WHO-EM/ARD/033/E

Country Cooperation Strategy for WHO and the Syrian Arab Republic 2008–2013

Syrian Arab Republic

World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

Abbreviations

CCA	Common Country Assessment
CCS	Country Cooperation Strategy
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FYP	Five Year Plan
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IMCI	Integrated Management of Child Illness
ISO	International Standards Organization
MDGs	Millennium Development Goals
MOH	Ministry of Health
PHC	Primary Health Care
SPC	State Planning Commission
SSA	Special services agreement
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner on Refugees
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational Scientific and Cultural Organization
WFP	World Food Programme
WHO	World Health Organization

Section 1

Introduction

Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS aims to bring together the strength of WHO support at country, Regional Office and headquarters levels in a coherent manner to address the country's health priorities and challenges.

The CCS development process examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to strengthen the impact on health policy and health system development, as well as the linkages between health and cross-cutting issues at the country level. The CCS as a medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

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 contribution in Member States towards achieving the Millennium Development Goals (MDGs).

The Syrian Arab Republic is undergoing a period of change and modernization. These changes, along with the formulation of a new policy by the Ministry of Health regarding its strategic direction for the next 20 years (2000–2020), make it a timely moment for WHO to update the Country Cooperation Strategy for this country.

The CCS for the Syrian Arab Republic is the result of a preliminary analysis of the health and development situation and of WHO's current programme of activities. A mission comprising two senior staff from the Regional Office together with the country office staff carried out extensive consultations from 12 to 16 August 2007 (Annex 1). During the mission, the team consulted with key officials within the Ministry of Health as well as officials from various other government authorities, United Nations agencies, nongovernmental organizations and private institutions. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed for the period 2008–2013.

Section 2

Country Health and Development Challenges

2.1 Country brief

2.1.1 Population

The Syrian Arab Republic, on the eastern coast of the Mediterranean Sea, has a population of 18.7 million (2006). Administratively, the country is divided into 14 governorates, 61 districts, 206 nahya, 85 cities and approximately 6080 villages. Between 1970 and 1994 the population growth rate was 3.3%. According to government sources, the rate dropped to 2.7% between 1994 and 2000, and had dropped to 2.45 by 2006. Over the past 20 years, fertility rates have been declining. According to the Central Bureau of Statistics, the total fertility rate decreased from 7.5 in 1978 to 3.6 in 2006.

The country has a young population profile: 39.4% of the population is under 15 years of age and 57% is 15–64 years. The urban to rural ratio is 54: 47 (Ministry of Health, 2006).

2.1.2 Political structure and development overview

After a long period of political stability the Syrian Arab Republic has initiated a well deliberated modernization and economic reform plan. The government is focusing on improving access to information technology and has pushed to improve the investment climate by easing controls and improving banking and foreign exchange regulations. The priorities are: institution building, industrial modernization and human rights/ civil society.

The *Human development report 2006* ranks the Syrian Arab Republic as 106th in terms of human development indicators, with a Human Development Index of 0.716, compared to 108th in 2002. Other sociocultural indicators for the Syrian Arab Republic are given in Table 1.

Table 1. Sociocultural indicators

	1990	1995	2000	2002	2004
Human Development Index	0.63	0.66	0.68	0.71	NA
Total literacy (%)	64.8	69.9	74.4	85.5	92.5
Female literacy (%)	48	54	60	78	78
Women as % of workforce	24	26	27	28	29
Primary school enrolment (%)	108	101	109	100	98
Female primary school pupils (%)	47	47	47	49	49
Urban population (%)	49	50	50	50	50

NA Not available
Source: National Information Centre and Central Bureau of Statistics

2.1.3 Economy

According to government statistics, the economy has been growing in the past decade. The growth has been helped by oil exports and increased agricultural production. The economy is dominated by the public sector, with vital financial contributions from the fields of agriculture and hydrocarbon extraction. Together they contribute to more than 45% of the GDP. In 2006, the GDP per capita was US$ 1430.

The start of the economic renewal was recognized in the Association Agreement with the European Union in December 2003. The revival is sealed by the adoption of the ambitious 10th five year development plan. The plan sets forth four main priorities: economic efficiency, social equity, preserving the environment and national security.

2.2 Health profile

2.2.1 Overview of health status

Health indicators have improved dramatically in the Syrian Arab Republic in the past three decades: life expectancy at birth increased from 56 years in 1970 to 72 years in 2006; infant mortality dropped from 123 per 1000 live births in 1970 to 18 per 1000 in 2006; under-five mortality dropped significantly to 22 per 1000 live births; and maternal mortality fall from 482 per 100 000 live births in 1970 to 58 in 2006. These and other health indicators are shown in Table 2. The Syrian Arab Republic is in epidemiological transition from communicable to noncommunicable diseases. The leading causes of mortality are related to noncommunicable disease, with a rise in pathologies of ageing.

Access to health services has increased since the 1980s, and rural populations are achieving better equity. National statistics indicate that the mean number of people served by a single medical doctor was 677 in 2006, with a range from 285 in Damascus, the capital, to 1095 in the eastern province of al-Hassakeh. Government expenditure on the health sector has increased as a proportion of total government expenditure, from 1.1% in 1980 to 4.17% in 2006 (Ministry

Table 2. Indicators of health status

Indicator	1990	1995	2000	2002	2004	2006
Life expectancy at birth (years)	66.4	68.3	69.7	70.3	71.2	72.0
Infant mortality rate (per 1000 live births)	37	30	24	18	NA	18
Probability of dying before 5th birthday (per 1000 live births)	44	36	29	20	NA	22
Maternal mortality ratio (per 100 000 live births)	123	107	71	65	NA	58
Normal birth weight babies (%)	93	95	95	95	95	95

NA Not available
Source: Ministry of Health data, 2006

of Health, 2006). Although there is no established system for health insurance, a draft proposal for a national system of health insurance is under study.

2.2.2 Social determinants of health

Population and health

Over the past two decades, the population growth rate has declined from 4.2% annually for the period 1981–1994 to 2.45% in 2006 (CCA 2005) (see Table 3). As well, there is steady growth in the urban population due to natural urban growth and rural to urban migration. Damascus, with a population of 4.23 million, and Aleppo with 2 million inhabitants, may suffer from further congestion and environmental problems.

Education

The Government has historically placed great emphasis on making education available for free to all citizens, stressing education as a means for economic development. Adult literacy rates have increased in the past decade from 64.8% in 1990 to 82.9% in 2002. Literacy rates among the age group of 15–24 years rose from 88% in 1990 to 94.8% in 2000. The most outstanding has been the increase in female literacy, which grew by almost 200% between 1970 and 2002 (CCS 2003).

Poverty

Overall, poverty affects 11.4% of the population and is more common in rural areas, where 62% of the country's poor people live. According to recent studies conducted by UNDP and WFP, poverty in the Syrian Arab Republic is concentrated in arid and semi-arid regions and among the small population of nomads and desert shepherds. Additionally, the urban unemployed, landless labourers and rural families in rain-fed areas with no land or with small land holdings are at risk and susceptible to food insecurity, especially in years of severe drought.

In the past few years there has been a growing national debate on poverty. Several initiatives have been initiated targeting poverty reduction. These include the healthy villages programme, currently implemented in approximately 600 villages.

Table 3. Population indicators

Indicator	1990	1995	2000	2002	2004	2006
Crude birth rate (‰)	37.0	30.9	29.0	28.8	26.8	30.0
Crude death rate (‰)	6.2	5.1	4.6	4.4	3.4	4.0
Population growth rate (%)	3.3	3.1	2.5	2.4	2.6	2.5
Dependency ratio (%)	102	91	78	74	73	74
% population < 15 years	47.8	44.9	40.8	38.9	39.5	39.4
Total fertility rate per woman	5.3	4.2	3.6	3.4	3.8	3.9

Source: Ministry of Health data

Environmental health

Rapid economic growth and urbanization have put serious pressure on natural resources in the Syrian Arab Republic. Increased urbanization and industrialization have led to environmental degradation. The air quality is poor in some large cities due to motor vehicle and industrial emissions, with the result that the incidence of respiratory diseases is 4 to 5 times higher in these areas (Ministry of Health statistics). Other environmental health challenges are water pollution, industrial pollution and contamination resulting from use of chemicals and agricultural activities. Difficulties also exist with regard to hospital and hazardous wastes and occupational health hazards in small industries and plants. Unsanitary habits and poor hygiene affect particularly the poor in urban and rural areas. Food safety needs strengthening.

Gender and women's development

Syrian women continue to make a significant contribution to public life at all levels. In the parliamentary elections of 2003, women won 30 of 250 seats; women have also been appointed as judges, ministers, deputy ministers and ambassadors. The largest women's organization in the Syrian Arab Republic, the Women's General Union, continues to expand its base, particularly in rural areas, and provides training in leadership skills, income generation and literacy and education on legal and social rights. Legislation has restored women's rights in marriage, divorce, custody of children and inheritance. The Syrian Commission for Family Affairs, a government body, has been formed to coordinate activities related to women at national level and ensure participation of women in policy-making and other important social issues.

2.2.3 Health sector and services

Organization of the health sector

The Constitution defines the right of citizens to comprehensive health coverage. The Ministry of Health has the statutory responsibility for the organization, coordination and management of health care services. The Ministry of Higher Education, Ministry of Defence and Ministry of Interior have also responsibilities for providing health services for specific settings and staff. In addition other ministries and state companies provide, directly and indirectly, health care services for their employees and dependents. The role of nongovernmental organizations in health provision is still limited, except for reproductive health services. The public service, which is a mix of curative and preventive health, is delivered through a governmental network of primary health care centres and public hospitals. The private sector, which is not fully monitored, provides only curative care and very little preventive care. The role of the private sector has increased substantially in recent years.

10th Five-year Plan for the Health Sector 2006–2010

The long-term objectives of the 10th five-year plan, which will also continue in the 11th five-year plan, are to:

- Enhance the population health by increasing life expectancy to 75 years,

reducing infant and child mortality rates to 12 and 14 per 1000 births respectively, and lowering the maternal mortality ratio to 32 per 100 000 live births

- Develop the health sector's financing system for comprehensive coverage for all citizens and raise the citizen's share of total expenditure on health to more than US$ 120
- Improve the performance and the level of health services to increase the productivity rate of the health workers to correspond approximately to US$ 2500 and increase the private and domestic sector contribution to health services provision to reach at least 50% of general investment in the health sector
- Modernize the health sector's management planning and supervision and increase investment in the field of information, research and disaster preparedness
- Modernize the pharmaceutical sector to raise investments in this field to more than US$ 3 billion and reduce medicine imports to become less than 5% of total expenditure on medicine

The five-year plan is well prepared and ambitious. A results-based framework for health sector reform has set quantifiable targets in five clusters around the long term objectives. These clusters are: enhancing public health; developing the health sector financing system; improving health services performance; upgrading management, planning and supervision; and modernizing the medicine sector. Human resources development is not selected as a cluster target but is looked at as a distinct issue within the respective five targets. The plan refers to present over-staffing, the need to improve efficiency and performance as well as productivity, health care quality, accreditation, fair health financing, health safety net for the poor and stimulating the contribution of the private sector. The plan, which is closely focused on the health system, identifies 35 strategies to achieve the five cluster targets.

Health system

Primary health care

Almost 90% of the population has access to primary health care institutions, though there is uneven utilization geographically and service wise. Primary health care services are provided through a network of more than 1600 centres. In 2006, the were 14.8 medical doctors, 7.4 dentists, 6.5 pharmacists, 18.8 nurses and midwives, 14.7 hospital beds and 0.91 primary health care units per 10 000 population. According to the Ministry of Health sources, trained health personnel attend more than 95% of births and more than 95% of the children are vaccinated. A new referral system is being implemented in two pilot governorates, Dara'a and Lattakia. Primary health care centres provide a package of services which includes immunization, reproductive health, IMCI, communicable disease control, health education, dental health and elderly health. Health staff working in primary health care centres include physicians, dentists, pharmacists, nurses, midwives and health visitors.

The constraints are lack of systematic monitoring, maldistribution of staff, lack of

Table 4. Service delivery data and trends

Indicator (%)	1990	1995	2000	2002	2004	2006
Population with access to health services (urban)	95	96	99	99	99	100
Married women (15–49) using contraceptives	NA	42	46	46	46	50
Pregnant women attended by trained personnel	NA	78	86	87	NA	73
Deliveries attended by trained personnel	NA	90	91	NA	NA	90
Infants attended by trained personnel	84	96	96	98	98	100
Infants immunized with BCG	100	100	100	100	100	100
Infants immunized with DPT3	94	98	97	97	100	99
Infants immunized with hepatitis B	0	88	93	93	98	98
Infants fully immunized (measles)	90	93	93	93	100	99
Population with access to safe drinking water	NA	80	82	82	82	88
Population with adequate excreta disposal facilities	NA	52	72	81	81	74

NA Not available

transportation to conduct supervisory visit at district level, and shortage of essential medicines. The vaccination programme is well utilized, compared to the low utilization of reproductive health services provided in the same centres. Studies are needed to identify factors behind utilization patterns.

Hospitals

The new orientation and priority objective of the Ministry of Health is to transform all public hospitals gradually to independent units with their own budget, flexible management and participation from the local community in the hospital board. Nine hospitals became autonomous bodies with the objective of moving towards partial cost recovery and participatory management to improve the performance. The Ministry of Health is expected to lead action for development of the national framework for accreditation. The legal framework for licensing and the operational framework for ISO certification need to be assessed. Hospital infection control, sanitation and waste management are important issues for support by WHO and other UN agencies and donors. Public–private distribution of hospitals and hospital beds is shown in Table 5.

Table 5. Public–private distribution of hospitals and hospital beds

Hospital feature	1970	2000	2004	2006
MOH hospitals	28	55	64	78
MOH hospital beds	3099	9887	10 873	12 372
Units of care	108 735	1 1803 039	21 214 803	NA
Surgeries performed	44 500	303 494	451 293	NA
Emergency attendances	170 919	2 172 250	3 741 151	NA
Private hospitals	49	325	353	NA
Private hospital beds	1196	5625	7147	NA

NA Not available

Human resources development

Human resources for health are trained by medical faculties, nursing schools and intermediate health institutes. The Centre for Strategic Health Studies was established in the Ministry of Health in 2006. The main objectives of the Centre are to develop human resources for health system management, public health and health economics, who will: improve the quality of health care services; undertake applied research; and provide the necessary consultations for the Ministry of Health. Currently the Centre consists of 3 institutes: the Institute of Health System Management, Institute of Public Health and Institute of Health Economics.

Since 1992, a substantial number of family physicians have been trained. The Ministry of Health and Faculty of Medicine, University of Damascus, are collaborating to upgrade training in family medicine. The family medicine curriculum was improved for the year 2006–2007 with technical support by WHO. However, challenges include shortages of well trained supervisors (mainly in the governorates), guidelines and logbooks for residents and the need to enrol more candidates for specialization. The density of health care personnel is shown in Table 6. Although there are separate plans and responses to the emerging needs of health and medical personnel, there is still a need to have a comprehensive national human resources development plan and strategy to determine the exact production, utilization and distribution of human resources for health at all levels.

Health information system

A Ministry of Health assessment of the health information system identified four areas for improvement.

1. Organizational, regulatory and legislation framework
2. Availability of information, (quality and quantity) as well as its access
3. Usage and protection of information
4. Sources of widely used indicators

Table 6. Health care personnel

Personnel per 100 00 population	1990	1995	2000	2002	2004	2006
Physicians	96	108	137	146	144	148
Dentists	32	57	68	85	85	74
Pharmacists	30	42	54	59	71	65
Nurses and midwives	137	164	196	165	159	188
Paramedical staff	32	66	74	85	85	89
Others (administrative)	66	73	89	101	110	NA

NA Not available

The Health Metrics Network has initiated a one-year memorandum of understanding to develop a health information system strategy with active involvement of all related sectors. The strategy is being finalized.

Health financing

Public health services are mostly free for everyone living in the country according to the constitution of 1972. Care for chronic diseases such as diabetes, obstructive pulmonary disease and psychiatric conditions make up a good part of public health and hospital care expenditure. The public health services are primarily funded by the government. Per capita expenditure on health was US$ 67 in 2007 as compared to US$ 61 in 2004. Out-of-pocket spending on health is growing as the cost of medical and health services is increasing continuously. The 10th five-year plan adequately addresses health financing, and the involvement of the regulated private sector in health is encouraged by the new policies.

Pharmaceutical sector

The Syrian pharmaceutical industry is producing good quality medicine based on international standards. The provision of safe and effective medicines is based on the essential medicine list. The government goal is monitoring the pharmaceuticals to ensure quality control. The results of quality control have been very good; however, the application of the national medicine policy and the rational use of medicines should be enforced.

Modernization of the health system

In 2004, the Ministry of Health and the European Commission signed a financing agreement to support the health sector with a grant worth US$ 30 million (1371 million Syrian pounds). Since 2002, the European Union has supported the Ministry's efforts to improve the delivery, efficiency and quality of health services. In particular, the European Union's support to the Ministry of Health has focused on: strengthening planning capacity at the national and regional levels; developing a health system to be responsive to population needs; improving administration and capacity of regional hospitals; and improving quality/accreditation and health financing. Following this programme, a US$ 100 million loan was

provided by the European Investment Bank to equip 17 Ministry of Health hospitals (120–200 beds).

Disease control

The burden of disease has shifted towards noncommunicable diseases and the incidence of cardiovascular disease, diabetes and cancer is increasing. Morbidity and mortality due to road traffic injuries and other types of accidents are also increasing. Mental disorders also represent a major public health problem. The major causes of morbidity and mortality are shown in Table 7.

The incidence of some communicable diseases has dropped dramatically in the past two decades in the Syrian Arab Republic. The country has been free from polio for many years now; a noticeable reduction in the incidence of childhood illnesses such as measles, pertussis and diphtheria is also evident. The Syrian Arab Republic has been malaria free since 2004. There were a total of 4144 reported cases of tuberculosis in 2006. During 1987–2006, nearly 4 million persons were tested for HIV/AIDS. Among those tested, 447 were living with HIV/AIDS. The main mode of transmission is sexual. There is a need to develop an integrated health surveillance system including required laboratories.

Health development based on community involvement

Community involvement in health development through the healthy villages programme started in the Syrian Arab Republic in 1996 in three pilot villages, and has expanded to cover more than 600 villages in 2007. The programme uses an innovative developmental approach aiming at improving the quality of life

Table 7. Top 10 causes of morbidity and mortality in the Syrian Arab Republic

Rank	Mortality	%	Morbidity	%
1.	Cardiovascular diseases	52.9	Digestive diseases	15.7
2.	Tumours	5.9	Respiratory diseases	13.2
3.	Accidents	5.6	Cardiovascular diseases	11.3
4.	Respiratory diseases	5.5	Infectious and parasitic diseases	6.9
5.	Congenital malformations	4.1	The eye and adnexa	4.0
6.	Genitourinary diseases	3.0	Genitourinary diseases	3.5
7.	Digestive diseases	2.1	Musculoskeletal system and connective tissue	3.4
8.	Nervous system diseases	1.8	Blood diseases	3.2
9.	Endocrine diseases	1.4	Accidents	2.9
10.	Infectious and parasitic diseases	1.2	Tumours	2.8

Source: Ministry of Health data, 2006

through enabling local communities to organize themselves to overcome the challenges at their localities and to be self-reliant. Its ultimate aim is a comprehensive socioeconomic development. Community ownership, partnership and self-responsibility are among the main features of this programme.

The healthy villages programme is part of the package of health modernization programmes that is supported by the European Union. It still requires monitoring and follow-up. Launching the healthy cities programme, addressing the social determinants of health, community safety networks, and establishing community-based rehabilitation and community preparedness for emergencies and disasters will be considered in the next planning cycle.

Emergencies

The major natural hazards affecting the Syrian Arab Republic are drought, flooding and earthquakes. While natural disaster management and mitigation strategies, institutions and policies have existed in the Syrian Arab Republic for the past 20 years, there is a great need for capacity-building in this area. In general, the country has in place basic disaster preparedness functions and is collaborating with the United Nations system to improve them. The probability of earthquakes in the Syrian Arab Republic is relatively high (UN CCA). Disaster preparedness plans are available but need continuous revision and updating. The overall health information system should be linked to the disaster preparedness system and should allow immediate information exchange between central, governorate and district levels. Intersectoral coordination and cooperation with neighbouring countries and international emergency services should be considered. The population of displaced Iraqis (more than 1.5 million) and their health care needs to be included.

2.3 Critical issues and challenges

The 10th five-year plan has set some daunting challenges that require major political, economic, social and institutional response from the public, government, private sector, civil society and international community. The five-year plan identifies three overarching challenges: growing needs and increased demand on health services; increased gap between the revenue and health services cost, particularly with rapidly escalating cost of modern health care and low per capita income; and weak health sector structures and functions.

These overriding challenges encompass a host of other subsidizing challenges.

- Developing/realigning operational medium-term health plans, based on the five-year plan
- Improving the capacity of the health system to play a leadership role in view of five-year plan and building sectoral alliances and partnerships for health
- Developing and enacting a comprehensive public health law
- Developing a comprehensive programme for health promotion and risk management

- Strengthening environmental health and nutrition programmes in the Ministry of Health
- Developing health financing policies and systems and improving concerned staffs' managerial skills
- Developing and strengthening the health information system
- Developing an integrated and comprehensive national plan for human resources development, particularly addressing high turnover of the staff and improving qualifications of nurses and allied health staff
- Improving health care quality and accreditation
- Increasing internal and external resources for health in a coordinated manner
- Improving health services management, efficacy and productivity and overcoming logistical difficulties
- Modernizing the medicine sector
- Developing an integrated disease control surveillance system

There are a number of facilitating factors which can be built upon to assist in meeting these challenges.

- A strong network of health care facilities spread throughout the country
- Improved basic health indicators
- A strong public sector with mass media and other public resources
- Committed national programme managers and key staff
- Excellent support from and good working relationships with all UN agencies

Section 3

Development Cooperation and Partnerships

3.1 Aid flow by donors

Regional development aid to the Syrian Arab Republic comes primarily from Arab multilateral agencies, and some directly from Arab governments. The unstable political situation in the Region has made it difficult for the Syrian Arab Republic to access developmental aid available to other nations. However, since 2000, with the start of new fiscal and institutional reforms, open market and less restrictive trade policy, there have been some encouraging trends in increased support from international donors. The European Union is currently the largest non-Arab provider of grants and loans to the Syrian Arab Republic. Recently the Government of Germany granted EUR 34 million to the Syrian Arab Republic. The other aid providers, to a much lesser extent, are the Japan International Cooperation Agency (JICA) and the Governments of Spain and Italy. Preliminary discussions are under way with the World Bank for a large package of support.

A number of national and international nongovernmental organizations and foundations are supporting the social and health sectors. These include the Agha Khan Foundation, Kariam Reda Said, Fardous, and the Syrian Family Planning Association.

3.2 United Nations system

Many United Nations agencies are present in Syria and they support a diverse set of development programmes. The Common Country Assessment (CCA) and United Nations Development Assistance Framework (UNDAF), which have been prepared in collaboration with the Syrian Government, guide UN system support for development and humanitarian projects. The UNDAF outlines UN development interventions in Syria from 2007 to 2011. Assistance will be provided towards five shared goals of economic growth, governance, basic social services, the environment and disaster management, with gender and human rights as cross-cutting issues. UNDAF enables UN support to be fully harmonized and aligned with the 10th five-year plan. WHO inputs in UNDAF are focused on: building the capacities of the health services to control communicable and noncommunicable diseases; ensuring access to quality health services including rural health services; prevention, care and treatment of HIV/AIDS; and building capacity for disaster management.

3.3 External support for the health sector

WHO has an extensive collaborative programme with the Ministry of Health and is considered the lead technical support agency for health from the UN system. WHO collaboration extends to almost all health programmes. WHO also assisted in the establishment of the School of Public Health (1989) and the Center for Health Systems Management (1997).

WHO assisted the Ministry of Health in securing over US$ 4 million from the Global Fund to Fight AIDS, Tuberculosis and Malaria to support the national programme for tuberculosis control. Another US$ 4 million will be contributed later. Through the Health Metrics Network, WHO has initiated work with the Ministry of Health to support all processes needed for evidence-based decision-making. A memorandum of understanding is expected to be signed by the Ministry of Health and Health Metrics Network to support the health management information system.

Support from other UN agencies, bilateral donors and nongovernmental organizations is shown in Table 8. UNICEF and UNFPA are among the key players in supporting health activities in areas related to maternal and child health. There is close collaboration between WHO, UNICEF and UNFPA at all levels. Collaborative activities may need to be scaled up in view of the challenges faced by the government to achieve the target of the FYP.

The European Union is providing the largest external support to the health sector. The European Union, through a grant amounting to EUR 30 million has been supporting an initiative to modernize the health sector starting in 2002 and spanning to 2009. Consequent to this, the European Investment Bank granted a loan of EUR 100 million for upgrading the equipment in 17 (120–200 beds) Ministry of Health hospitals.

In view of the 10th five-year plan, one of the targets of which is to raise the health expenditure from US$ 60 to 120 per capita, more efforts are needed to advocate for and market the national health strategic plan. The Syrian Arab Republic needs to streamline more resources to execute the plan, bearing in mind that the current estimated contribution of donors according to the Central Bureau of Statistics in cooperation with State Planning Commission is only around 2% of the total governmental health expenditure.

3.4 Coordination

The State Planning Commission is the official government authority for coordination of external assistance for all sectors including health. In relation to health, the CCS mission evaluation concluded that there is need for closer coordination between the Ministry of Health and the external and internal partners for health in close harmony and collaboration with the State Planning Commission. While overall coordination is the mandate of the State Planning Commission, for operational coordination and fine tuning of collaborative activities the coordination role of the Ministry of Health is crucial. The UN agencies have proposed that the Minister of Health chair a coordinating committee for health sector, with participation from the heads of UN agencies and with WHO as the secretariat of the committee.

As well, the Ministry of Health as the leader of the health sector should introduce new modalities of working with civil society and the private sector, building consensus and coordination around key technical and operational strategies, accelerating progress and increasing innovation.

Table 8. External support to the health sector

Donor agency or government	Type of support
UNDP	Goal setting for health sector (National Millennium Development Goals), Human Development Report, AIDS, Social determinants of health (poverty reduction and sustainable environmental development)
UNICEF	Maternal and child health care, immunization nutrition, HIV/AIDS, healthy villages and avian influenza, adolescent health
UNFPA	Mainly reproductive health, HIV/AIDS and other sexually transmitted infections, and gender
UNAIDS	HIV/AIDS
FAO	Avian influenza
Syrian Arab Red Crescent	Humanitarian activities
Italy (Italian Cooperation)	Center for specialized nurses. Equipment for Al-Marra Hospital in Idleb Governorate, US$ 7 million
Japan (JICA)	Equipment for the Damascus Hospital, Al- Golan Hospital, US$ 4.3 million Support for emergency: delivery of ambulances with radio communication and JICA project to strengthen reproductive health services in Manbej district (Aleppo)
Spanish Agency for International Cooperation	Nursing education
Greece	Support for the surveillance of brucellosis in four selected governorates (end in 2005)
Aga Khan Development Network	Heath care for disabled, institutional capacity building, supplies and equipments. Support the curricula of nursing programme, support the healthy villages program through skill development and microcredit schemes
Reda Said Foundation	Human resources development for health (nurses and midwives)

Source: Ministry of Health data, 2006

3.5 Challenges

- Developing a well deliberated strategy and plan for mobilizing additional resources from external sources
- Assisting the government for establishing a more transparent financing system with clear accountability mechanisms to encourage flow of external support
- Collaborating with the European Union to spearhead a consortium of donors for health and humanitarian assistance
- In the light of anticipated long term stay of displaced Iraqis and the recommendation of the recent ministerial conference, determining how to cater for the Iraqis refugees' health and basic needs and how to secure sustained external support for this purpose
- Strengthening the capacity of the Ministry of Health to lead and create and facilitating mechanisms, forums, and structured contact between health related ministries, civil society, nongovernmental organizations and private sector for collective health development

Section 4

Current WHO Cooperation

4.1 WHO operations

WHO collaboration with the Syrian Arab Republic extends over many decades, starting from 1948. The first agreement between the Ministry of Health and WHO to start a national workplan to eradicate leprosy and smallpox was signed and implemented in 1950. The 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, the collaboration has expanded to cover disease control, establishment of primary health care, human resource development, family planning, environmental health and healthy lifestyles, healthy villages and many other health initiatives. In the biennium 2000–2001, WHO adopted a cluster approach, in which several programmes were grouped together. The rationale was to allow for more integration, better management and more flexible administrative and financial procedures. This has led to the involvement of senior officials in the Ministry of Health to lead the clusters in order to facilitate coordination during the implementation of the work plans.

The focus of WHO cooperation with the Ministry of Health, in accordance with the first Country Cooperation Strategy (2002–2007), was on seven priority areas: health development based on community improvement; development of human resources; environmental health; health; economics and financing; health management development and administrative reform; noncommunicable diseases; and population and health.

Despite the fact that most of these priorities were reflected in the operational plans of the previous two biennia, the workplans were not entirely focused along the strategic thinking of the Country Cooperation Strategy. Furthermore, in the biennium 2004–2005, the number of priority clusters was modified to 8: development of the health care system; environmental health and communicable diseases; health management development; health promotion and protection; healthy villages; human resources development; noncommunicable diseases; and supportive services.

The total budget in 2004–2005 was US$ 1 302 300. Out of this amount, 25% was allocated to the first cluster, which includes primary health care, while the budget allocated for the noncommunicable diseases cluster was only 6%, despite it being one of the main priorities. Overall, the balance of budget allocation to different activity components was not in accordance with operational planning guidelines (e.g. national training activities constituted about 40% of the budget). However, the total implementation rate for all programmes was 100%.

The number of priorities in the biennium 2006–2007 nearly doubled, to reach 14: health policies; human resources; primary health care; healthy lifestyles; nursing; communicable diseases; noncommunicable

diseases; environment and occupational health; secondary health care; emergency preparedness; public health laboratories and pharmaceuticals; medical education, school health and healthy villages. The total budget allocated for the 2006–2007 biennium was US$ 1 371 000.

In addition to the increase in the number of priority clusters, there has been also a sharp increase of programmes within each cluster, amounting to a total of 45 programmes. Implementation of national training activities also increased in the 2006–2007 biennium. 45% of the total WHO regular budget was spent on national training activities. As well, in the past two biennia many fellowships have been offered to national staff under different health programmes.

4.2 Support to key areas and comparative advantage

WHO has supported the Ministry of Health in health policy and advocacy, information, research and development, norms and standards, partnerships, technology, tools and guidelines. WHO has helped the Ministry of Health to mobilize substantial resources to fund programmes such as tuberculosis, nursing, reproductive health and emergency preparedness and response. Also WHO was the lead agency for health during the Lebanese crisis in 2006, and WHO also convened a ministerial consultative meeting to discuss the needs of countries that have given safe haven to a huge number of displaced Iraqis.

WHO, as a close partner of the Ministry of Health, is well positioned to support health policy-making and long-term planning as well as human resources development for health, studies and research, and control of communicable diseases. WHO also has good potential to provide support in the areas of resource mobilization, health promotion and risk factor management, health financing and environmental health. However, in order for WHO to influence these areas effectively, WHO country presence needs reorienting and strengthening.

4.3 Collaboration with other UN agencies

WHO is a keen player in the UN country team and is recognized as the lead agency for health in the UN system. There is a close working and consultative relationship between WHO, UNICEF and UNFPA. Furthermore, WHO has recently developed much closer ties with the European Union in support of the health sector. WHO is also well positioned to lead the drive for resource mobilization from external support agencies and the UN to enable the government to achieve the goals set by the 10th five-year plan.

4.4 Challenges

There are a number of challenges that WHO faces in order to be able to play a strategic role in supporting the Ministry of Health and helping to coordinate UN system support for health development. These challenges include the following.

- Maintaining the focus of WHO collaboration on strategic cluster priorities
- Evaluating the current terms of reference, roles and responsibilities of national staff in order to optimize their inputs and potential

for effective follow-up, backstopping and administrative efficiency

- Developing a broadbased understanding with national authorities about how much time and support of WHO staff should be directed to fulfil the WHO core functions
- Helping with strategic issues such as enhancing the information database, development and implementation of integrated national human resources strategy for health, supporting intersectoral and intrasectoral collaboration, improving technical and evidenced-based management of health programmes, and resource mobilization
- Focusing on collaboration with the Ministry of Health while maintaining regular contact with all stakeholders in health in the country, including the environment, education, poverty reduction, research institutes and academia, and the rural and urban development sectors

Section 5

Strategic Agenda for WHO Cooperation

Section 5. Strategic Agenda for WHO Cooperation

5.1 Introduction

The General Programme of Work is a requirement specified in Article 28(g) of the WHO Constitution. The General Programme of Work analyses current health challenges in light of WHO's core functions and sets broad directions for its future work. The core functions as stated in the Eleventh General Programme of Work, covering the period 2006–2015, are as follows.

- Providing leadership on matters critical to health and engaging in partnership where joint action is needed
- Shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge
- Setting norms and standards, and promoting and monitoring their implementation
- Articulating ethical and evidence-based policy actions
- Providing technical support, catalysing change and building sustainable institutional capacity
- Monitoring the health situation and assessing health trends

The analysis in the Eleventh General Programme of Work reveals several areas of unrealized potential for improving health, particularly the health of the poor. The gaps are identified in social justice, in responsibility, in implementation and in knowledge. WHO's response is translated into priorities in the following areas according to its results-based management framework.

- Providing support to countries in moving to universal coverage with effective public health interventions
- Strengthening global health security
- Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health
- Strengthening WHO's leadership at global and regional levels and by supporting the work of governments at country level

The Medium-term strategic plan 2008–2013 an integral element in WHO's framework for results-based management translates the Eleventh General Programme of Work's long-term vision for health into strategic objectives, reflects country priorities (particularly those expressed in country cooperation strategies) and provides the basis for the Organization's detailed operational planning. The strategic objectives provide clear and measurable expected results of the Organization.

The structure of WHO's Secretariat assures involvement with countries. Headquarters

focuses on issues of global concern and technical backstopping for regions and countries. Regional offices focus on technical support and building of national capacities. WHO's presence in countries allows it to have a close relationship with ministries of health and with its partners inside and outside government. The Organization also collaborates closely with other bodies of the United Nations system and provides channels for emergency support.

In developing strategic priorities for collaboration between WHO and the Government of the Syrian Arab Republic during the mid-term period 2008–2013, special care has been taken by the CCS mission to ensure that these priorities are in line with the Organization-wide priorities and overall strategic directions during the same period.

5.2 Rationale and guiding principles

The 10th national five-year plan 2006–2010 transparently analyses the status of the health sector in the Syrian Arab Republic. The plan identifies clear cut challenges and has provided a sound basis for the health sector development, which will continue to the 11th five year plan in 2010–2015, directing the support of all national and external stakeholders and partners. In general, WHO collaboration with the Government of the Syrian Arab Republic will be focused on helping the government to achieve the targets set out in the plan. WHO support will be focused primarily on strengthening the programmes in the Ministry of Health as well as other partners in health development in line with the five-year plan.

WHO collaboration in the Syrian Arab Republic in the next six years will be guided by the following guiding principles and strategic approaches.

- Achieving equity and social justice through creating a health safety net and making an essential health care package available to all people
- Strengthening the technical and evidence-based management of the health sector
- Strengthening the capacity of the Ministry of Health to play its leading role in the health sector
- Promoting the health agenda in economic and social development schemes
- Mobilizing the necessary internal and external resources in a coordinated manner

5.3 Strategic directions

5.3.1 Implementation of the national five-year plan

- Technical review and monitoring of the different health programmes through joint periodic assessment by the Ministry of Health and WHO
- Developing a national health resource mobilization strategy and programme and fostering closer relationship with key international funding agencies and donors to support the five-year plan, including assisting the Ministry of Health in establishing the UN and donors group for health
- Strengthening the collaborative capacity

of the Ministry of Health to enhance the input of all sectors for health

- Advising on the development of a comprehensive public health law
- Supporting development of a comprehensive and integrated plan for human resources development for health
- Supporting the ongoing initiative to develop a comprehensive health information system

5.3.2 Health system development

Management

- Improving management and performance
- Ensuring accessibility to the essential health package for the marginalized and underserved population
- Strengthening public–private partnership and regulating the private sector

Health financing

- Building the capacity of the national staff and preparing the national health account
- Establishing a fair health financing system based on equity and safeguarding the poor and under-privileged
- Developing health insurance schemes
- Optimizing the efficient utilization of financial resources

Regulatory and supervisory function

- Supporting the development of protocols, norms, standards and criteria for quality management
- Supporting regulatory bodies, e.g. national regulatory authority for medicines and biologicals, food regulatory authority.
- Supporting the role of Ministry of Health in licensing and accreditation

Medical education

- Establishing a standing consultative mechanism between the Ministry of Health and medical faculties to harmonize the medical and allied staff education with the health needs
- Supporting medical faculties, developing national curricula and trainers, and developing a standard professional medical diploma
- Producing a core group of specialists in medical education and developing a master's degree programme in medical education

Research

- Identifying the priority areas for operational research and preparing protocols and technical management mechanisms for planning and conducting operational research
- Ensuring the use of research and study results in policy and strategy development and implementation of major programmes
- In a phased manner, incorporating operational research as an inbuilt feature of major health programmes

5.3.3 Health promotion and protection

Healthy lifestyles and the tobacco-free initiative

- Reviewing/developing and implementing the necessary surveys to evaluate the magnitude of the problem of unhealthy lifestyles
- Developing and supporting implementation of health advocacy and awareness raising programmes in collaboration with UNICEF and UNFPA
- Developing and supporting government efforts to achieve the objective of the Framework Convention on Tobacco Control

Food safety and nutrition

- Assessing food safety status and strengthening the food safety programme, including food inspection, criteria, norms and awareness-raising
- Supporting the nutrition programme, in collaboration with UNICEF and other partners.

Social determinants of health

- Strengthening the environmental health programme of the Ministry of Health and collaborating with concerned stakeholders
- Continuing support to the healthy villages programme with special focus on promoting, implementing and evaluating the impact of education, health and community-based initiatives on poverty reduction
- Initiating the healthy city concept and programme

5.3.4 Primary health care

- Reviewing primary health care, including appropriateness of current approaches, structure, utilization by people, quality, coverage and network/referral system
- Developing a basic primary health care package
- Introducing family medicine practice
- Integrating noncommunicable diseases and mental health in primary health care
- Including emergency care in primary health care

5.3.5 Health programmes

- Developing an integrated noncommunicable disease programme, including strengthening of cancer and diabetes registries and advocacy and awareness campaigns for early detection of cancer, diabetes and hypertension
- Developing a programme for healthy lifestyle and risk management
- Strengthening the mental health programme
- Strengthening prevention of and response to road traffic accidents and injuries

- Revising, updating and expanding programmes on communicable diseases and epidemic management including infection control in health facilities
- Continuing the collaboration with the theme group on HIV/AIDS to support the national AIDS programme according to UNAIDS division of labour

5.3.6 Emergency preparedness

- Enhancing the national preparedness plan for emergencies and national disasters including the availability of skilled emergency health managers and technical staff
- Supporting simulation exercises and community preparedness
- Ensuring a proper coordination mechanism to better respond to emergency needs, particularly logistic support and provision of basic health needs

Section 6

Implementing the Strategic Agenda: Implications for WHO

Section 6. Implementing the Strategic Agenda: Implications for WHO

6.1 Overview

The strategic directions set forward in chapter 6 of this Country Cooperation Strategy (CCS) will have huge managerial, technical and operational implications for WHO at all levels. The CCS is framed for WHO to assist the Government of the Syrian Arab Republic achieving the targets of its 10th five-year plan for health. The plan aims at a fundamental overhaul and modernization of the health sector and at the same time expansion and improvement of health care services. Implementation of the plan will require more technical support from WHO at all levels. WHO is expected to provide advice on modern administration and management of health services, including health system development, health financing, human resources development, information system, health promotion and risks factor management, environmental health, nutrition, resource mobilization and emergency preparedness.

6.2 Implications for the country office

Technical backstopping

The first challenge for WHO country programme and the Ministry of Health is how to implement a more focused cluster approach as agreed with the Ministry of Health in 2001. This will entail a systematic dialogue and consensus building between WHO and the Ministry of Health, at all levels. The office must also focus on the priorities and strategic directions set which in brief call for a more robust follow-up and backstopping on the following areas.

- Health system development. Health system management and performance, health financing, human resources development, quality assurance and accreditation, information management, evidence for policy, and operational research
- Health promotion and risk factor management. Social determinants of health including environmental health, healthy lifestyle, primary health care network, reproductive health, healthy villages and noncommunicable diseases
- Resource mobilization and emergencies

In light of these challenges, a detailed assessment of current national staff of the country office needs to be undertaken and see how the work could be reorganized or whether additional staff are needed. The tenure of services of the key technical staff could be considered after the assessment. However, there is an urgent need to recruit a national professional officer with public health background for health systems development. There is also need to recruit an officer for resource mobilization and emergency preparedness. After assessment of the staff situation, the country office in collaboration with the Regional Office should develop a staff development plan for training and upgrading of staff.

During the past two biennia, considerable staff time has been devoted to following up

national training. For many other items, the country office staff has difficulty receiving feedback from the national programme managers. This problem needs to be addressed through dialogue and redesign of the feedback procedures to be simple and conducive to quick response.

Operation and administration

The administrative assistant is a fixed term staff; the remaining staff working in administration are all SSA holders. There is a need for clear-cut delineation of responsibilities and tenure of service for general staff to provide the required support, including hierarchy and job description.

An important component of the country office should be an advocacy and knowledge management centre. In addition to the library, there should be an information centre with regular contact with media, production of a periodic newsletter and regular update of the website. The centre should have a complete set of reports of WHO missions and visiting consultants as well as technical reports and studies.

6.3 Implications for the Regional Office

The Regional Office has to support the involvement of concerned technical units to be in much closer contact with programme development, technical monitoring and evaluation. The full involvement of the Regional Office in key strategic priorities such as health system development (health financing, human resources for health, quality assurance and accreditation, information system, evidence for policy), health promotion and risk factor management, environmental health and respective efforts to mobilize resources is vital. To achieve these, a structured systematic arrangement should be made for technical units to prepare a collective and coordinated "road map" for the implementation of the strategic directions, including backstopping, monitoring and evaluation. The "road maps" should allow flexibility but maintain continuity and complementary of successive joint programme review and planning missions. The role of the Regional Office in helping with resource mobilization is crucial in terms of technical input, liaison and fundraising among donors. In the light of the health care needs of the displaced Iraqis, both the Regional Office and headquarters should actively support the country office in strengthening capacity to deal with this crisis as well as emergencies that might occur in the future.

6.4 Implications for headquarters

Headquarters will need to allocate time and resources to support the following activities.

- Participation along with the Regional Office for key strategic areas of health system development, health and risk factors management
- Involvement in development of the "road maps"
- Strong advocacy among donors for resource mobilization in coordination with the Regional Office

Annex 1

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