Strategic Plan (2026-2028)

Ministry of Health

Syrian Arab Republic

Table of Contents

Acknowledgement **3**

1. Executive Summary **4**

- *a. 2.1 Strategic Plan Purpose*
- *b. 2.2 Post-Liberation and Early Recovery Context*
- *c. 2.3 Link to the Five-Year National Health Strategy*
- *d. 2.4 Strategic Planning Process and Methodology*

2. Introduction **5**

3. Ministry of Health Overview **9**

- *a. Mandate and Authority (Decree 111 of 1966)*
- *b. Organizational Structure (Central and Governorate Levels)*
- *c. Centralized Stewardship Role of the Ministry of Health*
- *d. Workforce Snapshot*

4. Context and Situational Analysis **10**

- *a. 4.1 Socio-Economic and Political Context*
- *b. 4.2 Burden of Disease*
  - *i. 4.2.1 Overall Mortality and Morbidity*
  - *ii. 4.2.2 Communicable Diseases*
  - *iii. 4.2.3 Noncommunicable Diseases (NCD)*
  - *iv. 4.2.4 Maternal and Child Health*
  - *v. 4.2.5 Mental Health and Psychosocial Support*
  - *vi. 4.2.6 Nutrition*
- *c. 4.3 Health System Status*
  - *vii. 4.3.1 Service Delivery and Infrastructure*
  - *viii. 4.3.2 Human Resources for Health*
  - *ix. 4.3.3 Pharmaceuticals and Supply Chain*
  - *x. 4.3.4 Health Financing*
  - *xi. 4.3.5 Health Information Systems and Digital Health*
- *d. 4.4 Key Challenges and Gaps*

5. Guiding Principles **19**

6. SWOT Analysis **21**

7. Strategic Goals and Pillars (2026-2028) **22**

- *a. 7.1 Health Infrastructure Rehabilitation*
- *b. 7.2 Health Workforce Development*
- *c. 7.3 Health Financing and Sustainability*
- *d. 7.4 Essential Health Service Package (EHSP) and Service Delivery*
- *e. 7.5 Governance and Partnerships*
- *f. 7.6 Access to Medicines and Medical Products*
- *g. 7.7 Digital Transformation*
- *h. 7.8 Health Security*

8. Monitoring, Evaluation, and Accountability **25**

9. Risks and Assumptions **26**

10. Annexes **27**

Acronyms

AMR	Antimicrobial Resistance
CHES	Continuity of Health Essential Services
DHIS2	District Health Information Software, Version 2
EHSP	Essential Health Service Package
EMR	Electronic Medical Record
GDP	Gross Domestic Product
HIS	Health Information System
HRH	Human Resources for Health
IHR	International Health Regulations
LMIS	Logistics Management Information System
MoH	Ministry of Health
NCD	Noncommunicable Disease
NHA	National Health Accounts
NHS	National Health Strategy
NGO	Non-Governmental Organization
OOP	Out-of-Pocket (Health Expenditure)
PHEOC	Public Health Emergency Operations Center
PHC	Primary Health Care
SWOT	Strengths, Weaknesses, Opportunities, and Threats
UHC	Universal Health Coverage
WHO	World Health Organization

Statement of His Excellency the Minister of Health

“In the Name of Allah, the Most Merciful, the Most Compassionate”

It is a source of pride for me to present to the esteemed reader the “Strategic Plan of the Ministry of Health of the Syrian Arab Republic 2026–2028,” as one of the basic building blocks in the path of early recovery and the reconstruction of a unified, just and sustainable national health system, after the pivotal stage through which our country is passing.

This strategy comes as the fruit of institutional and consultative work that extended over several months, in which the various central directorates of the Ministry, the health directorates in the governorates, and the technical and administrative staff at all levels took part. From the outset, we were keen that this document should not be a closed, desk-bound effort, but rather the outcome of broad dialogue based on evidence and field data, and reflecting the priorities of citizens and the needs of health-service providers alike.

It also gives me pleasure, in this context, to record my deep appreciation for the constructive cooperation with all ministries and national partner entities, foremost among them the Planning and Statistics Authority in the Syrian Arab Republic, which, through its expertise, contributed to aligning the plan with the general national orientations and ensuring its coherence with developmental priorities and performance indicators at the State level; as well as the General Secretariat of the Presidency of the Republic, which provided follow-up, facilitation and guidance, thereby strengthening the overarching national character of this plan and consolidating its direct linkage with the State’s higher strategic orientations.

I also extend my thanks to the other partner ministries and institutions, in particular the Ministries of Finance, Higher Education, Communications and Technology, Social Affairs and Labor, Defense and Interior, and to our partners from UN and international organizations and national bodies, for the technical advice and practical contributions they provided, which helped to shape the axes of the plan and its priorities in a more realistic and effective manner.

I likewise extend my sincere thanks and appreciation, in particular, to Dr. Salah Safadi and his specialized team, who led the preparation process, coordinated the collection of inputs from the various directorates and partner entities, and drafted the final version of the document. This team presented an honorable example of institutional work and national commitment, and contributed to the plan’s emerging in a coherent and implementable form.

This plan has sought, with a high degree of candor and responsibility, to answer two fundamental questions: Where do we stand today after years of conflict and the accompanying fragmentation of the health system and weakness in resources? And where do we want to reach during the period 2026–2028, so that we may pave the way for a subsequent phase of greater stability, development and sustainability within the framework of the medium-term national health strategy? The plan has focused on rehabilitating health infrastructure, developing human resources, improving health financing, strengthening governance and partnerships, digital transformation and health security, in a way that rebuilds trust between the citizen and the public health system.

This document is not the end of the road, but rather the beginning of a new phase of organized collective work. The responsibility for implementing the plan and following up on its results rests upon all of us: in the Ministry of Health, in the governorate health directorates, and in all partner ministries and entities, each within its own area of competence. From this standpoint, I call upon all directorates and programs, as well as our partners in State institutions and national and international bodies, to deal with this plan as a practical, everyday reference and a driver of continuous change and improvement, and not merely as a document placed on shelves.

And as we place this plan in the hands of the political leadership, national institutions, and our partners inside and outside the country, we renew our commitment that the human being shall remain at the heart of every policy, programme and intervention, and that we shall continue, together, to build a health system that is more just, efficient and resilient, befitting the sacrifices of our people and their aspirations in the new Syria.

And Allah is the One Who grants success.

Dr. Musab Al-Ali
Minister of Health
Syrian Arab Republic

Acknowledgement

The Ministry of Health is pleased to extend its sincere thanks and appreciation to all those who contributed to the development of this National Strategic Plan, from within and outside the Ministry. This collective effort involved the active engagement of the Ministry's central directorates – in particular the Directorates of Planning and International Cooperation, Primary Health Care, medical infrastructure, Human Resources, and Pharmaceuticals and Medical enginreering– as well as the governorate Health Directorates and the technical and administrative teams who supported data collection, analysis, and the organization of consultations and workshops.

The Ministry also expresses its deep gratitude to national partner institutions, including the Planning and Statistics authority and other relevant ministries and public bodies, and to its partners from universities and academic institutions, and from UN agencies, international organizations and national organizations, whose technical inputs, comments and feedback significantly helped to strengthen the quality and relevance of this Strategy.

The Ministry likewise extends its sincere thanks and appreciation, in particular, to **Dr. Salah Safadi**, **Ms. Sophia Shalabi and Ms. Aya Ibrahim**– who led the preparation process, coordinated the collection of inputs from the various directorates and partner entities, and drafted the final version of this document.

Given the large number of colleagues and partners involved at different stages of the process, it is not possible to list all contributors by name in this section; however, this in no way diminishes the Ministry's profound appreciation for every person who contributed ideas, effort or support – whether small or large – to bringing this Strategy to completion and into implementation.

1. Executive Summary

The Ministry of Health (MoH) entered a new era following Syria's liberation in December 2024. The Strategic Plan (2026-2028) provides a roadmap for early recovery and for strengthening the health system over the long term, establishing the foundations and core evidence for the comprehensive framework that will follow. It outlines clear national priorities to restore essential health services, rebuilding trust in the health system, and laying the groundwork for a unified, resilient, and sustainable sector. The plan promotes gender equity across all components to ensure fairness and inclusion in workforce development, service delivery, and governance. It also serves as a bridge to the upcoming medium term National Health Strategic Plan, ensuring that the priorities, lessons, and outcomes of this period directly shape the next phase of health sector reform. Together, these frameworks represent a continuous process of rebuilding and development, guiding Syria toward a nationally led, unified, and resilient health system that ensures access to health care for all.

Vision*: Moving towards an integrated and resilient health system that provides equitable, high-quality healthcare that is accessible, affordable and available to reach for all.*

Mission*: The Ministry of Health will achieve its vision by rebuilding and modernizing the national health system to deliver equitable, high quality, and resilient services for all Syrians. The Ministry will restore and expand essential health infrastructure, strengthen and motivate the health workforce, reinforce health security efforts, and ensure effective coordination and integration across all levels of care. Through evidence-based planning, sustainable financing, and digital transformation, the Ministry will advance efficiency, accountability, and quality of health care for every person without geographic or socioeconomic discrimination.*

Overall Goal: Strengthen the effectiveness and efficiency of the health care system to improve population health and reduce morbidity and mortality

Specific Objectives for 2026-2028:

1. Rehabilitate health sector facilities based on an integrated mapping of health facilities and health workers that reflects priority needs for rehabilitation.
2. Strengthen evidence-based and accountable management of financial and human resources.
3. Ensure the availability of integrated health services with readiness, equity, and strengthen primary health care systems.
4. Enhance governance, partnerships, and coordination with relevant sectors.
5. Improve equitable access to essential medicines and medical products through local production, regulatory oversight, and reliable supply chains.
6. Activate health information systems and launch digital health systems to support evidence-based decision making.
7. Strengthen the national health security system to ensure public health preparedness and resilience.

To achieve these objectives, the health sector has adopted policies, that if implemented, will improve the quality of health services at all levels:

- Safe, effective, and adequately resourced health facilities capable of delivering the Essential Health Services Package (EHSP)
- Availability of the health workforce
- Development of human resources for health and strengthened partnerships with educational institutions and Syrian diaspora experts abroad
- Strengthened financial sustainability of health sector financing
- Enhance access to primary health care, nutrition, and mental health services
- Strengthened community engagement in the health sector
- Alignment of initiatives with national priorities and stronger partnerships with health-sector stakeholders
- Availability of safe and effective medicines
- Prioritization of national pharmaceutical production
- Transition to a national digital health system
- Continuity of essential health services during emergencies
- Multisectoral and cross-border coordination in health security

Expected Result by the End of 2028:

- Rehabilitation and equipping of hospitals and primary health care centers to restore their capacity to provide essential services
- Mapping, training, and support of the health workforce through the approved Human Resources for Health Strategy and initial retention measures
- Reestablishment of National Health Accounts with improved financial governance and initial mobilization of domestic resources
- Strengthened primary health care systems, completion of the Essential Health Services Package, costing of the package, and piloting in select health facilities as the basis for national rollout
- Improved equitable access to essential medicines and medical products through strengthened local production, regulatory oversight, and reliable supplies
- Establishment of institutional coordination platforms with stronger leadership from the Ministry of Health and partner engagement
- Launch of core digital health systems through piloting electronic medical records, training the health information system workforce, and adopting a national digital health policy and data protection framework
- A functional national health security system with integrated surveillance, laboratory, and rapid response capacities to strengthen public health preparedness and resilience

2. Introduction

2.1 Strategic Plan Purpose

This Strategic Plan (2026-2028) represents the Ministry of Health’s framework for the early recovery phase of the health sector in Syria. It is not intended to serve as a long-term comprehensive strategy

but rather as a focused effort to rebuild the foundations of the health system and create the conditions necessary for sustainable development. After more than a decade of conflict and fragmentation, the health sector is entering a new phase that requires rebuilding trust, restoring functional performance, and paving the way for long-term reform. In this context, the Ministry adopted a plan focused on early recovery, building data systems and institutional capacities, and preparing for the launch of the medium-term National Health Strategic Plan (2029-2033).

The plan aims to guide the immediate rehabilitation process by restoring essential services, strengthening the health workforce, and improving financial and administrative mechanisms while generating the evidence base needed for future reforms and investments. This two-year phase will allow the Ministry to consolidate lessons learned, set clear priorities, and produce the information necessary for responsible planning of the next development stage. The plan provides direction for government institutions, international partners, and non-governmental organizations, ensuring coordinated activities under the leadership of the Ministry of Health. By defining national priorities for early recovery, the plan establishes a shared framework for investment, coordination, and accountability that supports the gradual transition toward a unified, equitable, and sustainable health system. It is aligned with the WHO health system framework and Sustainable Development Goals (SDG), ensuring that recovery efforts contribute to universal health coverage, equity, and resilience. It recognizes that recovery requires addressing gender and social disparities that were exacerbated by the crisis and commits to integrating gender considerations across all stages of planning, workforce rebuilding, and service delivery.

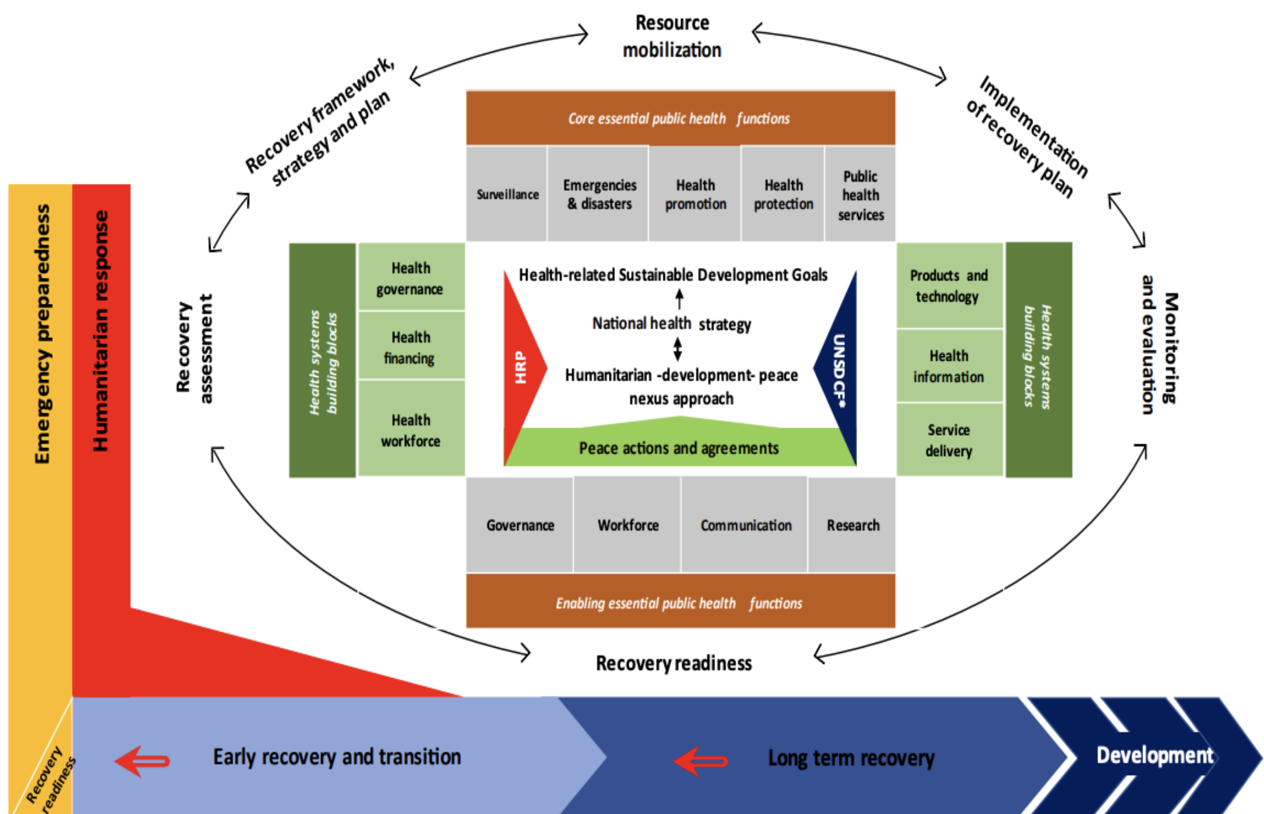
2.2 Post-Liberation and Early Recovery Context

After more than a decade of conflict and disruption, Syria's health system is entering a critical phase of rebuilding. Years of fragmentation, reduced public financing, and dependence on humanitarian aid have weakened institutions and service delivery across all levels of care. While major challenges remain, the current context presents an opportunity to move from a crisis-oriented model toward a nationally led recovery process. The Ministry of Health recognizes that lasting reform cannot begin without first restoring the essential foundations of functionality, coordination, and trust.

Early recovery provides the framework for this transition. It marks the beginning of recovery and reform by connecting humanitarian action with long-term development. This approach focuses on restoring essential services while rebuilding health system functions, rehabilitating infrastructure, and strengthening supply chains and information systems so that care becomes more reliable and efficient. It also places emphasis on strengthening community and institutional resilience, ensuring that local structures and the health workforce are able to sustain services during future challenges. At the same time, early recovery prioritizes stronger governance and accountability, allowing the Ministry to lead with greater coordination, policy coherence, and transparency in collaboration with national and international partners. The prolonged conflict has exacerbated gender-based health disparities, including increased risks of maternal mortality and gender-based violence, while also creating opportunities to strengthen women's roles in health system recovery and leadership. Implementation will apply a conflict-sensitive and inclusive governance approach through

participatory planning, equitable resource allocation, and transparent coordination mechanisms at both national and governorate levels. These measures will ensure that recovery efforts strengthen national cohesion, promote accountability, and avoid reinforcing inequalities across regions.

The WHO operational framework illustrates how early recovery functions as both a bridge and a feedback mechanism between humanitarian response and long-term development. It shows that recovery does not occur in isolation or as a linear process but rather as a continuum that connects crisis response, system rebuilding, and preparedness for future shocks. As health systems move from emergency conditions toward stabilization, early recovery focuses on restoring services, strengthening governance, and rebuilding the core functions that allow the system to operate effectively. At the same time, it reinforces future preparedness by integrating lessons from the crisis and ensuring that recovery investments contribute to greater resilience. This cyclical process of assessment, planning, implementation, and monitoring helps countries transition from reliance on humanitarian aid toward nationally led, sustainable development while maintaining readiness for future emergencies.



Source: World Health Organization. (2021). *Framework for health system recovery in fragile and conflict-affected settings.* Retrieved from https://applications.emro.who.int/docs/Health-systems-recovery-eng.pdf

Through these interconnected areas, early recovery establishes the foundation for the health system's transition from emergency response toward sustainable development. It enables the Ministry to focus

resources on achievable priorities that demonstrate effectiveness, enhance coordination, and generate the data needed for evidence-based planning and investment. It is also a period to strengthen institutions and develop the systems that will guide the forthcoming medium term National Health Strategy and future reforms. By adopting this approach, the Ministry seeks to move the health sector from fragmentation and humanitarian dependence toward a unified, nationally owned system capable of delivering equitable, quality care and advancing Syria's progress toward resilience and universal health coverage.

2.3 Link to the Medium-Term National Health Plan (2029-2033)

This Strategic Plan forms as a bridge between the humanitarian response and long-term reform. This initial phase of early recovery is designed to achieve tangible progress while laying the foundations for a stronger and more resilient health system. By the end of this phase, the Ministry of Health aims to restore the core functions of priority facilities and strengthen its workforce through targeted training and initial retention measures. Additionally, the plan emphasizes the creation of a reliable baseline for the health sector. Facility and workforce mapping, the reinitiation of National Health Accounts, and the strengthening of health information systems are all critical steps that will generate the evidence needed to design effective policies. As part of this effort, preparatory work will begin for a comprehensive Household Income and Expenditure Survey in collaboration with the Ministry of Finance. This will establish the foundation for assessing household health spending, out-of-pocket expenditures, and financial hardship, providing essential data for equitable health financing and donor alignment. The strengthening of PHCs through the development of the Essential Health Service Package will provide a nationally agreed framework for service delivery that aligns with Universal Health Coverage principles and guides future investment. Together, these actions will provide the data, systems, and institutional capacity required to design and implement the five-year National Health Strategy. That strategy will build on the foundations laid during early recovery, shifting the focus from restoration to long-term resilience, sustainability, and equity.

2.4 Strategic Planning Process and Methodology

The Ministry of Health adopted a participatory and evidence-informed methodology to develop this Strategic Plan, ensuring that it reflects both international best practices and Syria's post-liberation realities. The process began with a review of strategic plans from other post-conflict countries to draw lessons on system rebuilding and long-term sectoral reform. While the Syria Ministry of Health's 2023–2027 Strategic Plan was reviewed, it could not be fully adopted due to the shift in national context, as the country has now entered a new phase requiring a whole-of-Syria approach and renewed leadership from the Ministry of Health. Therefore, the National Expert Committee, under the Ministry of Health, led the development of the National Health Strategic Plan 2026–2028, providing strategic guidance, coordination, and technical oversight throughout the process. On September 2, the Committee convened a strategic planning workshop with all relevant department heads and staff, where a SWOT analysis was conducted, the mission and vision were discussed, and feedback was gathered on draft objectives. The SWOT exercise reflected the perspectives of Ministry of Health staff and served as a valuable tool for identifying key challenges and priorities, although it

is not intended as a comprehensive national assessment. Each Ministry department also prepared a context analysis about their department to offer additional details about their needs, challenges, and opportunities.

Following the workshop, the Committee consolidated inputs and prepared the initial draft of the plan. Directors and managers within the Ministry of Health were consulted for feedback, and community perspectives were gathered through surveys conducted across primary health centers to ensure that the voices of frontline providers and citizens were reflected. In the subsequent phase, the Ministry held targeted consultations with international and local NGOs, private sector representatives, UN agencies, development partners such as the World Bank, and technical experts from key fields including health financing, supply chain management, and health workforce planning to validate priorities and ensure alignment with broader recovery and development frameworks. These consultations informed the final revisions before the draft was submitted for endorsement by the Minister of Health. Once endorsed, the Ministry of Health initiated follow-up meetings with other government ministries, including the Ministries of Finance, Communication, Higher Education, and Foreign Affairs to present the plan and promote cross-sectoral coordination and ownership.

The Ministry of Health reviewed and refined drafts of the plan through internal discussions, drawing on comparative lessons from other post-conflict contexts. The process highlighted the urgent need to strengthen data collection and analysis. Current facility reports, workforce statistics, and expenditure data remain fragmented and insufficient, creating significant gaps in evidence. To address these, the plan commits to conducting baseline studies, including National Health Accounts, out-of-pocket expenditure surveys, and costing exercises. By combining qualitative insights from consultations with quantitative evidence generation, the plan remains grounded in Syria’s realities while positioning the Ministry of Health as steward of the health sector and custodian of its long-term transformation.

3. Ministry of Health Overview

3.1 Mandate and Authority (Decree 111 of 1966)

The Ministry of Health (MoH) derives its mandate from Legislative Decree No. 111, issued on September 1, 1966. This decree grants the MoH the position to organize and oversee the national health sector with the overarching objective of improving health indicators and ensuring equitable access to medical services. Within this mandate, the MoH is tasked with developing health infrastructure through the establishment and management of hospitals and health centers, as well as supporting scientific research through study centers and technical laboratories to safeguard service quality and drug safety. The Ministry is also responsible for monitoring nutritional status, setting preventive health policies, strengthening primary healthcare, combating communicable and noncommunicable diseases, regulating pharmaceuticals, and advancing policies in mental and environmental health to ensure a comprehensive system of care. In the post-liberation context, this legal mandate has gained renewed significance as the MoH reestablishes itself as a central role in

health sector reform, with a focus on infrastructure rehabilitation, workforce development, and strengthening institutional governance.

3.2 Organizational Structure (Central and Governorate Levels)

The organizational structure of the MoH reflects its dual role at the central and governorate levels. At the central level, the Ministry operates through 28 specialized directorates, each tasked with technical and administrative functions such as planning, service delivery, health financing, human resources, and regulatory oversight. At the governorate level, health directorates act as the operational arms of the Ministry, coordinating hospitals, primary health centers, and community-level services. This structure provides an integrated system in which central directorates set policies and standards, while governorate offices adapt and implement them according to local needs. The organogram in the annex reflects institutional reforms designed to enhance coordination, accountability, and responsiveness across central and governorate levels of governance.

3.3 Centralized Stewardship Role of Ministry of Health

The MoH serves as the steward of the Syrian health sector, exercising centralized leadership over policy direction, standard-setting, and regulation. This stewardship function ensures that national health priorities are aligned with broader development objectives, donor investments, and international commitments such as Universal Health Coverage (UHC). While implementation is delivered through hospitals, health centers, and governorate directorates, the Ministry retains responsibility for safeguarding equity, efficiency, and quality across the system. In the post-liberation period, the MoH's stewardship role has become increasingly vital, as it works to restore public trust, coordinate fragmented actors, and reestablish national ownership of the health agenda.

3.4 Workforce Snapshot

As of 2024, the Ministry of Health employed approximately 78,500 individuals across its central administration, health directorates, hospitals, and primary health centers. This workforce represents a broad mix of health staff, including physicians, nurses, midwives, pharmacists, technicians, and administrative staff. The majority are deployed in hospitals and primary healthcare facilities, with governorate-level directorates overseeing their distribution and supervision. However, significant imbalances remain in the geographic distribution of staff, with rural and underserved areas facing persistent shortages. Ongoing efforts are focused on workforce development and training, alongside reforms to improve deployment, retention, and performance management. The Strategic Plan leverages this workforce base as an essential asset for driving early recovery and laying the foundation for long-term system strengthening.

4. Context and Situational Analysis

4.1 Socio-Economic and Political Context

Syria is currently in the early recovery phase after more than a decade of conflict, sanctions, displacement, and natural disasters. According to the United Nations, 16.7 million people are in need

of humanitarian assistance in 2025, the highest figure since the beginning of the crisis, with 15.8 million requiring urgent health support. Poverty is widespread, with more than 90% of Syrians living below the poverty line and millions depending on humanitarian aid for food, water, and health services. The World Bank reports that the economy has contracted by more than 80% since 2010, with inflation and unemployment at persistently high levels. Water scarcity and recurrent droughts have deepened vulnerabilities, limiting access to safe drinking water and heightening risks of waterborne diseases. In addition, the expected return of around 2 million Syrian refugees over the coming two years will place further strain on an already weakened health system, which must be strengthened to cope with the additional caseload.

4.2 Burden of Disease

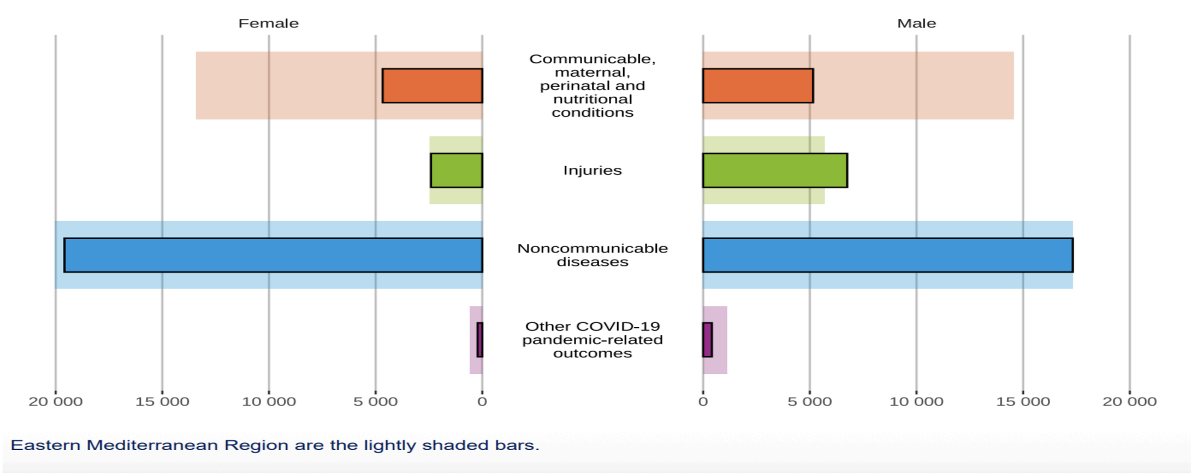
4.2.1 Overall Mortality and Morbidity

According to WHO estimates, life expectancy at birth in Syria was 72.4 years in 2021. This reflects a partial recovery from the sharp decline during the conflict, when it fell from about 75 years in 2010 to as low as 55 to 56 years by 2014, primarily due to a reduction in large-scale conflict fatalities and demographic shifts, with some localized health interventions contributing. However, progress has since stalled and life expectancy remains below pre-conflict levels. Syria recorded 109,058 deaths in 2021, with 75% attributed to noncommunicable diseases (NCDs), 13% to communicable, maternal, perinatal, and nutritional causes, and 11% to injuries. Cardiovascular disease is considered the leading cause of death, with ischaemic heart disease and stroke account for a large portion of premature mortality. Injuries, particularly road traffic accidents, rank among the top causes of death for men, while neonatal conditions, congenital anomalies, and lower respiratory infections remain significant for children.

Morbidity patterns mirror mortality. According to WHO Global Health Estimates, Syria's age-standardized disability-adjusted life years (DALYs) rate in 2021 was approximately 27,700 per 100,000 population, which is considerably higher than regional comparators and reflects both premature mortality and years lived with disability. Noncommunicable diseases account for nearly 70% of total DALYs, with ischaemic heart disease, stroke, diabetes, and cancer among the top contributors. Injuries remain a significant cause of health loss, particularly for young men, and contribute to more than 10% of total DALYs. Communicable diseases, maternal conditions, and neonatal complications continue to represent around 15% of total DALYs, underscoring gaps in maternal and child health services and inconsistent immunization coverage. Years lived with disability are increasingly driven by musculoskeletal disorders, mental health conditions such as depression and anxiety, and metabolic risks like diabetes, while years of life lost remain concentrated in cardiovascular disease, neonatal disorders, and trauma.

Syria's mortality and morbidity data has historically been incomplete and unreliable, with gaps in coverage and accuracy that predate the conflict. Disease surveillance remains fragmented and heavily dependent on partner-operated systems, limiting early detection and coordinated response and

weakening national health security. Weak reporting systems and selective information practices have obscured preventable deaths and chronic health challenges, and these problems worsened during the war. Much of the data disseminated by international agencies still relies on the same limited sources, making it useful for identifying broad patterns but insufficient as a reliable baseline. The priority for the MoH is to build stronger health information systems that generate accurate and representative data. Establishing such credible baselines will be essential for guiding recovery priorities, supporting evidence-based reforms, and ensuring that planning reflects the real health needs of the population.



Reference: World Health Organization. (2023). Syrian Arab Republic: Global Health Estimates country profile 2021. WHO. *https://srhdpeuwpubsa.blob.core.windows.net/whdh/DATADOT/COUNTRY/PDF/760_Syrian%20Arab%20Republic.pdf*

4.2.2 Communicable Diseases

Communicable diseases remain a major public health concern in Syria. According to WHO, outbreaks of cholera, measles, influenza, acute respiratory infections, tuberculosis, and cutaneous leishmaniasis have been recurrent in recent years. Between August and December 2024, Syria reported more than 1,400 suspected cholera cases and seven deaths, with transmission linked to drought, damaged water systems, and poor sanitation. Cutaneous leishmaniasis remains endemic, particularly in Aleppo, Idlib, and Al-Hasakeh, where large numbers of cases continue to be reported. Vaccination coverage remains suboptimal, with BCG at about 84%, DTP1 at 81%, DTP3 at 73%, and measles-containing vaccine (MCV1) as low as 74%. These levels are below regional averages, where DTP3 coverage is around 88% and MCV1 about 80%. Displacement, overcrowding, and inconsistent vaccination delivery continue to create high risks for outbreak-prone diseases.

4.2.3 Noncommunicable Diseases (NCDs)

NCDs are the leading cause of mortality and morbidity in Syria. According to WHO estimates, cardiovascular disease accounts for about 25% of all deaths, with cancers, diabetes, and chronic respiratory disease contributing significantly. Limited diagnostic capacity, treatment interruptions, and medicine shortages have worsened outcomes. Hypertension and diabetes often go undiagnosed or untreated until late stages. Cancer services are particularly constrained, with shortages in oncology medicines and radiotherapy equipment. As the population ages and preventive services remain weak, the burden of NCDs will continue to rise unless addressed through strengthened primary care and community-level interventions.

The burden of NCDs in Syria is closely tied to the broader social determinants of health that have been eroded by more than a decade of conflict. Widespread poverty, food insecurity, and unemployment have reduced people's ability to afford nutritious diets, stable housing, and safe living environments. Damage to water and sanitation systems, poor waste management, and exposure to air pollution have increased risks for both respiratory and cardiovascular disease. Displacement and overcrowding have intensified psychosocial stress while limiting continuity of care, and untreated mental health conditions further contribute to the progression of chronic illnesses. At the same time, health system disruptions such as destroyed infrastructure, shortages of skilled staff, and frequent medicine and supply gaps have undermined access to diagnostic and treatment services. Garry et al. (2018) highlight that the provision of NCD care in Syria has been impeded by these intersecting structural and health system barriers, leaving patients vulnerable to treatment interruptions, unmanaged complications, and deepening inequities across urban and rural populations.

4.2.4 Maternal and Child Health

Maternal and child health indicators in Syria remain fragile despite gradual recovery in recent years. According to UN IGME (2023), the under-five mortality rate is estimated at 20.6 per 1,000 live births, down from 35 per 1,000 in 2015 after peaking during the conflict, though still higher than the pre-crisis 2010 low. Infant mortality stands at approximately 19 per 1,000, and neonatal mortality at 11 per 1,000 live births. The maternal mortality ratio is estimated at around 20 per 100,000 live births, though national reporting remains incomplete due to fragmented surveillance and weak referral systems.

According to WHO and UNICEF (2023), DTP3 immunization coverage is approximately 80%, but significant disparities persist in hard-to-reach and rural governorates. Antenatal care coverage was around 62% in 2022, and postnatal care coverage only 43%, reflecting limited access to comprehensive reproductive, maternal, and newborn services. Persistent shortages of midwives, obstetricians, incubators, and functional referral systems continue to undermine safe delivery and neonatal survival, especially in peripheral and newly accessible areas.

The leading causes of child morbidity and mortality remain prematurity, birth asphyxia, acute respiratory infections (including pneumonia), diarrheal diseases, and malnutrition. Recurrent vaccine-preventable outbreaks and limited continuity of maternal-child health services further compound risks to infants and young children. By comparison, UNICEF (2022) reported Jordan's under-five mortality at 14 per 1,000 live births and infant mortality at 12 per 1,000, underscoring the need for sustained investment in Syria's primary care, community midwifery, and neonatal referral capacity.

4.2.5 Mental Health and Psychosocial Support

The burden of mental health conditions has increased significantly due to prolonged conflict, displacement, and economic hardship. WHO estimates that about 1 in 10 people in Syria live with mild to moderate mental health conditions and about 1 in 30 with severe conditions, amounting to several million people nationwide. The most common disorders include depression, anxiety, and post-traumatic stress disorder, alongside severe illnesses such as schizophrenia and bipolar disorder. Specialist services are scarce, and integration of mental health into primary care remains limited. Most care continues to be provided by NGOs and humanitarian actors, with little sustainable capacity within the public health system.

4.2.6 Nutrition

Syria continues to grapple with widespread food insecurity and malnutrition, posing serious risks to child health and development. According to UNICEF, the prevalence of global acute malnutrition (GAM) rose from 1.7% in 2019 to 4.8% in 2023, reflecting a worsening trend. In the same year, nearly 2.9 million children aged 6–59 months were screened for acute malnutrition, with thousands of severe acute malnutrition (SAM) cases requiring therapeutic feeding interventions. Stunting remains a major concern, affecting 16.9% of children under five. Despite these pressing needs, nutrition services within primary health care facilities remain limited, with significant gaps in SAM management, routine screening, growth monitoring, and counseling. Compounding these challenges, micronutrient deficiencies and poor infant and young child feeding practices continue to add to the burden of malnutrition nationwide. Micronutrient deficiencies remain widespread, with nearly one third of children under five affected by anemia. Coverage of vitamin A supplementation is still below regional targets, leaving many children at risk of preventable illness. Infant and young child feeding practices also remain inadequate. Only about 40% of infants are exclusively breastfed during the first six months of life, which is well below global recommendations. According to UNICEF's 2025 update, only 35% of children continue breastfeeding until the age of two.

Poor maternal nutrition contributes to low birth weight and adverse pregnancy outcomes, while weak antenatal and postnatal care at the primary health care level heightens nutrition-related risks for both mothers and newborns. High food prices and declining household incomes reduce the quality of diets available to families, and limited access to primary health care further worsens the situation, as many facilities lack the nutrition services and supplies needed to provide adequate support. These pressures

restrict household options, drive reliance on negative coping strategies, and increase the long-term risks of both undernutrition and obesity.

4.3 Health System Status

4.3.1 Service Delivery and Infrastructure

The health system remains fragmented and under-resourced. According to WHO, as of early 2025 only 54% of hospitals and 39 % of primary health care centers are fully functional, while the remainder are either partially functional or completely non-functional. Many facilities are damaged, under-staffed, or functioning as “empty shells” with buildings intact but lacking staff, equipment, or medicines. Over 90% of medical devices are more than five years old, and shortages of spare parts, oxygen, and laboratory supplies disrupt continuity of care. Emergency and intensive care units cannot meet demand, and maternal and child health services are particularly affected by shortages of midwives, incubators, and obstetric equipment. Patients increasingly rely on overcrowded urban hospitals, private providers that are unaffordable for most households, or humanitarian-supported facilities that face funding shortfalls.

The organizational model that Syria is moving toward envisions an integrated and coordinated health system that connects community-based services, primary health care centers, and hospitals through clear referral and feedback mechanisms. Primary health care serves as the foundation and first point of contact, providing preventive, promotive, and basic curative services while referring patients who require advanced care to district or specialized hospitals. Hospitals deliver secondary and tertiary care and play a supportive role for primary care centers by offering supervision, back-referral, and capacity building to ensure continuity and quality of care. Governance is structured across three levels, with the Ministry of Health providing national leadership and oversight, governorate directorates managing coordination and supervision, and facility teams ensuring implementation and quality of services.

As part of this reform, the Ministry of Health will update and implement the Essential Health Service Package (EHSP) as the basis for equitable access to high-quality care. The revised package will define the essential preventive, promotive, and curative services that every facility should offer and will be introduced gradually, starting with the most critical areas such as maternal and child health, non-communicable diseases, communicable diseases, and emergency care. To ensure the EHSP is applied effectively, the Ministry will organize regular visits from health managers and supervisors to guide facility staff, identify gaps, and strengthen service quality. Health directorates will monitor whether facilities have the necessary medicines, staff, and equipment to meet EHSP standards and will review results after rollout to inform adjustments and support continuous improvement.

Supervision and monitoring will be coordinated between governorate directorates and health facilities using standardized tools connected to DHIS2 for timely reporting and follow-up. The EHSP

framework will also reinforce quality of care and strengthen referral pathways, ensuring that patients who need advanced care can be transferred smoothly from primary health centers to hospitals and then followed up afterward at their local facility. This two-way flow of care will help ensure that patients receive the right level of treatment at the right time while maintaining safety, consistency, and accountability across the health system. Together, these steps will improve quality, build patient confidence, and restore public trust in the health sector.

4.3.2 Human Resources for Health

Syria's health workforce remains critically understaffed compared to international norms. According to WHO (2020), the country had only about 2.2 doctors per 10,000 population, far below regional averages and well below the WHO-recommended threshold of 23 doctors, nurses, and midwives per 10,000 population. The WHO HeRAMS Public Hospitals Report (2021) found that in many governorates, combined densities of doctors, nurses, and midwives were often below 5 per 10,000. The Health Sector Annual Report (2022) estimated that up to 50% of Syria's health professionals have left the country since the start of the conflict. The shortage is particularly acute in family medicine physicians, as well as among specialists such as anaesthesiologists, intensivists, and oncologists, alongside nurses and midwives in both rural and urban areas. Low salaries, limited career advancement, and restricted access to continuing medical education continue to undermine retention across the system.

Health education institutions also face major challenges. Many experienced teaching staff have emigrated, reducing the availability of qualified faculty across medical and nursing schools. Several universities and training programs have been damaged or disrupted, limiting enrollment capacity and access to practical training. Accreditation of qualifications remains inconsistent, with no standardized national system in place to ensure that graduates meet uniform competency requirements. This gap undermines confidence in the quality of training, creates uncertainty for graduates, and affects their ability to practice or pursue further specialization. These challenges weaken the pipeline of new health professionals and contribute to the long-term shortage of skilled staff across the health system.

4.3.3 Pharmaceuticals and Supply Chain

Before 2011, Syria's domestic pharmaceutical industry produced about 90% of local demand through more than 60 factories, and according to the European Union's 2023 report on Syria's pharmaceutical industry, medicines were exported to up to 60 countries. The conflict disrupted this system, reducing output by more than 70% as factories were damaged, supply chains broken, and access to raw materials curtailed. While some production has resumed, supply remains far below pre-conflict levels, and domestic production now covers only part of the essential medicines list. Shortages of antibiotics, insulin, oncology medicines, and anaesthetics are common. Regulatory oversight remains weak, with outdated laws, fragmented enforcement, and no standardized national system to monitor quality, pricing, or distribution. This lack of standardization and regulatory control makes it difficult to guarantee safe, effective, and affordable medicines. Supply chains remain fragile, with frequent stock-outs and cold chain disruptions affecting vaccines and other sensitive products.

4.3.4 Health Financing

Syria's health financing is among the weakest in the region. In 2023, the country's GDP stood at approximately $20 billion, with GDP per capita of only $847. Government spending on health accounted for just about 1.41% of GDP in 2022, one of the lowest rates in the Middle East. As a result, households carry a disproportionate share of the cost of care, with out-of-pocket (OOP) payments representing nearly 46% of total health expenditure. This level is far above Lebanon at 33% and Jordan at 40%. Both neighboring countries also allocate a greater share of GDP to health, with 1.96% in Lebanon and 2.49% in Jordan, and benefit from higher per capita incomes of $3,478 and $4,466 respectively. These imbalances illustrate how Syria's chronically low public investment and economic collapse have shifted the financial burden to households, leading to delayed care, underutilization of services, and widening inequities, especially for the poor and those in rural areas.

GDP Comparison — Syria, Jordan, Iraq, and Lebanon (World Bank WDI, Latest Available)

Country	Population (millions) (2024)	GDP, current USD (billions) (2023)	GDP per capita (USD) (2023)	Government health spending (% of GDP) (2022)	Out-of-pocket (% of current health expenditure) (2022)
Syria	24,672,760	$20.0B	$847	≈ 1.41%	45.73%
Jordan	11,552,876	$53.4B	$4,466	2.49%	40.21%
Iraq	46,042,015	$279.6B	$5,965	2.18%	47.83%
Lebanon	5,805,962	$20.08B	$3,478	1.96%	33.42%

Sources: World Bank — World Development Indicators *(https://databank.worldbank.org/source/world-development-indicators) and World Health Organization* — Global Health Expenditure Database *(https://apps.who.int/nha/database). Retrieved August 25, 2025.*

The system is further weakened from heavy dependence on unpredictable humanitarian assistance and by extreme fragmentation in how funds are managed. While donors and NGOs remain critical lifelines for health services, their contributions are often short term and project-based, bypassing government systems and creating duplication in some regions while leaving others underserved. While a central budget allocation system exists within the public sector, there is no effective unified national pool that adequately spreads risk or enables resource reallocation across regions, which limits redistributive capacity and reinforces geographic and socioeconomic disparities. Public facilities depend on rigid line-item budgets that offer little flexibility and are not linked to performance or outcomes. Donor-financed programs often establish parallel payment mechanisms outside government structures, resulting in inefficiencies and poor alignment with national health priorities. At the same time, Syria lacks an explicit health benefits package to define the services that should be available to all citizens. Service provision therefore varies widely depending on facility, location, and donor support, leaving households uncertain about entitlements and exposing them to unpredictable and often unaffordable costs.

The conflict has further distorted financing and compounded inefficiencies. Attacks on hospitals and health workers, as documented by initiatives such as the Healthcare Protection Project, have

destroyed infrastructure, displaced staff, and forced facilities to adopt costly protective measures such as relocation, camouflage, and underground operations. These realities increase operational costs, divert scarce resources away from service delivery, and push many families into private or informal markets where prices are unregulated. For vulnerable households, the combination of high OOP payments, unpredictable service availability, and limited donor presence has resulted in high levels of catastrophic health expenditures and growing inequities in access to essential services.

Governance challenges cut across all dimensions of health financing. Decision-making is divided between the Ministry of Health, the Ministry of Finance, and a wide range of external actors, with weak coordination and limited accountability for how resources are allocated and spent. Public financial management systems remain constrained and lack transparency, while sanctions and broader fiscal pressures have further undermined the government's ability to mobilize and channel funds effectively. Thus, these factors have created a financing environment that is fragile, fragmented, and inequitable. Syria's health system is characterized by constrained and unpredictable public financing, a heavy reliance on households and humanitarian aid, weak pooling and purchasing arrangements, lack of a defined benefits package that specifies which services are guaranteed to the population, and a health financing system that struggles to absorb or respond to the disruptions created by conflict.

4.3.5 Health Information Systems and Digital Health

Health information systems are fragmented and incomplete. Most facilities continue to rely on paper-based reporting, and national mortality registration remains partial. NGOs and international partners often operate their own parallel reporting systems, which are not integrated into a unified national framework and lead to duplication and data gaps. There is also no modern, digitalized human resource information system, leaving health workforce records incomplete and outdated and hindering effective workforce management. Digital tools such as DHIS2 have been piloted in certain areas, including immunization tracking, but scaling remains limited by weak infrastructure, poor connectivity, and insufficient training of staff. Electronic medical record (EMR) initiatives have also been introduced in select facilities, but adoption is inconsistent, and there is no national standard or system compatibility across systems. Weak data governance continues to hinder evidence-based planning, monitoring, and evaluation across all levels of the health sector.

4.4 Key Challenges and Gaps

The Syrian health system is constrained by structural challenges. Many facilities remain damaged and under-equipped, and only a fraction are fully functional. The health workforce is severely depleted and unevenly distributed, with persistent shortages of doctors, nurses, midwives, and specialists. Low salaries, limited career progression, and weak training and accreditation systems further undermine retention and the pipeline of new professionals. Health financing is dominated by out-of-pocket payments, which account for nearly half of total spending and expose households to financial hardship. Public investment remains among the lowest in the region, leaving Syria behind most neighboring countries and widening inequities in access. Pharmaceutical production has

partially recovered but still covers only part of the essential medicines list, while weak regulation, lack of standardization, and fragile supply chains lead to recurrent shortages of antibiotics, insulin, oncology drugs, and anaesthetics.

Health information systems remain fragmented, with most facilities relying on paper-based reporting, NGOs operating parallel systems, and electronic medical records introduced inconsistently and without national standards or system compatibility. Current resources and institutional capacity for planning, monitoring, and evaluation across all levels of the health sector remain limited. Ongoing economic difficulties and international sanctions further constrain financing options and make it difficult to access the full range of technical partnerships and investments that would accelerate progress. Within this context, developing a comprehensive national HIS will require a phased approach. The immediate priority is to establish data standards, pilot solutions in selected facilities, strengthen workforce capacity, and put in place governance frameworks. These steps will create a realistic pathway for gradual expansion over the five-year plan while ensuring sustainability and alignment with available resources.

Alongside these technical barriers, the health sector also faces governance challenges. Inefficiencies and entrenched interests within and around the health system continue to distort resource allocation, complicate procurement and human resource management, and weaken oversight. These practices often blur lines of accountability and create incentives that do not support reform. Addressing them will require persistence, stronger oversight, and the steady expansion of accountability and transparency mechanisms that build public trust and shift incentives toward performance and integrity.

5. Guiding Principles

Strategic Vision
The Ministry of Health is committed to building a resilient health sector that can withstand sudden shocks and crises without interrupting essential services. This long-term vision emphasizes continuity of care, institutional strength, and equitable access, ensuring that the health system remains stable, adaptive, and responsive in the face of future challenges.

Participation and Consensus Orientation
The health system will be shaped through inclusive dialogue and collaborative decision-making. Communities, health workers, civil society, and other ministries will be meaningfully engaged in planning, implementation, and monitoring to strengthen ownership, ensure consensus, and align services with real needs.

Conflict-Sensitive Transparency
Transparency in governance, data, and resource use is essential to re-establishing credibility in the health system. Practices will ensure open information-sharing while being mindful of conflict legacies and diverse community experiences to avoid inequities and reinforce fairness.

Responsiveness
Policies and services will be flexible and adaptive, able to evolve with the changing health needs of Syrians. Responsiveness will be guided by continuous feedback, evidence, and a people-centered approach that prioritizes dignity and respect.

Equity and Inclusiveness
Health services must be delivered fairly and without discrimination. Special attention will be given to vulnerable groups, including women, children, the elderly, people with disabilities, and those with chronic conditions, ensuring that no one is left behind in the national health agenda.

Effectiveness and Efficiency
Resources will be managed responsibly to maximize health outcomes. Effectiveness will be pursued through evidence-based policies and results-focused implementation, while efficiency will be promoted through rational use of medicines, technologies, infrastructure, and workforce capacity.

Accountability
Clear roles, responsibilities, and performance monitoring will underpin the health system. Regular reviews, stakeholder engagement, and transparent reporting will ensure that commitments are met and that institutions remain accountable to the population.

Ethics
The health system will be grounded in ethical principles of medical practice, human rights, and integrity. Ethical standards will guide governance, research, and service delivery to ensure fairness and respect for human dignity at all levels.

Localization
National ownership will be central to the health system's transformation. Syrian institutions, expertise, and communities will lead the process, with international support directed toward reinforcing rather than substituting local capacity.

Social Trust
Reestablishing and sustaining trust between citizens and the health system is a cornerstone of long-term stability. Trust will be fostered through fair service delivery, participatory governance, and alignment with community needs and expectations. It will serve as the operational foundation for equity, accountability, and resilience.

6. SWOT Analysis

Strengths	**Weaknesses**
- Presence of qualified and specialized health professionals across different fields - Strong commitment, responsibility, and sense of mission among staff - Existing network of health facilities across urban and rural areas - Good reputation of the health workforce and trust from the community - Accumulated institutional experience in responding to emergencies and crises - Ability to mobilize human resources quickly when needed - Existence of some coordination mechanisms and partnerships with health actors - Availability of staff with academic and strong training backgrounds - Community engagement in certain health programs	- Severe shortage of financial resources; heavy dependence on external donors - Weak health information systems; poor or unreliable data collection and reporting - Shortage of essential medicines, equipment, and medical consumables - Overworked staff; high levels of stress, exhaustion, and burnout - Lack of ongoing training and capacity-building opportunities - Weak monitoring, accountability, and evaluation structures - Insufficient technical and administrative planning capacity - Poor infrastructure in many health facilities (damaged buildings, outdated equipment). - Lack of access to some areas including northeast Syria and Sweida - Lack of humanitarian aid alignment and harmonisation with health national plans.
Opportunities	**Threats**
- Political stability - Economic improvement. - Active support from diaspora, international partners and donors for rebuilding the health system - Chance to unify the health system after years of fragmentation - Potential investment in digital health and health information systems - Partnerships with universities and research centers to strengthen evidence-based health policies - Ability to expand community health worker programs and preventative care efforts - Growing demand from population for equitable access - Opportunity to design new health financing mechanisms, including health insurance schemes	- Security instability affecting planning and implementation - Donor fatigue and decrease in external funding - Deep economic crisis limiting national budget allocation to health system - Continuous migration of qualified health workers abroad - Persistent public mistrust in government institutions if performance does not improve - Sanctions and restrictions blocking medical imports and technical support - Vulnerability to epidemics and emerging diseases - Overlapping mandates and competition among health organizations - Risk of corruption and mismanagement of limited resources - Social and regional inequalities leading to uneven access to services

- Prospect for public-private partnerships in service delivery and supply chains - Increasing interest in aligning with international health strategies and frameworks (UHC, SDGs)	- Pressure from sudden humanitarian emergencies diverting attention from long-term reforms

7. Strategic Goals and General Objectives (2026-2028)

7.1 Health Infrastructure Rehabilitation

Rehabilitating health infrastructure remains one of the most urgent priorities for Syria's health sector in the early recovery phase. Years of conflict and neglect have left many hospitals, primary health care centers (PHCs), and referral facilities damaged, under-equipped, or only partially functional. Without safe and adequately resourced facilities, essential services cannot be delivered, and public trust in the health system cannot be restored. The Ministry of Health views early recovery as a bridge from humanitarian response to development, ensuring that rehabilitation investments lay the foundation for sustainable, nationally led system strengthening. The Ministry will establish a validated national facility registry as the foundation for planning and monitoring rehabilitation efforts, prioritize facilities based on need, and ensure compliance with WASH and safety standards. Integration of facility-level information with digital tools and equity monitoring will guide transparent and evidence-based resource allocation.

By the end of 2028, a national facility registry will be integrated into the health information system, priority hospitals and PHCs will be rehabilitated and equipped, and equity monitoring reports will inform investment decisions. These outcomes will restore functionality and provide the physical backbone for broader health system reforms. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.2 Health Workforce Development

A strong, skilled, and motivated workforce is the foundation of a resilient health system. Years of conflict have weakened Syria's health workforce, resulting in migration, uneven distribution, and shortages in critical specialties. Training institutions have faced disruptions, limiting professional development and reducing the supply of qualified graduates. The Ministry of Health will establish a Health Workforce Unit to lead national mapping, training, and deployment efforts. It will finalize and implement the Human Resources for Health (HRH) Strategy and Roadmap, expand competency-based training modules, and introduce retention and incentive programs for priority cadres, with linkages to community health workers where relevant. A Health Labour Market Analysis and workforce investment note will guide future planning and financing decisions.

By the end of 2028, a Health Workforce Unit will be established, a national HRH roadmap will guide recruitment and distribution across all governorates, in-service training will be expanded, and formal

partnerships with universities and development partners will strengthen workforce capacity and retention. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.3 Health Financing & Sustainability

Health financing is a vital component of system recovery and long-term resilience. In Syria, public health spending has remained far below regional averages, and years of conflict, economic crisis, and sanctions have further weakened fiscal capacity. As a result, the health sector depends heavily on external support, while households face high out-of-pocket costs that put many at risk of financial hardship. Without a clear understanding of current health expenditures and reliable mechanisms for resource mobilization, the system cannot move toward equity or universal health coverage. The Ministry of Health is committed to reestablishing the foundations of financial governance in the sector. This includes restarting the National Health Accounts, mapping existing health services, and piloting cost analyses to better understand the resource needs of the system. A strengthened Universal Health Coverage (UHC) Unit within the Ministry will coordinate financing reforms, engage with partners, and ensure that spending decisions are evidence-based and aligned with national priorities.

By the end of 2028, a Health Financing Unit will be established within the Ministry of Health to guide sector-wide financial reforms and dialogue. An updated National Health Accounts and costed service maps will inform transparent and efficient financial governance, enhance resource mobilization, and protect households from financial hardship. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.4 Service Delivery

Strengthening service delivery is central to the recovery of Syria's health sector. Years of conflict have fragmented service provision, left facilities unevenly resourced, and created large gaps in access to essential care. Strengthening primary health care, including by defining and implementing an EHSP will ensure that services are standardized, equitable, and aligned with the principles of universal health coverage. The EHSP will serve as the framework for what every citizen should be able to access, regardless of geography or socioeconomic status. It will also incorporate basic mental health and psychosocial support as part of primary care, ensuring that communities have access to essential services that address both physical and mental well-being. There will also be a focus on equitable access, readiness, and integration of community health components within the PHC network.

The Ministry of Health aims to update and merge existing service packages into a single national EHSP, revise and standardize treatment protocols, and establish surveillance and response systems to better manage public health threats, including preparedness and response interventions. Demand generation components will also be taken into account. These measures will not only improve the

quality of services but also bring consistency across facilities and partners. Piloting the EHSP in selected facilities will help refine the package before it is scaled nationally.

By the end of 2028, a nationally endorsed EHSP will be piloted and costed, standardized protocols will be implemented across Ministry facilities, and quality assurance mechanisms will be institutionalized to improve service quality, equity, and efficiency. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.5 Governance and Partnerships

Strong governance and effective partnerships are vital for sector recovery and accountability. The Ministry of Health will enhance stewardship by clarifying institutional roles and strengthening coordination, planning, and accountability systems at national and subnational levels. To improve transparency and partner alignment, the Ministry will operationalize a National Health Coordination Platform with a donor coordination and reporting mechanism jointly managed with the Ministries of Finance and Foreign Affairs. This platform will align external support with national priorities and consolidate health expenditure data to inform the NHA process. At the governorate level, Health Coordination Committees chaired by local health directorates will support supervision, performance review, and data validation. Expansion of DHIS2 and digital dashboards will strengthen data-driven decision-making.

By the end of 2028, core governance and partnership mechanisms will be established and operational, laying the groundwork for unified national leadership, better aid coordination, and stronger accountability across the health sector. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.6 Access to Medicines and Medical Products

Equitable access to quality-assured medicines and medical products is essential for functional service delivery. The Ministry of Health will establish a Supply Chain Unit to lead procurement, logistics, and distribution of essential medicines and vaccines, ensuring uninterrupted availability nationwide. The Supply Chain Unit will coordinate forecasting, strengthen LMIS systems, expand cold-chain infrastructure, and align partner support with national standards. Complementary reforms will enhance local pharmaceutical production, quality testing, and regulatory oversight, including a national pharmacovigilance framework.

By the end of 2028, a fully functional Supply Chain Unit will be operational, LMIS piloting will be completed, and quality control and regulatory mechanisms will be institutionalized to ensure transparent, efficient, and reliable access to safe medicines and medical products. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.7 Digital Transformation

Digital transformation is critical to strengthening health information systems and enabling data-driven governance. The Ministry of Health will establish a Digital Health Unit to coordinate digital policy, interoperability, and investment. Priority actions include developing and piloting an electronic medical records system in selected PHCs, training health information system personnel, and integrating facility registries with DHIS2 platforms. The Ministry will also develop a national digital health policy and data protection framework to ensure secure information sharing and patient privacy.

By the end of 2028, the Ministry will have established the foundations for digital health transformation, including the completion of a national system readiness assessment and initial implementation of electronic medical records, health registries, and data dashboards. Efforts will also focus on developing a skilled digital workforce and a validated policy framework to strengthen transparency, coordination, and efficiency across the health sector. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

7.8 Health Security

Health security is a core pillar of national resilience and essential to achieving Universal Health Coverage. The Ministry of Health will strengthen surveillance, preparedness, and response capacities to prevent, detect, and manage public health threats while maintaining essential services during emergencies. A national surveillance and response framework aligned with IDSR and IHR (2005) will be developed and implemented, integrating outbreak preparedness, maternal and perinatal death surveillance, and community reporting. Rapid Response Teams will be reestablished across governorates, AMR monitoring expanded, and Field Epidemiology Training strengthened to improve early detection and response. The Ministry will establish an IHR and Health Security Unit, a Public Health Emergency Operations Center (PHEOC), and a Continuity of Essential Health Services (CEHS) framework to sustain care during crises. Cross-sector collaboration will be enhanced through a One Health platform, while risk communication and community engagement will be institutionalized to build public trust and promote early action.

By the end of 2028, Syria will have an operational national surveillance and response system, functional rapid response teams, expanded laboratory and AMR capacity, a Health Security Unit, an PHEOC, and a CEHS framework ensuring service continuity. Further details on activities, outputs, and indicators are provided in the logframe in the annex.

8. Monitoring, Evaluation, and Accountability

Monitoring and evaluation of the Strategic Plan is essential to ensure accountability, guide decision-making, and prepare the foundation for a five-year national health strategy. Given staffing and institutional constraints, the MoH will adopt a streamlined approach that draws on existing data sources and partner support rather than creating parallel systems. Progress will be measured using a core set of indicators identified in the logframe, covering each strategic pillar. Data will primarily be drawn from MoH facility reports, service delivery statistics, supply chain records, and partner

reporting mechanisms. Since these sources are often incomplete due to disrupted reporting systems and uneven coverage, the MoH will bridge gaps through rapid assessments that provide quick snapshots of service availability, supervision visits that verify information and reinforce accountability, and targeted surveys that capture community-level needs and service quality. These tools will help validate routine reporting and strengthen the evidence base until national systems are rebuilt.

The Planning and Statistics Directorate will lead the monitoring and evaluation process, with departmental focal points responsible for consolidating progress on specific objectives. To keep reporting practical, the committee will introduce a Quarterly Implementation Update template that departments and partners can complete using data they already generate. These will be synthesized into Quarterly Progress Briefs to inform leadership discussions, highlight achievements, and flag bottlenecks. At the end of each year, the committee will convene an Annual Review Workshop with MoH directorates and partners to validate progress, analyze gaps, and identify lessons learned. The findings will be documented in an Annual Progress Report, serving both as an accountability mechanism and as a basis for refining implementation in the second year and shaping the five-year strategy. To ensure transparency and accountability, key updates will be shared with leadership, partners, and stakeholders during coordination forums. Over time, these mechanisms will evolve into a more comprehensive national M&E framework anchored in a revitalized health information system. All indicators will be disaggregated by sex and, where relevant, by age and geographic area to ensure equitable monitoring and reporting.

9. Risks and Assumptions

The implementation of the strategic plan will unfold in a complex environment where both internal and external factors may affect progress. Recognizing these risks and stating assumptions transparently allows the Ministry of Health to manage expectations and adapt as conditions evolve. By outlining these risks and assumptions, the plan establishes a balanced framework for implementation, while allowing flexibility to adapt as conditions change.

Risks

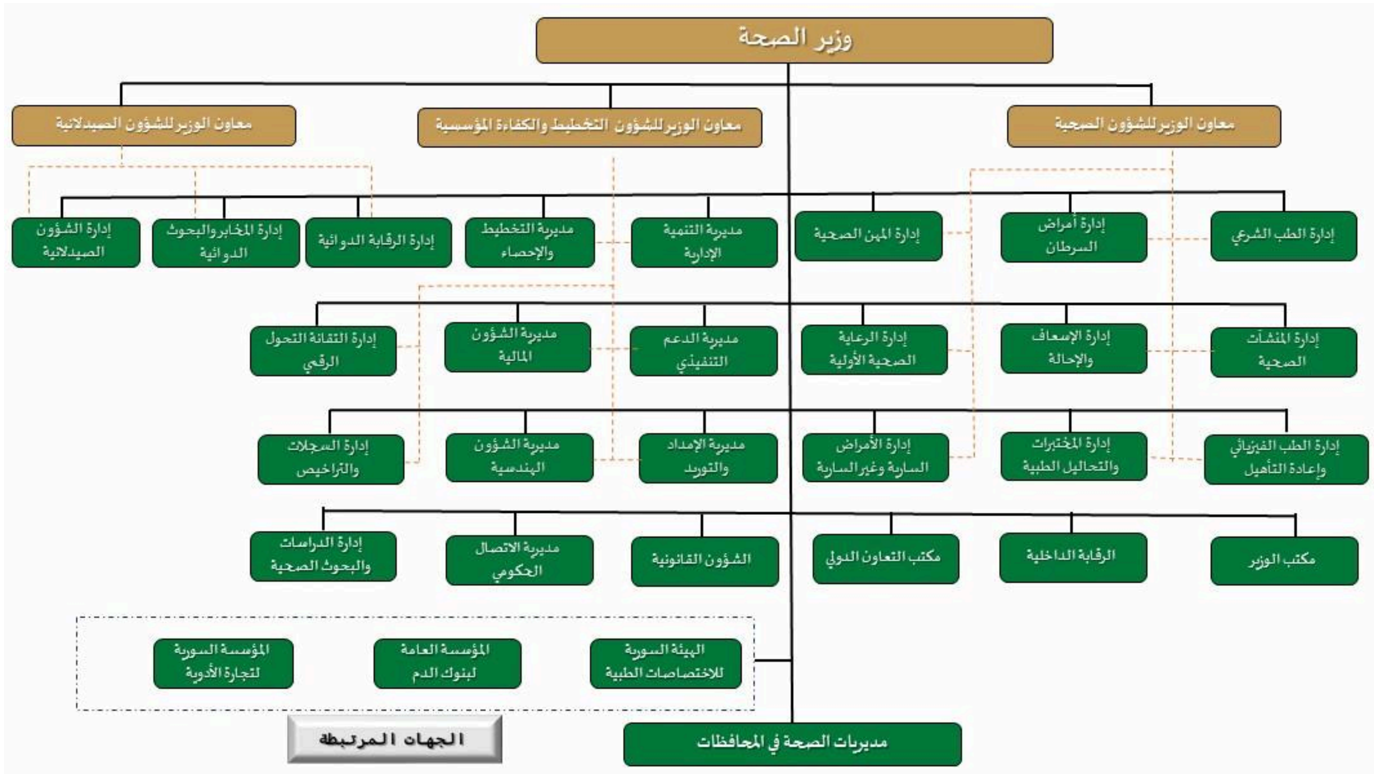
- Political and security developments may disrupt access, delay rehabilitation, or constrain partner engagement.
- Economic constraints and sanctions may reduce fiscal space for health investments.
- Incomplete or outdated health records and information systems may slow planning and allocation of resources.
- Shortages and uneven distribution of health workers may limit the ability to scale up services, especially in rural areas.
- Donor fatigue, shifts in partner priorities, and fragmented or parallel financing mechanisms may reduce predictability of funding and weaken alignment with national strategies.
- Delays in establishing pooled or harmonized financing arrangements could limit the ability to channel resources effectively.س

- Procurement bottlenecks, damaged infrastructure, and administrative delays may slow implementation.
- Delays in establishing the Health Financing Unit, pooled funding mechanisms, or harmonized partner coordination may reduce financial predictability.
- Weaknesses in procurement systems, cold-chain capacity, or supply-chain coordination could lead to stockouts of medicines and vaccines.
- Data fragmentation, weak interoperability, or delays in digital transformation could slow evidence-based planning and monitoring.
- Health security threats, including disease outbreaks, antimicrobial resistance (AMR), or climate-related emergencies, may disrupt service delivery and divert resources.

Assumptions

- Stability will continue to improve sufficiently to allow phased rehabilitation and service delivery.
- Partners will maintain technical and financial support for priority areas, including health financing, workforce, digital health, and supply-chain strengthening.
- Data systems and digital platforms will continue to expand, enabling better integration, transparency, and reporting across all programs.
- Emergency preparedness, risk communication, and health security systems will remain functional and responsive during crises.
- The Government will remain committed to leading recovery efforts and coordinating with partners.
- International agencies, NGOs, and diaspora professionals will sustain technical and financial support during the early recovery phase.
- Health workers will engage positively with training, supervision, and incentive mechanisms to improve service quality and retention.
- Communities will progressively regain trust in public facilities and participate in new initiatives such as the Essential Health Service Package and community health models.
- Where data and records are incomplete, the Ministry will use rapid assessments, supervision visits, and targeted surveys to validate and fill gaps until national systems are strengthened.
- Donors and partners will work toward greater coordination and alignment, progressively reducing parallel funding streams and strengthening national ownership of recovery efforts.

10. Annexes



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