annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

المركز السوري لبحوث السياسات
Syrian Center For Policy Research

DEVASTATION OF THE RIGHT TO HEALTH DURING THE CONFLICT IN SYRIA

2023

Syrian Center for Policy Research

This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

The report is published by the **Arab NGO Network for Development** (ANND). It can be obtained from ANND or can be downloaded from the following website: **http://www.annd.org**

SUPPORTED BY

Brot für die Welt | Norwegian People's Aid | People Change the World Diakonia

DEVASTATION OF THE RIGHT TO HEALTH DURING THE CONFLICT IN SYRIA

Syrian Center for Policy Research[1]

The Syrian Center for Policy Research (SCPR) is an independent, non-governmental, and nonprofit research center; which undertakes policy-oriented research to bridge the gap between research and policy making process. SCPR aims to develop a participatory evidence-based policy dialogue to achieve policy alternatives that promote sustainable, inclusive, and human-centered development.

[1] The authors of the report are: Rabie Nasser, Hamed Saffour, and Majd AlGhatrif.

CONTENTS

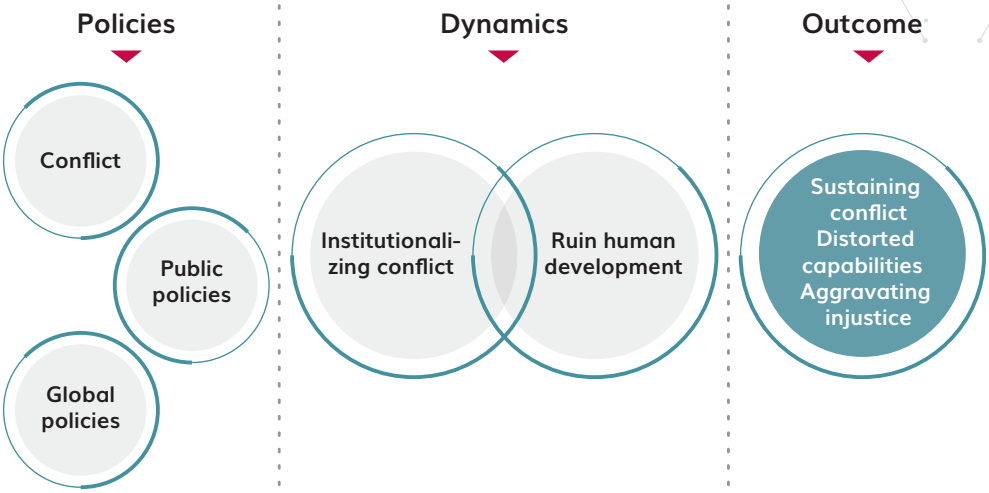
INTRODUCTION

The health sector lies at the heart of every political, social, and economic system that governs a country. The sector has two major interlinked components, the health system and the health outcome or population health (WHO 2008). A healthy population and an effective, efficient, just, and accountable health system are vital goals of the sustainable development paradigm that is based on empowering people's capabilities and functions. In addition to external factors such as the geopolitical situation, the health system and its outcome are formed by key determinants (WHO 2008), including: the power structure and political system; the social relations and norms; the economic performance and status of living conditions; environmental conditions and demographic characteristics.

This paper is written as part of the Arab Watch Report on Economic and Social Rights 2023 on the Right to Health. It aims to assess the right to health during the conflict in Syria. The paper uses the political economy approach (Cohn & Hira 2020) to deepen the understanding of power relations in conflicts through analyzing the context of war, mapping the key actors, analyzing the policies and interventions, and assesses the impact of different factors on populations' capabilities (as per the capabilities approach, developed by Sen 1999). It integrates the political, social, and economic spheres in the time of war to diagnose the complex dynamics of the conflict.

This paper summarizes the disastrous health outcomes, identifies the key actors and their policies that affect population health and health system, and diagnoses the social determinants of health in the conflict context. In the context of the conflict, the warring actors' policies create dynamics that institutionalize conflict and weaponize health systems to dominate power and subordinate people and society (**Figure 1**). Finally, it provides recommendations to counter the conflict dynamics and mitigate the negative impacts on public health.

Figure 1. Policies, dynamics, and outcomes of conflict



Source: SCPR, 2022

The report relies on several surveys that have been conducted by the Syrian Center for Policy Research (SCPR) in the whole of Syria, the population status survey 2014, socioeconomic surveys 2020 and 2021,[2] and citizenship surveys 2022. These surveys used participatory approaches with the local community and comprised in-depth interviews with key informants. Also, this paper uses the monthly SCPR Consumer Prices surveys 2020-2022; the SCPR contribution to the Lancet-AUB Commission on Syria;[3] and a background paper on Syrian Conflict and Health Capabilities.[4] The paper also uses relevant secondary data and literature from different sources, cited throughout the report.

The intractable catastrophic conflict in Syria reflects a critical failure of international, national, and local mechanisms to enforce the right to protect, as millions of Syrians have been killed, injured, kidnapped, tortured, displaced, and deprived from basic rights. The conflict has squandered massively people's rights, capabilities, and options. This has been associated with a severe distortion of institutions and socioeconomic and environmental systems. The conflict also has dangerous effects for the region and the whole world such as the aggravation of transnational conflict economies, identity politics and extremism, oppression and unaccountable political powers, normalization of grave human rights violations, and struggles in the Security Council.

The intractable armed conflict has fragmented the geography of Syria between several local, regional, and international

[2] These surveys cover the whole of Syria. They were administered to several purposively selected key informants in each district to assess the socioeconomic status in the respective district. In 2020, 134 interviews were conducted, in 2021, 179 interviews were conducted, and in 2022, 232 interviews were conducted across all of Syria.
[3] Read more about the Lancet-AUB Commission on Syria here.
[4] See the background paper on Syrian Conflict and Health Capabilities here.

actors. This fragmentation resulted in the creation of institutions highly dependent on violence; as the conflict became the source of power, resources, and incentives. These institutions negatively affected the overall health system; including hampering access to services and medications; perpetuating pervasive discrimination; weakening healthcare capacity; causing the destruction of health infrastructure, including the targeting of hospitals and Healthcare Workers (HCWs); and triggering the deterioration of the Syrian pharmaceutical industry (Fouad et al. 2017; SCPR 2020).

COVID-19 is a new factor that damaged public heath directly as the confirmed cases and related deaths increased substantially, and the pandemic caused the further deterioration of the socioeconomic situation for Syrians across the country. Moreover, the earthquake in February 2023 added a new level of suffering for Syrians. The catastrophic impacts of this earthquake were not limited to physical and human losses but extended to impact Syria's economic, social, and political structures.

RIGHT TO HEALTH IN LEGISLATIONS

The right to health is addressed in the Syrian constitutions of 1974 and 2012 in addition to the five years plans and health related legislations. For instance, the 2012 Syrian constitution referred to the right to health in Article 22: "1- The state guarantees every citizen and his family in cases of emergency, sickness, disability, orphanhood, and elderly. 2- The state protects the health of citizens and provides them with means of prevention, treatment and medication." Article 25 of the 2012 constitution states that "Education, health and social services are basic pillars for building society, and the state works to achieve balanced development among all regions of the Syrian Arab Republic."

The 10th Five-Year Plan (10th FYP), covering 2006-2010, was the most promising government plan to develop heath policies and outcomes. The Plan highlighted six principles for health development (The 10th FYP 2006[5]):

> 1. The state's commitment to ensuring healthcare for all citizens without discrimination and working to improve health conditions throughout their lives.
>
> 2. The Syrian people are the focus and goal of the comprehensive development process, and ensuring

[5] The original text in Arabic translated by the authors.

a better health condition for all of them is the best investment in the process of sustainable development.

3. Improving the health status of the poor and deprived groups represents the most effective way to improve the health status of society.

4. Preventing disease and promoting healthy lifestyles represents a priority for the health sector.

5. Equitable distribution and availability of basic and emergency health services to all citizens, regardless of their ability to pay.

6. A high-performance and quality health system that citizens trust and participate in at all levels.

The plan also critically analyzed the health system prior to 2006: "...the structural and functional weaknesses of the health system prevented the optimal investment of the limited resources available. The weakness of the health system is evident in the absence of a regulatory reference and a clear health policy that sets priorities and coordinates the roles of stakeholders to prevent overlapping roles, conflicts of interest, bureaucratic inflation, and random growth of the private sector. This has led to poor response of health services to the real needs of the population, poor distribution, low quality, and poor economic efficiency" (The 10th FYP 2006).

The Constitution and the 10th Five Year Plan addressed the right to health and insisted on the importance of establishing an effective health system and inclusive health policies. However, the 10th FYP adopted implicit neoliberal policies such as aiming for cost recovery and targeting the poor. For example, the plan stated that "A fee system will be used in all health institutions to cover the costs of health services not included within the basic health services portfolio for solvent people. It is worth mentioning that the costs of providing the poor with those services will be through the security and protection nets." Also, the plan considered changing the role of the state in health towards regulating function and expanding the role of the private sector in providing services: "The state will focus on providing an enabling environment for the private and civil sectors to increase investments in the health sector and provide economic, financial and legal incentives to encourage these two sectors to respond to the health needs of

citizens according to a national plan; yet the state will continue to play a key role in providing these services in disadvantaged areas and for poor people. (....) while the state will stop capital investment in health facilities (except in cases of extreme necessity)" (The 10th FYP 2006).

PUBLIC HEALTH PRIOR TO THE CONFLICT

In Syria, prior to the conflict, the health sector witnessed several phases, of which the first – in the nineteen sixties and early nineteen seventies – was marked by a horizontal expansion in infrastructure, services, and human resources, particularly in the public sector. This phase ended in the late nineteen seventies when the country witnessed an escalation of internal and external conflicts with a severe distortion in institutional performance which continued during the nineteen eighties. These conflicts, especially the internal one, and the dominance of military and security-based governance created a reversed socioeconomic transformation in Syria. The political power excessively used violence and withdrew gradually from providing adequate health services for the population while the private sector expanded to fill the gaps in providing health services and participating as a producer in the pharmaceutical industry. The quality of services dropped substantially, and governance of the sector was severely damaged.

In the third phase, which began in the early 1990s, the political regime gradually shifted towards neoliberal market-oriented policies[6] which were associated with severe inequality and created new alliances between the military/security and the private elite. The public resources allocated to the health sector dropped substantially, and the cost accumulated at the expense of the ordinary people. The economic "reform" was associated with the continuation of the authoritarian political regime. The neoliberal policies expanded in the first decade of the new millennium, and the public sector shrunk in the health sector while the cost of health services increased. Several external donors, particularly the European Union (EU), supported the health sector "reform" which aimed at changing the role of the public sector towards regulation, and gradually implemented the principle of cost recovery, in addition to replacing free services with an insurance system.

The marginalization of most Syrians and the absence of political participation prevented any channel to correct the public health policies. Additionally, the corrupted and inefficient institutions led to the deterioration in health system's performance and hence the public health outcome. The reduction of oil production in the new millennium affected public revenue, the structure of trade, and available rent for

[6] As part of the radical change that was associated with the dissolution of the Soviet Union.

the elite. This led to a drop in public investments and public services, and a reduction of subsidies for basic commodities including oil derivatives and basic food items. These socioeconomic "reform" policies increased the cost of living, created only few job opportunities, expanded the informal labor market, and reduced the labor force participation rate for men and women (SCPR 2016). Therefore, the determinants of health had already deteriorated prior to the conflict.

Syria witnessed a substantial shift in the stages of epidemiological transition during the last quarter of the previous century, as chronic diseases formed about 60% of the overall diseases burden in Syria, while maternal and child diseases formed 25%, and accidents and injuries formed 15%. The following diseases were the main causes of mortality in Syria in 2008 (Higher Commission for Scientific Research 2011):

- Heart and blood vessels diseases: the main cause of mortality in Syria, as the rate of mortalities caused by these diseases was 49.2%.
- Respiratory diseases and infant diseases: the second largest cause of mortality, causing 11.1% of the number of deaths.
- Malignant tumours: is the third most common cause of mortality in Syria (6.7% of the total deaths).
- Accidents: 5.5% of all deaths.

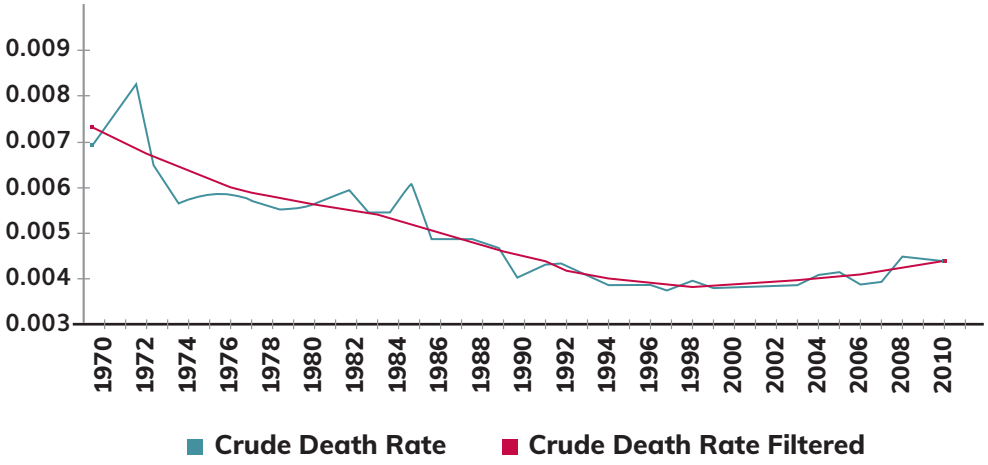
As for the nature of common diseases, the Health Expenditure Survey in 2010 shows that 20.1% of healthcare services were provided for treatment of respiratory disorders, 13.1% for heart problems, 11.2% for muscular system disorders, and 10.9% for dental issues. These were followed by gynecological diseases, intestinal disorders, diabetes, and tumors. The results indicate that respiratory problems among children aged less than fifteen years rose significantly. The survey shows that the health system focuses on treatment of chronic and acute diseases, whereas it spends little effort on precautionary measures. It also indicates that medical care is mainly a private service, as only 18% of medical services are provided through the public sector.

The Forced Dispersion report showed an increase in life expectancy at birth from 64 years in 1978, according to a fertility survey in 1976-1978, to about 71 years in 1995 and 72 in 2000. Life expectancy did not increase between 2000 and

2007 and then declined to 70.8 in 2010[7] (SCPR 2016). These numbers indicate a decline in the level of Syrians' wellbeing and wellness during the last decade.

Other health outcome indicators reflect the inefficiency of the health system such as high rates of chronic diseases, which increased from 7.9% in 2001 to 10.3% in 2009, and the mortality of children under 5 years of age from 20.2 children per thousand to 21.4 per thousand in 2001 and 2009 respectively (Family Health Survey 2001 and 2009). Also, the crude mortality rate increased from 3.8 per thousand in 2000 to 4.4 per thousand in 2010 (**Figure 2**). The increase of the mortality rate indicates the status of inequality and ineffectiveness of the health system and the public health policies in Syria before the war (SCPR 2016).

Figure 2. Crude death rate in Syria 1970 - 2010

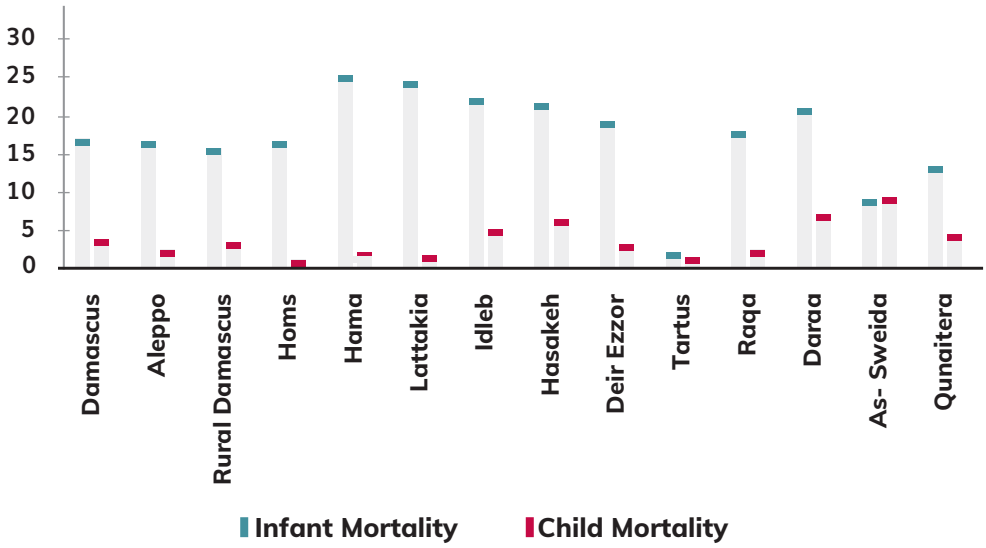


Source: Vital records and SCPR's calculations.

The openness, deregulation, and privatization expanded the role of external and internal private elites in designing public policies and increasing inequalities between regions, population groups, and classes. For example, health indicators in 2009 such as the child mortality rate per thousand live births indicated high rates in Hama and Lattakia (25), Idleb and Hasakeh (22), compared to (2) in Tartous (**Figure 3**) (Central Bureau of Statistics 2009). The average population-to-doctor ratio is 1185 in Idleb, 1157 in Hasakeh, compared to 186 in Tartous and 340 in Damascus, while the national average is 661. Indications from public health and healthcare systems also suggest general neglect of rural areas, particularly in the northern and eastern regions (Central Bureau of Statistics 2012).

[7] According to the Human Development report, the life expectancy in Syria reached 74.7 in 2010, which is higher than the average life expectancy of high human development countries (73.9).

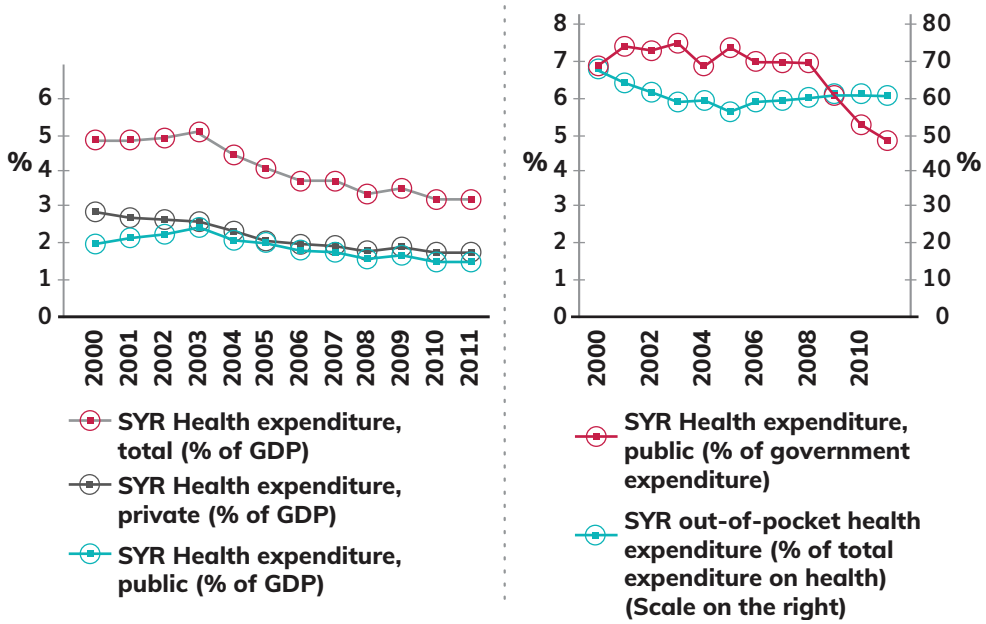
Figure 3. Infant and Child Mortality Rates in 2009 across governorates



Source: Central Bureau of Statistics of Syria, 2009, "Health Household Survey - Papfam"

Furthermore, the public expenditure on health dropped from 2% of GDP in 2000 to 1.5% in 2010, while the private expenditure on health dropped dramatically from almost 3% of GDP to 1.7% in 2000 and 2010 respectively (**Figure 4**). Additionally, instead of the large public health infrastructure, equipment, and subsidies, medical care was mainly a private service, as only 18% of medical services were provided through the public sector (Central Bureau of Statistics 2011).

Figure 4. Expenditure on health



Source: World Bank Indicators 2022

PUBLIC HEALTH DURING THE CONFLICT

PREFACE

The conflict in Syria has multidimensional socioeconomic, political, environmental, and geopolitical roots, however, the core root can be labeled as the "institutional suffocation" as the political oppression was the extreme factor that abused the public authorities, prevented power sharing, marginalized most Syrians, and shrunk the public space with the hegemony of the military and economic elite.

The social movement in 2011 called the "Arab Spring" demanded freedom and social justice and represented accumulated political and developmental grievances that the ruling authorities failed to address or mitigate. The authorities decided to suppress the movement using violence, which triggered a vicious cycle of armed conflict dynamics that created new unprecedented levels of injustice, violations, and deprivations.

Several global and regional powers were involved in the conflict which internationalized it and expanded the resources and means allocated to fuel the battle. The brutality and intensity of the conflict have resulted in a failed country where the political power has been fragmented between state and non-state actors. Public institutions and resources are reallocated to destructive policies and activities and the social fabric has been degraded based on identities, political affiliations, and economic interests. The human and economic resources have been destroyed or distorted. At the same time, enormous humanitarian efforts and interventions have been initiated to support Syria, which has become dependent on international aid.

The armed conflict in Syria ruined human capabilities and freedoms, as defined in Sen's capability approach (Sen 1999), as the orientation of public policies and interventions were shifted towards fueling and sustaining the violence and military battles and/or mitigating the impact of the war on allied institutions and communities. The conflict led to a radical reformation of the roles of the subjugating political actors, each of whom adopted conflict-centered policies that supported their priorities to "win" the war. Nevertheless,

humanitarian and/or pro-peace actors expanded their roles to mitigate the impact of the conflict and facilitate reconciliations or peace building initiatives in addition to their developmental contributions to plant new foundations for sustainable development in the future. However, those pro-peace actors in many cases lacked the power and capacity to stop the war, as the sources of power during the conflict, including military, economic and institutional, were controlled by the subjugating actors. The shrinking space for civil society, humanitarian and development actors forced them to adapt their strategies and subordinate to the rules of the oppressors.

The conflict led to a substantial and direct deterioration of human capabilities including basic rights such as the right to life, dignity, equity, security, protection, work, decent living conditions, health and education among others. Conflict prevents people from being or doing what they value, and more dangerously, it might force them to alienate themselves from their public and private interests which might lead them to the identification with the oppressors or war lords.

DEVASTATING HEALTH

The violence unleashed in wartime has had profound and immediate impacts on the fabric of life in Syria. The section investigates the enormous health burden caused by the conflict.

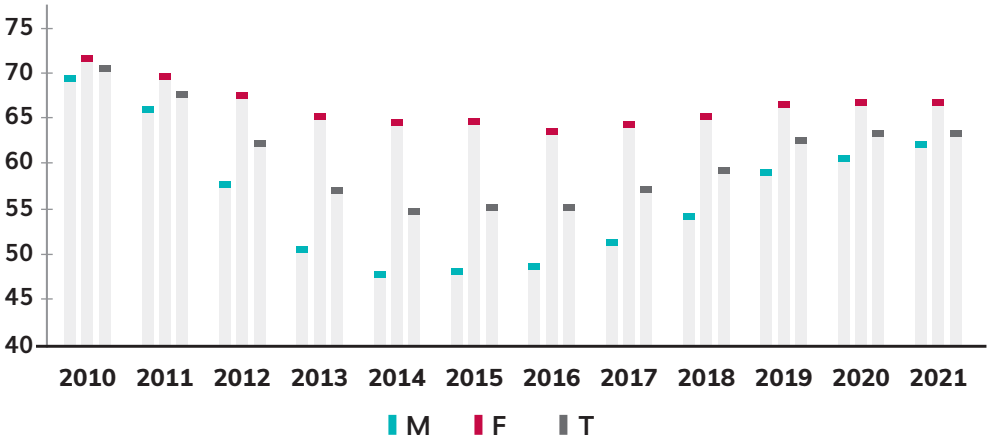
This section provides key health status indicators in Syria during the conflict, that includes communicable and non-communicable diseases, mortality rates and life expectancy, disability, and malnutrition. It shows the severe collapse of the public health sector that was accompanied with grievances, violations, and inequalities.

According to SCPR estimations the conflict in Syria caused the death of more than 700 thousand persons.[8] This represents the brutal violation of people's right to life. Accordingly, the mortality rate surged as the most catastrophic impact of the conflict. The crude death rate rose from 4.4 persons per thousand in 2010 to 10.9 per thousand in 2014, after which it gradually declined to 7.1 per thousand in 2021. The high number of lives lost reflects the brutality and intensity of the Syrian conflict (SCPR 2020). Males of working age were disproportionally affected by this, which widened the gap in life expectancies between men and women to around 17 years in 2014 and reduced again to 5 years in 2021. However, the mortality rates of women, elderly and children exposed the

[8] Human Status in Syria: estimates based on the results of a survey conducted by SCPR in the whole of Syria through 2,100 in depth interviews with key informants.

grave violations carried out by the warring parties (**Figure 5**).

Figure 5. Life expectancy by gender (2010-2021)



Source: Population survey 2014 and SCPR estimations, 2022

The earthquake in February 2023 led to 10,659 deaths among Syrians in the affected areas and for Syrians residing in Turkey,[9] and 11,829 injuries inside Syria. The victims were distributed as follows: 1,935 victims and 3,450 injuries in Government of Syria (GoS) controlled areas, 1,295 victims and 1,499 injuries in areas controlled by the Syrian Interim Government (SIG), and 3,162 victims and 6,880 injuries in areas controlled by the Syrian Salvation Government (SSG). These losses in human lives led to a sharp increase in death rates and a significant decline in life expectancy in the affected communities.[10]

Many communicable diseases outbreaks occurred during the conflict. In 2013, 37 cases of wild poliovirus type 1 (WPV1) were detected in Deir-ez-Zor, one of the most deprived governorates in Syria before the conflict. Combined with low immunization coverage, the weakening of the health system led to 74 cases of circulating mutated poliovirus type-2 (cVDPV2) confirmed in Syria in 2017. The outbreak was officially declared over in November 2018 (Reliefweb 2017). With public health infrastructure still compromised, low immunization rates, and poor living conditions, the threat of future outbreaks and an export of WPV and cVDPV2 to other areas remains high (SCPR 2020). Furthermore, cases of measles have increased since 2011, with 594 reported cases in 2014 and 738 cases in 2017. Recently, the suspected cases in 2022 increased by 29.4% compared to 2021, the cases concentrated in Raqqa, Idleb, and Aleppo (WHO 2022). The reported cases are defined as laboratory confirmed, epidemiologically linked, and clinical

[9] The statement of the Turkish Interior Minister on March 4, 2023, indicated that the number of Syrian victims in Turkey had reached 4,267 out of a total of 45,000 victims.

[10] Syrian Center for Policy Research, 2023: Field survey on the impacts of the earthquake. It is worth noting that the number of casualties in Syria, according to the official statistics of the GoS and the Assistance Coordination Unit, is about 5,914 victims and 10,849 injuries. This is less than the center's figures for the increased number of deaths in the Jabal Sam'an area, which reached 991 according to the Center's field survey, compared to 444 according to the Syrian Ministry of Health data.

cases as reported to the World Health Organization (WHO).

From 2012 to 2022, the most prevalent communicable diseases were influenza-like illnesses (ILI) followed by acute diarrhea (WHO 2022). Acute Bacterial Diarrhea (ABD) cases increased in 2022 by 7% compared to 2021. Moreover, in September 2022 an outbreak of cholera was declared in Aleppo where 15 cases were confirmed (UN-OCHA 2022a). In the Northeast region, the number of new typhoid cases reported across the three governorates was also high, reaching approximately 3,430 in October and 2,595 in November 2018. This outbreak is thought to be due to the consumption of unsafe water and follows the ABD outbreak in Deir-ez-Zor Governorate (UN-OCHA 2018). Conditions across many internally displaced populations (IDP) sites are already dire and poor weather and heavy rains represent an increased risk of outbreaks of water-borne diseases including typhoid and ABD.

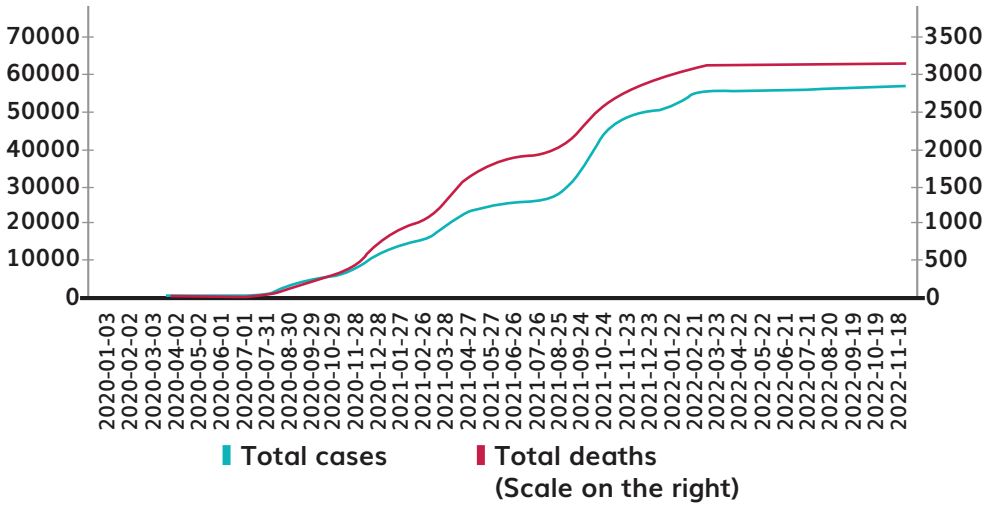
Confirmed cases of leishmaniasis also increased during the conflict. In 2021, the cases exceeded 78,000 cases, and were concentrated in Deir-ez-Zor and Aleppo, Hama, and recently in Hasakeh. This epidemic is associated with poor infrastructure, sanitation, and environmental degradation (WHO 2022).

The first COVID-19 cases appeared in March 2020 (Figure 6) and thereafter the Government of Syria imposed precautionary measures including curfews, as well as closing schools, public institutions, and private firms with the exceptions of vital public services and the productive firms such as manufacturing and agricultural companies. Internal trade almost stopped and external trade with Iraq, Lebanon, and Jordan dropped by almost 80% (SCPR 2020). Economic activities reduced sharply, and many people lost their jobs and sources of income. Poverty rates surged and the health system was not able to deal with the catastrophe. The Autonomous-Administration (AA) and opposition-held areas imposed a curfew as well in March 2020 and the suffering of people aggravated in their areas. However, with the reported low spread of the virus in Syria, the government, AA, and the opposition decided to remove most of the transmission control measures in May 2020. The commitment of people to the measures in most regions almost disappeared. The second breakout of COVID-19 during the summer from July-September 2020 had a huge impact on the health system and many infected people chose to stay at home. In the northeast the cases increased substantially since September 2020, and the AA imposed a lockdown from October 2020 to February 2021, while the northwest witnessed a rising number of cases since May 2021 (iMMAP 2021). The most

dangerous wave occurred mainly in the northeast and GoS-controlled areas during September and October 2021. Doctors without Borders (MSF) estimated that the cases in this region doubled between August and September 2021 (MSF 2021).

The lack of transparency of the institutions that are responsible to report the COVID-19 cases, in addition to the poor health system led to the conclusion that the burden of the Coronavirus on the Syrian population is underestimated.[11] Moreover, the fragmented and damaged health system cannot provide infected people with the necessary care due to the lack of infrastructure and medical staff and the inefficient and corrupt management (Abbara et al. 2020). Civil society played an important role at this stage through providing treatment in their facilities or supporting the patients at their homes.

Figure 6. COVID-19 accumulated cases and deaths in Syria, March 2020 to November 2022



Source: Our World in Data, 2022, Link

Notwithstanding the impact of COVID-19 on population health in 2020 and 2021, injuries and NCDs have been the major causes of death during the conflict. The main NCDs were cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes. Furthermore, the conflict led to an increase of risk factors that are associated with NCDs such as overweight, blood pressure, and blood sugar (WHO 2022).

In 2021, it was estimated that 25% per cent of the population have disabilities compared to 10-15% globally, likely a result of war injuries. Disabilities here refers to difficulties in at least one of the six functional domains: seeing, hearing, walking, cognition, self-care, and communication (Health Cluster & World Health Organization 2022). Disability affects individuals,

[11] WHO estimated the number of confirmed cases in Syria by Nov 2022 by 210324 cases and 7246 deaths, while the official data referred to 57423 cases and 3163 deaths in the whole of Syria.

households, communities, and countries for years to come. People with disabilities have a lower lifetime earning potential and may require additional support from both family and public services. Owing to the prevalence of disability in Syria because of the conflict, these issues will place additional strains on health services and propagate vulnerability in the future (SCPR 2020).

Mental health issues are another burden of the conflict. According to a nation-wide survey conducted by the WHO in 2020, "44% of Syrian participants living inside Syria [were] more likely to have a severe mental disorder, 27% had both likely severe mental disorder and full post-traumatic stress syndrome (PTSD) symptoms, [and] 36.9% had full PTSD symptoms" (WHO 2022). Another survey conducted in Germany with Syrian, Afghan, and Iraqi refugees reported that 74.7% of refugees experienced personal violence before or during their migration. More than 60% of people were traumatized by war experiences, with more than 40% being directly attacked by military forces. More than one in three people have had to cope with the disappearance or murder of relatives and people close to them. One in five was tortured and nearly 16% were held in camps or in solitary confinement, or witnessed killings, ill-treatment, and sexual violence. More than 6% were raped (Schröder et al. 2018). Children, as the most vulnerable group, suffer persistent feelings of fear of being surrounded by violence, experience frequent nightmares, and have difficulty sleeping. Additionally, children's behavior has become more aggressive. Children expressed how their high levels of stress manifest in physical symptoms such as headaches, chest pain, and difficulty breathing (Save the Children 2017).

The above mortality and morbidity rates show part of the health burden on the Syrians because of the conflict. It shows the severe violation of the right to health from a health outcomes perspective. This severe burden is associated with distortion of health system and deterioration of health determinants which will be discussed in the following sections.

DEVASTATING THE HEALTH SYSTEM

The conflict has significantly damaged the Syrian health system through the destruction of healthcare infrastructure, the flight and killing of healthcare professionals, the lack of medical device maintenance and spare parts and the collapse of the pharmaceutical industry. One of the most visible impacts has been the fragmentation of health authorities across the country. The different fighting parties have created their own

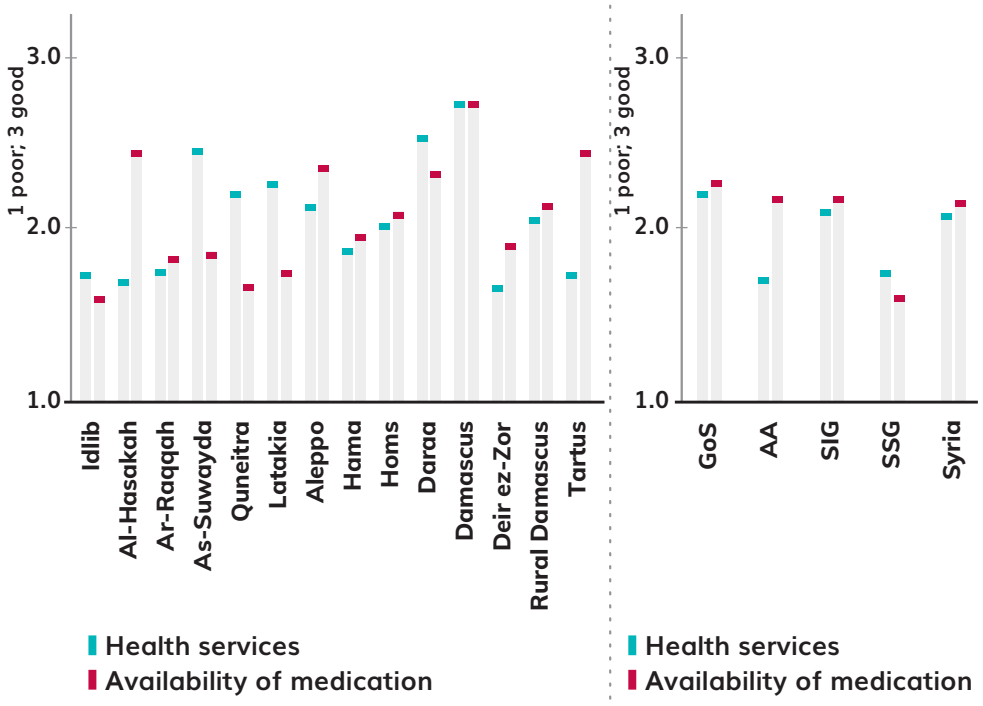
institutions which are often of weak governance. At the same time, the role of civil society has greatly increased in the field of health services and reproductive health, where hundreds of associations and initiatives concerned with health and humanitarian services have contributed to providing essential health services for people in many areas, especially those threatened by siege. However, civil organizations suffer from a lack of resources, poor coordination, and poor governance which has prevented civil society from being able to meet the increasing health needs of population (SCPR 2019).

HEALTH SYSTEMS PERFORMANCE

There has been a sharp decline in the availability of health services during the conflict. More than half of the Syrian population is unable to access appropriate health services. Moreover, the pre-conflict results highlight the huge disparities across regions in terms of accessing health services; particularly in the northern and eastern regions including Ar-Raqqa, Hasakeh, Aleppo, Idleb, and Deir-ez-Zor. The functionality of public hospitals has been assessed at three levels: fully functioning, partially functioning, or not functioning. By November 2022, out of the 203 reported public hospitals in the whole of Syria, 65% were fully functioning, 17% were partially functioning, including due to shortage of staff, equipment, medicines or damage of the building, while 18% were non-functioning. In terms of functionality of PHCs, by November 2022, 56% out of 1,941 centers were reported as fully functioning, 19% were partially functioning, and 25% were non-functioning (completely out of service) (WHO 2022).

Accessibility to health services goes beyond the readiness of health facilities, as people face different security, financial, and governance obstacles to fulfil their needs for healthcare. The socioeconomic survey 2020/2021 assessed the ability of the Syrian population to access health services. **Figure 7** shows that many segments of society cannot access quality services in different governorates and controlled areas.

Figure 7. Accessibility to health services and availability of medication 2021



Note: Participants were asked to rank access to healthcare services on a scale of 1: poor access for the whole population and 3: good access for the whole population. Participants were asked to assess availability of medication on the same scale.

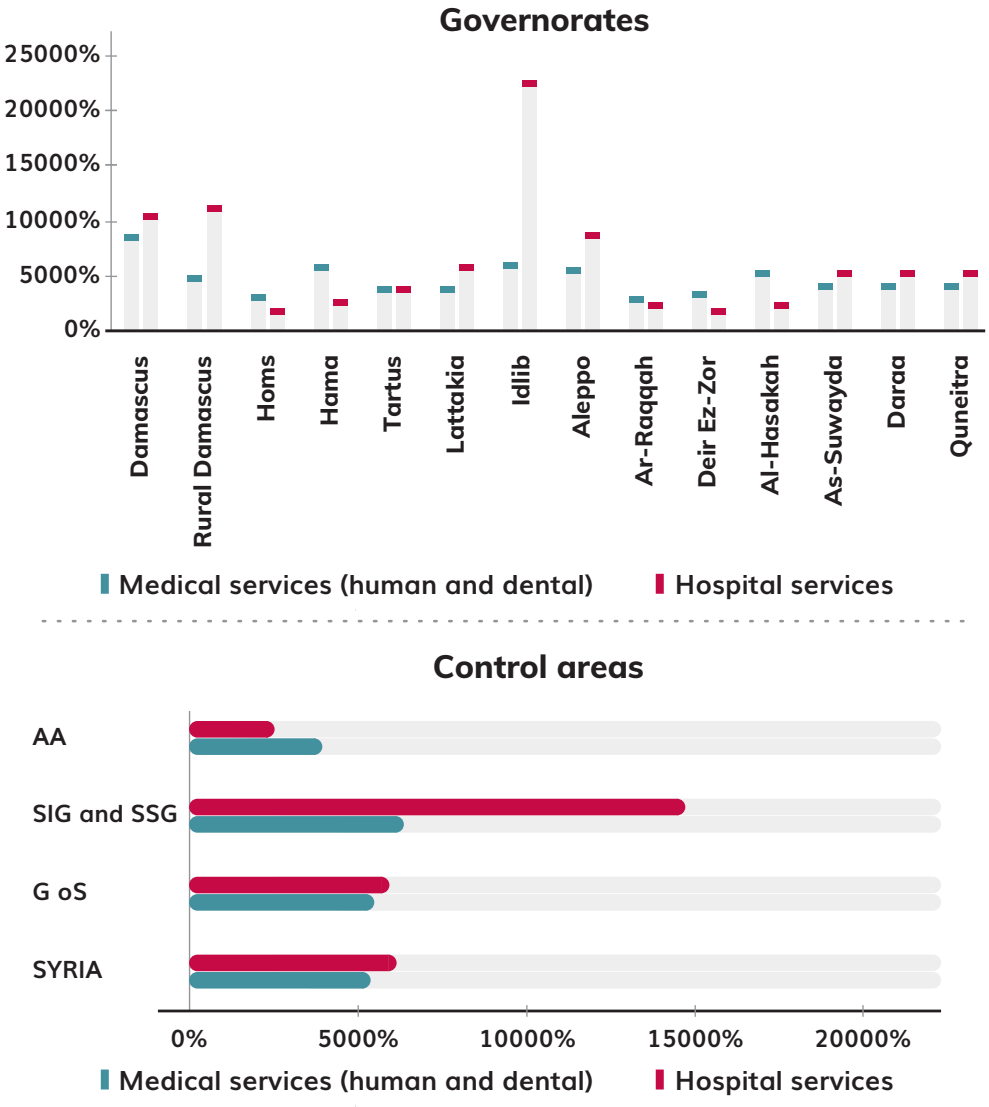
Source: SCPR, Socioeconomic Survey 2021

The earthquake has affected the already conflict-affected health sector, where 55 health facilities were damaged in northwest Syria (Assistance Coordination Unit 2023). In its current state, the health system was unable to meet the increasing needs of the injured and affected in many areas, such as the Badama and Harim regions (REACH 2023), and in the shelters. In GoS-controlled areas, 116 health facilities were directly damaged, including 14 in Aleppo, 54 in Latakia, and 48 in Hama, and they need infrastructure repairs and support with medical equipment. Reports on monitoring infectious diseases have also shown an increase in cholera, acute diarrhea, and respiratory diseases in various regions (UN-OCHA 2023).

The consumer prices monthly survey shows the enormous increase in the cost of private health services. Overall, the inflation rates between 2022 and 2009 reached 6,249% for the hospital services and 5,459% for medical services. The opposition-controlled areas witnessed the highest inflations rates for private services, while AA areas witnessed the lowest inflation rates (**Figure 8**). The surge in prices was associated with a drop in the household's income which created a severe

challenge for people to access health services and forced many of them to rely on public and civil society facilities which suffer in many cases from low quality, lack of necessary services, and mismanagement.

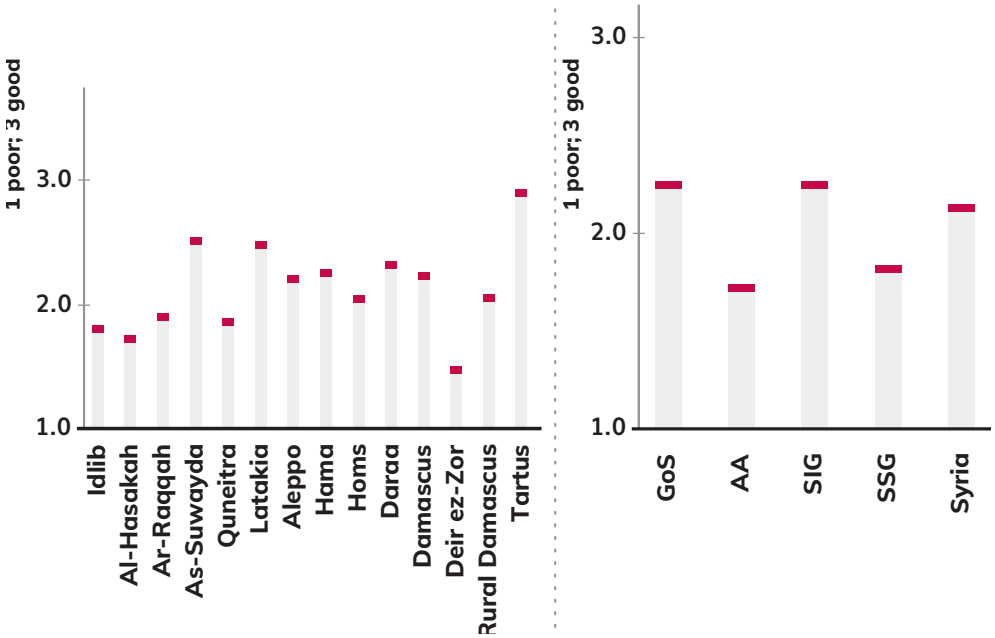
Figure 8. Health group inflation rates 2022 compared to 2009 (%)



Source: SCPR 2022, Monthly Survey of Consumer Prices in Syria

Women have specific challenges in accessing health services. The socioeconomic survey shows the poor access of women to reproductive health services due to the poor infrastructure, restriction on mobility, and the increase of prices of services in the private sector, the main provider of these services (**Figure 9**).

Figure 9. Accessibility to reproductive health by women 2021

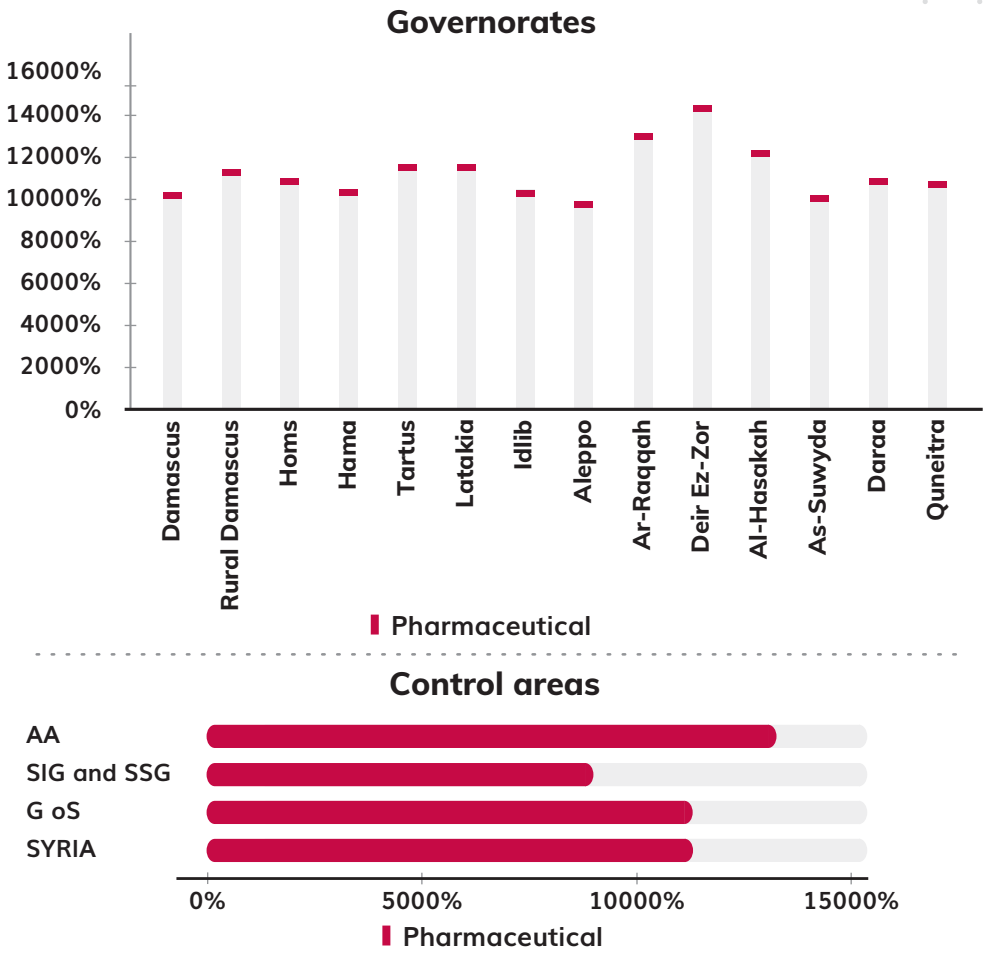


Note: Participants were asked to rank access to healthcare services on a scale of 1: poor access and 3: good access.

Source: SCPR. Socioeconomic Survey 2021

There has also been a dramatic decline in the availability of medicine during the conflict reflecting a deterioration in the quality and effectiveness of health services. The socioeconomic survey 2020/2021 shows the poor unequal access to medicine across regions (**Figure 7**). The partial lack of access to medicines is mainly due to the decline of locally produced medicines. This in turn can be explained by the sharp decline in the sources of income for most people, and the surge of prices of medicines by 11,335% in 2022 compared to 2009 (**Figure 10**). Additionally, the destruction of the local pharmaceutical industries and necessary infrastructure, in addition to sanctions, which have blocked imports of equipment and components required to produce pharmaceuticals have all contributed to the poor access to medicines. The lack of medicines has severe adverse implications for people with chronic diseases such as diabetes, high blood pressure, and kidney disease (SCPR, 2022b). Furthermore, the quality of medicine dropped in all regions and especially in AA and opposition-controlled areas; as these regions face more restrictions on importing of medicines and do not have a well-established mechanism to monitor the quality of imported medicine.

Figure 10. Medicines inflation rates, 2022 compared to 2009 (%)



Source: SCPR 2022, Monthly Survey of Consumer Prices in Syria

The availability of trained medical staff is crucial to providing appropriate health services, particularly in times of armed conflict. The conflict led to a loss of healthcare professionals and reduced mobility between institutions. Based on WHO estimates, the number of medical staff dropped by two thirds during the conflict (WHO 2017). The availability of medical staff has varied notably between governorates. In 2020, based on the number of public medical doctors in public hospitals and public health centers (WHO, HeRAMS 2020a, 2020b), and on the estimation of population per governorate (SCPR 2021), the ratio of public medical doctors per 10,000 inhabitants at the country level was estimated to be eight. The ratio of public medical doctors per 10,000 inhabitants reached 24, 22, and 20 in Damascus, Lattakia, and Tartous respectively, compared to only six, five, and two in Aleppo, rural Damascus, and Daraa. Governates that are outside of Government of Syria control severely lack public medical doctors (under the supervision of

GoS) and depend on the health systems that were developed by the opposition in the northwest and by the AA in the northeast. The factors driving the emigration of medical personnel from cities and areas under government-control such as Damascus and Lattakia include financial security, children's education, and avoidance of the military draft. In previously besieged areas such as eastern Ghouta, few doctors remain. In areas previously under the control of ISIS, doctors were exposed to assaults by the fighting parties, such as in Al-Boukamal in Deir-ez-Zor, and all hospitals prioritized combatants.

Year 2022 witnessed shocking rates of emigration with a number of well renowned doctors, praised in the community for their humanitarianism, eventually leaving the country. The dynamics affecting physicians appear to be similar across Syrian communities with some differences due to variations in their ability to emigrate (ability to obtain a passport and a visa), availability of credentialing mechanisms that allow re-credentialing abroad (i.e., recent graduates of nonaccredited medical schools in northeast and northwest Syria), and the availability of high-paying INGOs compared to the local market (in northeast and northwest Syria).

HEALTH SYSTEMS ACTORS AND POLICIES

Health providers

Health in Syria is deeply rooted in a complex socio-political context. The extraordinary health disparities which emerged due to war strategies, as well as distorted and violent forms of governance in certain communities have radically disrupted and transformed the social determinants of health in the country. Social determinants of health are known to shift in conflict settings, as structural elements of society have profound impacts on health (Marmot & Wilkinson 2006). The breakdown in institutions created life-threating forms of institutional discrimination and societal fragmentation. The transformation of power has produced new institutions where discrimination is the norm and the redistribution of resources and power favors special interest groups such as the regime's military and economic elite, the military opposition groups, and extremist militias (SCPR 2019).

The fragmentation and politicization of population and governance has led to different health systems across the country:

a. In the Government controlled area, the Ministry of Health leads the sector; however, its role shrunk, while the role of humanitarian international and local actors, civil society and

the private sector has expanded dramatically. The health system is characterized by discrimination, corruption, and ineffectiveness. Furthermore, and as described in more detail in the section below on Health-related War Policies, the role of health system became part of the war, as a means to fuel the conflict, violate rights, and subordinate people. The targeting of health facilities and workers led to a severe damage to readiness, efficiency, and fairness of health system.

b. In Autonomous Administration controlled areas, the political authority adopted a different governance health system compared to the opposition-held areas, as they established a health commission to supervise the health facilities and pay salaries for the health employees. Cross borders partners supported operations in the area. However, the GoS continues to operate in the region, which suffers from an unstable security situation and the ongoing displacement of civilians, in addition to a limited number of implementing partners. The AA was unable to match the needs for health services and medicines due to damaged infrastructure, weak administration, as well as lack of staff, medical equipment, and funds.

c. In Salvation government areas, the Syrian civil society has become significantly important in providing health services, primary healthcare, and reproductive health. Hundreds of associations and initiatives concerned with health and humanitarian assistance have contributed to providing basic health services to people in many areas, especially those threatened by besiegement. As of 2015, health systems in the opposition-held regions continue to rely on the structure of the Syrian public health system but gradually expanded it, primarily through the active involvement of the health directorates, civil society, UN agencies and donors in the design and planning of the health sector in the region. After the control of Idleb by Al-Nusra, a Ministry of Health was established, an authority characterized by fragility and limited capacity to influence the sector, coupled with numerous restrictions on any support to sustain the health initiatives in this region. However, the health NGOs and health directorate continued to provide services in Idleb, but they suffer from severe attacks on health facilities, a lack of resources, sanctions, and poor coordination and governance.

d. Turkish-Backed Opposition Areas follow the structure of the Turkish health system and have developed their

public facilities and infrastructure accordingly. Prior to these operations, health NGOs played an important role in providing healthcare services in these areas. However, the Turkish government role has limited the role of civil society in providing public services. The Turkish role consists of supervising the sector and providing services and undertaking difficult treatments and operations and cases for which treatment is not available in local hospitals and clinics. In this area, the responsibility of obtaining medicines and healthcare shifted from the public sector to citizens, local and international organizations, or the private health sector, which exacerbated the economic situation of the people. Additionally, the restriction on cross border operations and on imports and exports through Turkey negatively affected the health conditions in these areas. The weakness of the administrative structure of the Interim Government, particularly in the field of the health sector, was associated with a set of challenges, including lack of funding, instability, damaged infrastructure, and a shortage of medical personnel.

e. The work of the private health sector has spread widely across all regions in Syria during the conflict. The private sector consists of formal and informal healthcare providers, including pharmacies and specialized hospitals, which include for-profit entities, whether local or foreign. The results of socioeconomic surveys conducted by the Syrian Center for Policy Research in 2020 and 2021 shows a significant drop in public health services and an increase in the provision of private health services. Many challenges are associated with the role of the private health sector such as lack of accountability and monitoring of quality in addition to increase of cost of services.

f. Civil society was a vital actor in providing health services. This is expressed through various forms of NGOs and community-based organizations (CBO), whether civil-based, faith-based, residence-based, or professional organizations/ initiatives. Need statements expressed by such organizations are driven by requests received of humanitarian cases of patients in need of high-cost therapeutic interventions. Professional input, however, promotes preventive and primary care programs with variable levels of efficiency. It is important to note that the heterogeneity at the level of organized work between communities, within and across areas of control, is significant. This is due to variable degrees of self-organization, which is dependent on the widely

variable social structures, leadership, local community resources, professional experience, and international support, whether from diaspora communities or other donors. In addition, it is important to note that the reliance on such community organizations to compensate for the shrinkage in state public health services varies substantially based on the activity of health INGOs in filling this gap. The latter, which are much more advanced operationally and financially, are major providers in northeast and northwest Syria, but not in GoS controlled areas, in which CBO charities play a greater role in covering this gap in public health services.

g. It is worth mentioning that the WHO and other UN agencies played an important role during the conflict in terms of maintaining information systems such as Health Resources and Services Availability Monitoring System (HeRAMS) and Early Warning, Alert and Response System (EWARS) that have provided vital information about health systems and morbidity. The WHO also supports local health providers with funds, equipment, and capacity building. The WHO role differs across controlled areas, as it directly supports the Ministry of Health in the GoS controlled areas, while it works through cross border mechanisms in the other regions. However, the role of the WHO and UN agencies was negatively affected with the severe compromises with the political actors which negatively affected their policies and programs. For instance, their response to the earthquake in February 2023 was widely criticized as their response was substantially different between Turkish affected areas and Syrian affected areas (Jabbour et al. 2023).

Health-related war policies

Several local, regional, and international parties have been involved in prolonging and fueling the conflict through various wars waged on multiple fronts, whereby weapons prohibited by International Humanitarian Law (IHL) have been used repeatedly. This conflict is characterized by wide use of indiscriminate military tactics that have resulted in destruction and besiegement of cities without any guarantee of civilians' right to protection.

An empirical study,[12] conducted by SCPR based on the Human Status Survey 2014 showed that political governance, social capital, education, conflict economies, living conditions, and displacement are the main determinants of health and outcomes.

[12] Based on a background paper submitted to Lancet-AUB commission on health and conflict in Syria.

The health determinants and health outcomes were severely and unevenly damaged during the conflict through war policies. The following are key health-related war policies:

- The warring parties are responsible for killing hundreds of thousands of combatants and civilians using all kinds of weapons and ammunition, including those that are internationally prohibited, such as chemical weapons. Millions of Syrians were injured during the conflict, some of them have become disabled or suffer from chronic disease.
- Torture, kidnapping, arbitrary arrests, and sexual abuse are part of the tools that have been used by the warring actors to subordinate their "enemies."
- Collective punishment is a core policy used during the conflict which inflicted stricter punishments on certain groups, communities, and regions. Since areas outside of governmental control are the most affected by the destruction of health services, they therefore have poorer health outcomes and systems (SCPR 2020).
- Besieging communities for up to seven years and depriving the population to the minimum conditions of decent living including access to health services, medicine, food, water, and energy. More than 2 million Syrians suffered from sieges for different time periods.
- Changing the function of the health system from providing healthcare to serving war and "loyal communities" and therefore distorting the ethical code of the healthcare sector.
- Adopting discriminative policies that prevent specific people from political, regional, or culture backgrounds from accessing healthcare facilities or medicine.
- Reallocation of resources from health and social protection sectors to conflict-related activities.
- Transferring the responsibility of healthcare from the state to civil society, private sector, and humanitarian organizations.
- The government removed subsidies of many basic goods, which increased the cost on producers and consumers and aggravated the deprivation.
- Targeting healthcare workers, which includes killing, kidnapping, and torturing among other violations.

Healthcare workers have been a direct target during the war (Blanchet et al. 2016). At least 914 medical professional personnel have been killed in Syria during the war until November 2019, of whom 265 were doctors. Almost 55% were killed in aerial attacks or shelling, while 141 were either kidnapped or detained and subsequently killed (Physicians for Human Rights [PHR] 2023).

- Destruction of health facilities and infrastructure: The targeting of public hospitals and healthcare workers became a defining feature in the Syrian war strategy. Between March 2011 and March 2020, Physicians for Human Rights (PHR) has corroborated 595 attacks on at least 350 separate medical facilities (WHO 2020). These systematic attacks on health facilities are described as the weaponization of healthcare, with people's need and right to health being intentionally deprived (Fouad et al. 2017).
- Forced displacement of population groups: The conflict has caused more than 6.6 million people to flee the country to seek safety in Lebanon, Turkey, Jordan, and other hosting countries. By August 2019, the number of internally displaced people (IDPs) had reached 6.7 million (UNHCR 2021), which is the world's largest number of IDPs due to conflict. Also, refugees experienced multiple forms of injustice which can be categorized into three dimensions: entry and movement; human development; and status, voice, and representation. Though these three are interconnected and overlapping, examining each allows for understanding the numerous and increasing deprivations which refugees suffer (SCPR 2020).
- Distorting access and quality of education: The Syrian population lost millions of years of schooling as the children (5-17) who were out of school in 2019 numbered 2.4 million. The current outcome is still disastrous as millions of children will suffer from a lack of skills and knowledge, in addition to the impact of the conflict. The conflict created a lack of curriculum consistency across Syria, with different education systems established in different regions depending on the ruling power (SCPR 2020).
- Damaging social relations: Social capital has deteriorated significantly during the conflict, reflecting a substantial aggravation of social injustice as it deteriorated the wealth of social relations and common values, harmed social solidarity, and diminished people's capabilities and agency. Moreover, the conflict created distorted relations

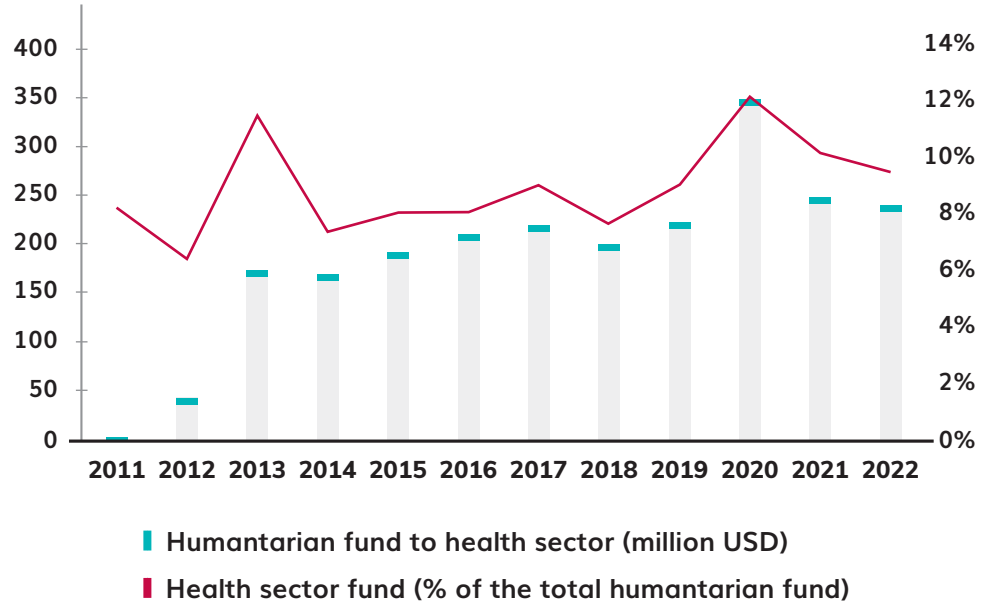
based on hate and rejection of the other, lack of sympathy, cooperation, and trust.

- Expanding Gender Based Violence and inequality: Women are among the main victims of the conflict in Syria. They face severe violations including killing, detention, kidnapping, sexual violence, labor in harsh conditions, and increased economic responsibility. Women have also been affected by more frequent incidents of underage marriage, customary marriage, trafficking, and other forms of exploitation. They also suffer from political, social, and economic exclusion.
- Violence against children: Children have suffered from many grave violations during the conflict including killing, injuring, and torturing. They are subject to kidnaping, recruiting, displacement, and abuse. Children have been deprived of access to health, education, and decent living conditions (WHO 2022). These current health burdens on them also indicate to the enormous morbidity rates in the future.
- Expanding of conflict economies: The collapse of real income and expenditure have not been homogenous across Syria. Inequalities surged across regions as well as between political affiliations, gender, age, displacement status, cultural identities, and socioeconomic backgrounds. For instance, the sieged cities and regions suffered from severe hardship for years and subordinated to the war lords who control the smuggling channels. The warring parties played a direct role in depriving society and facilitating the creation of the conflict elite.
- Surging of overall poverty: SCPR estimated that the overall poverty rate reached its peak at 89.4% by the end of 2016. The poverty rate slightly dropped in 2019 to 86% due to positive economic growth. Yet, in the last quarter of 2019 the country witnessed further economic deterioration, before being hit by the COVID-19 pandemic, which has led to a surge in the unemployment rates and cost of living. The overall poverty rate exceeded 93% in 2021 and the poverty gaps doubled between 2019 and 2021 prices (SCPR 2021).
- Increasing food insecurity: A large percentage of Syrians are unable to access nutritious food due to high levels of poverty and deprivation, unjust public policies, discriminatory institutions, and the prevalence of conflict economy. The results of a SCPR study on food security in Syria in 2019 (SCPR 2019) showed a sharp decline in food

security during the conflict by about 42% between 2010 and 2018. In 2021, the World Food Program (WFP) highlighted that 60% of Syrians suffer from food insecurity.

- Degrading environment: The conflict, and the quantity and type of weapons used, poses a serious environmental threat to arable land, as toxic substances have caused soil contamination, which adversely affects the quality of agricultural land and its cultivability or productivity. The conflict has led to the waste of many natural resources such as forests and water resources as a result of destruction, vandalism or misuse, such as logging for heating or drilling of artesian wells in unsustainable ways. Waste and pollution factors affect the long-term potential of environmental sustainability and create intergenerational future injustice (SCPR 2020).
- Dependency on humanitarian support: The conflict caused a severe deterioration of public health services and fund, for instance, the public health expenditure dropped by 68% in real terms between 2010 and 2020 (SCPR 2021). This deterioration was associated with a substantial surge in the health needs, and increased the need for international humanitarian support for the health sector. In this regard and based on the UN-OCHA Financial Tracking Service (2022b), around 2.3 billion US dollars was directed to the health sector between 2011 and 2022, which accounted for 9.3% of the total humanitarian fund that was directed to Syria through humanitarian response plans 2011 to 2022 (**Figure 11**). Almost 50% of health sector funds were received by UN organizations, as the WHO received 29% of the health fund, followed by UNICEF (11%), UNFPA (5%), and UNHCR (1%). The other half of the health fund was received by INGOs, and NGOs led by Syrian American Medical Society (SAMS) (4%), Islamic Relief Fund (3%), and Union of Medical Care and Relief Organizations (UOSSM) (2%) (UNHCR 2022). Additionally, the health sector also benefited from funds directed to mutual sectors. The conflict changed the role of actors in the health system with the declining role of the public sector and expanding of the international sector (UN agencies and INGOs), in addition to the expanding role of local NGOs and private sector.

Figure 11. Health Humanitarian Fund for Syria, 2011-2022



Source: UN-OCHA, 2022b, "Financial Tracking Service"

CONCLUSION

This paper reads public health as a basic human right and as an aspect of human capability (as defined by Sen 1999) within the political, social, and economic context in the time of armed conflict in Syria. The paper analyzed the impact of conflict dynamics on right to health through the assessment of health outcomes, impact on health system, health related policies in the time of conflict, and the determinants of health.

The paper highlights how warring parties targeted public health, distorted the health system, and reallocated tangible and intangible resources away from healthcare to fuel the war. The conflict-centered institutions destroyed several determinants of health, such as governance, social capital, welfare, living conditions, food security, and environmental sustainability. Political authority is fragmented between several state and non-state actors and has become the "enemy of public health." Additionally, several regional and international actors involved in the armed conflict were complicit in the escalation of public health deterioration.

The burden of conflict on public health has included direct and indirect death, injuries, and disability. In addition, there are serious morbidity cases such as mental diseases, malnutrition, and infectious diseases. The health system witnessed a severe distortion in governance. The destruction and lack of maintenance and investment have negatively affected infrastructure, including power and water stations and networks, firms, residential buildings, and roads. The loss of human capital was substantial, as health workers have been targeted by the warring actors and many fled the country. The health system suffered a shortage of public and humanitarian funding. Finally, the system suffered from a lack of adequate and up to date statistics.

The damaging of health capabilities of the population will impact the future of development in Syria for generations to come, as most Syrians lost unevenly substantial elements of their health and wellbeing, which will affect their functions. Therefore, it is crucial to further investigate the health burdens and design prioritize the most affected population in all policies and interventions.

All health capability policies and programs should be linked

to a long-term strategy that addresses the root causes of conflict, as exclusive and inefficient institutions, social injustice, economic exploitations, and a weak rule of law and accountability can reproduce the conflict again.

The conflict created mechanisms that enable violence, injustice, and violations. Therefore, the needed institutional strategy should dismantle violent foundations and invest in peace building policies. The future of health in Syria will depend on the fair engagement of disadvantaged communities and the responsibility of the state, civil society, and private sector.

Health and wellbeing are the essence of human dignity and enable the prosperity of communities. Syria reconstruction public policy and activities must invest their focus on promoting health equity and reducing health disparities through the reconstruction of social institutions and infrastructure. Our evidence helps guide these discourses: (i) this paper locates the most vulnerable populations (i.e., the health disparities) and suggests that healthcare reconstruction be prioritized in areas which were outside of government control, (ii) it presents the core social determinants of health, which are rooted in political and social contexts and suggest that reducing discrimination and advancing social capital, economic opportunities and education has extraordinary potential to improve health disparities.

Better medical care and infrastructure alone will not generate major gains in population health or quality of life, but the future of health in Syria will depend on the surrounding socio-political landscape. Action on social determinant of health inequities is a political process that must engage both the agency of disadvantaged communities and the responsibility of the state.

The following are selected key policy options to target these interacting societal issues and improve population health:

- Restoring security by investing in re-building social institutions which promote social cohesion, the inclusion of women in the public sphere, trust building, community solidarity, and systems of reciprocity. Community driven reconstruction (CDR) is one mechanism for establishing human and community development in post-conflict settings (Fearon et al. 2009). Policymakers should widen their understanding of security threats and broaden the security mandate from a narrowly focused perspective on preventing land mines and terrorism to a focus on the relationship between social relations, interpersonal security, and wellbeing.

- Transforming oppressive institutions. The wide understanding of human security needs requires further efforts to transform the oppressive conflict-centered institutions and create a platform to end the conflict through a just and sustainable settlement that ensures democratic and inclusive governance and counters the foundations of the conflict.
- Establishing and enforcing rule of law which protects all people. It is critical to end and prevent the regime and actors' sponsored torture, imprisonment, and disappearance, which has clear negative impacts on physical and mental wellbeing of both victim and community. This includes shifting the distribution of power within societies to benefit disadvantaged groups and reducing discrimination in municipalities to rebuild community trust in political systems.
- Reconstructing a productive and inclusive economy with equal opportunities paves the way for healthy and decent living conditions for children and counters the conflict economic dynamics. The right to decent work and food security and decent living conditions are crucial determinants of sustaining an equitable and productive economy.
- Integrating health with other sectors and prioritizing the most affected people during the conflict. This requires a reinvestment in an efficient and just health system within the political and social context and assuring the integration between health and the comprehensive developmental landscape.
- Optimizing the function of NGOs and CBOs, especially those that are residence-centered, provides opportunities to catalyze more adaptive community health responses and better health outcomes. Many spontaneous initiatives emerge in response to crises. It is necessary to harness organic tendencies, empowering CBOs, and institutionalizing them into more enduring, community organized work. Such initiatives can be used to catalyze communities' organizational tools to advance their understanding of the root causes of their needs through knowledge-production and develop decision making tools to design practical programs that address amenable root causes to achieve community-wide and long-term returns. Progress in this direction will help promote equity and gradually restore notions of social rights, including that of health.

- Investing in human capital for the health sector and facilitating the return of displaced health workers and developing linkages with specialist diaspora. This requires a guarantee of protecting health workers and health facilities.

REFERENCES

- Abbara, A., Rayes, D., Fahham, O., et al. 2020. "Coronavirus 2019 and Health Systems Affected by Protracted Conflict: The Case of Syria." International Journal of Infectious Diseases, 96:192–5.
- Assistance Coordination Unit. 2023. "Humanitarian Situation in North-West Syria Following the Devastating Earthquake." Link.
- Blanchet, K., Fouad, M. F., Abbara, A., & Sahloul, Z. M. 2016. "The Effects of Conflict on Syria's Health System and Human Resources for Health." World Health & Population, 16(01):87-95.
- Central Bureau of Statistics. 2012. "Statistical Yearbook of Syria 2011."
- Central Bureau of Statistics. 2011. "Health Expenditure Survey 2010." Damascus.
- Central Bureau of Statistics. 2009. "Household Health Survey in Syria."
- Cohn, T.H., & Hira, A. 2020. "Global Political Economy: Theory and Practice." 8th ed. Routledge.
- Fearon, J.D., & Weinstein, J.M. 2009. "Can Development Aid Contribute to Social Cohesion after Civil War? Evidence from a Field Conflict Liberia."
- Fouad, F.M., Sparrow, A., Tarakji, A., et al. 2017. "Health Workers and the Weaponisation of Healthcare in Syria: A Preliminary Inquiry for The Lancet–American University of Beirut Commission on Syria." Lancet, 390(10111): 2516-2526.
- Health Cluster & World Health Organization. 2022. "Syrian Arab Republic: Public Health Situation Analysis (PHSA) Long-form | Last update: 18 August 2022." Link.
- HeRAMS. 2020a. "Public Hospitals in the Syrian Arab Republic." Annual report, WHO.
- HeRAMS. 2020b. "Public Health Centres in the Syrian Arab Republic." Annual report, WHO.
- Higher Commission for Scientific Research. 2011. "Health Sector Research Strategy 2011-2020," (Unpublished document, in Arabic). Damascus.
- iMMAP. 2021. "Syria: COVID-19 Situation Analysis." Link.
- Jabbour, S., Abbara, A., Ekzayez, A., Fouad, F.M., Katoub, M., & Nasser, R. 2023. "The Catastrophic Response to the Earthquake in Syria: The Need for Corrective Actions and Accountability." Lancet, 401(10379): 802-805.
- Doctors without Borders (MSF). 2021. "Responding to COVID-19; Global Accountability Report 5."
- Nasser, R., & Dukmak, A. 2022. "Syrian Conflict and Health Capabilities," part of a report titled "Syrian Trade, Health and Industry in Conflict Time (2011-2021): A Study on the Impact of War, Public Policies and Sanctions." Konrad-Adenauer-Stiftung (KAS): Syria/Iraq Office. Link.

- Physicians for Human Rights. 2023. "Medical Personnel are Targeted in Syria." Link.
- Planning and International Cooperation Commission of Syria. 2006. "The 10th Five Year Plan," Chapter 20. Damascus.
- REACH. 2023. "Earthquake Response Rapid Needs Assessment – 15 February 2023 | Northwest Syria." Link.
- Reliefweb. 2017. "Syria: Polio Outbreak." Link.
- Save the Children. 2017. "Invisible Wounds." Link.
- Schröder, H., Zok, K., & Faulbaum, F. 2018. "Gesundheit von Geflüchteten in Deutschland – Ergebnisse einer Befragung von Schutzsuchendenaus Syrien, Irak und Afghanistan." WIdOmonitor, 15(1):1–20.
- Sen, A. 1999. "Development as Freedom." Oxford University Press.
- Syrian Center for Policy Research. 2016. "Forced Dispersion, Syrian Human Status: The Demographic Report." Beirut.
- Syrian Center for Policy Research. 2017. "Social Degradation in Syria." Beirut.
- Syrian Center for Policy Research. 2019. "Health Determinants during the Conflict in Syria: Empirical Study". A background paper submitted to the Lancet-AUB Commission on Health and Conflict in Syria.
- Syrian Center for Policy Research. 2020. "Justice to Transcend Conflict." Beirut.
- Syrian Center for Policy Research. 2022. "Socioeconomic Surveys 2020 and 2021." Beirut.
- Syrian Center for Policy Research. 2022b. "SCPR Monthly Consumer Prices Index 2020-2022." Beirut.
- The World Bank. 2022. "World Development Indicators." The World Bank: Washington DC.
- UNHCR. 2023. "Emergency appeal: Syria emergency." Link.
- UN-OCHA. 2018. "Syria Crisis: Northeast Syria: Situation Report." No 27. August. Link.
- UN-OCHA. 2023. "North-West Syria: Situation Report." Link.
- UN-OCHA. 2022a. "United Nations Resident and Humanitarian Coordinator in Syria, Imran Riza, statement on the outbreak of cholera in Syria, 12 September 2022." Link.
- UN-OCHA. 2022b. "Financial Tracking Service." Link.
- World Health Organization (WHO). 2022. "Syrian Arab Republic: Public Health Situation Analysis (PHSA)." Long-form | Last update: 18 August.
- World Health Organization (WHO). 2017. "Healthcare a Casualty of 6 Years of war in the Syrian Arab Republic." Link.
- World Health Organization (WHO). 2008. "Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health." CSDH Final Report. Geneva.

annd
Arab NGO Network for Development
شبكة المنظمات العربية غير الحكومية للتنمية

AMERICAN UNIVERSITY OF BEIRUT
FACULTY OF HEALTH SCIENCES

The Arab NGO Network for Development

works in 12 Arab countries, with 9 national networks (with an extended membership of 250 CSOs from different backgrounds) and 25 NGO members.

P.O.Box Mazraa 5792/14 Beirut, Lebanon

The Faculty of Health Sciences at the American University of Beirut

aims since its inception to shape the public health discourse by preparing professionals to be agents of change, and producing research that impacts practice and policy, and thus the health of populations.

American University of Beirut
P.O.Box 11-0236 / Faculty of Health Sciences
Riad El-Solh / Beirut 1107 2020
Lebanon