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Country cooperation strategy for WHO and the Syrian Arab Republic

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1. INTRODUCTION

This Country Cooperation Strategy (CCS) defines the broad framework for WHO's work with the Government of the Syrian Arab Republic in the next five years (2003–2007). The strategy articulates a coherent vision and selective priorities for all levels of WHO in its work with the Government of the Syrian Arab Republic. It is based on a systematic assessment of developmental challenges and health needs; government policies and expectations; and the activities of other developmental partners in the Syrian Arab Republic.

While the clear aim of this CCS is to ensure greater responsiveness to country needs, the CCS also reflects WHO's values, principles and global and regional strategies. Important elements of the CCS include greater selectivity in the range of activities and, to encourage strategic planning, greater emphasis on the role of WHO as policy and technical adviser.

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

The main objectives of the CCS for the Syrian Arab Republic are to develop a strategic framework for WHO technical collaboration in line with country priorities and to assist harmonizing inputs of various partners in health to maximize the impact and rationalize the use of limited available resources.

The CCS is a product of intensive work conducted by a team of WHO staff members from its different levels, with a national team composed of senior officials led by the Minister of Health. Intensive interaction was made with some health-related sectors and most of the UN agencies working in the Syrian Arab Republic.

2. POPULATION, SOCIOECONOMICS, HEALTH AND DEVELOPMENT

2.1 Overview

Population

The Syrian Arab Republic, on the eastern coast of the Mediterranean Sea, has a population of 17.13 million according to the projection of the Central Bureau of Statistics (CBS) in 2002. Administratively, the country is divided into 14 governorates, 61 districts, 206 *nahya*, 85 cities and approximately 6080 villages. Between 1970 and 1994 the population growth rate was 3.3%, one of the highest in the world. According to government sources, the rate dropped to 2.7% between 1994 and 2000. It is currently estimated at 2.45%. Over the past 20 years, fertility rates have been declining. According to the CBS, the total fertility rate has decreased from 7.5 in 1978 to 3.8 in 2002, owing in some measure to increased contraceptive use as well as an increase in the average age of first marriage, from 24.5 in 1993 to 25.1 in 2000. The Syrian Arab Republic has a young population profile, with 40.5% of the population under 15 years of age. The proportion of the population aged 15 to 59 years is more than 50%.

The urban to rural ratio is almost equal (according to latest statistical report from the government, this ratio is 50.1:49.9).

Development and change

For the past three years the Syrian Arab Republic has been undergoing political and economic transition. There has been political stability in the past three decades, leading to a successful transition of power to new leadership. With the appointment of the new cabinet in March 2000 and the election of the new President, modernization has been the keyword. The new government has started a public debate on developmental issues and problems, emphasizing modernization and transparency in public institutions. As part of this modernization, the government is focusing on access to information technology. Many measures have been taken to improve the investment climate in the country, easing controls, and improving the banking sector and foreign exchange regulations. The most outstanding has been the lifting of the restrictions on the establishment of private banks and opening of a stock market. However, decentralization, simplification of regulations, and modernization of infrastructure still pose a major challenge towards the move to a market-oriented economy. The *Human development report 2002* ranks the Syrian Arab Republic as 108th, compared to 97th in the same report for 2001, with a Human Development Index of 0.691 for 2000, compared to 0.700 for 1999.

Economy

According to government statistics, the economy has been growing at an average rate of 5%–7 % annually since 1991. GDP per capita has been increasing since 1990. The strong growth has been partly a result of oil exports and increased agricultural production. The 2002 estimates show a GDP at SPD 51 478 (approximately US$ 1000), up from US$ 839 (constant 1992 prices) in 1989. It should be noted that the estimates of real GDP per capita in US$ may differ from one source to another due to multiple exchange rates in the country in the past. However, economists predict that GDP growth rates in 2000, 2001 and 2002 at around 1.45, 2.1 and 3% respectively. The Syrian Arab Republic had been classified by the World Bank as a severely indebted lower income country because of its very high foreign debt to GDP ratio (137.5% in 1999 estimates) and its debt-service burden. In 1997, an agreement was reached with the World Bank for the settlement of arrears, and by October 2002, the Syrian Arab Republic was expected to be free from arrears to the World Bank.

Poverty

Though social indicators have shown great improvement, the income disparity gap remains an area of concern, as does poverty. According to CBS in mid 1997, 69% of workers earned less than $100 a month. According to the UN Common Country Assessment (CCA), 54% of the population are below poverty line. In 2002, 17.8% of the population did not have access to safe drinking water, and 18.8% were without adequate extra disposal facilities. In the past few years there has been a debate on poverty with increased openness. Several initiatives targeting poverty reduction have been initiated. These include the Healthy Villages Programme (HVP), currently implemented in approximately 335 villages. HVP is a successful

community based initiative linked directly to improved health outcomes. It is a well-organized programme with voluntary participation of the community. The HVP aims at improving the quality of life in rural and marginal urban areas, with full participation of the community, coordinated multisectoral support and bottom-up planning leading to changes in roles.

One major challenge in tackling issues of poverty is insufficient data to correctly measure the scope and nature of poverty in the country. The President has emphasized eradication of poverty through focusing on regional disparities and creation of employment.

Employment

Serious challenges are faced with regard to employment. The population in the working age group has increased from 3.8 million in 1970 to 9.09 million in 2000. With this increase there has also been an increase in unemployment. In 1999, the CBS put the unemployment rate at 9%, though western sources put it much higher. Some recent reports indicate the rate of unemployment may reach 22%. Additionally the public sector suffers from low productivity and disguised underemployment, meaning shorter working hours or extremely low wages. There are restructuring efforts currently under way to tackle this situation. Improving and strengthening the capacity of human resources, decreasing dependency on the public sector, and encouraging the private sector to play a greater role are some of the measures being undertaken to improve the labour situation.

Education

Great emphasis has been placed on education as a means for economic development. According to UNESCO, the adult literacy rate has increased from 45.5% in 1970 to 85.5% in 2002. The most outstanding has been the increase in female literacy, which increased by almost 200% between 1970 and 2002. Primary education is universal. However there are still disparities in illiteracy rates between males at 9.5% and females at 26.1%. Dropouts in schools are another problem, especially girls in high-risk areas, and with the enrolment falling further as pupils move into secondary school. With increase in population, there is need for higher allocations for education, which was 6.8% in 2001.

Women's development

The position of women in the country has been improving since the 1970s. As mentioned earlier, the illiteracy rate has dropped from 55% in 1981 to 26.1 % in 2000. Notable achievements have been made in education and health field, but disparities still exist in employment. Among the Arab nations, the Syrian Arab Republic has the highest number of women Parliamentarians, at 18.

Food and nutrition

Sound government policies have led to increased food production and food security and improved nutritional status, with expansion of agricultural land and animals, and subsidized food to low-income families. The result is that the Syrian Arab Republic faces no food

shortages except in conditions of severe drought. The average consumption of calories per capita in 1996 was 3351 per day. Chronic under nutrition has dropped from 20.8% in 1996 to 7.8% in the 2000 as shown in MICS survey by UNICEF. The survey results also showed that girls were not disadvantaged when compared with boys. However severe malnutrition in the rural areas is still a matter of concern, where 9% of children under 5 years are severely stunted, and there has been very slow decline from the levels in 1994, which stood at 10.4%.

Health development

Great strides have been made in health, as is evidenced by the improvement of the health indicators. Life expectancy at birth has increased from 56 years in 1970 to 71.2 years in 2002. The infant mortality rate dropped from 123 per 1000 live births in 1970 to 18.1 in 2001, and under-five mortality rate also dropped significantly, to 20 per 1000 live births. Maternal mortality has fallen from 482 per 100 000 live births in 1970 to 65.4 in 2002. Access to health services has increased since the 1980s as a result of government efforts to provide universal health coverage for all. According to UN estimates, the proportion of the population with access to health services has risen from 76% during 1985–1988 to almost 90% in 2000. The urban–rural gap is also narrowing. During 1985–1988, 60% of the rural population had access to health services as compared to 92% of the urban population. By 1990–1995, access in rural areas increased to 84%, while in urban areas it increased to 96%.

Health expenditures

Reports from government show that there has been some increase in the level of government spending in the health sector. The expenditure of the Ministry of health as a proportion of total government expenditure was 1.1% in 1980. It increased to 3.8% according to the 2002 national budget report. However, the total expenditure on health as a percentage of GDP was 2.5 according to the *Human development report 2002*, with the private spending on health far outstripping public spending. The private health expenditures on health were 0.9% of the GDP. The 2002 Human Development Report indicates that there has been a small increase in public spending on health as % to the GDP from 0.4% in 1990 to 1.5% in 2002. The national expenditure on health in US$ at official exchange rate in 2002 was one billion. According to national health accounts, private expenditure on health as a percentage of total expenditure on health was 48.5%. This represents the out-of-pocket expenditure. However, so far there is no private health insurance.

Table 1. Distribution of amount of funds by the type of expenditure on health, 2002

Type of expenditure	Amount
Family expenditures on health	US$ 548 million
Total expenditures on health	US$ 1 billion
Per capita expenditure on health	US$ 59
Expenditures on health as % of GDP	5%
Families expenditures on health as % of total expenditures	55%
Government expenditure as % of total expenditure	45%
Expenditure on drug as % of total expenditure	34%

Primary health care

Both public and private sectors provide health and medical care, with most primary health care being provided by the public sector. In 2002, the rate per 10 000 population was 14.6 for medical doctors, 85 for dentists, 5.8 for pharmacists, 19.5 for nurses and mid wives, 13.8 for hospital beds and 0.8 for PHC units. Almost 90% of the population have access to primary health care institution, though there is uneven utilization geographically and service wise. According to the Ministry of Health sources, antenatal care is provided in 74% of PHC centres, trained health personnel attend more than 95% of births and more than 90% of the children are vaccinated. According to the same source, there are great efforts to improve the secondary health care level and recognized need to strengthen the referral system, with a view to fill the gaps in health services to improve the availability of specialists as needed, to reach the remote areas, and to have an impact on neonatal mortality.

Immunization

There has been a dramatic improvement in vaccination coverage in the last decade. In 1981, the percentage of infants immunized against tuberculosis was 36%. By 1998 this stood at 100%. Similarly the immunization against DPT, polio and measles was 14% in 1981, and this increased to 97% in 1998. These high coverage rates could be attributed to the increased success in reaching mothers, better provision of knowledge and improved awareness of the public on diseases. The problem of tracking all children in some eastern governorates was dealt with successfully in the latest national campaign of 2002.

Communicable diseases

Communicable diseases have dropped dramatically in the last two decades. In 2000 there were no cases of cholera, diphtheria or polio. Incidence of malaria is less than 1 case per 400 000 population. There were a total of 5915 of reported cases of tuberculosis and 13 cases of HIV/AIDS in 2002. DOTS coverage is 100%. However, while the incidence of these diseases has reduced considerably, the prevalence of some communicable diseases such as tuberculosis, leishmaniasis, zoonotic diseases and water-borne diseases are still a cause of concern. Diseases such as hepatitis and HIV/AIDS represent a category of high risk. Efforts to eliminate diseases such as leprosy, neonatal tetanus and measles require further support as coordination among related sectors remains weak, and the surveillance system requires further strengthening.

Noncommunicable diseases

With the decrease in the incidence of communicable diseases and the increase in life expectancy, the burden of disease has shifted towards noncommunicable diseases and the incidence of cardiovascular disease, diabetes and cancer is increasing. Added to this is the problem of lack of reliable data on noncommunicable diseases. Strategies to tackle these diseases are not yet identified and there are no comprehensive national plans. Morbidity and mortality due to traffic accidents and other types of accidents are also increasing. Mental disorders also represent a major public health problem.

2.2 Challenges, issues and constraints

The Ministry of Health has adopted a number of main strategies for 2000–2020. These strategies were derived from statements of the president, from government policies on health, situation analyses and from the recommendations of WHO. The overall goal remains continuing emphasis on primary health care, strengthening and developing secondary and tertiary care, and ensuring equity in health care.

Emphasis has been placed on development of human resources, improved fair financing of health, provision and maintenance of equipment, upgrading of ambulatory services, improving health administration and management, conducting more health research, strengthening drug and food quality control, increasing community participation, emphasizing the role of health as a development sector, and reviewing all health related legislation to implement these new strategies.

There are several facilitating factors on which the health sector can build. These include a strong network of health care facilities spread throughout the country; improved basic health indicators; a strong public sector with mass media and other public resources; committed national programme managers and staff; and excellent support and good working relationships with all UN agencies

There are also some constraints which need to be considered, such as rapid turnover and drain of skilled personnel; inadequate coordination within different departments of the Ministry of Health; complicated financial administrative procedures; inadequate qualified nursing and paramedical staff; low levels of resources for health; logistical difficulties, especially lack of adequate mobility; and low intersectoral collaboration with other ministries and departments.

The challenges facing the health sector include the lack of coordination between different providers of health services; stagnant budget allocations for health despite the increasing demand and cost; difficulties in meeting the growing needs and misuse of free services; dependency of most of the poor on free public health services; minimal use of the limited existing health legislation; and the unstable quality of health and medical services. In addition to these challenges, there are also problems related to distribution, utilization and quality of all categories of health personnel in the different health institutions. This problem is very obvious at the periphery of medical care. Another challenge is related to the coverage of health services. It is clear that accessibility of health services is high; however, this doesn't necessarily mean that accessibility matches the exact need and demand of the population, and hence it affects acceptance and utilization of health services. Some important services in many hospitals such as nursing and catering remain insufficient. The absence of a medical council as a peer group for medical practice has a negative influence on the quality of medical care. Similarly, the mixed public and private practice could have negative impacts as well.

2.3 Priority areas

The Ministry of Health has identified seven priority areas as strategic directions for the next five years. These are: 1) health development based on community involvement; 2) development of human resources; 3) environmental health; 4) health economics and financing; 5) health management development and administrative reform; 6) non-communicable diseases; and 7) population and health. A number of challenges have been identified in each priority area.

1) Health development based on community involvement

Community involvement in health development through healthy villages and healthy cities in the Syrian Arab Republic constitutes one of the most important developmental initiatives. The healthy villages programme (HVP) started in 1996 in three villages and has expanded to cover more than 300 villages in 2002. It is an innovative developmental approach aiming at improving the quality of life through enabling local communities to organize themselves to overcome the challenges at their localities and to be self-reliant. It is a comprehensive socioeconomic developmental programme based mainly on the intersectoral approach and the strong involvement and participation of the community. Feelings of ownership, partnership and self-responsibility are among the main features of this programme.

The HVP includes many components such as basic development needs, self care, community school, village information centre, healthy lifestyles, baby-friendly homes, baby-friendly communities, women's empowerment, community-based safe motherhood, community entertainment, scouting for intellect and innovation of people and income generation. It represents one of the most important areas of common interest and joint planning and action among several UN agencies, donors and nongovernmental organizations.

The achievements made in this area are remarkable. However, the need to sustain such important achievements involves developing clear strategy for sustainability and continuity. This strategy can be easily developed in the Syrian Arab Republic because of the high levels of political commitment, national NGO enthusiasm and donor interest.

2) Development of human resources

Human resources for health and capacity-building constitute important priorities. It has been recognized that to date there has been unclear vision and mechanisms for implementation of the continuing education system. Plans and responses to the emerging needs of health and medical personnel have been fragmented. The management of production, utilization and distribution of human resources is weak. There are quantitative and qualitative problems related to the profession of nursing, midwifery and paramedics. The job descriptions of most health cadre at all levels need to be updated. There is also a lack of standards and norms to measure the performance of health personnel. The School of Public Health and School of Health Management have made considerable contribution to management effectiveness, but their sustainability remains an important issue.

In the area of production of human resources, several challenges exist. These include: inadequacy of the number of institutions; poorly equipped institutions; old curricula; inadequate or poorly qualified teaching staff; lack of needs-based training; lack of accreditation system; weak intersectoral collaboration; lack of some important specialities, leading to external dependency; uneven quality of graduates and training; training that is vertical and not integrated; lack of incentives; and poor quality of continuing education programmes.

In the area of management of human resources, the challenges include the mal-distribution of available personnel, with overstaffing in hospitals and health centres in big cities and understaffing in rural areas; improper utilization of human resources; lack of criteria for selection to posts; outdated, little-used job descriptions; lack of regulations for the distribution of human resources; low salaries; lack of systematic performance appraisals or evaluation; lack of effective system of rewards or punishment; carelessness and lack of sense of responsibility among a large number of staff; and outdated staffing patterns.

3) Environmental health

Rapid economic growth and urbanization have put serious pressure on natural resources in the Syrian Arab Republic. Increase in urbanization and industrialization have led to environmental degradation and negative impacts on the health of the people. The health effects of water pollution have been considerable, with almost 900 000 cases of waterborne diseases reported in 1996. In 2000 and 2001 respectively, 5101 and 5781 cases of typhoid fever were reported. Similarly, 45 290 and 34 629 of diarrhoeal diseases among children under five were reported in the same period.

The air quality is poor in most of large cities due to motor vehicles and industrial emissions. The health impact of these can be seen by the fact that the incidence of respiratory disease is 4 to 5 times higher in polluted areas than in clean ones. Improving environmental health requires close intersectoral collaboration. There is need to strengthen the health sector to engage in partnerships with other sectors to tackle this growing problem. There are many challenges in environmental health such as water pollution due to drainage, industry, chemicals and agricultural activities, leading to increasing prevalence of waterborne diseases; increasing air pollution from transport and industry, leading to increased chest infections; safe disposal of hospital waste; lack of intersectoral collaboration of different players; the existence of small factories for plastic and other chemicals in houses, lead to emerging diseases related to environment and occupational hazards; insanitary personal habits and bad hygiene; lack of professionals in environmental specialities; poor equipment and reagents; weak preparedness for outbreaks; need for legislation and appropriate institutions; need for community-based initiatives for integrated development programmes such as healthy cities, healthy environment for children alliance; and need to strengthen the district health system

4) Health economics and financing

Health financing issues require considerable strengthening. There is a need to update legislation and regulations to meet the new challenges of private provision of health care,

health insurance and other new issues. The total expenditure on health as a percentage of the GDP remains rather low. In 2001, it did not exceed 3.4%. The involvement of the private sector in health is encouraged by the new policies of the government but it is not yet properly regulated. Out-of-pocket spending on health is growing.

In addition, there has been a continual reduction in per capita expenditure on health. The cost of medical and health services has increased. Sophisticated new technologies in the medical field are not always affordable. Increased burden of diseases on the poor is growing. There is a lack of professionals and experts in health economics and financing. The involvement of private sector in health insurance remains very weak. The unit cost for medical care has not yet been estimated. Free hospital services have led and continue to lead to misuse and wastage. Political commitment, which is always high, has not been translated into adequate budget allocations. Data collected at different levels are not analysed properly or used for decision-making.

5) Health management development and administrative reform

Stewardship of health needs to be strengthened to improve the decision-making process based on appropriate information and evidence. There is a need to update information technology for knowledge management, introducing telemedicine, electronic health records and computer-based database systems. The use of electronic cards, or ‘smart cards’, for specific diseases is planned but not yet implemented. Issues related to health financing and alternatives, such as cost sharing and health insurance, need to be developed. Quality assurance along with systems for food and drug administration are important priorities for the next few years. Issues such as decentralization, with appropriate delegation of authority at the level of the governorates, district health system and autonomous hospitals need to be addressed.

Some of the challenges identified include: complicated administrative procedures; inadequate managerial skills at all levels; wastage; inefficient and ineffective health management systems; unclear policies in many areas such as privatization, decentralization, institutionalization, and legislation; poor skills in leadership, computer use, planning, monitoring and evaluation; lack of teamwork; unclear roles, duties and responsibilities of each unit, division and staff; need for clarification of regulations, command lines, internal relationships; need for simplification of the organigram of the Ministry of Health; and unclear or unimplemented functions of each health facility.

6) Noncommunicable diseases

The burden of disease in the Syrian Arab Republic has shifted towards noncommunicable diseases. The incidence of cardiovascular disease, diabetes, and cancer is increasing. However, reliable data on noncommunicable diseases are lacking. Strategies to tackle these diseases are not yet identified. There are no comprehensive national plans. Morbidity and mortality due to traffic accidents and other types of accidents are also increasing. Mental disorders represent a major public health problem.

7) Population and health

The population of the Syrian Arab Republic increased approximately four-fold between 1960 and 2000. It is planned to change the Ministry of Health in the near future to the Ministry of Health and Population. Increasing importance is being given to demographic and population issues.

There are many challenges facing the government in this area. These include increased population growth with limited resources; increased pressure on available health services; imbalance in economic and population growth; consequences of large family size; reduced opportunities for education, employment, food, and medical care; increased poverty and increased crime; inadequate reproductive health services and family planning; poor awareness of population issues; and increased prevalence of sexually transmitted disease. There is need to develop partnerships in the area of population and linkages of all health issues to population indicators. In addition, health care supply must be matched to the demand, and use of decision support systems institutionalized. A centre of population studies should also be established.

The identification and assessment of the seven priority areas by the government and the identification of the key challenges highlight the need for a more focused strategy leading towards a more equitable and efficient health system, providing the right mix of services to the population.

3. DEVELOPMENT ASSISTANCE: AID FLOWS, INSTRUMENTS AND COORDINATION

In the last 20 years, development assistance to the Syrian Arab Republic has been low. The amount of development aid has been subject to wide fluctuations and constitutes a relatively small proportion of the Syrian Arab Republic's spending on development. According to the CCA, the Official Development Assistance (ODA) to the Syrian Arab Republic was at an average rate of 3.5% between 1988 and 1998. Total ODA reached its highest level of US$ 745 million in 1994, but gradually declined to US$ 156 million by 1998. Most of this aid comes from Arab multilateral agencies, and some directly from Arab governments. The unstable political situation in the Region has made it difficult for the Syrian Arab Republic to access developmental aid that was available to other nations. Most of the development assistance in general, and for health in particular, used to flow through the UN system, and to a lesser degree through agencies such as AGFUND, JICA and GTZ.

Recently, with the change in leadership more windows of opportunity have opened up, for example with the European Union and some other donor countries such as Iran, Italy, Germany, Japan and Spain. Pledges have been made to support the health sector from these donors, and some agreements have been signed in 2002. The relationship with the European Investment Bank has been reactivated. The bank is to provide a loan of EUR 100 million for equipping some hospitals in selected districts to support the secondary level of health care. The European Union supported the Ministry of Health with EUR 30 million as a grant. Spain

will deliver supplies and equipment for two new hospitals with a total amount of US$ 15 million.

According to the International Health Directorate in the Ministry of Health, bilateral collaboration with some donor countries has recently improved. Several technical collaborative agreements have been signed, with Italy and Spain. Others with Germany and Japan are close to being signed.

In the health sector, UNICEF and UNFPA play a significant role, along with WHO. Under the supervision of the Resident Coordinator, the UN country team in the Syrian Arab Republic has made remarkable achievements in areas of coordination, joint planning, transparency, information sharing and some other common logistical and administrative matters.

WHO is an active member of this team. Preparation of the CCA, involvement in the early steps of UNDAF process, joint planning with relevant sister agencies working in health sector and information sharing were among the main activities in which WHO participated. The preparation of CCA started in the second half of 2000. The resident coordinator took the initiative to prepare the draft based on frequent discussion with all UN agencies working in the Syrian Arab Republic, including WHO. WHO has reviewed the chapter on health in CCA.

The UNDAF process started in the Syrian Arab Republic in late 2000, after the final draft of the CCA had been prepared. A task force from representatives of all UN agencies and the government was formed. The main goals and objectives were agreed. Four thematic groups were set up. The draft UNDAF is now ready.

For joint planning, UNICEF, UNFPA and WHO conducted several meetings among themselves to discuss the contents of their plans in health sector for 2001. They also held similar joint meetings with the Ministry of Health. An overall framework and skeleton of the plan was discussed and all agreed to consider it for their detailed plans. Transparency has received high attention from all partners. This mechanism helped significantly in improving focus, reducing overlap and avoiding duplication. In late 2001, a proposal to form a Task Force on Health (TFH) was discussed and agreed upon. The membership will include WHO, UNICEF and UNFPA. The term of reference and the plan of action for TFH were prepared in 2002.

Since 2000, two major areas have been given priority in the Resident Coordinator System. These two areas were the healthy villages programme and HIV/AIDS control. With regard to healthy villages, most UN agencies have been involved in the past in different ways because these agencies have interventions directed at community development. However, a common understanding was reached on the healthy villages approach. It could provide an umbrella for most of the initiatives at community level, and the wide range of its components could cover the requirements of most UN agencies. Two meetings were conducted with the Minister of Health for this purpose. All heads of UN agencies in the Syrian Arab Republic were invited. The second area was the HIV/AIDS control, which is supported by UNAIDS. The Country Theme Group is currently chaired by the WHO Representative. WHO

contributed all necessary information to the members of UN country team through regular publication and reporting. The national programme for HIV/AIDS control has received direct technical and financial support from WHO. The surveillance system for HIV/AIDS was the main area of focus of WHO in this programme.

4. WHO CURRENT COUNTRY PROGRAMME

4.1 WHO operations

WHO has established a wide range of collaborative programmes with the Government of the Syrian Arab Republic, and played an important role in national health development. The central goal has been to achieve the highest level of health for all. Over the years the collaboration has increased in a number of areas, especially in areas relating to human resource development, health system strengthening, health promotion and control of communicable diseases. With the increasing number of programmes and activities, it was felt that the work of WHO needed to be brought under umbrellas or clusters in an attempt to facilitate coordination and establish appropriate linkages.

In the biennium 2000–2001, WHO adopted a cluster approach, in which several programmes were grouped together. The rationale was to allow for more integration, better management and more flexible administrative and financial procedures. This has led to the involvement of senior officials in the ministry of health to lead the clusters in order to enable more coordination during the implementation of the work plans.

In cluster approach, all WHO-supported programmes were grouped into five main clusters, representing the major priority areas for the Syrian Arab Republic. They are: evidence-based formulation of health policy and health management; development of human resources for health; health system development and healthy villages; health protection and promotion; and control of communicable diseases.

WHO’s past support has focused on policy guidance, technical assistance, training, fellowships and support for international standards and guidelines. During 2000–2001, 165 visitors came to the Syrian Arab Republic for different purposes and for different periods. Short-term consultants represented 46.1% of visitors. The trainees in the country represented 32.7% of visitors, WHO staff accounted for 18.2% and delegates were 3.0%. A little more than 70% of visitors stayed between one and two weeks and 7.9% stayed more than 4 weeks

The same biennium witnessed a growing trend of Agreement of Performance of Work contracts (APW). such contracts provided opportunities for nationals to improve their capacities through the process of learning by doing. They also provided flexibility for WHO to make use of the available national expertise through simple formalities and less complicated procedures. During 2000–2001, 72 APWs were signed, 17 of which were with institutions and the rest with individuals. The APWs covered several main purposes such as development of manuals or guidelines on specific technical issues, technical support to programmes, conducting a study or a survey and others.

In addition, WHO awarded 188 external fellowships to Syrian fellows in many specialties in health. The cost of these fellowships were covered from three main sources mainly, regular budget (48.9%), extrabudgetary resources (32.4%) and UNFPA (18.6%). Over and above, WHO has facilitated and funded the participation of 64 Syrian officials in meetings and conferences held outside the country.

A considerable portion of the time of WRO staff was spent on the monitoring and follow-up of many national training activities implemented during the biennium. WHO supported technically and financially 763 national training activities. More than 20 000 participants attended these NTAs, and more than 3400 facilitators and lecturers provided technical support to them.

Local costs are used to cover important gaps that health programmes are facing during the implementation process. In the biennium 2000–2001, local costs were used to cover printing of educational materials (30.6%), profit-free loans for self-reliance at community level (17.6%), field visits for supervision and monitoring of programmes (12.9%), conducting important surveys or studies (4.1%), and miscellaneous costs for the benefit of the national health programmes (34.8%).

4.2 Support for key areas

WHO's core functions include policy and advocacy; technical and policy support; information, research and development; norms and standards; partnerships; and technology, tools and guidelines. The Syrian Arab Republic adopted the strategy of health for all with primary health care as an approach to attain this goal. This was followed by updating of legislation, restructuring of the Ministry of Health and introducing a number of organizational changes to meet new requirements. To ensure adequate response to the growing needs in this important area, and in order to make use of WHO technical capacity, many national programmes were established. These include health policies and management support; health system trends assessment and information; health legislation; quality assurance, and health system research.

It must be noted that although many favourable conditions exist such as high levels of commitment in the Ministry and enthusiasm among national programme managers, there are still some constraints, namely the limited number of skilled and competent personnel, shortage of resources and lack of coordination. These contribute to relative delay in the process of change and despite the high levels of commitment. In order to cope with the expanded functions, the Ministry of Health, in collaboration with WHO, has collected all effective rules, regulations and related decrees. Review of this legislation is ongoing. The organigram of the Ministry of Health has been restructured. Several rules, by-laws and regulations are being updated.

4.3 Additional functions

In addition to the regular functions of the WRO in implementation and monitoring of the work plans included in the WHO–government technical support document, i.e. JPRM

document, many other functions were also performed by the WR office in the Syrian Arab Republic during the biennium. These included execution of two UNFPA-funded projects, activities supported by extrabudgetary resources from WHO, unplanned activities with the Ministry of Health, working within the UN country team and other additional activities carried out by the WHO Representative Office

4.4 Support for regional and HQ activities

The Regional Office (EMRO) and HQ have supported additional activities from extrabudgetary resources in the Syrian Arab Republic in the past few biennia. These included support for assessment of health system performance; burden of disease studies; surveys on health and health system responsiveness, poliomyelitis eradication; Tobacco-Free Initiative and several other activities.

4.5 Support for UNFPA projects

WHO usually executes some UNFPA-funded projects in the area of reproductive health and information, education and communication. In particular, WHO executes the components related to international experts, fellowships, local training activities, personnel, local duty travel and other miscellaneous expenses. Because of the technical nature of WHO-executed components, and their high relevance to WHO mandate and capacity, no major difficulties or constraints were encountered in implementation of the projects. The excellent relationship between WHO and beneficiaries facilitates mutual understanding of the objectives and purposes of projects. This relationship also removes obstacles and facilitates implementation. The involvement of several national sectors in the implementation of these projects, such as the Ministry of Health, Ministry of Information, Youth Revolutionary Union and the Labour Union, has helped generate a sense of partnership among the national sectors concerned with reproductive health. This is expected to contribute to ensuring sustainability and building national capacity in reproductive health in the country.

4.6 Current comparative advantages and constraints

The WHO country office in the Syrian Arab Republic has a number of comparative advantages. WHO is recognized as the primary agency in health by the government as well as by the UN sister agencies and other donors. In the judgement of the Ministry of Health, WHO provides sound and impartial technical advice. Because it is not regarded as a major funding agency, WHO is not seen as prescriptive or imposing an outside agenda. Technical backup from EMRO and Geneva in providing expert advice and best practice at short notice is an important advantage. In addition, the rapid access to decision-makers and policy-makers in the government, the close involvement with the Ministry of Health in framing policies for modernization and the strong links with other ministries and NGOs represent other valuable advantages. However, WHO also faces some constraints in the Syrian Arab Republic.

- Small WHO presence in the country, with the WR as the only international staff and 2 national technical officers on an SSA basis.

- General difficulty in securing support for innovative approaches in a bureaucratic system for which change does not come easily.

- Perception that WHO funds belong to specific programmes.

These advantages and constraints have been taken into account in framing the country cooperation strategy for the next five years.

5. WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has re-evaluated the way in which it should work, against a background of improved understanding of the importance of multisectoral responses which are required to achieve better health; the relationship between improved health and poverty reduction; the emergence of the private sector and civil society as important players to complement the evolving role of the state; the increased involvement of development agencies concerned with the health sector and the heightened importance of the safeguarding of health in the proliferating occurrence of conflict and disaster.

In response to challenges emerging from the broadened context of international health, WHO globally will adopt a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction. It will play a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise. It will trigger more effective action to improve health outcomes, and to decrease inequities in health, through partnerships. It will create an organizational culture that encourages strategic thinking.

Globally, WHO is focusing on its four strategic directions of reducing excess mortality of poor and marginalized populations; dealing effectively with the leading risk factors; strengthening sustainable health systems; and placing health at the centre of the broader development agenda.

Regionally, in EMRO, the focus will be given to the priorities that have been set out by the Forty-eighth Session of the Regional Committee for the Eastern Mediterranean in resolution EM/RC48/R.5 (2001), on priorities for strategic aspects of country programmes. They include:

- Development of human resources for health
- Poverty reduction and better health through the basic development needs approach
- Control of communicable diseases of regional importance
- Creating healthy communities and promoting healthy lifestyles
- Noncommunicable disease prevention and control
- Maternal and child health
- Access to, and rational use of, affordable essential medicines and vaccines
- Development of health systems and services

- Promotion of technology transfer, health information support and capacity-building in health research
- Environmental health.

At country level, the joint programme review and planning mission represents the overall framework for collaboration between the Government of the Syrian Arab Republic and WHO. Areas of common interest for technical and financial collaboration are identified every two years. The main indications for strategic planning and detailed operational planning are conducted during these missions.

6. STRATEGIC AGENDA FOR THE NEXT FOUR YEARS

6.1 Overview

As mentioned earlier, The Ministry of Health has adopted a number of national strategies for 2000–2020 based on statements by the President, government policies on health and the recommendations of WHO. The overall goals of these broad national strategies are to continue emphasizing primary health care, while strengthening and developing secondary and tertiary care, and ensuring equity in health care.

WHO's support in the past has focused on the Ministry of Health and has consisted of technical assistance, training, fellowships, guidelines and support for international standards. WHO sponsored international fellowships and trained key personnel from the Ministry of Health, other health related sectors and universities. WHO also provided funds for Ministry of Health staff to attend international meetings and conferences, as well as to procure key health reference materials and essential supplies and equipment. WHO continues to play an influential role with the Ministry of Health. The flexibility of WHO funding procedures makes it possible for WHO to move quickly to support key strategic activities.

In the last biennium, the WHO collaborative programme has been apportioned along the following lines: national training activities and technical contracts represented 21% each of the allocated budget; consultants 13%; local cost 12%; fellowships 10%; supplies and equipment 8% and 15% for different miscellaneous items.

With the development of the WHO Corporate Strategy and a re-evaluation of the comparative advantages of WHO, the Country Cooperation Strategy intends to take a more strategic approach in its support to the Ministry of Health. Instead of providing limited support to the implementation of health activities, WHO can have a greater impact by a more strategic selection of activities. This involves five functions that emphasize modes of assistance that can be best carried out by WHO. These five functions are:

Function 1: Catalysing adoption of technical strategies and innovation; country-specific adaptation of guidelines; seeding large-scale implementation
Function 2: Supporting research and development; policy experimentation; simulating; monitoring health and health sector performance; trends assessment and anticipation

Function 3: Providing information, sharing knowledge (global, interregional, intercountry); advocacy; generic policy options and positions; cases studies, standards and guidelines
Function 4: Providing specific high-level policy and technical advice; serving as a broker and arbiter; exercising influence on policy, action and spending of governments and development partners.
Function 5: Supporting implementation of some routine, long-term activities.

It is recognized that the implementation of these five functions is not necessarily the same in all the components of the Country Cooperation Strategy. In general, WHO will place most of its attention on providing high level technical and policy advice, sharing knowledge and advocacy. While direct implementation will be restricted, more attention will be put on catalysing the implementation of standards and guidelines to meet conditions in the Syrian Arab Republic.

Based on joint discussion between the national team and WHO team, the following seven priority areas have been identified as the strategic agenda for WHO collaboration in the Syrian Arab Republic for the next 5 years:

1) Development of human resources
2) Health management and administrative reforms
3) Community-based initiatives for achieving the MDGs
4) Environmental health
5) Health economics and financing
6) Noncommunicable disease
7) Population and health.

6.2 Planning for priority areas

Human resources development

In the area of production, qualification and continuing education, the issue of sustainability of efforts started will be given higher attention. The School of Public Health and Scholl of Health Management will continue to receive technical and financial support. The current budget of the Ministry of Health is being increased to provide improved teaching and staff development with importance given to training of trainers. Criteria for training of trainers are being established. A plan for a comprehensive system for continuing health and medical education is being developed, along with a review of teaching curricula and teaching methodologies in these institutes. A plan for projected human resources needed for the next 10 years will be made. Gaps in specialities will be filled as required by medical and health needs. Priority will be given to local production, but a plan for a national fellowship programme for studies abroad will also be prepared.

WHO will strengthen its role in assisting the government formulate these plans and provide expertise in the areas of training and design of curricula. It will:

- Provide the required experts and consultants in the short term but with a view to upgrading skills of the nationals for longer-term sustainability.

- Assist the government in the execution of the fellowship programme for studies abroad.

- Provide WHO modules on human resources projection to be utilized for estimation the need of human resources at all levels.

- Give higher priority to capacity building of national staff through national training activities and continuing education programmes.

Health management and administrative reform

The government is reviewing the legislative regulations and by-laws to meet the needs of the current situation. All administrative procedures will be reviewed to overcome complicated routine and unnecessary bureaucratic layers. Administrative procedures will be computerized. Managerial and administrative skills of health care managers will be improved at all levels of the health system. Job descriptions of different categories of staff will be reviewed and a clear system of performance assessment, incorporating a system of reward and punishment, will be established. Staff criteria for each post will be set up, and the criteria will be used to fill the posts with appropriate candidates. A study will be conducted to assess frustration levels of staff and schemes for creating incentives and job satisfaction will be put in place. Efforts will be made to ensure that the appropriate organizational structure is in place to implement the new strategic directions. Health management will be strengthened at all levels of the health system and it will be accompanied by decentralization of responsibility to appropriate levels. Clear lines of accountability will be revised and clarified, within the revised management structure. Leadership skills will be strengthened.

WHO will provide support to the Ministry of Health in the area of health regulations and laws. It will:

- Assist the government in strengthening health management by providing guidelines and norms as well as sharing the experiences of other countries in this area.

- Continue to provide experts in different fields of health management, administration and financing.

- Technically support an administrative reform programme to improve the performance of the health system.

Community-based initiatives for achieving the MDGs

The Healthy Villages programme in the Syrian Arab Republic is one the most successful examples of community involvement leading to direct impact on improved health outcomes. Under this programme, village development committees are established with specialized sub committees. Family and health surveys are conducted. Utilization of the family health card

and a vital statistics network is growing in all villages. Multisectoral committees have been established at national, provincial and local levels. An assessment of 96 villages at the end of 2000 has shown that immunization coverage increased from 79.4% to 96.2% in these villages. TT vaccination for pregnant women increased from 56.7% to 81.3%, antenatal care from 49.3% to 78.4%. There were significant achievements in other social areas too, for example, coverage of safe potable water rose from 63% to 85%; sanitation coverage increased from 45% to 70%. 19 public gardens were set up and more than 276 496 trees were planted. Another significant achievement of this programme was a successful anti-smoking programme in Aqraba village. This highly successful model of community-based health outcomes is now being expanded within the Syrian Arab Republic and other countries.

WHO will continue to support this initiative and use its advocacy to assist the government in mobilizing additional resources through other partners. Specifically, it will:

- Assist in developing monitoring and evaluation tools for the programme.
- Provide support in sensitizing the community.
- Assist in developing further this initiative as a concrete model for the achievement of some of the Millennium Development Goals.

Environmental health

The fast pace of urbanization in the Syrian Arab Republic has led to increased impact on environmental health. The challenges identified in environmental health include water pollution due to drainage, industry, chemicals and agricultural activities, leading to increasing prevalence of waterborne diseases, and increasing air pollution from transport and industry, leading to an increased in respiratory infections. In the past, WHO has supported activities in environmental health including monitoring water and air quality, food sanitation, control of hazardous substances, occupational health and healthy cities. Despite widespread understanding of the importance of multisectoral approaches in developing a healthy environment, there has been low commitment in efforts to make this a reality. The major obstacles are the complexity of the issues in this area and a lack of clear institutional responsibilities, in both the public and private sectors. There is great need for better coordination between all sectors involved. In particular, the Ministry of Health has to play more active role in environmental health.

WHO will in the next five years, attempt to play a more strategic role in environmental health. Specifically, it will:

- Investigate institutions and stakeholders that have the potentials to improve the environment. This will involve an assessment of current roles and responsibilities and potentials for the future.

- Work with the Ministry of Health to develop clear policies and priorities for a healthy environment. This will include key areas for improvement and outline strategies for possible activities in the future.

- Work with various institutions to determine appropriate indicators of environmental quality and mechanisms to monitor and enforce environmental standards.

- Undertake an inventory of donor partner involvement in the area of environmental health and propose approaches for improving coordination.

Health economics and financing

This has been identified as one of the strategic areas that requires strengthening. The Syrian Arab Republic is currently developing a system of national health accounts, which is needed to make informed decisions regarding investments in health. Similarly there is a need to conduct household surveys to determine spending on health and on use of facilities. There exists capacity within the country to carry this out.

WHO will provide specific high-level policy and technical advice to the Ministry of Health, serving as a broker and arbiter and advising developmental partners regarding spending in the health sector. Efforts will focus on improving activities in health financing with special attention given to ensuring that health system changes are pro-poor. These efforts will give highest priority to monitoring public and private expenditures at the district and provincial levels in order to monitor the utilization of health services and to provide support for prepaid health schemes. In addition, the existing prepaid health insurance schemes need to be harmonized and coordinated, as the current system is fragmented and has too many players. WHO will assist the Ministry of Health in its efforts in this regard.

Noncommunicable diseases

The stepwise surveillance system for noncommunicable diseases will be the starting point to identify the real magnitude of the problem in the Syrian Arab Republic. Standardized management of different noncommunicable diseases will be developed, disseminated and implemented at different levels of health care delivery system. National surveys to discover and document risk factors of each disease will be conducted.

Population and health

The population of the Syrian Arab Republic increased approximately four-fold between 1960 and 2000. The government is giving increased attention to issues relating to demographics and health as a result of the increased population growth and the increased pressure on available health services and medical care.

The WHO will in the next five years assist the Ministry of Health in providing systems that link health issues to population indicators. It will assist in the setting up of a Centre for

Population Studies and work alongside other UN partners such as UNFPA and UNICEF in this area.

7. IMPLICATIONS FOR WHO: SOME POINTERS

This Country Cooperation Strategy will be a significant step in the collaborative work of WHO and the Government of the Syrian Arab Republic. It will strengthen WHO's contribution to national health development. Implementation of this strategy will have considerable implications on the working of WHO at various levels.

Implications for the country office

- Stronger human resources, especially in the area of health sector reform
- Emphasis on improving the evidence base with systemized data collection and capacity to analyse the data for policy inputs
- Stronger technical and advocacy capacity in areas relating to environmental health
- More strategic location of the WHO office

Implications for the Regional Office

- More systematic response to urgent technical requirements of the Syrian Arab Republic
- Enhanced sharing of regional experiences and other resources, especially in the priority areas in the CCS

Implications for HQ

- Rapid response to calls for technical back up and support
- Extra resources directed towards the priority areas as defined by the CCS