Reinventing State: Health Governance in Syrian Opposition-Held Areas

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Executive Summary

The Syrian conflict that erupted in March 2011 impacted the health system right from the beginning: health facilities and health workers were systematically targeted, resulting in the almost total collapse of the health system. The Syrian government, under pressure from the armed opposition, withdrew from large territories in different parts of the country, including large parts of the rural hinterlands of northern, eastern and southern regions, in addition to substantial parts of the metropolitan areas of the two major urban centers of Damascus and Aleppo.

With the withdrawal of the government and its institutions, thousands of civil society organizations, hundreds of local administration councils and many other technical directorates were established in opposition-held areas (OHAs) in order to face the challenge of providing services to the people who remained in those areas. However, a great deal of debate ensued as to the institutional legal frameworks that should govern the opposition-led institutions. Generally, the central bodies were not able to claim full authority over local institutions, such as Education Directorates (EDs) and Health Directorates (HDs), or local administration units. As a result, a unified governance structure was largely missing, and different stakeholders established different governance structures. Some followed top-down models, others bottom-up models and others a mixture of both. And even those who followed the same model, interpreted it differently. Donor funds also contributed to the state of fragmentation by refusing to stick to a common funding approach and to deal with the central governance model, opting instead to intervene directly in the field. With the many actors and security challenges involved, this competition negatively affected all humanitarian sectors and the health sector was not an exception.

This research focuses on governance within the health sector in OHAs to draw a comprehensive overview of the emerging experience of the health sector's governance and study whether the resilience of bottom-up service delivery in the health sector can provide the impetus for a state-building project that can codify institutional structures and ensure their accountability in the future.

A timeline analysis of the development of the health sector governance shows the unfolding of three main phases with evolving governance models. The first starts with the uprising in March 2011, where the early response did not have a clear hierarchical structure. Doctors and activists loosely coordinated their work and the main health service was in the shape of field hospitals trying to treat people injured in the demonstrations. The second phase was marked by the establishment of a top-down governance led by the Syrian Interim Government (SIG) in 2013, which gained some international support. This government operated from outside the country, suffered from poor planning, and enjoyed little support from actors inside the country. The relationship between health actors inside the country drastically deteriorated around the beginning of 2015 after funding was gradually reduced by international donors. The third phase started around the end of 2015, when Syrian NGOs and health directorates decided to come together to establish an alliance to support health governance. The alliance helped in fostering

collaboration amongst local and international NGOs, the Health Cluster, and local actors. This model proved to be more resilient as it led to coordinated if not entirely central planning, better response, neutralization of various non-state actors, and better service provision as the research revealed.

The withdrawal of state institutions by the Syrian government has forced the opposition to start their own state-building project in order to first provide services to people living in OHAs, and to provide evidence to the Syrian people and to the international community that they are able to run a state. Facing this challenge led several groups of a political and technical nature to establish institutions to fulfill these objectives. These groups took two different approaches. The first was top down, led by political institutions, such as the Syrian Opposition Coalition (SOC), which was formed by the opposition in the diaspora and supported by Arab and international donors, with the aim of gaining legitimacy from both the international community and the Syrian people. The other was bottom up and led by local actors; it had a slower approach, and focused more on the technical side than on the political side, motivated predominantly by service provision and regulation.

The research showed that the bottom-up approach proved far more successful than the top-town one, and that the failure of the top-down approach to public health revolved mainly around the various stakeholders' lack of consensus and understanding of the social factors affecting governance. For example, competing social orders tend to create competing governance structures, that if not considered and accounted for will enshrine parallel structures and institutions, negatively affecting health systems. However, a top-down approach was subject to skepticism and lacked acceptability at the community level as institutional bodies claiming the role of the center were not accountable to the ground and lacked understanding of the needs on the ground and service provision sensitivities. Initial attempts at institutionalizing medical services received timid acceptance. However, this acceptance proved to be superficial and it collapsed when challenged by questions such as allocation and distribution of resources, different norms and contradictory salary scales. The top-down approach relied on traditional opposition actors who lived abroad or were living abroad at the time. This was seen as an imposition by regional and international powers establishing governance structures and filling them with people they already knew and were part of their patronage networks, rather than people who had local legitimacy and lived with the people inside the country.

The research also pointed to a productive approach that looked at state building from the bottom up, with focus on needs and improving service provision, rather than political aspirations. A new normative field gradually emerged by having different actors negotiate processes out of necessity as resources were limited and needs were shifting from immediate trauma response to meeting long-term public health concerns. One can even speak of an emerging model of interaction that can transcend the limits of health services to other related sectors. However, despite its success in creating accountability inside the sector, this accountability has remained weak as other sectors, especially the justice and police sectors, are still

absent. The absence of rule of law instruments – policymaking, judiciary oversight, and policing – caused a gap in consolidating a replicable normative framework.

Regulating private providers is another area of contention. Prior to the conflict, the private sector was providing as much as 50 per cent of all services. The emerging normative framework was not able to engage these actors as supply-side funding sidelined them. As such, the ability of institutions to enforce standards remained limited. Thus, this bottom-up form of governance and state-building normalization fell short of contributing to a broader state-building project.

The state-building project, although it showed some visible success in the health sector, cannot be successful if it is not applied across sectors and geographies. Unmatched development of a unified governance model in education, local administration, justice, etc. will hinder the development of the governance in the health sector itself. Different donor funding schemes across sectors largely contributed to the fragmentation of the governance in OHAs. The research clearly pointed out the limitations of sector-specific thinking despite its indispensability for evolving socially acceptable and resilient institutions.

The research emphasizes that state-building projects during conflict should focus more on bottom-up approaches with clear understanding of competing social orders and the interests of all stakeholders including local communities, civil society, NGOs and INGOs, UN agencies, militias, political actors, and donors. Governance is the art of striking a balance between all of these actors with the aim of optimizing service provision.

In addition to that donors must use a coordinated approach to fund governance projects. This has two sides. First, territorial and sectoral governance, across regions and sectors, should follow one governance system, and second, funding should use similar mechanisms that are built on the principle of striking balance between all stakeholders. Although this might sound obvious, reality shows that different donors support varying governance structures across geographies and sectors.

It is also important to note that supporting governance in one sector cannot guarantee success in this sector. That is, sectors are interlinked, and a weak governance system in one sector affects the others.

Moreover, we should keep the emphasis on the technical nature of the local authorities rather than their political role, as this helps in protecting the sector from the interventions and polarizations that mark conflict zones and helps in protecting service provision to people in need. Lastly, there seems to be no system to include the private sector in the Cluster, which leaves a considerable service provider outside the system.

Contents

Acronyms

ACMC	Aleppo City Medical Council
ACU	Aid Coordination Unit
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CSOs	Civil society organizations
DFID	Department for International Development
EDs	Education Directorates
EPHF	Essential Package Health Functions
EWARN	Early Warning and Response Network
FMU	Free Medical Union
FSA	Free Syrian Army
GHAs	Government-held Areas
HC	Health Cluster
HCLA	High Council of Local Administration
HDs	Health Directorates
HIS	Health Information Systems
HPF	Humanitarian Pooled Funding
HTS	Hay'at Tahrir Sham (Organization for the Liberation of the Levant)
INGOs	International Non-Governmental Organizations
ISIS	Islamic State of Iraq and Syria
KIIs	Key Informant Interviews
LACs	Local administration councils
LACU	Local Administrative Councils' Unit
LCC	Local Coordination Committees
LHCs	Local Health Committees
MoE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
OCHA	Office for the Coordination of Humanitarian Affairs
OHAs	Opposition-held areas
PAC	Physicians Across Continents
PAHO	Pan American Health Organization
PC	Provincial Council
PYD	Partiya Yekitiya Demokrat (Kurdish: Democratic Union Party)
SAG	Strategic Advisory Group

SAMS	Syrian American Medical Association
SD	Standard Deviations
SEMA	Syrian Expatriates Medical Association
SIG	Syrian Interim Government
SOC	Syrian Opposition Coalition
THC	Turkey Health Cluster
UFSD	Union of Free Syrian Doctors
UMO	Unified Medical Office
UN	United Nations
UNDP	United Nations Development Program
UNSC	United Nations Security Council
UOSSM	Union of Medical Care and Relief Organizations
AWHO	World Health Organization
WHO -EMRO	World Health Organization – Eastern Mediterranean Regional Office
YPG	Yekîneyên Parastina Gel (Kurdish: People Protection Units)

Introduction

The Syrian conflict that erupted in 2011 has multiple roots; paramount among them is the failure of its governance model to deliver quality services in an equitable manner. Peaceful calls for reform eventually were caught between violence and counter-violence that evolved into a fully fledged civil war. By mid-2012, the armed opposition started to take over large territories in different parts of the country. This included large parts of the rural hinterlands of northern, eastern, and southern regions, and eventually the opposition was able to capture substantial parts of the metropolitan areas of the two major urban centers of Damascus and Aleppo.

With the acquisition of territory, the opposition was challenged to provide services and stability to populations under its control. The political and armed opposition had to face the question of state building; how, by whom, and with what money would health, education, agricultural services, humanitarian aid etc. be provided. Various Syrian opposition bodies and factions had to fill the vacuum and establish institutions, local councils, and civil society organizations to respond the needs of communities living under their control. The new bodies created faced major challenges, such as lack of financial resources, limited human resources and experience, and, most importantly, the institutional-model legitimacy required to manage the process. Striving to provide services soon became a political problem of state building.

Across the opposition-held areas (OHAs) thousands of civil society organizations (CSOs), hundreds of local administration councils (LACs), and many other technical directorates were established in order to provide services to the people that remained in those areas, who at a peak constituted over 40 per cent of the total Syrian population. Financial and technical resources were solicited from international and regional donors who responded by delivering disparate aid packages in a highly asymmetrical manner that contributed to further fragmentation of the political order in the OHAs. Attempts to aggregate the political and military command of the opposition in a central body succeeded in creating the Syrian Interim Government (SIG) in 2014.

The SIG attempted to aggregate territorial control by establishing ministerial portfolios along with their line ministerial directorates (health, education, public works, etc.) as well as governorate-level structures (governorate councils) to oversee the work of the local councils. Additionally, two bodies were adapted from the earlier days of the uprising and transformed into central technical offices: the Aid Coordination Unit (ACU) and the Local Administrative Councils' Unit (LCAU).

However, a great deal of debate ensued as to the institutional legal framework that should govern the opposition-led institutions. While the SIG eventually opted to adopt governance models that adhered to Syrian law and institutional models, other authorities on the ground (mainly those controlled by armed actors) competed with the SIG's legitimacy and access to local institutions. In many of the OHAs, the central bodies were not able to claim full authority over local institutions, such as Education Directorates (EDs) and Health Directorates (HDs), or local administration units. As a result, a unified governance structure was largely

missing, and different armed stakeholders established different governance structures across the different areas of control, as well as across different service sectors in the same area. Some followed top-down models, others bottom-up models, and others a mixture of both. Donor funds contributed to the state of fragmentation by refusing to deal with the central governance model and opting instead to intervene directly in the field. Local civil society actors often acted as intermediaries between donors and local councils, further complicating the scene and contributing to the fragmentation.

Even when local intuitions followed the same model, they interpreted it differently depending on various factors, such as geographical dispersion, legacies of the early days of the uprising, the role of civil society, donor policies, pressure from armed and terrorist groups, leadership, personal power plays, and possibly other factors. Moreover, these institutions had to face various challenges, including bombardment of facilities, displacement, pressure from militia and terrorist groups, shortage of funds, and pressure from neighboring countries. Of course, different structures have varying levels of resilience and adaptability. Yet the net result is that over the six years since the opposition was driven to control areas by force under the rubric of »liberation« over half of the remaining populations of those areas have deserted them.

This research tries to focus on governance within the health sector in opposition-held areas. Health services were initiated early on as part of the support to the initial demonstrations and then became an urgent necessity as the conflict dragged on and became more violent. The urgency of the medical care for the victims of the war left a heavy mark on the institutions that evolved progressively to respond to other medical needs (primary care, public health, chronic diseases, etc.). The voluntary nature of the early institutions and their management under various civil society and humanitarian organizational models delayed the emergence of viable governance bodies and often led to unspoken competition between the CSOs and the HDs.

The competing claims to legitimacy that donors, international organizations and local communities faced further hindered the long-term response to medical care in the OHAs. The eventual creation of the Health Cluster under the supervision of the United Nations (UN) Office for the Coordination of Humanitarian Affairs (OCHA) managed to mitigate issues of distribution and data but did not resolve problems of access and equity.

Nonetheless, the health sector was a pioneer in terms of attempting to mitigate the differences among all the actors and stakeholders, and pilot efforts were made to bridge the gap between central opposition bodies and local ones, as well as between civil society groups and quasi-governmental institutions. A new *modus operandi* emerged that attempted to recognize the agency role of all actors and define mandates and responsibilities. This pioneering effort took into consideration the limitations of local institutions and their need to navigate among competing power brokers and claims of legitimacy, while at the same time addressing the need to create an economy of scale to deal with health issues and share knowledge and institutional models among the different areas of control. In

doing so the different stakeholders had to negotiate the parameters of what constitutes a »health sector« and work out sectoral boundaries both vertically and horizontally. The paper explores how the creation of a health sector was negotiated in the OHAs.

1. Research Problem

Various types of stakeholders have emerged to respond to the health needs of communities in the OHAs. These actors had competing visions of a state-building project, with models ranging from the normative implied in the Syrian legal system to the more operational ones advocated as urgent response measures. Health service actors had to negotiate not only service delivery but also the legitimization process that governs the service's delivery. Forging a »health sector« and defining its boundaries and mandate was one of the compromises that enabled a critical mass of stakeholders to work together. Defining the sector required pushing the boundaries defined by the UN and other international organizations, asserting the »political neutrality« of humanitarian interventions on the one hand, while building the legitimacy of the institutional bodies of the opposition on the other hand.

The boundaries of the health sector are continuously being challenged by opposition governance models' competing claims of legitimacy. This includes dichotomies like:

- The SIG vs. the newly formed »Salvation Government«,
- The local vs. the central bodies,
- The quasi-governmental bodies vs. civil society actors,
- The Syrian bodies vs. the Turkish and Jordanian ones,
- The humanitarian actors vs. the stabilization and development actors,
- The Syrian priorities vs. donor mandates,
- Opposition models of governance vs. those provided by the central state,
- And most importantly the different models of public oversight and accountability; for instance, the HD in Idlib had a board of trustees and its management was elected, while in other areas the management was nominated by the SIG or by the local governorate-level council. In turn, this created various competing management issues (salary scales, competency requirements, etc.).

The main research question for this study can thus be summarized as:

Can the resilience of bottom-up service delivery in the health sector provide the impetus for a state-building project that can codify institutional structures and ensure their accountability in the future?

The resilience of the »health sector« is not immediately evident. Other sectors did not exhibit similar resilience. Defining what factors affected the resilience of the model will require examining a variety of issues, including:

- How has the humanitarian discourse shielded the sector from most of the quibbling about formal governance, but has this also hampered its institutionalization?
- How has the state-building project in the health sector evolved? How does it compare with other sectors such as education? What lessons can be drawn from the experience?

- Who are the main actors in the health system in OHAs and what are their assumed roles? How can resilience be supported and negotiated between actors who seek only the legitimacy of their political project and those who only seek to deliver vital services?
- What competencies and values are likely to survive and affect the larger transformations of the Syrian institutional governance model in the future?

The report starts by explaining the methodology used. Then, we explore literature that describes the health crisis in Syria and governance in OHAs. Afterwards, we elaborate on the concepts of health system and health governance as seen by researchers in the field and organizations like the World Health Organization (WHO), the World Bank, and the UN Development Program (UNDP). After that, we move to analyze data collected. Finally, we conclude with set of recommendations and further research required.

2. Research Design

2.1 Methodology

The main aim of this research paper is to draw a comprehensive overview of the emerging experience of the health sector's governance. The research's preparatory phase started with a desk review of documents from the Health Cluster (HC), HDs, NGOs (Non-Governmental Organizations), and other related entities. One major resource for the desk review was a series of eight workshops conducted by many actors in the sector – including HDs, LACs, NGOs, and service providers – and facilitated by the research advisor over the period from January 2017 to June 2018. During the desk review, several unstructured interviews were conducted with actors who appeared in the documents to verify dates, facts, incidents, and documents in order to draw a timeline of the health governance development from 2011 until 2018. Most of the unstructured interviews were conducted online through WhatsApp or Skype.

Then a process of literature reviews to examine concepts such as health systems, health governance, and health governance in conflict, in addition to governance in Syria both pre- and post-conflict, was carried out.

Based on the literature and desk review, the questionnaire for the in-depth interviews was designed and tested with two participants. The resulting questionnaire was used in the semi-structured interviews with the rest of the sample.

Afterwards, in-depth qualitative interviews were conducted with 30 people over a period of four months – from September 2018 to January 2019. Both online and face-to-face interviews were used in the interest of assessing health system stakeholders' perceptions of the governance of the health system and its associated challenges, as well as to deepen our understanding of how such stakeholders become more resilient in a continuously changing political and military context.

Results of the Key Informant Interviews (KIIs) were entered to MAXQDA software. Annex 1 shows the coding system used in the research.

In order to validate results, a focus group discussion – in which eight experts in health systems, health governance in conflict, and the Syrian conflict participated – was held in collaboration with the Department of Public Health at the American University of Beirut.

According to Marshall (1996), the KII method is »an expert source of information« (1996, p. 92) where informants have the ability to provide much information and deep insights about events and activities that happened around them. Tremblay described informants as »natural observers« (1957, p. 693) who are interested in the behaviors and cultural developments of those around them. Hence, researchers are interested in investigating their observations on certain occasions or in relation to certain experiences.

Kumar (1989) defines a KII as a qualitative interview for a selected group of individuals who could provide needed information and insights on a specific subject. Kumar demonstrated several uses for and benefits of the KII method that led us to rely on it as a main tool for the research design; it allows you to gain direct information from knowledgeable people and to explore a variety of insights and ideas, and it is not complex or expensive to implement.

According to Marshall (1996), the main advantage of KIIs is to obtain high-quality data in a relatively short period of time. The author further explained that the KII method is widely used in social sciences and is prominently implemented in health research. Nevertheless, informants are sometimes unlikely to represent all the views of the individuals in community (cf. Marshall, 1996). Therefore, the present study has to not only increase the sample size, but also to diversify the sample unit amongst different factors such as geographical location, position, organization, and stakeholder variety.

The semi-structured interview is one of the important methods that allow interviewers to benefit from a written guide (also called protocol) to ensure that all topics are covered as well as to use probes to elicit comprehensive and valuable information, while allowing the interviewees to freely talk (Barriball & While, 1994; Polit, Beck, & Hungler, 2001).

2.2 Sample Design

The assumed shift in responsibilities and roles within the health sector inside Syria means that many active actors have been playing important roles in leading the sector.

For this reason, when the sample was designed, we considered including all possible effective and affected actors on the supply side, i.e. representatives of organizations and institutions concerned with service planning and provision, in addition to representatives of the service recipients, i.e. local councils.

The total number of key informants contacted was 35 (100 per cent); 33 (94.2 per cent) responded.

The sample was divided into four main categories: public sector, private sector, NGOs, and UN and donor community. In the public sector, actors are technical or political bodies and sometimes can play both roles. A challenging issue was the definition of a public sector institution. In this research, we considered a public sector institution any institution that claims a public sector role (regulation, planning, leading, and controlling), uses public sector titles (ministry, directorate, etc.), and has connections to political bodies. Accordingly, the Assistance Coordination Body is considered a public institution as it claims public sector roles (central planning and coordination) and is connected to the Syrian Opposition Coalition (SOC), and its director is directly appointed by it despite the fact that it is registered as charity in Turkey. All hospitals are considered public sector as they report to a public body, i.e. HDs. The SIG, LACs, and Provincial Councils (PCs) are

also public sector bodies. However, entities that are connected to militias, such as the »Salvation Government« (SG), are not considered public sector.

Up until now females have had very little representation in managerial positions, even in INGOs and UN agencies, although their representation is still better in these bodies than in Syrian NGOs. For this reason, 17 interviewees were male and held the top position in the structure they represented; they included heads of provincial councils, directors, and ministers. In the sample, there is only one female, who is the manager of one of the hospitals in Idlib.

There were 19 participants from the public sector, forming about 55.88 per cent of the total number of key informants who were interviewed and representing three public hospitals (8.8 per cent), seven directorates (20.58 per cent), four provincial councils (11.76 per cent), and five local councils (14.7 per cent).

When designing the sample, we considered the contextual differences between various locations within Syria. That is, in northern Syria there is access to a neighboring country, Turkey, and the environment is more stable compared with other locations. In northern Syria we also included representatives from Aleppo HDs and provincial councils who were forced leave Aleppo's city center to continue their work in the Aleppo countryside. From this region, key informants represented two hospitals, four directorates, three province councils, and five local councils.

In southern Syria there were two different contexts: the besieged Ghouta area of Damascus, where financial, human, and medical resources were limited and the security issues were the main concern, and Deraa, which had been stable for a long time in terms of security and had limited access to neighboring country Jordan. From this region, key informants represented one hospital, two directorates, and one provincial council.

Participants from Deraa were fewer than planned due to active military actions and security instability, so out of the four participants from southern Syria only two were from Deraa, while one refused to participate.

There were 12 participants from the NGO sector and donor community, representing 35.29 per cent of the total number of key informants who were interviewed. Five represented local NGOs (14.7 per cent), three represented donors and INGOs (8.8 per cent), and four represented UN agencies (11.7 per cent). Defining local and international NGOs was again a challenge. All NGOs operating in OHAs are not registered in Syria due to political issues. Local NGOs are registered in neighboring countries and/or in Europe and North America. Accordingly, the criteria used in identifying local vs. international NGOs was borrowed from the UN Office for Humanitarian Coordination. OCHA considers as local only NGOs that operate in Syria only. Also, Syrian NGOs tend to have members who are Syrian or of Syrian origin. Consequently, the sample has three INGOs and five local, i.e. Syrian NGOs. In addition, the group contained a representative of one donor, an ex-Health Cluster coordinator, an ex-Health Cluster co-lead, and two OCHA officials.

In Syria, three different types of organizations responded to the crisis: local NGOs, INGOs, and UN agencies. All UN agencies comply with humanitarian principles and their focus was on a humanitarian response. The situation is different for local and

INGOs, and some of them supported the stabilization process through enabling local administration entities as well as service provision and humanitarian work. Out of 12 interviewees from UN agencies and the donor community, two were female.

There were only three (8.8 per cent) participants from the private sector out of the total number of key informants interviewed: one (2.9 per cent) represented a private laboratory, one (2.9 per cent) a private warehouse, and one (2.9 per cent) was an owner of one of the private hospitals.

As health is interlinked with almost every other sector, the sample included both medical and non-medical entities. From the public sector, the sample included four heads of provincial councils, five of heads of local councils, an Education Directorate representative, and a civil defense representative, comprising 11 (32.35 per cent) of the total size of the sample. On the other hand, the sample contained five health directors and four hospital managers, comprising 26.47 per cent of the total sample size. On the donor and UN agencies level, three representatives work in health and non-health sectors (9 per cent of the sample) and two (6 per cent) work specifically on health. On the NGO level, three (8.8 per cent) work only in health and five (14.7 per cent) work in all sectors including health. In the private sector all interviewees were from the health sector. In general, the sample contains 15 (44.1 per cent) who work only in health, 17 (50 per cent) who work in health and other sectors, and two (5.88 per cent) who work in non-health sectors, namely education and civil defense.

Geographically, the sample tried to cover all OHAs. All NGOs, both local and international, UN agencies, and donors work in all governorates. In the private sector, there are two (5.88 per cent) from Idlib and one (2.9 per cent) from Aleppo. In the public sector, there are two (58.8 per cent) from Deraa, four (11.76 per cent) from Aleppo, six (17.64 per cent) from Idlib, two (5.88 per cent) from Damascus countryside, one (2.94 per cent) from Homs, and three (8.82 per cent) from Hama. It was very difficult to communicate with people from Homs, Deraa, Latakia, Damascus countryside, and Qunaitera, as these areas were taken by the Syrian government just before the research commenced, and the only governorates remaining under opposition control at the time the research started were Idlib, Aleppo, Hama, and Latakia; however, Latakia directorate covers a very tiny portion of the entire governorate.

It is worth noting that this research is focused only on OHAs and, hence, the sample did not contain participants from Democratic Union Party (PYD)-held areas like Raqqa, Der'Azzor, and Hasakeh, nor from government-held areas such as Damascus, Latakia, Tartous, and Sweidaa. Also, and despite the fact that northern Aleppo is still referred to as an OHA, the study does not cover it. This is due to the reality that this area is fully controlled by the Turkish government, which has installed its own system.

One ethical issue has to be taken into consideration. This issue is that the main author in this research was the head of one of the medical organizations that helped in establishing the health system in OHAs. Hence, the sample was purposefully expanded to include interviewees from organizations that have no

partnership with his organization in order to achieve the maximum possible objectivity.

2.3 Interview Design, Processes, and Analysis

The interview questionnaire for KIIs was designed based on the six pillars of the WHO health system. These are: governance, service delivery, human resources, health information systems, finance, and medicine and technology (WHO, Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action, 2007).

Considering the steps of Creswell (2004) in designing interview protocol, our interview protocol consisted of (1) an introductory section that included a brief overview about the research questions and main objectives, (2) inquiries related to interviewees' background and their experiences, and (3) open-ended questions designed in accordance with WHO's pillars (see Figure 2).

The questionnaire was designed by a board of experts and then tested with two people in both face-to-face and Skype format, and the questions were reviewed accordingly. After that, an English translation of the questionnaire was prepared.

The interviews were conducted both face-to-face and online via Skype and WhatsApp calls depending on the accessibility and availability of our interviewees. However, both strategies are alike in terms of data quality and interview responses (Colombotos, 1969). Thirty interviews were conducted in Arabic and three in English.

The 33 interviews were accomplished within a four-month period. Each one lasted 45-60 minutes. The interviews were immediately transcribed, translated, coded, and then analyzed, following the recommendations of many researchers in the field of qualitative analysis such as Marshall & Rossman (2011) and Merriam (1998).

The focus group was conducted in collaboration with the American University of Beirut, which has among its personnel and faculty participants from the medical field as well as experts in the Syrian context.

According to Saillard (2011), software for qualitative analysis facilitates the coding and analysis of textual information in order to cluster founded themes and provide deep insights and interpretations. Therefore, we rely on MAXQDA software as a tool for our analysis. Creswell (2004) suggested six steps to be followed for analyzing qualitative data; these are illustrated in Figure 1.

First, after data was collected from the interviews and the focus group, the data was organized and prepared for analysis. Second, we skimmed the data to generate an overall understanding of what had been discussed. Third, coding processes were started following Tesch's (Qualitative research: Analysis types and software tools, 1990) approach, which comprised preparing transcriptions, bracketing sentences and paragraphs, categorizing topics, and ending with providing adequate labels and terms. After that, we clustered all the resulting

terms into broad themes. Then, we interlinked all results to shape the conclusion of analysis. Next, we finalized this process through interpretation of all the outcomes, aiming to draw a full, comprehensive picture of governance in the Syrian health sector.

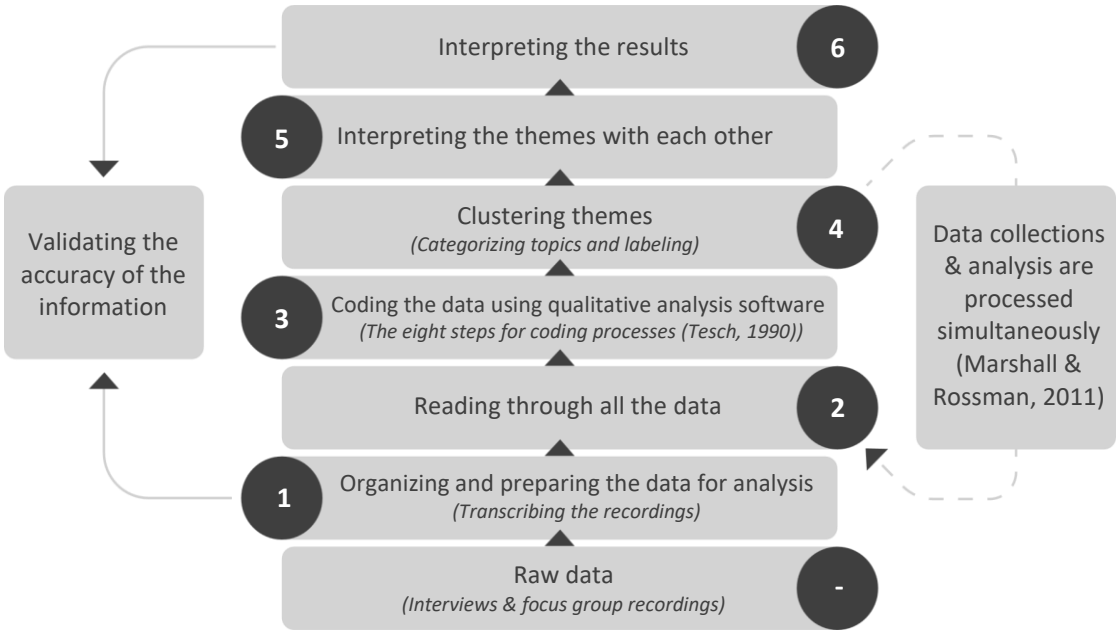

Figure 1: Data analysis procedure for the in-depth interviews – adapted from Creswell (2014)

2.4 Ethics, Validity, and Reliability

The research takes into consideration several principles as a code of conduct considering the sensitivity of the conflict. We attempted to minimize risk of harm for both researchers and participants.

Additionally, the interviewees were informed about our research aims, in addition to the main stakeholders in this research project. Thus, we sent in advance an administrative consent form asking for their voluntarily participation and permission to record and quote them. Furthermore, the research process protected the anonymity and confidentiality of the interviewees and their information. Moreover, participants were explicitly provided with the right to withdraw at any time from the interview or refrain from answering any question.

According to Yin (2009), qualitative research should document the procedures and steps of coding in order to have a reliable approach. Accordingly, we have followed the four qualitative reliability procedures of Gibbs (2007). Therefore, the transcripts were checked with the aim of avoiding any mistakes during this stage. Furthermore, we made sure that there were no drifts in the codes' definitions during the coding process. Additionally, regular meetings and communications with coders were conducted to enhance and develop the coding system. Finally, we cross-checked our coding system through two independent researchers. They coded two different interviews and compared their results to ours in order to

conduct an »inter-coder agreement« test. The result of the statistical test was 87 per cent, which indicates high agreement and consistent coding.

The expert focus group discussion lasted for almost five hours, evaluating methodology and results. On the methodology side, participants helped in evaluating process and sample. On the process side, participants emphasized adding the workshops facilitated by the research advisor as a major part of the desk review. Accordingly, participants asked to add more representatives from the local councils and at least one service provider from the private sector. Consequently, four representatives from LACs and an owner of a private hospital were added.

3. Syria Health Crisis in the Literature

The health system was one of the major victims of the Syrian war right from the beginning (Maziak, 2018). Attacks on health facilities and lack of safe and secure environments are among many factors that led to physicians' exodus. In 2016 there were 199 attacks on health-care facilities. More than 782 health workers were killed by bombardment, torture, shooting, and execution. All parties committed violations against health workers with the Government of Syria accused of committing the majority of violations (M Fouad, et al., 2017). The number of doctors who remain in the country or OHAs is unknown. While Alsaied, et al. (2017) refer to 42,000 doctors having left the country by 2016, WHO estimates that more than 80,000 health workers had already fled the country by 2013 according to Stone-Brown (2013). While conducting this research, there were only 600 physicians, 1,100 nurses, 721 technicians, and 170 midwives providing health care for the at least 3 million people who live in the Idlib governorate[1], according to the numbers provided by Idlib Health Directorate.

Secondary health care was heavily affected by the exodus of doctors, bombardment of hospitals, huge shortage of technical staff and nurses, damage to equipment, and lack of medical supplies (Mowafi, et al., 2016). By 2015, five years after the start of the war, there were »ninety-four hospitals that provide operative trauma care inside Syria, with 538 surgeons, 378 other physicians, and 1,569 nurses of any kind providing care for 12 million people in April 2015 (nongovernment, non–Islamic State territory). There is an unmet need for biomedical engineering support, with large numbers of critical equipment in need of repair, and trauma volume is high, with a mean (SD) of 228 (305) patients presenting monthly to Syrian hospitals« (Mowafi, et al., 2016).

Primary health care was also severely damaged. According to Alsaied, et al. (2017): »The health-care system in Syria has been greatly damaged, and tremendous efforts are ongoing to provide access to various health-care services including primary care to the population. Despite these efforts, the current system is very vulnerable and not sustainable«. Lack of pediatric health care put Syrian children at risk for serious infections, epidemics and morbidity (Berlaer, et al., 2017).

[1] Interview with a high-ranking HD officer.

Children suffered from under-nutrition, anemia, and the breastfeeding rate was low.

Syria saw several polio, measles, and scabies outbreaks after a long disappearance of these diseases in the country (DeJong, et al., 2017). Mental health care was another huge challenge even before the war: »There were 70 psychiatrists and 2 public psychiatric hospitals serving the entire population, and there was extensive stigma towards mental illnesses« (Abbara, Blanchet, M.Fouad, & Sahloul, 2016). Evidently, the situation drastically worsened after the start of the war (Panter-Brick, et al., 2017). Right now, there are only two psychiatrists and two small-scale mental illnesses hospitals.[2]

The severity of the disaster becomes even worse if we add to it one major aspect, which is the absence of a health authority that tackles emergency response, vaccination campaigns, drug control, strategy and policy development, resource allocation, etc. in large parts of the country and especially in OHAs. Instead, the international community relied on INGOs and Syrian NGOs from 2011 until 2014 when the UN installed its Cluster system to coordinate the response. In government-held areas (GHAs), the government, through the government Ministry of Health (MoH), remained the health authority, coordinating aid and maintaining services despite a huge shortage of physicians, mortar attacks, economic sanctions, financial difficulties, and a shortage of medical supplies and equipment. North-east Syria, which is still under the control of the Kurdish YPG militia, also imposed its own governance system.

For the years that followed the establishment of the Health Cluster in Gaziantep, the Cluster remained the main health governance structure. The »Cluster Approach aims to improve coordination, leadership and accountability of different humanitarian sectors such as health, nutrition, protection, and logistics. Clusters are partnerships of humanitarian organizations, both UN and non-UN« (Diggle, et al., 2017). The Cluster holds bi-monthly meetings for its Syrian and international NGOs, collects data from them, leads technical working groups, issues service provision standards, helps in funding, communicates with donors on priorities, and sets emergency response plans. The Amman Health Cluster played a similar role with a smaller capacity due to difficult access to the southern part of Syria, and almost stopped after the government took over Deraa and Qunaitera in July 2018.

In addition to the Health Cluster, other players claimed roles that would otherwise be the responsibilities of the government. For example, the ACU is administering the independent Early Warning and Response Network (EWARN) system. »EWARN was established by the ACU in June 2013 with the assistance of the US Centers for Disease Control and Prevention (CDC)« (Sparrow, Almilaji, Tajaldin, Teodoro, & Langton, 2016). The Syrian Immunization Group is a loosely defined group connected to the WHO that is conducting vaccination campaigns in collaboration with Syrian NGOs, the ACU, and HDs (WHO, 2018).

[2] Interview with Dr. Munzer Khalil, Director of Health in Idlib.

Along with these bodies, the political opposition, and in particular the SOC, established several bodies including a ministry of health under the SIG. The Ministry of Health in the OHAs established and adopted 11 HDs by June 2014 (Alwasl, 2014). The first opposition HD was established on May 1, 2013 under the name of Free Idlib Health Directorate. The relationship between the SIG and HDs remained unstable and varied from one directorate to the other.

The opposition MoH is still seen as having a weak structure, and its presence is just nominal. In addition to the political opposition, militia and extremist groups have tried to establish health offices and even ministries, such as the »Salvation Government« ministry of health that is connected to the terrorist group Hay'at Tahrir Alsham (Organization for the Liberation of the Levant; HTS). However, this ministry is not functioning and has only the minister as its personnel.

4. Local Governance in Opposition-held Areas after 2011

To understand health governance in opposition-held areas it is necessary to understand the complex governance systems in these areas and the various players affecting and affected by these systems.

Ever since the Syrian crisis transformed into an armed conflict, donors, civil society organizations, opposition political factions, activists, and armed groups have tried to establish governance systems to control aid and service provision. During 2012-13, several forms of governance emerged to fill the void created by the absence of state institutions. Initially, during 2011 and 2012 young activists established the Local Coordination Committees (LCCs) to organize protests and demonstrations, and to respond to humanitarian needs (Hajjar, et al., 2017) (Khalaf, 2015) (Hallaj, 2017). These LCCs transformed into various forms such as LACs, civil society groups, and NGOs on the civil side. As soon as these bodies were formed, attempts were made to create central bodies to control, standardize, and lead these bodies. Consequently, in December 2012, the SOC established the ACU to coordinate increasing donor aid to OHAs. The unit's reputation was challenged by assorted allegations, including mismanagement of funds and misinterpretation of role (Svoboda & Pantuliano, 2015; Oweis, 2014). Later, in 2013, two central bodies were established by the SOC: the SIG and High Council of Local Administration (HCLA). The SIG was established in March 2013 by the SOC to »... exert control over Local Councils and streamline their funding mechanisms« (Becker & Stolleis, 2016). However, the SIG was always perceived as a weak government in exile with limited resources and challenged legitimacy (Becker & Stolleis, 2016; Rangwala, 2015).

The HCLA was established in March 2014 by the SOC with the declared goal of moving »... Syria from a centralized dictatorship to decentralized freedom« (Yazigi, 2014). Many saw this body as part of the political struggle inside the SOC rather than a response to governance needs in OHAs (Oweis, 2014). Eventually, both structures failed to claim the central authority and control over LACs. The HCLA ceased to exist and SIG remains very weak with just nominal presence.

Militias also tried to have their own share of »civil« governance entities in order to control service provision (Hallaj, 2017; Khalaf, 2015). Although some attempts were made by several militia groups, the most powerful interventions were made by Jabhat Alnusra (Alnusra Front; NF) and Ahrar Alsham – both Salafist groups present mainly in northern Syria – and Jaish Al-Islam in Eastern Ghouta in Damascus rural areas (Hallaj, 2017; Al-Tamimi, 2018). These factions tried to control already established local councils and technical directorates and establish their own administration bodies. For example, Jaysh AlFath, made up mainly by NF and Ahrar Alsham, established the Civil Administration for Services as soon as Alfath Army took Idlib governorate, and the Islamic Commission for the Administration of Liberated Areas was established with 10 offices including health, education, and police (Aldorar, 2015; Al-Tamimi, 2018). The most recent entity was the "Salvation Government" (SG) established by HTS (Al-Tamimi, 2018). The SG had 11 ministries, including education, health, and local administration; not surprisingly, it didn't have a ministry of defense as defense was left to HTS itself (Al-Tamimi, 2018). Despite that, researchers and activists claim the militia failed in providing civil services and/or establishing governance entities. Almost all of them agree that militias in general and specifically HTS succeeded in controlling the judiciary system through establishing Sharia Courts and disallowing independent, civil courts (Hallaj, 2017). Two areas escaped Sharia Courts: Deraa and northern Aleppo. In Deraa, Dar Al-Adl (Abode of Justice) was formed to unify all courts under one civil judiciary system (Al-Koshak, 2015). The second area, Aleppo, was liberated from ISIS by Turkey-backed Free Syrian Army (FSA) factions and is now known as the Euphrates Shield area in Aleppo, where »Turkey has set up a full range of administrative services, from police and post offices to schools (where Turkish is now taught as a second language) and local councils operating under Turkish control« (Salt, 2018).

To conclude, we can confidently say that there is no single governance model applied in all regions under opposition control. The governance model applied depends on various factors, including foreign power intervention, donor policies, internal conflicts inside political bodies and militias, access, etc. Also, the struggle to delegitimize the Syrian government in Damascus on one hand and to find ways to optimize service and aid provision on the other has pushed the opposition to create LACs and bodies to centralize control. However, experience shows that little success has been achieved in this regard and several bodies have played against each other, resulting in a failure to create one central governance body.

Apart from militia-imposed governance structures, one can recognize two approaches referenced in the literature. The first is mainly a top-down approach that relies more on the international legitimacy through the creation of the SIG and HCLA. The other is a bottom-up approach with the hope for community representation through local administration councils. Surprisingly, the experience of technical directorates such as health and education were little studied by researchers. Directorates were mentioned just as part of service provision, or as a source of information but not as governance structures (Meininghaus, 2016; Alzoubi, 2015). This might be the result of the relative newness of the experience.

5. Health Systems and Health Governance

Researchers and practitioners have tried to define health systems from different points of view. These frameworks vary in perspective, elements of the system, terminology, and taxonomy (Shakarishvili, et al., 2010). For example, Mills (2014) focuses on four key actors (governments and professional entities, population, funding agencies, and service providers) and four key functions (regulation, financing, resource allocation, and service provision). However, the most widely used framework is the one suggested by the WHO (Shakarishvili, et al., 2010). According to WHO (2000) a health system is »all the activities whose primary purpose is to promote, restore or maintain health«. WHO's framework is expanded in its 2007 report (WHO, 2007) and explains health system components as: health information systems (HIS), health financing, health workforce, access to essential medical products, vaccines and technologies, and leadership and governance. The most important building block in this framework is governance as it is at the center of the system (see Figure 2). The figure clearly shows the centrality of health governance in the health system. According to WHO (2007): »The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block of any health system«. Health governance is defined by WHO as »... the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest.« It also defines it as: »... a wide range of steering and rule-making related functions carried out by governments/decisions makers as they seek to achieve national health policy objectives that are conducive to universal health coverage. Governance is a political process that involves balancing competing influences and demands. It includes: maintaining the strategic direction of policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behavior of a wide range of actors – from health care financiers to health care providers; and establishing transparent and effective accountability mechanisms« (WHO, 2018). This definition, however, assumes the presence of a government that guides the whole system – both private and public institutions – and involves political and technical actions; although, it explicitly says that this function is not exclusive to governments.

Again, there is no consensus on what the function of governance, let alone health governance, is (Barbazza & Tello, 2014; Siddiqia, et al., 2009). The world Bank defines it as the »... the manner in which power is exercised in the management of a county's economic and social resources for development« (World Bank, 1992). UNDP finds that governance is »... the exercise of economic, political and administrative authority to manage a country's affairs at all levels. It comprises the mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences« (UNDP, 1997). Pierre (2000) argues that »governance refers to sustaining coordination and coherence among a wide variety of actors with different purposes and objectives such as political actors and institutions, corporate interests, civil society, and transitional institutions«. The United Nations

Economic and Social Council (2006) sees that »while the government of a traditional State has to cope with internal challenges and external challenges from the above actors, some of the functions previously the preserve of government may be taken over some of the same parties. This definition gives credence to the assertion made earlier that governance is broader than government«.

WHO (2007) identifies six functions: policy guidance, intelligence and oversight, collaboration coalition building, regulation, system design, and accountability. The Pan American Health Organization (PAHO) describes health governance as a function of governments, and categorizes its functions as leading, regulation and enforcement, and execution of Essential Package Health Functions (EPHF) (USAID, 2007).

Although not specific to health, the UK government's Department for International Development (DFID), UNDP, and the World Bank provide guidance on what good governance is. Despite the fact that they do not describe what governance should do, a sense of what good governance is can help in understanding health governance.

Figure 2: The six building blocks of a health system (WHO, Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action, 2007)

This research follows the WHO's definition and framework for its application in the response to the crisis in Syria by Health Cluster. Consequently, the questionnaire was developed on the basis of the six pillars. Afterwards, analysis will be based on the functions of health governance as suggested by the WHO, i.e. maintaining the strategic direction of policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behavior of a wide range of actors – from

health-care financiers to health-care providers; and establishing transparent and effective accountability mechanisms.

6. Health System in Syria before the Crisis

To further understand the health system after the crisis, it is vital to explore the system before the crisis. According to WHO-EMRO (2006), Syria's health system was developing rapidly in the first decade of the third millennium, with declining mortality rates, declining rates of communicable diseases, increasing life expectancy at birth, »access to secondary care services is good with more than 70 per cent of the rural population having access to the secondary care services«, and one hospital bed available for 680 people. In 2006, numbers indicated 1.4 physicians and 2.0 nurses and midwives per 1,000 persons. The WHO-EMRO report continues: »Theoretically, legislation requires full time employment for physicians and paramedics in public health sector, however part-time private practice by most physicians and nurses is widely and openly practiced«. The report also shows that there was not one community health worker in the entire country (WHO-EMRO, 2006).

The government was the main funder for the health system in the country with almost 50 per cent of the total expenditure covered by it. »The first pathway of funding consists of Ministry of Finance (MOF) funding, which goes principally to the Ministry of Health, Ministry of Defense, Ministry of Education, Ministry of Labor and Social Affairs. The second funder is direct household funding, which goes directly to the private sector-private clinics, pharmacies, labs, and few private hospitals. The third source was professional associations, but this was very limited compared to government and private sector« (WHO-EMRO, 2006).

The health system governance was a centralized system with line ministries controlling planning, budgeting, project implementation, appointments, etc. (Hallaj, 2017). »Health planning takes place at the central as well as regional level« (WHO-EMRO, 2006). Decentralization was never achieved with line ministries controlling more than 80 per cent of the budget. Despite governorate committees that consist of the governors and heads of the directorates of health, education, agriculture, etc. the line ministries will always have the final word.

Despite the advances in the sector, these were not fairly distributed in the country. There is little literature on the distribution of services and budgets through governorates. One can cautiously infer from Hallaj (2017) that Damascus, Aleppo, Homs, Tartous, and Latakia had the biggest share of the public spending (Figure 3). This matches an internal study conducted by the opposition Idlib Health Directorate that claims the number of beds in public hospitals as one per 573, 672, 2,113, and 1,379 people in Latakia, Tartous, Idlib, and Raqqa respectively.

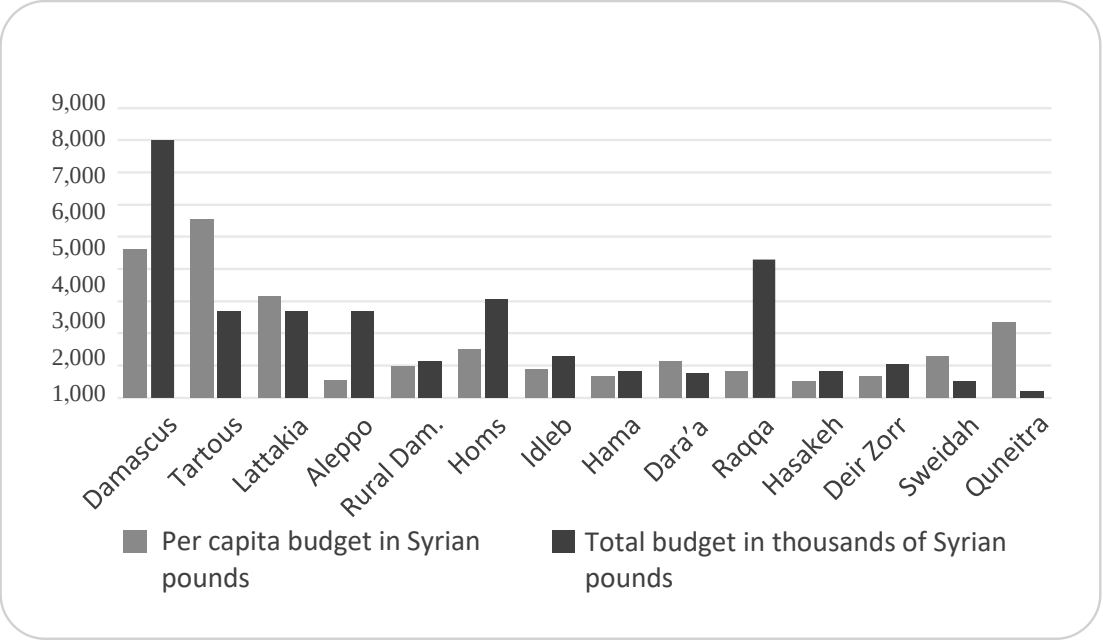

Figure 3: Total and per capita distribution of the independent provincial budgets in Syrian pounds in 2010 (Hallaj, 2017) (Note: Spellings in Figure 3 reflect the original source graphic.)

7. Health Governance in Opposition-held Areas after 2011: Chronological Overview

As mentioned in section three, ever since mid-2012, political opposition, civil society, activists, and even militias have tried to install a governance system for the health sector to help in providing services amid the increasingly difficult humanitarian situation on the one side and to create a competing structure to the government one on the other. As mentioned earlier, the first response from protesters was to establish LCCs. These LCCs transformed into NGOs, LACs, and »Revolutionary Commissions and/or boards«. Some others also transformed into militias (Hallaj, 2017). On November 19, 2011, Idlib established »The Medical Office for Command of the Revolution«, which lasted until December 2012. After that, Idlib established the »Medical Commission for Idlib Governorate«, which was the immediate predecessor of the directorate, in November 2012. The last entity lived until March 2013, when the directorate of Idlib was established. The reason behind this transformation as explained by Dr. Munzer Khalil, was the move from the »political role of doctors into a more technical role«.

Hama followed the same order, with its Health Directorate name declared in April 2014. Before that the »Medical Office of the Revolutionary Command Council« was established in October 2011. The »Medical Commission of Hama Governorate« was established in mid-2012.[3] Similar to Idlib, Hama did not witness a major struggle between rural area and urban area doctors, nor between doctors from different political or social backgrounds. The reason here is that the opposition

[3] Interview with Dr. Maram Aslsheikh, Director of Health in Hama Governorate.

never controlled any parts of the city until now, and most of the doctors working in the governorate are from the rural areas. »There was once an issue led by a doctor from the city, but it did not succeed for two reasons. Number one, only a few doctors supported him, and two, some charismatic doctors from the city interfered every time there was a potential conflict«, said Dr. Abdulrahman Alomar, a member of the Hama HD trustees board.

Deraa established its directorate in March 2014 as a body that belongs to the SIG, and the two bodies named the »Medical Commission for the Western Part of the Governorate of Deraa« and the »Medical Commission for the Eastern Part of the Governorate of Deraa« merged under the directorate. »The process went very easy and without any struggle. As we have always tried and keep good relations with all parties on one side, and strike balance between these parties in the representation of regions and currents«.[4]

Damascus' rural areas established the directorate around mid-2014 as a result of the establishment of SIG. However, the directorate remained weak as a result of the struggle between two entities in Eastern Ghouta: the Union of Free Syrian Doctors (UFSD) and the Unified Medical Office (UMO) (UMO, 2013). UFSD was formed as a result of the conservative, Islamic forces and the secular elements in Damascus Doctors Coordination, which in turn was part of the Local Coordination Committees, the first organization for the opposition to coordinate demonstrations and aid. UFSD was meant to be a country-wide organization, with more conservative elements, but remained mainly in Eastern Ghouta. In November 2012, UMO was formed on a more technical basis, and hence attracted the secular elements in the medical field in Eastern Ghouta, where two persons represented each big hospital in each area or the medical office in each town. »A long tension between Unified Medical Office (UMO) and Free Doctors Union (UFSD) led to a gap in the health governance in this area which made a body like [the] Health Directorate not just the needed governmental body as it is the case in other OHAs, but a need to find a leadership for the medical work«.[5] The struggle lasted until 2017, when the two forces decided to establish a strong directorate, with the leadership of a well-reputed doctor in the area. UFSD decided to become an NGO and it registered in Turkey (UFSD, 2011). UMO stayed as a medical relief body, with an unclear identity and relation to the HD.

Aleppo witnessed similar challenges. Three months after armed opposition entered parts of Aleppo city in July 2012, Aleppo City Medical Council (ACMC) was established on October 24, 2012. The Free Medical Union (FMU) was established immediately afterwards. »The ACMC was more for the city, and FMU was mainly for the rural part of the governorate. The two entities competed all the time against each other. All initiatives to resolve the conflict failed. This impeded the medical office in the governorate council to function as a central health governance authority on one side or to have a strong Health Directorate until now«.[6] Since its

[4] Interview with Dr. Khaled Alomayyan, the Health Director of Deraa Governorate.
[5] Interview with Dr. Mohammad Kattoub, a former member of the UMB, and Damascus Doctors Members, November 2018.
[6] Interview with a former member of Aleppo Governorate Council. November 2018.

establishment, the directorate has had five directors, whereas neighboring Idlib has had only one.

In March 2013, the SIG was formed with Ghassan Hito as its first prime minister. The government lasted for six months only. In September 2013, the second government was formed with Dr. Ahmad Toumeh as its prime minister. No health minister was immediately appointed, and Dr. Adnan Hazzouri served as deputy prime minister for health affairs »due to the political atmosphere in the SOC at the time«.[7] Two months later, Dr. Adnan Hazzouri was appointed as the first minister of health. After the establishment of SIF, HDs started to appear, with Idlib taking the lead. The first body to call itself »Health Directorate« was formed in Aleppo in February 2013, as it was established along with the establishment of the governorate council of Aleppo[8], although it waited until November to be officially announced. Idlib HD was established on March 1, 2013, immediately linking itself to the SIG.

The relationship between HDs and the SIG started to deteriorate from the beginning of 2015. According to one of the HD directors, the reason for this deterioration was first that the ministry insisted on bypassing HDs and implementing projects itself. Second, the ministry showed little interest in building the capacity of the HD itself and refused to pay 2,000 USD as operational budget for the HDs. Third, the ministry did not live up to its promises and it decided to cut more than 60 per cent of the pledged budget for Idlib HD, for example. »The deterioration of the relationship between the SIG and HDs was a result of the SIG staying abroad and with no offices inside the country despite the fact that at that time there was no radical force like HTS today to prevent them from going inside. They even stayed in a hotel for three months waiting for a building to rent. Their salaries were very high in comparison to the salaries of people inside Syria. Also, there was no effective utilization of the 50 million euros they received from the Qatari government. In addition to all of this, there was no strategic plan. The only documents I received were few papers and organogram of the ministry«.[9] »Our salaries were really high. I myself got shocked with my salary as a health minister. It was 6,000 USD and then 5,000 USD. The rest of the 30 staff salaries was suitable for people who live in Turkey. We were told by the SOC that this salary is political. However, I don't think this created any problem with doctors inside Syria as they understood this political role on the one hand and the fact that the costs in Turkey are higher than inside Syria. Our relationship with health directorates remained very positive until I left the ministry. Later on, the relationship deteriorated as a result to the fact that the ministry had no resources«.[10]

Afterwards, the ministry lost its funding sources (mainly Qatari) and remained a symbolic body with few staff and almost no resources. Despite this difficult relationship, most directorates kept the logo of the SIG except for Idlib HD, which still has not used the logo of the SIG, although it says in all meetings that it considers itself part of the interim government. The reason behind this decision is

[7] Interview with Dr. Adnan Hazzouri, the first minister of health, November 2018.
[8] Interview with a former member of Aleppo Governorate Council.
[9] Interview with the incumbent minister of health Dr. Firas Aljundi.
[10] Interview with Dr. Adnan Hazzouri, the first minister of health in the SIG.

to avoid conflict with HTS, which considers the SIG as an enemy to it as the HD director claims.

An important change happened on September 14, 2015, when five major diaspora Syrian medical NGOs (Union of Medical Care and Relief Organizations (UOSSM), Syrian American Medical Association (SAMS), Syrian Expatriates Medical Association (SEMA), Physicians Across Continents (PAC), and Sham Humanitarian Foundation) decided to support Health Directorates and signed the »Code of Conduct for Non-Governmental Organizations (NGOs) working in the Syrian Medical Humanitarian Affairs«. The second article of the charter says:

»Working on the full support of emerging and existing medical institutions and on the governance framework of the Health Sector in Whole Syria. This includes the following:

a. Full coordination and gradual provision of necessary resources, according to the plans set forth by the organizations that have signed collaborative agreements with the medical institutions

b. Support the unification of the health and administrative criteria; to raise the standards of healthcare provided to the people«

This charter ended almost three years of an uneasy relationship between local health authorities, represented by HDs and Syrian NGOs. »We listed Syrian NGOs as our first challenge when [we] held the first meeting to establish the directorate. They control funds and they have political agendas that serve their own founders' interest. We had huge doubts when we heard about the charter and their intention to support us. Now, we consider that moment as a major development that led to the success of the project«, said Dr. Munzer Khalil, the director of Idlib HD.

Another important moment was when the managers of the five Syrian medical NGOs and the directors of health of Hama and Idlib on January 29, 2016, started a fundraising trip in European countries to fund Health Directorates. The trip proved successful and Idlib Health Directorate got its first funding around June 2016 as a pilot project.

In October 2017, the project was expanded to cover all directorates in OHAs, including Aleppo, Hama, Deraa, Homs, Qunaitera, Damascus rural areas, and Latakia. In addition to the directorates, the project funded the so-called Coordination Body – later called the Technical Body – to coordinate amongst these directorates. However, due to the military offensive, led by the government of Syria and its allies, and the retaking of Homs rural areas, Eastern Ghouta, and Deraa and Qunaitera, Homs and Damascus rural areas directorates ceased to exist in April and May 2018 respectively and Deraa in July 2018. Damascus HD almost entirely moved to Idlib and dissolved itself, whereas Deraa and Homs remained in areas under government control and dissolved themselves too.

The Technical Body's creation was immediately a source of tension amongst several players, including Health Cluster coordinator WHO, ACU, and the MoH in the SIG. The MoH saw it as a competitor to the ministry and a parallel structure. The coordination in the first place created a confusion with the Cluster

coordinator.[11] Although it was named the Technical Body instead of the Coordination Body, the tension has not yet been resolved. ACU took the side of the SIG and claimed that the Technical Body was a competitor to the ministry. However, members of the body conjecture that ACU fears that the Technical Body is a threat to the EWARN, which is run by them.

Another important point of time was the establishment of »Salvation Government« by the Islamist extremist group HTS on November 2, 2017. The HD in Idlib found itself in direct confrontation with HTS and had to decide between openly declaring that it is part of the SIG and running into conflict with HTS or staying neutral and isolating itself from the political struggle and insisting on remaining a technical body. The »Salvation Government« established a ministry of health, but had no, or very limited, activity. On one occasion, the SG tried to interfere in hospitals in order to impose Sharia dress for women and isolate women patients and doctors from the males. The immediate reaction by the HD from one side and the NGOs allying with it on the other side was to suspend work and issue statements aimed at making the SG recall its decision (Syrians for Truth and Justice, 2018).

[11] Several informal interviews with staff from the Technical Body, donors, UN-agencies, INGOs, and Syrian NGOs.

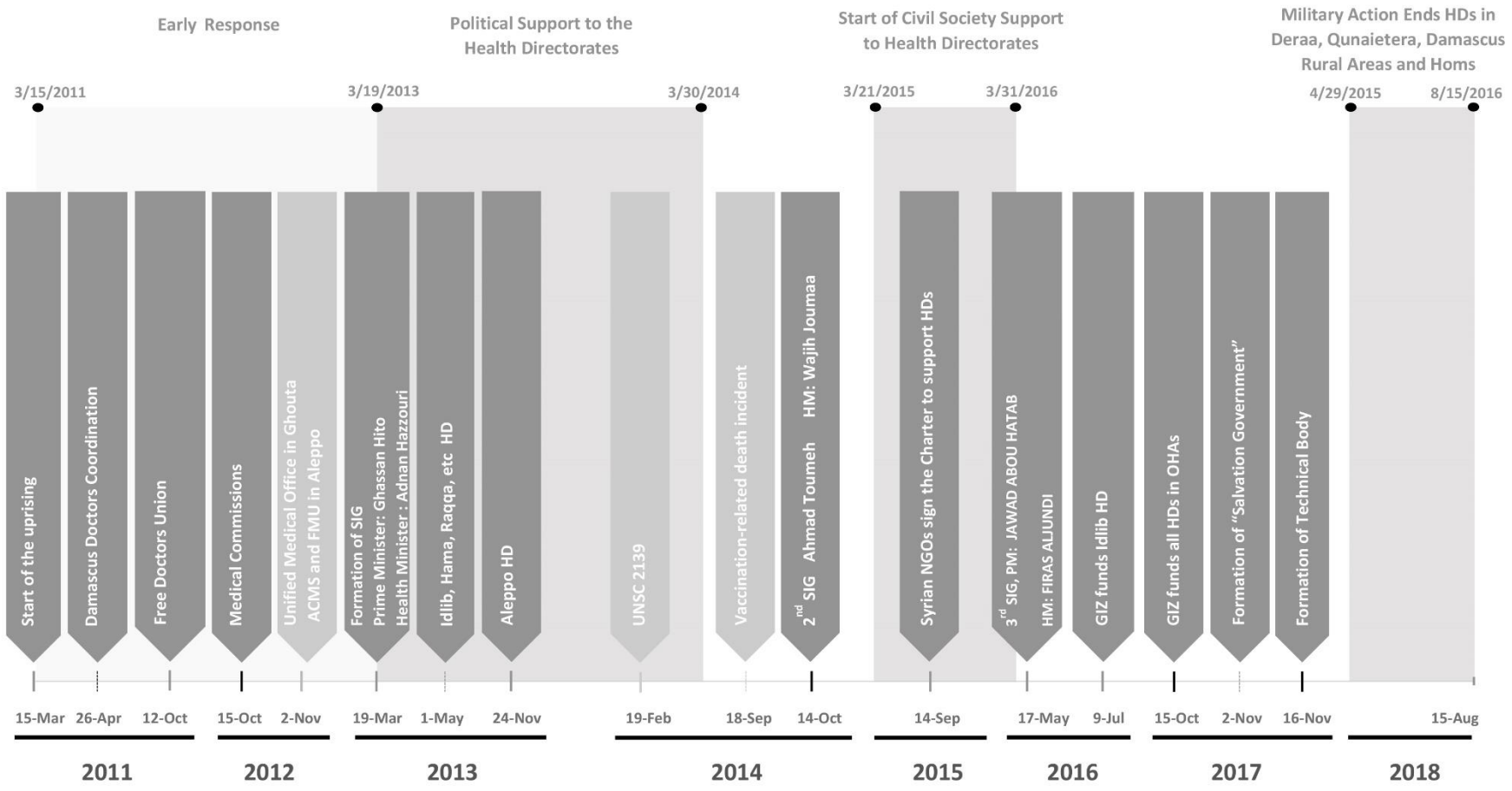

Figure 4: Timeline of the development of health authorities in OHAs

Looking at the timeline we conclude that three major phases framed the medical governance in opposition-held areas. The first began with the start of the uprising in March 2011 and took the shape of coordination between doctors and medical workers. They used to open small field hospitals, treat people wounded in the demonstrations, communicate informally through social media, use basic tools, give too little attention to document funding, and use poor security measures. Although there was a clear development line in the governance of the sector, the two later phases still inherited many features from the first phase. That is, despite developments in governance structures, functions still expected from central governance structures, such as planning, budgeting, standardization, etc., are weak in comparison to emergency response planning. Moreover, most of the secondary health-care facilities (hospitals) are still treated as field hospitals rather than ordinary hospitals, which means low-quality service provision. Although many would defend this as shelling and the targeting of hospitals force health service providers to deal with hospitals as field hospitals.

It is remarkable that the first divide in the health sector happened just three months after the start of the uprising, with Damascus Doctors Cooperation witnessing a rift between secular and conservative participants that eventually led to the creation of the Free Doctors Syrian Union that is more conservative. These tensions remained divisive years after this incident and characterized governance structures in Ghouta until it was taken by the regime. Most donors and Syrian actors gave little attention to the social dichotomies and their impact on response and governance.

HDs transformed into their technical form after several political mutations. This was the result of political and social tensions. However, even at the time of writing this report, these tensions still impact the governance structures of the HDs. For example, until now the tension between urban and rural areas in Aleppo prevents the creation of a stable structure.

It is clear that two approaches to health-care provision developed in Syria between 2011 and 2015. The first was top-down, advocated for, and led by political opposition that started around mid-2013 and lasted until early 2015, and the other was more bottom-up, led by HDs and Syrian NGOs, lasted from 2011 to 2013, and had more focus on the technical side, which started from 2015. Finding ways to match these two projects might be very efficient and effective. The SIG in its quest for legitimacy tried to establish institutions inside the country. However, lack of an inclusive, participatory approach on the one hand and weak administrative experience on the other created a tense relationship with these bodies, leaving only a nominal, symbolic relationship with them.

The 2139 United Nations Security Council (UNSC) resolution in 2014 brought about Cluster-led health governance. The cross-border resolution allowed Syrian NGOs to grow very fast, with organizations increasing their budgets by millions in a span of a few years. This growth allowed Syrian NGOs to acquire funds, training, and access to donors and policymakers, whereas HDs and the SIG were completely marginalized.

We found that NGOs posed a major obstacle to the HDs at the beginning as political agendas were mixed with humanitarian, technical interventions on one side and lack of experience on the other. However, the creation of an alliance between some Syrian NGOs and HDs created a force that enabled local health authorities to avoid facing militia and extremist groups. Also, the lack of technical resources within militias prevented these militias from controlling technical bodies. However, this alliance is seen as a threatening power for many actors, including the ACU, the SIG, and some Syrian NGOs. Overlooking this tension might threaten the project. Much more advocacy and communication ought to happen to protect this alliance.

8. Results of the Research

8.1 Health Governance Actors

It is obvious that there are multiple players impacting health system governance without one single body to run all functions of health governance, i.e. policy guidance, intelligence and oversight, collaboration coalition building, regulation, system design, and accountability. The main two parties that play a major role are Health Directorates, with their associated technical body, and the Health Cluster. In addition to these two bodies, the ACU, NGOS, and INGOs also play different roles. This could be seen from the terms of reference (ToR) of the Strategic Advisory Group (SAG), whose primary role is »… to provide strategic guidance to the THC [Turkey Health Cluster], monitor THC performance, oversee the implementation of the work plan and support THC functions as appropriate. The SAG will work closely with the THC Unit and the Health Cluster Coordinator«. The SAG is formed of one WHO representative, one other UN agency representative, four NGO representatives, the Health Cluster Coordinator, and the Health Cluster Co Lead (WHO, 2018).

So far, the Health Cluster is the information hub the members of which are from INGOs and NGOs as well as HDs. Its meetings are coordinated by the WHO and until June 2018 a Syrian NGO used to co-coordinate. The Health Cluster gathers information from its members, provides technical assistance through standards, supports capacity-building programs, and sets priorities, hence funding, for the Humanitarian Pooled Fund (HPF). As of June 2018, there were five Health Directorates, 39 Syrian NGOs, 25 INGOs, 11 donors, four consortia, and four observers who attend bi-weekly meetings, discuss current issues, share information, and provide common understanding of the opportunities, needs, and challenges.[12] Health Directorates have attended these meetings since the beginning of 2016 as a result of the advocacy of Syrian NGOs and acceptance of the Cluster coordinator at the time. HDs attend the Cluster meetings as observers and do not have voting power inside the Cluster. It is clear that HDs' presence in the Cluster played a positive role in the process of building a health system. »How

[12] Several meetings with Cluster co-coordinator at the time.

do we know what the priorities are without HDs and the Cluster?« asked an INGO program manager. »Everyone sees that HDs presence in the Cluster as very essential, even within the UN sphere«, said a manager at one of the local NGOs. »Although we don't have a voting power, we never felt this is an issue. We are always consulted and our priorities are taken for granted. Of course, we felt stronger when the SAG was effective, as it is a smaller, more strategic group, but still we feel powerful and our opinion is respected«, said one HD director. This integration in the roles between HDs and the Cluster is seen as inevitable for many reasons. First, the Cluster is the only mechanism for exchanging information between the different parts of the country as there is no way for directorates or NGOs operating in areas controlled by different political or military parties to exchange data. Also, for many donors and UN agencies, HDs are unknown bodies and cannot be trusted. »Our aim is to have a Whole of Syria Approach, which made it necessary for us to exchange information with the hubs in Damascus, Amman, and Iraq. HDs cannot play this role for political reasons. Also, we don't know these bodies very well as we don't have access to Syria, so we can't assess the credibility of the information they provide us with«, said one of the OCHA officials. »As I understood from my colleagues in the WHO, a good health system was established in Northern Syria thanks to very smart doctors and strong leadership«, said another official from the OCHA.

This integration of the roles of the Health Cluster and HDs did not go unchallenged. As the WHO's definition for governance stresses the political nature of those who govern the system, the WHO could not easily accept the role of a body linked to the SIG, which is in turn internationally unrecognized. There was no clear system for that. SAG ran for almost two years with the presence of HDs inside it. However, in mid-2018, the WHO almost stopped SAG, saying that HDs are not eligible for SAG membership, as they are not part of any formally recognized government. Consequently, SAG became idle, and remains so at the time of writing of this report. In order to deal with this matter, UN agencies dealt with HDs as purely technical bodies without any political role. »In our work, we avoid LACs, but we deal with technical bodies such as HDs«, said one official from OCHA. He said also: »We don't deal [with] political entities even in Damascus unless we want to discuss access on the basis of the humanitarian principles we abide with. Also, we deal with political entities in order to advocate for our work, as these entities have influence on the community. We don't provide services to the political bodies, but we deal intensively with technical entities such as HDs because we work in the same place«. This settlement between the Cluster and HDs helped in creating a line of coordination and somehow created a strategic hub for the sector.

The two entities, i.e. the Cluster and HDs, are the two main governance structures, and they collectively perform most of the health system governance functions as prescribed by the WHO definition, including direction and policy development, correcting undesirable trends, and regulating the behavior of the actors in the sector. However, these functions are not performed in a consistent manner. That is, some of the functions are challenged by the fact that there is no clear accountability system that could be implemented, which means there is no power to impose the law. »Let me be frank with you, even the strongest directorate we have, which is Idlib, cannot implement law because it doesn't have the power to

do so«, said a manager of one of the Syrian NGOs. Hence, the only accountability mechanism that could be used is to mobilize donors to control funding. Also, the Cluster is supposed to be a mechanism for emergency response at times of crises. It assumes there is a recognized government that is responsible for the entire system. Moreover, HDs were established during the crisis and, as mentioned above, inherited the mechanism of the first response. This means that both HDs and the Cluster are unprepared for peace-time functions of health system governance.

Another aspect that is still missing is a clear definition of the roles of other local actors, such as LACs and provincial councils. Both local and provincial councils have an office called »Medical Office«, but these offices have varying authority and roles.

In the north, LACs had a supportive role with limited authority and HDs were far stronger than local authorities, whether LACs or Provincial Councils. »LACs have a great role in supporting us, during the period of establishing any health facility, by providing land and buildings and maintenance of water and electricity networks after establishment«, said one of the health directors. »Initially we started communicating with local councils and doctors in [the] local community, but we discovered that this is not always available as the context is very dynamic. Then we went to HDs, and we felt they are much [more] stable and capable [than LACs] … and only through the relationship with the HDs we got our acceptance in the community«, said one of the INGO officials.

In the south a better relationship between HDs and the provincial council and LACs was formed. There was a clear collaboration between them even on a strategic level. In Deraa, for example, the PC and HDs were conducting workshops to build up annual strategies. »The provincial council, and due to responsiveness and dedication of the HD, practiced a supervisory role over HD. The Medical Office in the PC used to provide us with [a] monthly report, which helped us a lot in regulating funding and [to] understand the progress of the sector«, said one provincial council head.

This difference in the perceived role of LACs and PCs, and its importance, was the subject of the newly introduced concept called Local Health Committees (LHCs). These committees were formed in 2018 and implemented in Idlib, Deraa, Aleppo, and Ghouta. The aim of these committees was to regulate the relationship between LACs and HDs as well as other actors, including Education Directorates and Community-Based Organizations (CBOs). »We found out that we face health problems that cannot be solved by the directorate only. For example, diarrhea is one of the major causes of child mortality, which is caused by polluted water … which could be managed by Irrigation Directorates and LACs«, said one HD official. Despite that, the role of LACs and PCs is still unclear when speaking with those operating in the health sector.

Another player is the private sector. As mentioned earlier, the private sector was responsible for almost 50 per cent of the service provision before the crisis. This role has dramatically deteriorated since the crisis began. The private sector was a victim of the funding mechanism. Donors refused to have partnerships with the

private sector and kept their funding to UN agencies and local and international NGOs. This funding mechanism empowered NGOs at the expense mainly of the private sector. Consequently, the private sector played no role in the process of making decisions and their information hasn't found its way to the Health Cluster or HDs. There is no representation for the private sector in any of the governance platforms and private sector organizations don't share their information through the EWARN system. This caused many of them to operate outside the »system« with very limited resources.

»Our relationship with the private sector was weak. We have strengthened our system in a manner that weakened the private sector …. We are proud that our system has developed dramatically, but what is scary is that the private sector has diminished and it is threatened to vanish. We will not be able to run the health system in the future without the private sector«, said one of the HD directors.

»The role of the private sector has become very limited …. We don't refer any patient to the private sector and they don't refer their patients to us«, said a manager of a hospital supported by one of the NGOs and that once was a private hospital.

»We attracted their personnel and paid them higher salaries, leaving them without skilled staff«, said a manager of one of the NGOs.

»[The] private sector needs us more than we need them«, said a provincial council member.

»We don't deal with the private sector«, said one of the donors' representatives.

»We destroyed the private sector through free-of-charge services. Before 2011 they used to cover 70 per cent, and now less five per cent«, said one of the NGOs managers.

»Before 2011 there used to be control by authorities. After 2011 there is almost no control … our relationship with the health authorities in the north is no more than medical consultation and no administrative consultation whatsoever«, said an owner of one of the private facilities.

»NGOs destroyed us. They took our skilled staff with their high salaries and we had to train our own low-skilled people to stay in the market«, said another owner of a private lab.

In addition to these players, donors, militias, and neighboring countries affected the functionalities of the health system. It is clear that the health sector remained relatively distanced from militias for many reasons, as stated by one of the health directors: »I think [the] reasons behind that is that the sector needs skills they don't have. More than one year after establishing their "Salvation Government" and they still have only one employee. Also, this is a critical service, if they interfere, they will lose it themselves and the community will revolt against them«. The reason behind their [militias] intervention in the sector could be that »education is ideological and attractive to Jihadist groups. Also, education is more geographically spread than health and hence controlling it means more control on the region and closer to the community, and these two are major objectives of the militias«, as one of the

education managers said. Donors also played an important role in shaping the governance of the system. Although donors supported NGOs, INGOs, and HDs, they still did that in an asymmetrical way. »Unfortunately, until now donors have not coordinated with each other on how to support existing governance structures, and this created a lot of problems«, said one UN official. »There is no criteria for support …. This has weakened all directorates«, a high-ranking official in a Provincial Council said. »In Afghanistan, all Western countries used to support the Afghan government. In Syria, however, we support the opposition, and it is the only case where we work so closely with the opposition to run public services. We do not have this approach anywhere else in the world«, said one donor representative. Regional powers, Turkey and Jordan for OHAs, played a mixed role. In areas like Deraa and Idlib, the intervention of these powers was limited as far as the health sector is concerned. However, when it comes to the northern Aleppo countryside, the Turkish government installed its own system, bypassing the Health Cluster and HDs alike. »There is now a new situation in the liberated areas (OHAs) that have become under the Turkish control. We have to sign all our agreements with the Turkish authorities. Although they sometimes delegate it to the LACs, but mostly they sign«, said a manager from a Syrian NGO. »In Idlib, we coordinate with the directorate and they decide where we work. But in Afrin [controlled by Turkey] there is a huge need, but we cannot work there because the Turkish government didn't allow us«, said a manager from one INGO.

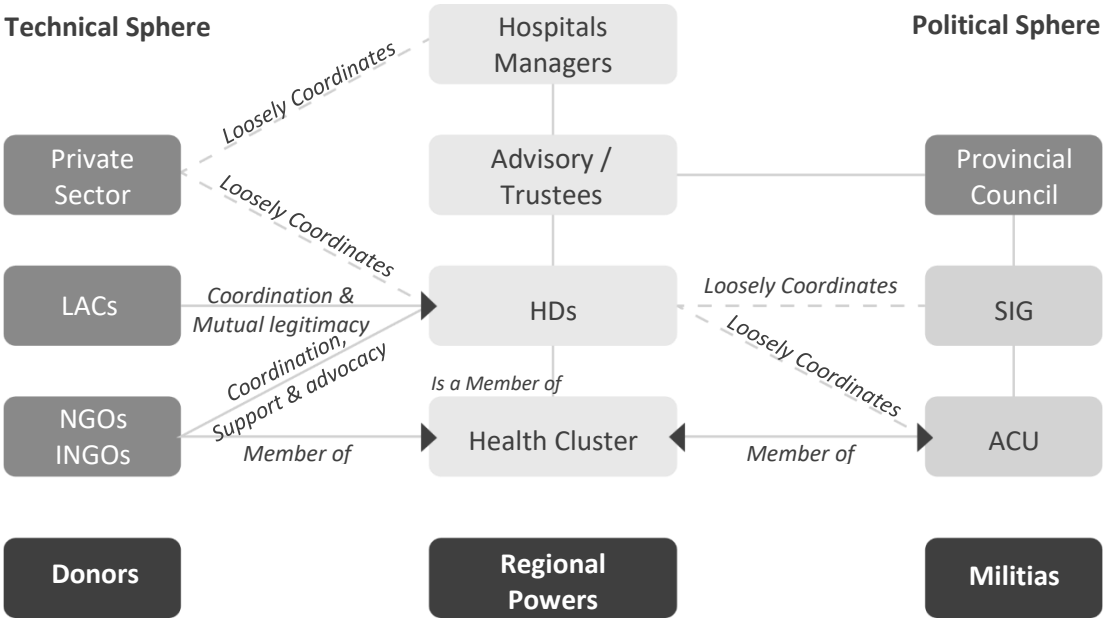

Figure 4: Health system actors and their interactions

To conclude, the health system was largely focused on the technical part away from political and military actors. This has strongly protected the system. For example, and during the time of writing this report, HTS controlled the majority of Idlib, the northern part of the Hama countryside, and the western part of the Aleppo countryside. HTS has explicitly said that it will hand over administration to

the »Salvation Government«. This caused the major donor to HDs to suspend its funding. Immediately, HTS was confronted with statements from hospitals, PHCs, PCs, NGOs, and the Health Cluster, all showing support to HDs, and emphasizing the neutrality of the sector. See Annex 3.

8.2 Health Governance Functions

As seen in the previous paragraph, not only is there no single entity that supervises the entire system, but there is no single entity that supervises even one of the functions of health governance. For example, the function of maintaining the strategic direction of policy development and implementation is divided between the Health Cluster and HDs. Also, detecting and correcting undesirable trends and distortions is done by NGOs, INGOs, and the ACU through their presence in the Health Cluster, but in a rather unstructured manner. In addition to that, there are functions that are not clearly defined in the ToRs of the different actors. For example, articulating the case for health in national development is not understood as a function of the Health Cluster or HDs, as there is no »national« agenda as such. This is quite understandable, as one national plan cannot be easily set in a conflict environment. The definition of health governance as put by the WHO assumes the existence of a government, which implicitly assumes that a national health plan is the responsibility of a government that controls the entire country. This is, however, not the case in a conflict like the Syrian conflict.

Regulating the behavior of a wide range of actors – from health-care financiers to health-care providers, is a complex task that is implemented to a limited extent by HDs and the Health Cluster. The Health Cluster in cooperation with the HPF regulates NGOs' behavior through due diligence and 4Ws (who, what, when, where). However, this due diligence is not applied on members that do not receive funding from the HPF. With limited capacity, HDs try to regulate the performance of the private sector, but they, i.e. HDs, do not have the capacity to enforce law. For example, dealing with fake certificates becomes a huge challenge for the sector. Laboratories, factories, and private clinics are outside the authority of HDs and the Health Cluster and are almost not regulated.

In addition, there are governance functions that are loosely implemented: for example, establishing transparent and effective accountability mechanisms. The main challenge for this function is law enforcement. As courts are controlled by militias, enforcement of law becomes a legitimizing force for these militias. Hence, the health sector is trying to expand its accountability system to avoid referring cases to Sharia Courts. Also, HDs are supposed to be accountable to their board of trustees. However, the existence of a relationship with the MoH/SIG complicates the relationship with the trustees. Whereas Idlib does not report to the MoH/SIG, Aleppo does, leading to the fact the director of health in Aleppo reports to the trustees and to the minister without clear separation of roles and responsibilities.

Governance function	Actor	Current role	Examples
Maintaining the strategic direction of policy development and implementation	Health Cluster	Identifying priorities for policy development	The Cluster proposed service provision packages such as health packages for primary health care
	HDs	Identifying priorities for policy development	HDs and their associated Technical Body proposed 119 policies in 2018
	INGOs and NGOs	Policy implementation	Most of the NGOs and INGOs are implementing these policies
	LACs	-	
Detecting and correcting undesirable trends and distortions	Health Cluster	Collecting information about undesirable trends and distortions; proposing intervention mechanisms	EWARN and data collected from the Cluster members led to responding effectively to outbreaks of polio
	HDs	Collecting information about undesirable trends and distortions; proposing intervention mechanisms; supervising implementation of interventions	
	INGOs and NGOs	Providing information to the Cluster and HDs; implementing policies and programs	All NGOs and INGOs regularly provide information about services provided
	LACs	Providing information to the HDs through Local Health Committees; supporting programs	
Articulating the case for health	Health Cluster	-	

in national development	HDs	-	
	INGOs and NGOs	-	
	LACs	-	
Regulating the behavior of a wide range of actors – from health-care financiers to health-care providers	Health Cluster	Regulating funding of donors through identifying priorities and the HPF	
	HDs	Regulating sector behavior inside Syria	
	INGOs and NGOs	Enforcing regulations set by HDs	
	PCs	-	
	LACs	-	
Establishing transparent and effective accountability mechanisms	Health Cluster	-	
	HDs	-	
	INGOs and NGOs	-	
	LACs	-	

Figure 6: Explanation of the role played by different actors

8.3 Health vs. Other Sectors

To understand governance in the health sector in OHAs, it is helpful to contrast it with other sectors. In this section, we will look into the education sector and civil defense.

The education sector is mainly supervised by Education Directorates (EDs) that are supposed to report to the Ministry of Education (MoE) in the SIG. Schools are supported by NGOs and EDs. NGOs in the education sector are smaller in size than those in health, bigger in numbers, and are rarely specialized in education only. The number of facilities, i.e. schools and institutes, and personnel providing education services is much bigger than in health. Also, the nature of education, and its connection to identity, makes it more attractive to militias. Moreover, unlike its behavior in health, the government of Syria did not make a full »withdrawal« from the EDs in OHAs and many of the schools in OHAs remained under its control.

All these differences resulted in different governance structures in the education field. First, the SIG has a stronger role in education than in health due to the certificates issue. As students require certificates that are recognized outside the country, and as Turkey recognizes the certificates stamped by the MoE/SIG, the

ministry kept its power over the sector inside the country. This, in addition to the impact of education on identity, has put EDs in direct confrontation with the »Salvation Government« that tried to interfere in the sector several times.

Second, donors have also affected the governance of education with their funding mechanisms. Unlike health where funding brings NGOs close to the HDs, donors in education opted to fund EDs through a profitable, non-Syrian company. This has distanced EDs from NGOs. For example, when donors decided to stop funding EDs at the beginning of 2018, under the pretext of alleged intervention by the »Salvation Government« in the field, NGOs took little initiative to support EDs. On the contrary, when donors decided to suspend funding to HDs in early 2019 as a result of HTS's rising control of OHAs, NGOs took a stronger stance and issued statements in support of the HDs. Also, the support of NGOs to HDs has led to the inclusion of the later in the Health Cluster since 2016, whereas at the time of writing this report EDs are still not a member of any Cluster. »We don't attend Cluster meetings. We meet with the Cluster on monthly basis, that too started only this year [2018]«, said one of the education directors.

Although civil defense does not really qualify as a full sector, it has remained an important actor since the start of the crisis, using different governance structures too. It is responsible for evacuating the injured people, providing shelters, and documenting violations. Before the crisis, civil defense used to be part of the Ministry of Defense in the Government of Syria. Since the crisis, the civil defense has acted like an NGO, and it is registered in Turkey and a European country. Its funding comes either directly through crowd-funding tools, or from donors through a private company called Mayday. It rarely interacts with NGOs and technical directorates, and if it does so, it does it in a rather informal manner. It is not part of any Cluster. »There have been continuous meetings with OCHA Gaziantep, and before three years [we] were offered to be part of the shelter and protection Cluster, but we did not have capacity for that as we were fully occupied with emergencies. Now we are trying to be in the Protection Cluster, but we are facing some challenges such as our name, and some NGOs and INGOs are against it«, said a manager at the civil defense. The SIG has no relationship with the civil defense, nor do LACs or PCs. All its planning happens internally.

	Health	Education	Civil Defense
Funding mechanism	Through NGOs	Through company	Direct funding and through private company
Role in Cluster	Integrated member in the Cluster	Informal, intermittent relationship	No relationship
Relationship with SIG	Nominal, more symbolic	Stronger relationship, through accreditation of students' certificates	No relationship
Role of LACs	Nominal	Stronger due to supervision of LACs of schools	Very weak
Role of PCs	Symbolic	Symbolic	No relationship
Militia intervention	Weak intervention	Considerable intervention	Weak intervention
Impact of neighboring countries intervention policies	High	High	Low

Figure 7: Differences among the three sectors

From the table we can see that there is no single governance system for the three sectors. Among many other factors, donor policies, intervention of neighboring countries, and the impact of militias are the main reasons for the fragmented governance structures. For example, Turkey's recognition of certificates issued by EDs and the MoE/SIG strengthened EDs and the SIG over the »Salvation Government« and led to more accountability for EDs with the MoE/SIG. Moreover, donor funding led to closer relationships between NGOs, the Health Cluster, and HDs. On the contrary, donor funding resulted in an almost isolated structure for the civil defense and a weaker relation for EDs with NGOs. Also, the alliances around HDs, the independence of the civil defense and their humanitarian nature helped in distancing militias from them. On the contrary, the education sector's nature and the weak alliances EDs developed led to a very tense relationship with militias and the »Salvation Government«.

9. Discussion and Recommendations

The research tried to investigate the process of producing a governance structure in the health sector in OHAs. Like all sectors, health went through different stages of governance in its quest to establish state-like institutions to govern the sector after the withdrawal of governmental institutions from all areas taken by the opposition. We described this process as re-inventing the state.

In this research we tried to answer the following questions: Who are the main actors in the health sector? How did they interact with each other in order to produce the governance system? Which approach was more resilient, bottom up or top down, and why? How does the experience of the health sector differ from other sectors?

The research showed that the development of governance in health sector involved multiple actors, who played different roles, both positive and negative. These actors are local and international, and of political, technical, and military nature, and include local NGOs, INGOs, UN agencies, donors, militias, political institutions, and local councils. Of course, it was not easy at all times to draw a line between these three categories. For example, ACU is technical body that is fully owned by the SOC, at the same time it is registered in Turkey as an NGO. Moreover, differentiating local from international is not an easy task, as most of the Syrian NGOs are not registered in Syria, but in Turkey or elsewhere in the world.

We observed that health governance as a state-building project for the Syrian opposition went through three major phases. The first was more of a local, unorganized intervention to help people injured in the demonstrations. This phase lasted for almost two years and ended with the rise of the SIG. The second phase was more of a top-down, political approach. This phase did not last for long, and the structure almost collapsed around the end of 2014 and beginning of 2015. The third phase was more of a bottom-up, technical approach, that witnessed the rise of HDs and support from Syrian medical NGOs. This phase has proven to be a successful model (Yazan Douedari, 2019). The system has connected various players, including HDs, the ACU, NGOs, and the Health Cluster as the most important players. Other players, such as LACs, PCs, and the MoH/SIG, play little or no role. The private sector is still »outside« the system and plays the role of an isolated service provider.

The alliance between Health Directorates and Syrian NGOs, on the one hand, and the emphasis of the technical, apolitical nature of the sector has helped in relatively shielding the sector from the interference of militia and political agendas alike. However, taking the functions of health governance as stated by WHO, some functions are still far from being performed by any of the actors. The most important function that is still missing is accountability, which strongly harms the system. Other functions, such as regulating actors and developing national plans and policies, are performed in a poor manner and require more effort from all players.

Donors have played a mixed role in supporting the governance of the health system. Donors have different approaches in different sectors, leading to

fragmented governance structures. The relative success of the health sector was the result of an apolitical, technical, bottom-up approach that brought local and international actors together, rather than isolating them as in education and civil defense. Moreover, it is clear that there is not one system to include local authorities in the Cluster system. Whereas HDs are permanent players in the Cluster, other local authorities are excluded from their respective Clusters.

Consequently, we first suggest that closer coordination between the Health Cluster and local health authorities is inevitable to optimize service provision during conflict. Although this might be obvious where state actors are still functioning, it becomes more essential, though more challenging, to liaise with quasi-governmental institutions. It is essential that the Cluster system is revised to include local authorities with clear roles and responsibilities for them. Excluding local authorities from the Cluster system clearly puts a question mark over coordination efforts and hence responsiveness in conflict zones. This coordination between HDs and the Health Cluster is also essential in order to improve accountability and set a clear policy to achieve that. Establishing a system to include LACs, PCs, and other local authorities will possibly be helpful. A strong accountability system will help isolate the sector from militias' interventions and political rivalries.

Supporting governance in one sector cannot guarantee success in this sector. That is, sectors are interlinked, and a weak governance system in one sector affects the others. Hence, we stress that supporting governance in conflict zones should be conducted in an integrated manner across sectors. It is important to mention here that the emphasis on the technical nature of the local authorities helps in protecting the sector from the interventions and polarizations that mark conflict zones and helps in protecting service provision to people in need. Moreover, there seems to be no system to include the private sector in the Cluster, which leaves a considerable service provider outside the system.

Finally, stronger donor coordination is needed to ensure a better governance system, whether inside the sector or across sectors. Having different funding modalities will lead to fragmented governance structures and consequently harm coordination and collaboration amongst sectors. In addition, donors should support bottom-up, local initiatives instead of top-down, donor-led, politicized approaches.

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Annex 1: Coding system used in MAXQDA to code interviews

Governance	
11. Challenges	12. Relationship
o New Principles	o Establishment
o Authority Gap	o Protection
o Polarization	o Profitability
13. Active Actors	o Negative Experience
o Community	o Support and Enabling
o Private Sector	o Advocacy
o UN Agencies	o Agreement
o Government	o Negotiation
- Local Administration	o Competition
Local Council	o Partnership
Provincial Council	o Coordination
- Non-Syrian Gov.	o Synergy
- Salvation Government	o Transition
- SIG	o Leadership
- Syrian Government	o Personality
- A Ministry	o Management
o Ministry of Health	o Overlapping Jurisdictions
o Non-State Actors	o Bottom Up VS Top Down
o Health Cluster	14. Legitimacy and Legality
o SARC	o Legality
o International NGOs	- Acceptability
o National NGOs	- Authority
o Health Facilities	- Community
o Health System	- Licensing
o Entities	o Legitimacy
15. Q5	- Accountability
o Heritage Rejection	- Bottom-Up
o Inherited	- Institutions
16. Neutral	- Leadership
o Neutrality	- Overlapping Jurisdictions
o Humanitarianism	- Power
17. Resilience and Risk Management	- Top Down
o Tailoring & Improvement	18. Decision Making
o Peace	o Data Driven
o Monitoring	o Planning
o Security	o Supervision
o Risk Management	o Monitoring
o Risk and Contingency	o Making Decision
19. Framework	
o Hierarchy	o Polices
o Administration	o Regulation
o Standards	o Procedures
o Improvement	

Service Provision	
20. Health Care Packages	**21.** Other Roles and Responsibilities
o Essential HC Package	o Supporting Activities
- Immunization	o Funding Provider
- Pharmacies	o Governance Support
- Nutrition	o Training Services
- Maternity	**22.** Quality Assurance
- Chronic Illness	o Quality of Services
- Health Facilities	o Quality of Health Care Indicators
Hospitals	- Antibiotic Resistance
Mobile Clinics	- Infections Control
PHC Centers	- Morbidity
Specialized Facilities	**23.** Access and Distribution
- Infectious Disease	o Tele-Medicine
- Rehabilitation Enters	**24.** Delivery Challenges
- Radiology Services	o Services Distribution
- Post-Operatory Practice	o Equality
- Emergency and Trauma Care	o Equipment Shortfalls
- Crisis Related Emergency	o Consumable Shortfalls
- Children Care	o Security
- Complementarity	o Accessibility
Referrals	o Lack of Awareness
Private Sector	o Malpractice
	o Medical Waste Management

Financing	
25. Financial Challenges	**26.** Funding Instruments
27. Sources of Funding	o Projects (Long-Short Term)
o Gulf Region	o Investment
o GIZ	o Fund Raising Campaign
o International Funders	o Support /Aid
o National Funders	o Charging and Fees
o Turkey	o Donors
o USA	o International Support
o Core Fund	**28.** Fiscal Space
o Private Fund	o Public Vs. Private Resources
29. Budgeting	- Private Resources
o Cost Center Vs Cost Item Budgeting	- Public Resources
o Short Term/ Long Term Budget	o Competition Over Resources
o Salaries	o Assets Sharing

○ Costs	○ Financial Cooperation
○ Revenue	○ Taxation
○ Analysis	○ Government Budget
○ Forecasting	30. Banking
○ Financial Risks	○ Financial Transfer
	○ Bank Account
	○ Sanctions

Financing "Continued"	
31. Financial Accountability	32. Funding Needs
○ Value for Money	○ Overhead Cost
○ Auditing	○ Resources Scarcity
○ Corruption	○ Dependence
○ Auditing	○ Running Cost
○ Financial Decision	○ Investment Cost
○ Reporting	○ Long Term Sustainability
○ Efficiency	○ Maintenance Operation
○ Control	○ Depreciation
○ Financial Transparency	○ Funding Gap
○ Excellency	○ Fiscal Equity
○ International Standards	

Information System	
33. Knowledge Institutionalization	34. Data Usage
○ Data Standardization	○ Transparency
○ Data Protocols	○ Accountability
○ Patient Data	○ Indicators
○ Hospital Data	○ Decision Making
○ Database Management	○ Evaluation
35. Communication Tools	○ Analysis
○ Reporting	○ Documentation
○ Platform	○ Hospital Data
○ Skype, WhatsApp	○ Patient Data
○ Indicators	○ Reporting
○ Internal Communication	○ 4ws
36. Value of Knowledge	○ Research
○ Cost of Data	○ Strategic Planning
○ Data Repository and Storage	○ Statistics
○ Reliability	○ Interpretation
○ Information Exchange	○ Advocacy
○ KPIs	○ Needs Assessments
○ Indicators	37. Information Sharing
○ Data Driven	○ Lack of Sharing
38. Date Security	○ EWARN
○ Data Repository and Storage	○ Information Flow
○ Confidentiality	○ Exchange
○ Power	○ Data
○ IT	○ Information Sharing Policy
	○ Platform
	○ Information

	○ ACU
	○ Data Repository and Storage

Human Resources	
39. Capacity Building	**40.** Challenges
○ Education	○ Salary
○ Skills	○ Competition
○ Training	○ Duplication
○ Capacity Building	○ Specialization
○ In Service Training	○ Lack of Coordination
○ Succession Planning	○ Shortage
41. HR Quality	○ Migration
○ Lack of Competences	○ Safety and Security
○ Skills	○ Turnover
○ Education	○ Return to Syrian Government
○ Knowledge	○ Labor Force / Market
○ Satisfaction	○ Accessibility
○ Professionals	**42.** HR System
43. Value	○ Regulation
○ Ethics	○ Syndicates
○ Certification	○ SBOMBS
○ Neutrality	○ Succession Planning
44. HR Integration	○ Bylaws
○ HR Sharing	**45.** Incentive Packages
○ HR Distribution	○ Salary
○ Safety and Security	○ Qualification
○ Salary Scale	○ Satisfaction
	○ Competencies
	○ Continuity of Staff
	○ Expertise / Experience
	○ Accreditation /Certification

Medicine and Technology	
46. Supply Chain	47. Quality of The Medicines
○ Local Factory	○ Pharmaceutical Control
○ Cross-Borders	○ Labs
○ Mediator	○ Lab Control
○ Warehouses	48. Challenges
○ Consumables	○ Smugglers
○ Suppliers	○ Narcotics
○ Logistics	○ Markets
	○ Medicine-Related Waste Management
	○ Affordability Prices
	○ Security
	○ Import
	○ Monopoly
	○ Medicine Availability
	○ Medicine Distribution

Annex 2: Questionnaire used in interviews

Introduction: Time: 5 minutes

Hello, My name is ..... and I work with .....

For starters, I'd like to thank you for your time and contribution to achieve the research "****". This research aims to examine the issues related to the Syrian health system in light of the conflict and how governing mechanisms evolved by time. As well as to know how to reactivate the system reaching what it is currently and what is the vision adopted to support long-term continuity starting from the beginning of the crisis and going through the current stage, and knowing the strategy used to ensure continuity in the post-crisis phase. We, in a MIDMAR institution, would like to share your opinion on many points related to the Syrian health sector and its current system in the areas of opposition control, its flexibility and its ability to withstand political, economic, social and military changes and compare them with other experiences. This is in order to draw lessons learned with a view to developing the process itself as well as transferring expertise to other regions or countries experiencing the same conditions. So we hope you can help us understand the situation better. The research takes into account the full freedom of the participant and the individual opinion or opinion of the institution with which he works, so please ensure that we will deal with all information provided to us today in strict confidentiality in accordance with your desire. To ensure accuracy in dealing with the information provided to us, and to avoid losing any part of what you will share, we kindly ask that you grant us approval audio recording of the interview. And use these audio recordings later for research purposes only: Do you agree?

Yes, I agree	I agree for the interview with no recording	I don't agree and prefer to withdrawal

The opinions represented and expressed during this interview are:

Personal opinions	The opinion of the institution I work with	Both mine and the institution opinions

Do you mind us using any of the following information?

My name:	I don't mind	I do mind
Job title:	I don't mind	I do mind
Organization/Institution name:	I don't mind	I do mind

General information

Name:

Organization/Institution: Job title:

What is the area of work of the organization/institution in which you operate and what is the approximate number of beneficiaries of the services provided?

Section one: Time: 15 minutes

1. What criteria do you adopt to accredit the local authority associated with the health sector? As well as building partnerships?
   Points to take in notice:
   a. (Legal framework - licensing - funding – implemented projects- administrative framework - etc.) "technical standards, geographical standards, security standards, political standards"

2. How did the coordination mechanism evolve with time, and on what does it depend? What is the impact of the emergence of local authorities on the nature of your relationship with the Syrian response?

Section two: Time: 15 minutes

In the circumstances of war, it is imperative that you deal with many other parties that are relevant to your organization, including (but not limited to): the local community - civil society organizations - the private sector - the public sector including the directorates - the local councils - Governmental entities.

3. What services does your organization receive from those other parties and what services your organization provides to these parties?
   Points to take in notice:
   a. With which of the business sectors does your business integrate, so with which of these sectors are you building joint ventures or partnerships?
   b. What are the services or facilities you receive from your partners or collaborators? As well as what services or facilities you provide to your partners or collaborators?
   c. Some situations require the ability to provide integrated service and the need for cooperation or agreement with the institutions of the Syrian government, what are the limits of your relationship with the institutions of the Syrian government, and what regulate these relations if any?
   d. Other parties.

Section three: Time: 5 minutes

4. What are the criteria that you follow to provide a fund for partners? How do you sort the budget between different sectors? How do you conduct financial auditing?
   Points to take in notice:
   a. What is your evaluation for your partners' performance? And what are the main problems you're facing? and how do you deal with them?

Section four: Time: 5 minutes

5. What role does your organization play to ensure fair and high-quality service for all beneficiaries? "(i.e. partner organizations)"

Section five: Time: 10 minutes

6. During your response, do you direct your partners to work on similar " mergeable" systems between different parties in preparation for a joint response in case of a solution to the Syrian crisis? If organizations are integrated into one system, will the response differ? And how?
   Points to take in notice:
   a. How do you work to ensure the possibility of subsequent merge between different authorities?
   b. How will you deal with the status of a merger at the institutional level between different actors?

Section six: Time: 10 minutes

7. Do you think that donors and organization supported governance in non-governmental controlled areas? Were there any gaps that needed to be bridged? Like what?

Section seven: Time: 15 minutes

8. What was your policy regarding information sharing and exchange between active actors working in the health sector? Who this mechanism was affected by the emergence of local authorities?
   Points to take in notice:
   a. What are the tools used for data collection, information management, data flow control, and updating?
   b. How was the organization's information sharing policy developed? What challenges do you face in implementing them?
   c. What is the mechanism for sharing information between you and other parties?
   d. Do you have cooperation with entities that collect data (eg, Health cluster - ICU - or research organizations) and how does this collaboration work?

Section nine: Time: 10 minutes

9. How was the humanitarian action policy agreed in Syria? What were the most important challenges facing its implementation? Was this policy agreed to be specific to the Syrian context, or is it a general policy in all areas of intervention? If available local authorities in non-governmental controlled areas are recognized as legitimate bodies, will your policy change?
   Points to take in notice:
   a. The objective of this question is to determine whether the specificity of the Syrian situation is taken into account in terms of supporting the emergence of local authority bodies in the political vacuum areas, or is dealing with the Syrian situation in similar ways to dealing with other cases that assume that there is no power dispute and therefore focusing only on the provision of services.

Additional information:

Is there any additional information you'd like to share with us?

Follow up:

Can we come back to you later in case of any inquiry?

Yes No

The results of this research will be presented to a group of local and international experts to capture the results in a focused discussion group. Do you recommend someone you know has sufficient experience?

Yes No

The recommended information:

Thank you

Annex 3: Statement by health facilities in support of HDs

Idlib Health Direcotrate

مديرية صحة إدلب
Idlib Health Directorate

Statement

Primary Health Care Centers hereunder signing the communique stress that they are working for Idlib Health Directorate as a technical service entity seeking to provide medical health including protection and treatment for all citizens and ensure vocational safety while taking all medical procedures, whether medical or non-medical. IHD also provides sustainable training and mentoring for all medical staff according to the national standards.

IHD is a technical institution that has nothing to do with the military and political changes on the ground. It toils to provide medical service to all beneficiaries within it administrative borders without any discrimination related to religion, color, ethnicity, political or social or economic status.

Hospitals signing the communique urge the international and local entities to neutralize medical sector that helps 3 million and half, one third of which is children and maintain the achievements of medical sector, away from military and political alienation on the ground.

	PHC Name		Name PHC		Name PHC
1	Muhabel PHC	20	AL-der-al-sharqe PHC	39	Hiesh PHC
2	AL Maara PHC	21	Azmarin PHC	40	Al jama`a PHC
3	Ariha PHC	22	Maaret Elnaasan PHC	41	AL salam PHC
4	PHC Kafar losen	23	Jesr al shugur PHC	42	Sarmada PHC
5	PHC Al maland	24	Maar Tahroma PHC	43	Termanin PHC
6	PHC AL mastoma	25	Alema PHC	44	Khan shaykun PHC
7	AL habit PHC	26	Salwa PHC	45	Hafasraja PHC
8	PHC Deir hassan	27	Ehsem PHC	46	Bsheiriyeh PHC
9	ber Armanaz Al PHC	28	AL dahar PHC	47	Jarjanaze PHC
10	PHC Orm eljoz	29	The green Idlib PHC	48	Afes PHC
11	PHC Kafar yahmol	30	Bsames PHC	49	Nassam al kher PHC
12	PHC Harbanosh	31	Hazarin PHC	50	Kherbet Eljoz PHC
13	Khuwara PHC	32	Zarzor PHC	51	AL samedon camp PHC
14	PHC Kafr Nobol	33	Qourqeena PHC	52	Meshmshan PHC
15	Dadikh PHC	34	Maar Dibsi PHC	53	Kafar owed PHC
16	Salqin PHC	35	Bzabor PHC	54	Korin PHC
17	Abe zar PHC	36	Al bara PHC	55	AL thawra PHC
18	Maasaran PHC	37	Dana PHC	56	Saraqeb PHC SAMS
19	PHC Kafar omim	38	Kelly PHC	57	Kafruma PHC

16/1/2019


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