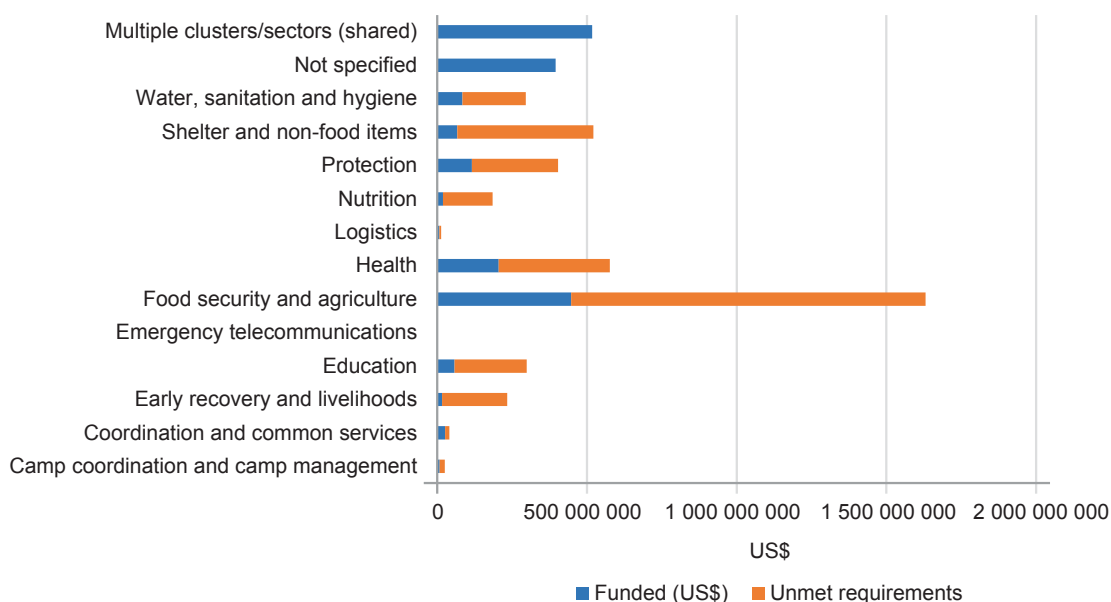


Fig. 15. Trends in response plan/appeal requirements



Source: Financial Tracking Service; OCHA Services. Syrian Arab Republic Humanitarian Response Plan 2021 (<https://fts.unocha.org/plans/1044/summary>).

Fig. 16. Funding progress by cluster, 2020

The WHO Country Office has been very effective in mobilizing resources from donors for humanitarian health assistance and strengthening programmes in the Ministry of Health and related ministries. WHO, as leader of the United Nations health sector outcome team, has a key responsibility for attracting funds from bilateral and multilateral sources, including WHO's Central Emergency Relief Fund.

5.3 Priorities for recovery and resilience

The impact of the multifaceted and long running protracted crisis continues to have severe economic, social and health consequences and has resulted in the large-scale displacement of local communities – 14 million civilians need humanitarian assistance and more than 12 million remain displaced – adding uncertainties to ongoing humanitarian efforts, including in the health sector (24).

Opportunities exist to move to development and early recovery and build a sustainable resilient Syrian Arab Republic, while also providing ongoing humanitarian assistance. The United Nations as a whole and WHO in particular need to redouble their efforts through trust, neutrality and the strong working relationship established during the crisis, ensuring principals and areas laid out by the Government in the post-war Syria 2030 and the United Nations Strategic Framework 2022–2024. With better basic services restored, the community as a whole and the returnees in particular will be encouraged to take part in the political, social and economic development processes. The strategic framework aims to ensure immediate protection and access to assistance that would lay the grounds for long-term return and more durable solutions (2).

5.4 WHO programmatic support, 2020–2023

WHO's programmatic support is dominated by providing humanitarian assistance prioritizing work in areas of greatest need and focusing on supplying essential medicines and supplies to primary and secondary facilities and ensuring basic services are not disrupted. In order to timely provide needed services to the population, particularly to IDPs in camps, WHO, as other United Nations agencies, works with national and international nongovernmental organizations and local suppliers.



A WHO team field visit to an IDP shelter in rural Homs.

Support and coordination of the national COVID-19 pandemic response was a key achievement, especially for a crisis-affected country like the Syrian Arab Republic. These efforts covered all 10 pillars of the pandemic response:

- coordination
- surveillance
- laboratory
- vaccination
- risk communication and community engagement
- ports of entry
- case management
- infection prevention and control
- maintenance of essential services and logistics
- vaccination.

At the same time, progress was made in building a resilient and responsive health system, while providing timely needed emergency support, including in the areas of: rehabilitation of infrastructure; building national health workforce capacity to improve their clinical, technical and managerial skills and competencies; improving laboratory services; providing needed medical supplies, equipment and medicines; improving health information systems; strengthening emergency preparedness, including disease outbreaks and coordinating emergency humanitarian health assistance.

Work also progressed in improving service delivery, particularly of the most essential functions such as immunization, child health, reproductive health, including family planning, maternal and newborn health, communicable diseases, noncommunicable diseases, including mental health, and water and sanitation and nutrition. These efforts were only possible through coordination across sectors in collaboration with United Nations agencies, including immunization (with the United Nations Children's Fund (UNICEF)); reproductive, maternal, newborn and child health (with the United Nations Population Fund, UNICEF and United Nations High Commissioner for Refugees); rehabilitation of health infrastructure (with the United Nations Development Programme, UNICEF, United Nations High Commissioner for Refugees and international nongovernmental organizations); food security and nutrition (with the Food and Agriculture Organization of the United Nations, UNICEF and World Food Programme) and water and sanitation (with UNICEF).

The previous country support plans for 2020–2021 and current 2022–2023 prioritize five main outcomes: improved access to quality essential health services and essential medicines; preparedness for emergencies; rapid detection and response to health emergencies; Health-in-All-Policies promoted; and strengthened capacity in data (Table 2). Support planned for the technical programmes in the current biennium builds on the successful implementation of plans in the last biennium.

Table 2. Biennial country support plans, 2020–2023

GOALS AND OUTCOMES	20–21	22–23
1 billion more people with coverage of essential health services	US\$ 4 759 750	US\$ 4 961 000
1.1. Improved access to quality essential health services	H	H
1.2. Reduced number of people suffering financial hardships	L	L
1.3. Improved access to essential medicines, vaccines, diagnostics and devices for PHC	M	M
1 billion more people better protected from health emergencies	US\$ 4 503 633	US\$ 4 831 000
2.1. Countries prepared for health emergencies	H	H
2.2. Epidemics and pandemics prevented	M	M
2.3. Health emergencies rapidly detected and responded to	H	H
1 billion more people enjoying better health and well-being	US\$ 1 465 817	US\$ 1 391 000
3.1. Determinants of health addressed	M	M
3.2. Risk factors reduced through multisectoral action	L	L
3.3. Healthy settings and Health-in-All-Policies promoted	H	H
Data and innovation	0	US\$ 100 000
4.1. Strengthened country capacity in data and innovation	H	H
Total (technical)	US\$ 10 729 200	US\$ 11 283 000

Code: H: high priority; M: medium priority, L: low priority

However, the main bulk of the funds supporting the work of WHO in the Syrian Arab Republic is from emergency operations funds. Although funding for the health sector within the Humanitarian Response Plan has been decreasing, WHO has been able to successfully mobilize and implement Outbreak Crisis Response resources for humanitarian support. For example, during the 2020 – 2021 biennium, more than US\$ 100 million was allocated and 85% implemented. In the first half of 2021 alone, these funds supported 27 nongovernmental organizations in delivering more than 125 000 trauma consultations, nearly 740 000 PHC consultations, nearly 100 000 mental health consultations, delivering more than 2000 tonnes of health supplies and reaching nearly 90% immunization coverage.¹

5.4.1 WHO response structure for Syrian Arab Republic

WHO's Office in Damascus leads the Whole-of-Syria health response, which includes national authorities and national and international nongovernmental organizations. The office comprises over 70 members and observers engaged in areas serviced by the Ministry of Health, namely southern Syrian Arab Republic and much of the north-east. This main office and five sub-offices in Aleppo, Deir-ez-Zor, Homs, Latakia and Qamishli with more than 100 national and international staff, are complemented by cross-border operations. This health response is organized under two WHO regional offices: the Regional Office for the Eastern Mediterranean and the Regional Office for Europe, with the former coordinating donor involvement, grant management and reporting. This work is framed within the WHO Emergency Response Framework to ensure the availability and equitable provision of health services throughout the country.

Table 3. WHO staffing in main and sub-offices, Syrian Arab Republic, November 2021

Area	Support staff	National Professional Officers	International Professional Officers	United Nations Office for Project Services (UNOPS)	Total
Aleppo	4	5	–	1	10
Damascus	25	15	10	34	84
Der Ezzor	–	–	–	1	1
Homs	2	1	–	1	4
Latakia	3	1	–	2	6
Qamishli	–	1	2	9	12
Total	34	23	12	48	117

The continued political and security instability, unilateral sanctions, heavy reliance on but declining interest by donors impedes WHO operations and support to national recovery efforts and hinders contribution to national activities and monitoring progress. Contracts and procurements are further complicated by rising inflation and fluctuating prices of locally purchased commodities and supplies. Lack of information and data on the current situation, disease burden and coverage of services impedes monitoring and reporting on programme implementation.

¹ Humanitarian response plan presentation. Infographic on Whole of Syria performance indicators.

WHO provided increasingly relevant and broadly effective response in the Syrian Arab Republic leading to the provision of integrated services across a network of partners, which increased the efficiency of operations with a high degree of responsiveness across geographic locations within the context of decreasing funding, and the impact caused to the health system due to the crisis. However, response level systems and protocols require further development to ensure sustainability of staffing, contracts and continuity of services. The numerous recommendations for strategic positioning, programming and operations need to be considered while implementing the CCS 2022–2025.¹

6. Strategic priorities

Clear plans and guidelines for government action exist, such as the National Framework for Regional Planning for 2035 with actions to address imbalances in localized health services and other sectors in view of achieving a balanced development strategy. The National Strategic Plan 2030 (Syria 2030) is operationalized into four phases with clear objectives for each stage: relief (2019–2021); recovery (2022–2024); upward (2025–2027); and sustainability (2028–2030) and beyond. The first national report on sustainable development 2030 (8) assessed the progress made and identified deviations from paths for achieving the SDGs. In addition, there are supporting national strategies, including the national strategy for women, children and adolescent health 2020–2025 and the national HIV strategy 2015–2019.

The above forms the foundation for developing the strategic agenda for cooperation between the Syrian Ministry of Health and WHO 2022–2025. The strategic cooperation agenda commenced with a systematic review of the documents made available by both the Government and United Nations agencies operating in the country and a meeting with key stakeholders between September and October 2021, following the process outlined in *Country cooperation strategy guide 2020: implementing the Thirteenth General Programme of Work for driving impact in every country (1)*.

A critical analysis of emerging priorities and needs formed the initial document that was shared and discussed during a national workshop in December 2021. During this national workshop attended by key staff in WHO and the Ministry of Health, participants discussed the needs and challenges of the health sector, the priorities for strategic collaboration between WHO and the country and finalized the WHO Country Support Plan, 2022–2023. Together they ensured that the collaborative framework aligned with global and regional priorities as outlined in the GPW 13 and Vision 2023 for the Eastern Mediterranean Region, as well as the national health plan for 2024. Following this workshop, the draft strategy was updated and underwent a peer review by the relevant technical units in WHO and by programme managers within the Ministry of Health. A second meeting was conducted in May 2022 to build consensus of the strategic priorities for collaboration and agreement on the monitoring and evaluation framework.

The aims of the current CCS are to ensure:

- 4 million more people will be protected from health emergencies by 2024
- 4 million more people will have universal health coverage by 2024
- 4 million more people will enjoy better health and well-being by 2024.

¹Independent evaluation of WHO's Whole of Syria response, 2021.



6.1 WHO strategic directions and support

Improving health and provision of health care services is the sole responsibility of the Government. WHO support, with its limited resources, will be impact-driven to supplement and complement government efforts in achieving national health development goals and its contributions to the global health agenda ensuring that no one is left behind. In the coming years, as the situation is evolving, WHO will continue its significant inputs in humanitarian health assistance while side by side mainly supporting efforts in recovery of a resilient responsive health system through policy formulation, developing strategic directions, setting programmatic and services delivery norms, and monitoring progress for maximizing impacts. WHO will also continue advocating for adequate health financing and equitable distribution of health and health care services, supporting resource mobilization and building health capacities to address the epidemiological transition, changing health needs and emergencies, including outbreak of diseases, ultimately supporting building a conducive environment for a healthier population contributing to nation-building and human development. WHO's support is based on the following principles:

- equity, reaching the most vulnerable populations and populations in need first
- coverage and access (geographical, social and financial)
- quality
- accountability
- humanitarian principles of humanity, neutrality, impartiality and independence.

The strategic directions for WHO collaboration with Syrian Arab Republic are aligned with the goals and targets of GPW13, Vision 2023 for the Eastern Mediterranean Region, national priorities and the United Nations Strategic Framework 2022–2024, specifically with the outcome aimed at ensuring that essential health services are still available and protecting health systems and the related programming priorities.



Strategic priority 1. Moving towards universal health coverage and enhancing access to health services through policy dialogues and investments and ensuring that the health care system will be resilient, accessible and of good quality.

- Strengthening health information, evidence, and health information management systems to provide timely, reliable and high-quality disaggregated health information on disease control and service coverage in order to improve health system performance reporting and monitoring.
- Strengthening the health workforce through the development of a human resources strategy based on the analysis of the health labour market.
- Conducting studies and joint reports addressing strategies, policies and plans, the range of services provided, and public health functions and programmes based on common assessments and evidence.
- Developing a national pharmaceutical local manufacturing enhancement plan in view of the current pharmaceutical situation and the impact of sanctions in this regard, including the role of the public and private sectors in the expected rehabilitation of the pharmaceutical industry.
- Building national management capacity, including strengthening donor coordination mechanisms for increased aid effectiveness.
- Re-assessing public health infrastructure at primary and secondary care level vis-à-vis population dynamics and related demographic and socioeconomic factors for comprehensive rehabilitation plan, priorities and investments.

Strategic priority 2. Protecting people from emergencies by strengthening national and subnational emergency preparedness and response.

- Increasing access to lifesaving and life-sustaining coordinated, equitable humanitarian health services across all levels of care – community, primary, secondary and tertiary with a focus on reproductive, maternal, newborn, child and adolescent health; noncommunicable diseases and mental health; PHC and referrals; and gender-based violence.
- Improving health system capacity to prepare for and respond to current and future emergencies and outbreaks, including and capitalizing on COVID-19 experience.
- Strengthening national and subnational emergency preparedness and response capacities, including International Health Regulations capacity and establishing a coordination mechanism for emergencies and institutionalizing a national public health emergency operations system and centres to that end.

Strategic priority 3. Building a conducive policy environment to promoting health and well-being.

Strengthening the whole-of-society approach to promote health, such as supporting policy, administrative and legal multi-sectoral frameworks.

Reviving the Healthy Cities Programme and other community-based initiatives to strengthen intersectoral collaboration at the local level and support community resilience.

Advancing the integration of health promotion and disease prevention within PHC to address health and well-being including noncommunicable disease risk factors, mental health and oral health.



Al-Taaluof provides MHPSS in rural Aleppo.

7. Implementing the strategic priorities: implications for WHO

Given the prevailing conditions in the country, particularly in north-east and north-west regions and with much of the population still requiring humanitarian assistance, basic services (food, shelter, water, education, health and sanitation) and the needs of returnees, the implications of addressing the strategic priorities for 2022–2025 on WHO at all levels are immense.

A country transitioning from protracted crises and emergencies through recovery to development requires solid and sustained support to rebuild the health system in light of the huge destruction and drain on the health workforce and resources. It will be critical to maintain ongoing efforts to provide much needed humanitarian health assistance while also supporting the recovery plan with a focus on increasing health care coverage by making health facilities more available, accessible and functional, increasing the number of qualified health professionals, strengthening delivery of integrated PHC services, promoting a decentralization approach, and addressing the determinants of health to reduce increasing inequity.

As the technical and coordination lead agency and coordinator of the United Nations health sector, the tasks and responsibilities of WHO are considerable and require sustaining a common platform for all partners with attention to aid effectiveness as per the Paris Declaration with the strategic priorities of the CCS.

7.1 WHO country office

The Organization enjoys trust and a long-standing close relationship with the Ministry of Health at the central level and with other governorates. Given their experience in the Syrian Arab Republic, some staff have the institutional memory of the Organization at country level, which adds considerable value to overall WHO technical support. Long-term international staff are required to ensure comprehensive support to the health sector, particularly in the areas of health system development, health financing and national health accounts, electronic health information systems, emergency and disease outbreak preparedness and response and resource mobilization. Technical support will also be needed in updating public health law and legislation. The Organization needs to shoulder this responsibility and deploy skilled professionals in this area by building the needed capacity in the Country Office and providing the necessary technical backstopping from the Regional Office for the Eastern Mediterranean and headquarters. WHO also needs to work with the Government in ensuring staff mobility around different governorates in order for WHO to provide timely support and monitor progress.

WHO has to play a major role in promoting partnership with key health supporting agencies such as UNICEF, United Nations Population Fund, World Food Programme, Food and Agriculture Organization of the United Nations, United Nations High Commissioner for Refugees, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, and various donors. Additional international staff will be required to support ongoing efforts in promoting partnership and enhancing aid effectiveness and donor coordination. The Syrian National Development Plan 2030 has added focus on the move from the emergency to recovery phase in order to achieve the SDGs and underlines Syrian Arab Republic's commitment to achieving the triple billion targets of GPW13. This is a major undertaking in which WHO technical support will be critical.

7.2 The WHO Regional Office and headquarters

Adequate and appropriate coordinated technical support and backstopping from the Regional Office and headquarters is necessary to enable the WHO Country Office to engage in policy advice and advocacy, facilitate smooth interaction with partners and improve the quality of delivery of WHO's work at the country level. While humanitarian assistance will continue, it is expected that WHO support for health system recovery will increase amid the challenges as a result of unilateral sanctions.



An Inter-agency mission to Latakia.

The importance of providing timely and high-quality technical support was highlighted both by national authorities and by the WHO Country Office during the development of this CCS. Some technical programmes have established special mechanisms for supporting country offices, in close coordination with regional focal points, to build national capacities. Adoption of this approach could be considered by the higher priority programmes (health systems, reproductive and child health, nutrition, noncommunicable diseases and mental health) in implementation of CCSs. Concerted efforts will be required (as part of the CCS process or separately) to assess the efficiency, effectiveness and impact of WHO support on strategic health outcomes and results and progress made on health indicators in the country. Given the extensive operations that will be required in the Syrian Arab Republic in the coming years, technical support is needed in programme evaluation, as well as in all aspects of WHO operations, including the recruitment of staff, timely approval of contracts and in facilitating logistics.

7.3 Monitoring and evaluation

Under the leadership of the WHO Representative to the Syrian Arab Republic, representing the United Nations Country Team, the CCS 2022–2025 will be monitored during its implementation by the joint Ministry of Health/WHO Committee established for this purpose. This Committee includes senior decision-makers from the Ministry of Health and WHO. It will also be monitored regularly as part of the biennial WHO Country Support Plan planning cycle conducted in collaboration with all programmes at the Ministry and representatives from subnational levels. A monitoring and evaluation framework based on SDG indicators included in GPW13 will be used along with key performance indicators (Annex 1) in monitoring timely implementation of programmatic activities.

Quarterly meetings of the Joint Committee will review progress and identify practical solutions to address challenges. Regular meetings are critical for assessing any changes in the health situation, national priorities, risks or if new evidence or information comes to light concerning national public health needs.

Annual reviews, in December 2022 and December 2023, will be conducted as part of the biennial planning process by the Committee in collaboration with additional government officials and partners, and ensuring participation of the three levels of WHO, identifying the lessons learnt, impediments and potential risks or contextual determinants requiring adjustments during the forthcoming CCS cycle. A final summative evaluation will be undertaken at the end of the CCS cycle to assess achievements, gaps, challenges, lessons learnt and to develop recommendations upon which to build the next CCS (1).

In cooperation between WHO and the United Nations Country Team in the Syrian Arab Republic and the Planning and International Cooperation Commission, WHO's contribution to achieving results and outputs in the strategic framework (2022–2024) will be monitored and evaluated based on the outcome indicators of the activities included in the joint work plan of the United Nations organizations. This joint work plan emanates from the strategic framework and the outcome indicators included in the implementation matrix of the strategic framework.

References

1. World Health Organization, 2020. Country cooperation strategy guide 2020: implementing the Thirteenth General Programme of Work for driving impact in every country (<https://www.who.int/publications/i/item/9789240017160>, accessed 13 January 2024).
2. United Nations Office for the Coordination of Humanitarian Affairs. 2021 Humanitarian Response Plan: Syrian Arab Republic (https://reliefweb.int/sites/reliefweb.int/files/resources/syria_2021_humanitarian_needs_overview.pdf, accessed 13 January 2024).
3. The National Development Program for Post-War Syria, Syria Strategic Plan 2030. In: Arab National Development Planning Portal [website]. Beirut: United Nations Economic and Social Commission for West Asia; 2021 (<https://andp.unescwa.org/plans/1379>, accessed 13 January 2024).
4. Syria 2021 Socio-Economic Impact Assessment, United Nations Development Programme (https://www.undp.org/sites/g/files/zskgke326/files/2023-01/UNDP_Syria_SEIA_report_4122022.pdf, accessed 15 January 2024).
5. Eastern Mediterranean Regional Health Observatory (<https://rho.emro.who.int/Indicator/TermID/46>, accessed 13 January).
6. Eastern Mediterranean Regional Health Observatory (<https://rho.emro.who.int/data-r>, accessed 13 February 2024).
7. Al-Moujahed A, Alahdab F, Abolaban H, Beletsky L. Polio in Syria: Problem still not solved. *Avicenna J Med* 2017;7:64-6.
8. Government of the Syrian Arab Report, The first national report on the Sustainable Development Goals (executive summary), 2018 (<https://www.arabdevelopmentportal.com/publication/first-national-report-sustainable-development-goals-sdg>, accessed 13 February 2024).
9. Muhjazi G et al. Cutaneous leishmaniasis in Syria: A review of available data during the war years: 2011–2018. *PLoS Negl Trop Dis* 13(12): e0007827. (<https://doi.org/10.1371/journal.pntd.0007827>, accessed 13 February 2024).
10. Abbara A, Rawson TM, Karah N, El-Amin W, Hatcher J, Tajaldin B, & Sparrow, A. (2018). A summary and appraisal of existing evidence of antimicrobial resistance in the Syrian conflict. *International journal of infectious diseases*, 75, 26-33.
11. Eastern Mediterranean Regional Health Observatory (<https://rho.emro.who.int/Indicator/TermID/48>, accessed 13 February 2024).
12. Eastern Mediterranean Regional Health Observatory (<https://rho.emro.who.int/Indicator/TermID/49>, accessed 13 February 2024).
13. World Bank. Mortality rate, infant (per 1,000 live births) Syrian Arab Republic (<https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=SY>, accessed 13 February 2024).

14. Hidden hunger in Syria. A look at malnutrition across Syria, with a focus on under-twos. Save the Children, 2020 (<https://www.savethechildren.org/content/dam/usa/reports/health/hidden-hunger-in-syrica-cc-2020.pdf>, accessed 13 February).
15. Alhaffar MHDBA, Janos S. Public health consequences after ten years of the Syrian crisis: a literature review. *Global Health*. 2021 Sep 19;17(1):111. doi: 10.1186/s12992-021-00762-9. PMID: 34538248; PMCID: PMC8449996.
16. WHO. Surveillance system for attacks on health care, 2024 (<https://extranet.who.int/ssa/Index.aspx>, accessed 13 February 2024).
17. WHO Health Resources Availability Monitoring System (HeRAMS), Fourth Quarter, 2020 Report, Turkey Health Cluster for Northwest of Syria, October–December 2020. OCHA Services, Reliefweb (<https://reliefweb.int/report/syrian-arab-republic/health-resources-availability-monitoring-system-herams-fourth-quarter-2#:~:text=HeRAMS%204th%20quarter%202020%20report,396%20in%203rd%20quarter%202020>, accessed 5 February 2024).
18. The Toll of War: The Economic and Social Consequences of the Conflict in Syria World Bank, 2017 (<https://www.worldbank.org/en/country/syria/publication/the-toll-of-war-the-economic-and-social-consequences-of-the-conflict-in-syria>, accessed 13 February 2024).
19. Health System Profile, Syria. Cairo: WHO Regional Office for the Eastern Mediterranean Region; 2018 (<https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/SYR-Health-System-Profiles-2018.pdf>, accessed 5 February 2024).
20. United Nations Statistics Division Demographic Statistics (2009), CRVS Technical Report Series, Vol. 1 March, 2009 Status of Civil Registration and Vital Statistics: ESCWA region (https://unstats.un.org/unsd/demographic-social/crvs/documents/Technical_report_ESCWA_Final.pdf, accessed 13 February 2024).
21. Clutterbuck, Martin, et al. "Establishing legal identity for displaced Syrians." *Forced Migration Review* 57 (2018): 59-61 (<https://www.fmreview.org/syria2018/clutterbuck-cunial-barsanti-gewis>, accessed 5 February 2024).
22. Ghisn, Z (2020) How economic sanctions negatively affect the health sector in Syria: a case study of the pharmaceutical industry (<https://blogs.lse.ac.uk/crp/2020/04/16/how-economic-sanctions-negatively-affect-the-health-sector-in-syria-a-case-study-of-the-pharmaceutical-industry/>, accessed 13 February 2024).
23. Syria Health Sector Bulletin, January 2022. Health Cluster (<https://healthcluster.who.int/publications/m/item/syria-health-sector-bulletin-january-2022>, accessed 5 February 2024).
24. UN special envoy for Syria, Geir O. Pedersen briefing to the security council on Syria, 26 January 2022 (<https://reliefweb.int/report/syrian-arab-republic/united-nations-special-envoy-syria-geir-o-pedersen-briefing-security-10>, accessed 13 February 2024).

Annex 1. Strategic plan implementation impact indicators

No.	Indicator	2021	2024	2024
1	Total fertility rate	3.1	3.1	2.5
2	Proportion of girls under 18 years old who are married (%)	11.0	11.0	5.0
3	Women of reproductive age (15–49 years) who had their need for family planning satisfied with modern methods (%)	60.4	64.0	65.0
4	Births attended by skilled health personnel (%)	99.3	99.3	99.3
5	Infant mortality rate (per 1000 live births)	18.7	17.0	13.0
6	Under-five mortality rate (per 1000 live births)	23.7	21.0	19.0
7	Neonatal mortality rate (per 1000 live births)	11.8	9.0	6.0
8	Coverage (%) of the penta vaccine (whooping cough, diphtheria, tetanus, <i>haemophilus influenzae</i> , hepatitis B)	76.0	96.0	97.0
9	Coverage (%) of MMR1 vaccine	76.0	96.0	97.0
10	Coverage (%) of polio 3 vaccine	68.0	96.0	97.0
11	Estimated number of newly reported HIV cases (per 100 000 population)	7.0	4.0	2.0
12	Total number of reported malaria cases	0	0	Free of malaria
13	Tuberculosis case notification rate (per 100 000 population)	19.0	10.0	Reducing mortality, detecting and treating all contacts
14	Tuberculosis treatment coverage rate (%)	89.8	90.0	95.0
15	Exclusive breastfeeding 0–5 months of age (%)	28.5	30.0	35.0
16	Stunting among children under five years of age (%)	12.6	Less than 10	Less than 7
17	Wasting among children under five years of age (%)	1.7	2.0	1.5
18	Prevalence of anaemia in children aged 6–59 months (%)	27.4	25.0	20.0
19	Prevalence of moderate acute malnutrition among women of reproductive age (%)	4.0	3.0	2.0

Annex 2. Implementation measuring indicators

#	Indicator	Source	Baseline information (2021)	Type	Goal (2024)	Source
1	MMR2 vaccination coverage	Ministry of Health administrative coverage	70%	Regional core health indicator	95%	Expanded immunization efficiency national strategy 2024
2	DTP3 vaccination coverage	Ministry of Health administrative coverage	66%	Regional core health indicator	95%	Expanded immunization efficiency national strategy 2024
3	Under-five mortality rate	Ministry of Health child mortality survey	23.7 per 1000 live births	Regional core health indicator	21 per 1000 live births (2025)	National strategy on reproductive, maternal, neonatal, child and adolescent health 2022–2025
4	Global acute malnutrition prevalence	SMART Survey 2019 (Central Bureau of Statistics indicators 2022)	1.7%	Regional core health indicator	<3%	Nutrition strategy, Regional Office 2024
5	Severe acute malnutrition prevalence	SMART Survey 2019 (Central Bureau of Statistics indicators 2022)	0.4%	Regional core health indicator	<3%	Nutrition strategy, Regional Office 2024
6	Percentage of births by skilled health workers	District health system 2018	96%	Regional core health indicator	99%	Expanded immunization efficiency national strategy 2024
7	Coverage of antiretroviral treatment among all adults and children living with HIV	National AIDS programme report	300 patients	Regional core health indicator	440	HIV strategy 2015–2019
8	Tuberculosis treatment success rate	National tuberculosis programme report	89%	Regional key indicator	90%	National tuberculosis control strategy
9	Health financing strategy development and implementation status	Ministry of Health	Implementation rate: 0%	Regional KPI	1	Ministry of Health Plan

#	Indicator	Source	Baseline information (2021)	Type	Goal (2024)	Source
10	Percentage of health facilities that have trained and supervised health workers and implemented integrated MHPSS interventions	HeRAMS mental health	40%	Another type	60%	Mental health strategy
11	Percentage of health districts where electronic routine health information systems are functional	Electronic routine health information system	65%	Another type	100%	Electronic routine health information system
12	Cutaneous leishmaniasis treatment coverage rate	National leishmaniasis programme report	85%	Another type	90%	Strategy on neglected tropical diseases
13	Percentage of reports investigated within 72 hours	EWARS	85%	Another type	90%	EWARS
14	Percentage of outbreaks that responded within 72 hours	EWARS and ministry reports	90%	Another type	100% (2024)	EWARS
15	Health workforce strategic plan development and implementation status	Ministry of Health	Implementation rate: 0%	Another type	1	Ministry of Health plan
16	PHC essential medicines coverage	HeRAMS and WHO country brief	Number of essential medicines reported as generally available (10 of 10)	Another type	80% coverage with essential medicines in operating PHC	HeRAMS and WHO country brief
17	NCD multisectoral strategy development and implementation status	Ministry of Health	Implementation rate: 0%	Another type	1	Ministry of Health plan
18	NCD surveys implementation status (World Adult Tobacco Survey, World Youth Tobacco Survey and Progressive Tobacco Survey)	Ministry of Health and Ministry of Education	Implementation rate: 0%	Another type	1	Ministry of Health plan and Ministry of Education plan

