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Cross-border lifelines and local rule: charting a post-authoritarian future for Syria's healthcare system

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List of Acronyms

HTS - Hay'at Tahrir al-Sham
OCHA - United Nations Office for the Coordination of Humanitarian Affairs
UNSC - United Nations Security Council
WHO - World Health Organization

Introduction

In insurgency and counter-insurgency contexts, the line between combatants and non-combatants becomes increasingly blurred. War infiltrates everyday life, transforming the traditional battlefield into a boundless battlespace devoid of clear geographic or temporal delineation. In Syria, particularly in urban environments, this context incentivised the mass destruction of critical infrastructure, including healthcare facilities, thereby shrinking the political, social, and biological viability of urban spaces. The destruction wrought by the war has left behind a healthcare landscape defined by infrastructural devastation, acute workforce shortages, and fractured governance structures amidst a highly volatile security context. Cross-border mechanisms for conflict response became increasingly crucial in this setting. This includes the Gaziantep Cross-border (GXB) humanitarian response program—commonly referred to as the northwest Syria cross-border operation—, one of several coordination hubs operated by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) that collectively support the implementation of the Syria Humanitarian Response Plan.[1] Established in 2013, the Gaziantep health hub, located in southern Turkey near the Syrian border, has been instrumental in facilitating cross-border healthcare coordination for Syrian refugees and conflict-affected populations in northern Syria. It served as a central coordination space across the Syrian-Turkish border, bringing together international organisations, local NGOs, and humanitarian actors to facilitate cross-border aid. It was particularly critical in serving regions like Northwest Syria, where international and local actors had to coordinate healthcare service provision and aid delivery across borders. The logistical, political, and humanitarian dimensions of cross-border healthcare delivery shaped not only access to care but also the institutional frameworks that emerged in the ensuing governance vacuum.

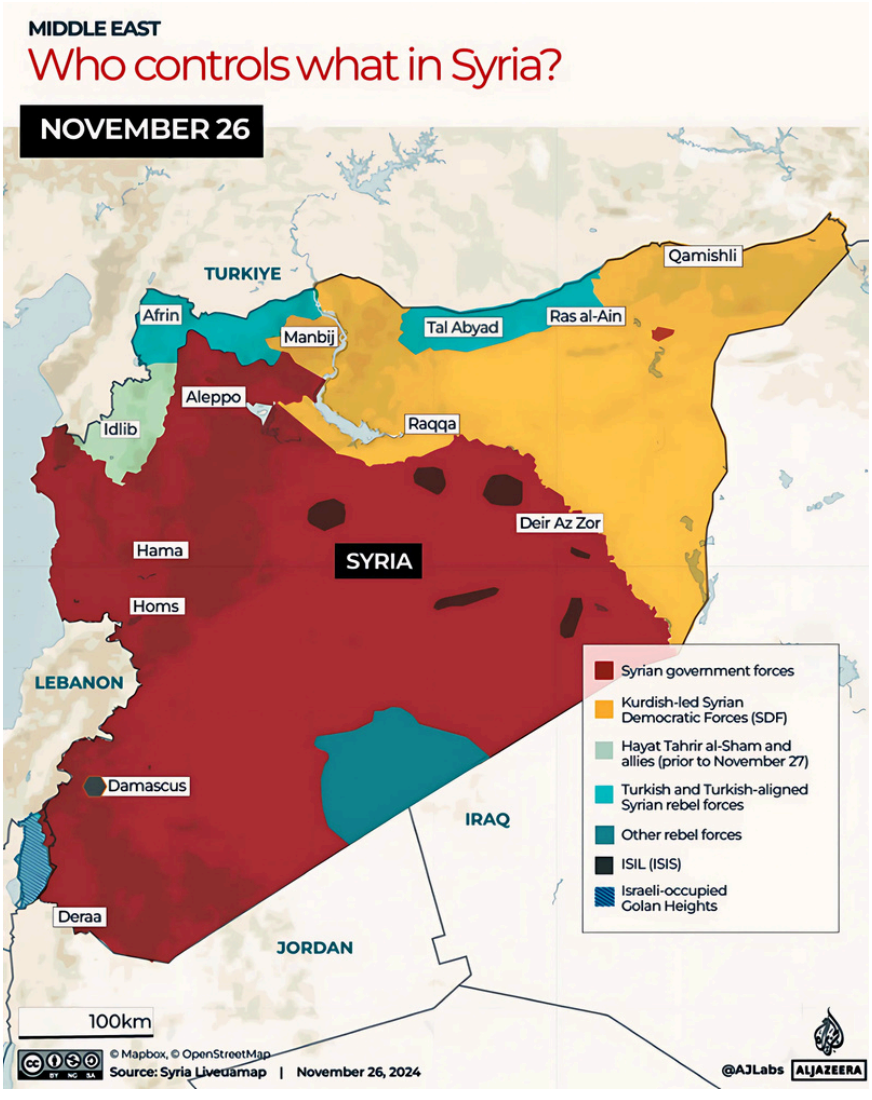
The fall of the Assad regime in December 2024 presents a pivotal moment for Syria to reconstruct its healthcare system, after a decade of conflict and violence intentionally directed against critical infrastructure. Hence, understanding the strategic manipulation of health systems that characterised wartime in Syria is essential to contextualising the broader implications for governance and the ways competing actors are shaping power dynamics in the post-conflict landscape. This paper interrogates the mechanisms of health governance in Northwest Syria under HTS and explores the implications of cross-border health coordination between Syria and Turkey. By looking at both models, it aims to outline the main priorities and challenges for rebuilding Syria's healthcare sector.

Political and geographical context

The Syrian case exemplifies how healthcare can become both a target and a tool of war. Under the Assad regime, medical neutrality was flagrantly violated, with over 600 documented attacks on healthcare facilities between 2011 and 2022.[2] The regime's deliberate targeting of hospitals and persecution of medical professionals decimated public health infrastructure, leaving millions without access to care. These acts weaponised healthcare infrastructure, transforming it into a means of coercion and control, while systematically dismantling the resources needed for community resilience. Additionally, the regime attempted to isolate and blockade areas under opposition control[3], ensuring that they not only lacked the necessary infrastructure, but also access to vital humanitarian aid and medical supplies.

This was the case in Northwest Syria, encompassing areas like Idlib and parts of Aleppo, predominantly controlled by Hay'at Tahrir al-Sham (HTS) before they toppled the regime and formed the new Syrian transition government. HTS emerged in 2017 as a non-state armed actor that became particularly dominant in northwest Syria. It was born out of a merger led by the successor of al-Qaeda's former affiliate in the country, with the aim of opposing the Assad regime and asserting political and administrative control over areas under its influence.[4] By consolidating control over much of Syia's northwest, HTS sought to establish an alternative governance structure, the Syrian Salvation Government (SSG), managing local institutions and basic service delivery and bolstering its legitimacy locally, regionally, and internationally through a technocratic model of governance.[5]

A snapshot of health governance in the region before December 2024 reveals various dynamics that are of key importance to understanding and exploring the transposition of this governance model from a geographically contained and somewhat enclaved area, to the whole of Syria. Health governance in areas outside of the Assad regime's control was heavily mediated by local health directorates, which collaborated with NGOs and humanitarian actors to maintain service delivery in the face of acute resource shortages and security challenges.[6] Cross-border humanitarian aid, facilitated primarily through the Bab al-Hawa crossing from Turkey, served as a lifeline for millions, delivering medical supplies, vaccines, and support for emergency healthcare interventions.[7] This mechanism was inherently fragile and precarious, subject to shifting geopolitical dynamics, the escalation of violence, and periodic legal threats. The reliance on short-term donor funding and the politicisation of aid further exacerbated these uncertainties, against the backdrop of the absence of a unified governance framework.



Map 1. Territorial control in Syria as of November 2024.
Al Jazeera. (2024, December 8). Taking Syria: The opposition's battles shown in 11 maps. Retrieved from https://www.aljazeera.com/news/2024/12/8/taking-syria-the-oppositions-battles-shown-in-11-maps-for-11-days

The consequences of the prolonged and multifaceted violence imposed on Syrians across the country were and continue to be staggering. Infrastructural devastation has rendered basic healthcare services inaccessible in many regions. Meanwhile, Syria's healthcare workforce has been critically diminished by displacement, emigration, and systematised violence. Public trust in health systems was similarly eroded, alongside access to basic services such as sanitation and the ability to enjoy basic goods.[8] In addition to the challenges posed by years of violence and internal fragmentation, external actors have further destabilised Syria's health and governance landscape. Following the fall of the Assad regime, Israel launched a sweeping military campaign targeting Syrian military and civil infrastructure, expanding its control to also include towns such as Quneitra.[9] This escalation introduced new instability in the south, complicating the transitional government's efforts to restore basic services.

In already devastated regions, renewed displacement and the collapse of fragile governance structures severely hindered the delivery of healthcare and essential aid. The Assad regime's fall cannot instantly reverse the challenges borne out of its violence, as emerging governance structures grapple with the dual imperatives of emergency response and long-term reconstruction.

Methodology

In order to illustrate the complexities underlying the exercise of violence against healthcare and its implications for health governance, this project employed a qualitative and participant-centred approach. Drawing from a broad range of sources, including thirty semi-structured interviews and focus group discussions with Syrian humanitarian workers operating across the Syrian-Turkish border, it tracked the historical progression of the politicisation of health governance in Syria and its subsequent weaponisation after 2011, to map and capture experiences of health insecurity. Central to this research, was understanding the particular health governance landscape in Syria's northwest under HTS' authority. While only one of several non-state actors that contested regime control, the group established the most developed civilian infrastructure and health governance model in opposition-held territories. Additionally, given its centrality in leading the transitional government after the fall of the Assad regime, this case offers a critical lens through which to understand the dynamics of health governance and social service delivery in post-Assad Syria.

Questions focused on the accessibility and availability of health services, safety concerns, trust in medical institutions and personnel, health vulnerabilities, and alternative governance models. Thematic analysis was then employed to identify recurrent patterns, themes, and narratives emerging from the focus group discussions and the interviews. This generated an in-depth analysis of the politics of transborder public health governance and the systematisation of health weaponisation as a practice in Syria. This practice is a well-documented strategy in both practitioner[10] and academic literature[11] on Syria, as the former Assad regime and its allied forces have expansively targeted medical facilities, personnel, and humanitarian aid routes to punish populations in opposition-controlled areas.[12] This research offers further empirical insight into how healthcare denial has been politicised and routinised, to provide a nuanced understanding of how health vulnerabilities have been manipulated, through sieges, aid blockades, and the politicised distribution of medical assistance, and what strategies have been employed by local actors to mitigate these impacts amidst limited resources and security risks.

Ethical considerations informed the study design, including informed consent, confidentiality safeguards, and trauma-sensitive questioning. Given the high risk of retraumatisation and the sensitivity of the political context, participants were provided with detailed information about the study's scope, voluntary nature, and anonymisation procedures. Interview protocols were adapted to ensure minimal psychological distress, particularly when recounting experiences of targeted violence, systemic neglect, or professional endangerment. The focus remained primarily on humanitarian workers due to their operational perspective and relative accessibility.

In addition to safeguarding participant wellbeing, the research was designed to uphold intellectual rigor and policy relevance. It sought not only to analyse the legacy of health system collapse and its governance repercussions, but to actively inform more contextually grounded and ethically responsive health strategies in Syria's transition. Insights from this research are intended to support humanitarian actors, transitional policymakers, and international health organisations working in Syria and similar border-conflict settings, where the line between health intervention and political survival remains dangerously blurred.

The legacy of conflict on health system collapse

The subversion of public health in Syria unfolded against a backdrop of complex revolutionary and counter-revolutionary dynamics. Born amid the regional wave of popular hope in the 2011 Arab Spring, the Syrian revolution was met with severe repression and indiscriminate violence by the ruling government.[13] Health infrastructure was systematically destroyed and manipulated. Hospitals and clinics suffered deliberate attacks, leaving medical facilities in ruins and exhausting resources.

Attacks on Syrian healthcare facilities

A surgeon previously based in Aleppo reported that the hospital he worked on was repeatedly bombed and destroyed over three times from 2011 to 2024.[14] Other healthcare professionals that were interviewed similarly reported a deeply embedded systematic attempt of dismantling and undermining healthcare services provision.[15] This included regular Russian airstrikes specifically targeting hospitals whose coordinates were shared by hospital directors under the UN deconfliction mechanism. The UN Syria deconfliction mechanism was a voluntary system through which humanitarian actors shared the coordinates of medical and civilian sites with the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) to prevent attacks, but it was widely criticised after several listed sites were deliberately targeted, particularly by Syrian and Russian forces.[16] To prove the disingenuity of the former Syrian regime and its Russian military ally, hospital directors reported that they sometimes provided altered coordinates, which were also reportedly targeted.[17]

This case exemplifies the strategic repurposing of humanitarian mechanisms as tools of war, helping target rather than protect hospitals and underscores the profound vulnerability of medical infrastructure in conflict zones where international norms are repeatedly violated.

Doctors, nurses, and paramedics themselves faced targeted violence, persecution, and displacement, leading to a severe shortage of skilled medical staff. The Assad regime criminalised medical neutrality by associating the provision of medical services with perceived dissidents, terrorism and national treason. According to various interviewees, even possessing a first aid kit was considered a crime, as it enabled care to be provided outside of state medical facilities and was as such perceived as an attempt to evade and hide links to opposition groups.

Beyond direct violence, a myriad of tactics was also deployed to increase health vulnerabilities while simultaneously restricting access to care, ranging from humanitarian aid blockades to the destruction of water and sanitation infrastructure. These curtailed the delivery of essential medical supplies and humanitarian aid, exacerbating vulnerabilities and precipitating catastrophic outcomes, including outbreaks of preventable diseases, heightened mortality rates, and a severe mental health crisis, crippling the system's capacity to function and recover.

In areas still under regime control by November 2024, hospitals were somewhat functional, but access to healthcare had become politicised and contingent upon political allegiances. Hospitals became sites of both conflict and power struggle. From the early days of the revolution, state hospitals were militarised, occupied by government forces to capture and incriminate wounded patients, turning medical treatment into an act of treason.[18] Medical knowledge itself was weaponised to inflict harm. Infamous examples include Tishreen Hospital, located in Barzeh, a northeastern district of Damascus, where regime-loyal health personnel used medical equipment and expertise for torture and murder, and Hospital 601, situated within the Mezzeh military airport complex in western Damascus, which operated as a detention, torture, and execution site. These cases highlight the centrality of health systems to maintaining the regime in place and imposing collective punishment mechanisms to discourage dissent, illustrating how political, military, and social competition heightened the strategic role of public resources and social services post-2011.

Health governance under HTS in Northwest Syria

The following section offers a close examination of the wartime health governance model established by HTS in Northwest Syria, focusing on key dimensions such as coordination, financial and operational constraints of health provision. HTS's technocratic approach underscores both the ingenuity and fragility of localised health governance under a protracted crisis. Analysing this infrastructure not only reveals how health systems were sustained in the absence of state capacity, but also raises pressing questions about what elements, if any, can be integrated or scaled in a future national reconstruction process.

Whilst public healthcare systems were under fire from the regime, opposition coordination committees rapidly expanded their roles, establishing makeshift field hospitals to treat the injured and distribute humanitarian aid. These efforts countered state interference in medical aid while showcasing the opposition's capacity to govern. The health governance model in HTS-controlled areas of Northwest Syria offers a lens through which to examine localised health management under crisis conditions.

The healthcare model implemented by HTS health directorates reveals valuable insights into maintaining service delivery amid systemic collapse. As the group contends with transitioning from a localised authority to a state actor, it needs to not only centralise decision-making processes but also establish institutions capable of delivering effective governance that balances effectiveness, inclusion, and legitimacy. Several challenges and limitations may emerge in future efforts to stabilise health systems in post-conflict Syria, underscoring the need for a comprehensive and cohesive health governance framework.

Governance and coordination

HTS's health governance in Idlib operated within an inconsistent and volatile environment, repeatedly and violently targeted by Syrian and Russian forces, which undermined the stability and effectiveness of its structures. With limited resources and in the absence of unified control to rebuild and maintain medical infrastructure, HTS informally delegated several health governance responsibilities to local health directorates and NGOs, as the latter stepped in to fill the governance void.

In-kind distributions of aid, which include direct delivery of food, hygiene kits, and medical supplies, frequently posed security challenges, as agents tasked with delivering cash or supplies faced significant risks due to the presence of armed groups and militias.[19] The need to implement security measures, including collaboration with security actors to protect distribution agents, reflects the precariousness of operating in such environments. NGOs attempting to provide humanitarian assistance often struggled to maintain neutrality while coordinating with local authorities and seeking protection from security threats.[20] The challenges in local law enforcement exacerbated these difficulties. Armed groups operating with varying degrees of independence and allegiances created an unpredictable security environment.[21] This not only hampered the ability of NGOs and local health directorates to carry out their missions effectively, but also made it more complicated for these organisations to maintain neutrality and a certain degree of autonomy while also seeking protection and attempting to coordinate with local authorities.

As HTS seeks to transition from a localised authority to a country-wide centralised governance model, it faces the dual challenge of consolidating power and acquiring national and international legitimacy. This requires the establishment of institutions capable of integrating fragmented governance structures while promoting inclusivity and transparency to accommodate local stakeholders and meet the expectations of international actors, whose support is often contingent on demonstrated accountability and adherence to humanitarian principles. However, centralising decision-making processes remains challenging, as regions across Syria encounter diverse needs and priorities, in addition to rising inter- and intracommunal violence[22] and regional escalation.

Financial and resource constraints

The sustainability of Syria's health sector across the country, regardless of territorial control, has long been hampered by its imposed reliance on external funding and the broader economic challenges posed by years of conflict and political instability. As the country embarks on its post-Assad reconstruction, these financial and resource constraints remain critical barriers to establishing a resilient and equitable healthcare system.

One of the most significant challenges facing Syria's health sector is its dependence on international funding, which exposes a critical disjuncture between local and international donor priorities[23], in addition to the volatility of the latter amidst a climate of global austerity and reduced humanitarian funding.[24] This reliance means that healthcare services, including emergency responses and essential care delivery, are often subject to abrupt changes in funding levels. Shifts in geopolitical alliances, global health priorities, and donor fatigue further exacerbate these vulnerabilities, leaving healthcare interventions without the necessary financial continuity to address long-term needs. One of the main frustrations expressed by many humanitarian workers was failure to move from emergency responses to sustainable reconstruction projects, because of both the limited timeframe of donor projects, and a lack of international political willingness to legitimise HTS[25] by endowing it with formal governance structures.[26]

Decreased funding levels overall have further constrained the health sector's capacity to deliver sustainable services.[27] Fluctuating international interest has led to periodic reductions in aid, limiting the scope of healthcare initiatives. Thousands of facilities in Syria's northwest were facing forcible closure because of a lack of funding, threatening to leave many with limited access to basic and specialised health services.[28] Vaccination campaigns and maternal health programmes have faced interruptions due to funding gaps, directly impacting vulnerable populations and undermining public health outcomes.

Beyond funding volatility, systemic hurdles within Syria's financial infrastructure have significantly restricted the flow of resources to the health sector. The country's fragmented and sanctioned banking system poses logistical challenges for the procurement of medical supplies and infrastructure development. International financial sanctions further complicate these issues, creating barriers to transactions with external suppliers and discouraging investments in healthcare facilities.[29] For example, sanctions on HTS have strained coordination efforts between local authorities and international donors.[30] In such cases, relationships must often be mediated by UN agencies and NGOs, adding layers of bureaucracy and reducing the efficiency of aid delivery.

The politicisation of aid further complicates the landscape of healthcare delivery in Syria. Selective approaches to funding and resource allocation can not only marginalise certain populations but can also erode public trust in governance institutions, leaving contested areas underfunded and underserved. This selective allocation of resources also undermines efforts to establish inclusive health governance frameworks. Populations excluded from these allocations face increased health vulnerabilities, deepening inequities, and fostering resentment toward governing authorities. If the public perception shifts towards seeing aid as a political tool, this can further damage trust in both local and international actors, complicating efforts to build a cohesive and legitimate health governance system.

Additionally, the systemic challenges of mass forced displacement and targeted violence against medical professionals have left the sector ill-equipped to address the population's growing health needs. Many doctors have stopped practicing to focus solely on managing and overseeing decentralised health governance structures, further limiting the number of doctors available.[31] Skilled medical professionals, including doctors, nurses, and technicians, have fled the country in large numbers, especially after witnessing their peers being detained, attacked, and killed.[32] The reduction in personnel has created critical gaps in service delivery, in an area where healthcare infrastructure and specialised care are already limited. The remaining workforce is often overburdened, operating in unsafe conditions. In Syria's northwest, an additional challenge was organised crime. Doctors were a frequent target of kidnapping, as their relatively higher salaries represented an opportunity for armed actors to demand high ransoms from their families.[33]

In addition to financial and personnel challenges, the Syrian health sector suffers from acute material resource shortages that undermine its ability to provide comprehensive care. Resource scarcity is particularly pronounced in mental health services, an area that has been consistently deprioritised in Syria's health agenda. NGOs and the Syrian civil society have made significant efforts to offer such services, especially after the devastating 2023 earthquake, as many struggled to face a new and unexpected multilayered trauma after years of violence and instability.[34] The absence of inpatient psychiatry services and dedicated mental health facilities leaves individuals with severe mental health conditions without adequate care. Psychosocial support services are minimal, despite the widespread psychological trauma caused by conflict, displacement, and insecurity.[35] The lack of mental health resources perpetuates cycles of neglect, contributing to broader societal challenges and undermining efforts to rebuild community resilience.

Limited strategic outlook

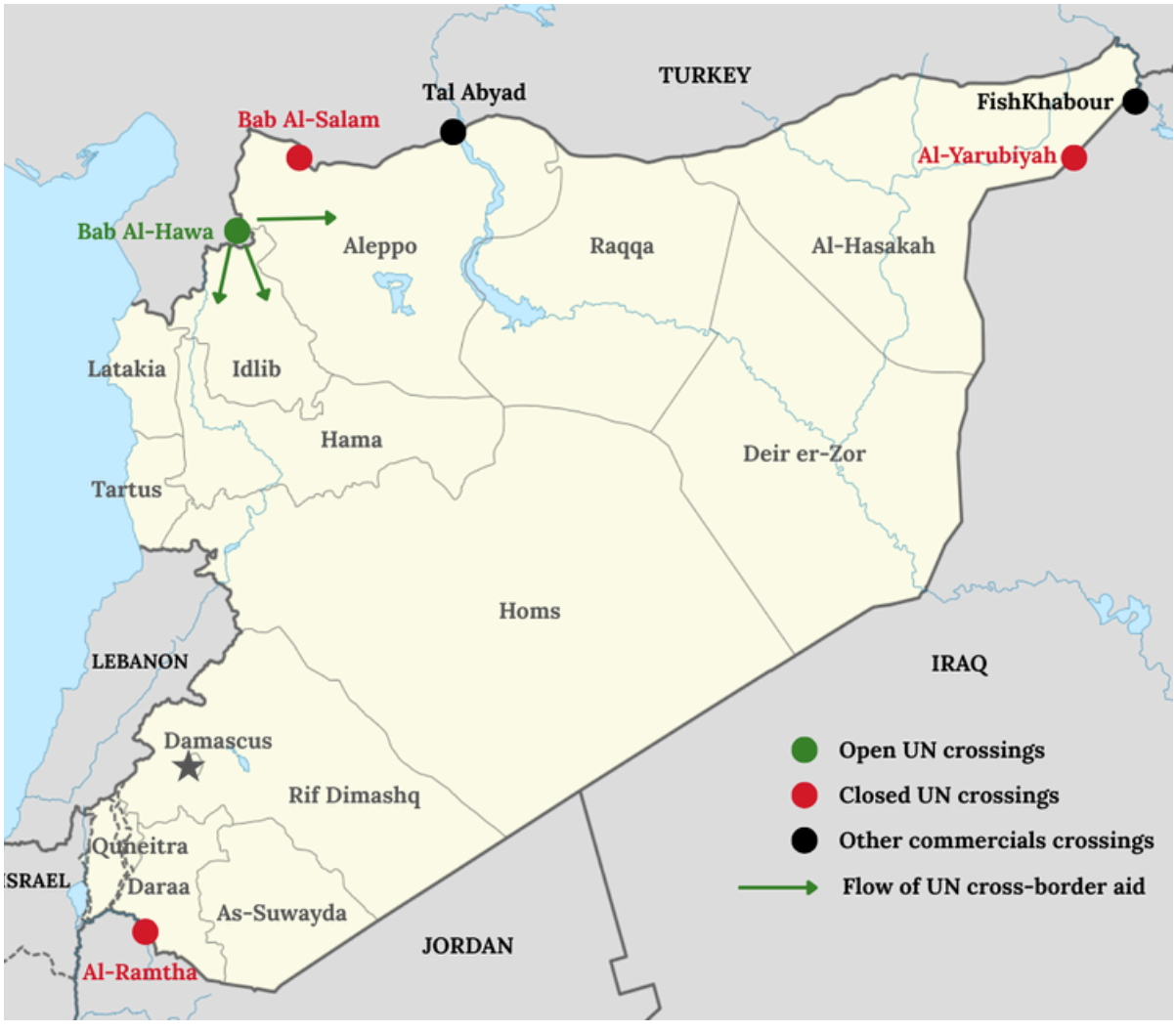
Throughout the years preceding the fall of the regime, the absence of cohesive planning and proactive strategies hindered both emergency responses and long-term development efforts in opposition-controlled areas. HTS delegated substantial operational authority to local health directorates, enabling them to coordinate with international humanitarian organisations and oversee day-to-day service delivery. This decentralised model allowed for a degree of responsiveness to localised needs, including curbing cholera outbreaks, administering maternal and child health programmes, and sustaining vaccination campaigns. However, it also introduced major limitations in strategic coherence and national-level coordination. The lack of a centralised body capable of harmonising interventions and setting long-term objectives made it difficult to articulate a unified health strategy, particularly one that could balance emergency preparedness with infrastructure rebuilding and workforce development. The absence of institutional continuity and the lack of integration between local, regional, and cross-border coordination bodies meant that systems were rebuilt repeatedly under fragile and inconsistent conditions, often subordinated to short-term survival imperatives.

In this governance vacuum, NGOs became the de facto stewards of the healthcare system. Local Syrian NGOs, in particular, served as crucial implementing partners, often mediating between donors and beneficiaries. Their technical capacity, operational reach, and access to external funding allowed them to fill critical gaps in both service provision and governance coordination. NGOs not only delivered essential services but also shaped health planning, capacity-building, and data collection. In effect, they substituted for state functions in many areas. However, their work was constrained by donor restrictions, security risks, and the politicisation of aid, which limited the scalability and sustainability of their interventions.

Cross-border health governance: The Gaziantep hub

The Gaziantep health hub, located in southern Turkey near the Syrian border, has been instrumental in facilitating cross-border healthcare coordination for Syrian refugees and conflict-affected populations in northern Syria. Functioning as both a logistical and operational nerve centre, it has supported the delivery of medical supplies, training of Syrian healthcare workers, and implementation of emergency health interventions. Despite its centrality, this humanitarian hub was increasingly constrained by a patchwork of political, legal, and logistical challenges.

At the heart of the operations enabled by the Gaziantep cross-border humanitarian infrastructure lies the Bab al-Hawa crossing[35], a critical humanitarian lifeline for over 4 million people[36] into areas like Idlib and northern Aleppo. The operational structure was highly complex, involving a constellation of actors: international organisations (such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF)), Syrian and international NGOs, local authorities, and Turkish authorities. Through this corridor, essential goods such as medications, vaccines, nutrition kits, and emergency medical equipment were delivered to populations otherwise isolated by conflict and political fragmentation. This system operated under the legal scaffolding of United Nations Security Council (UNSC) resolutions, which formally authorise cross-border humanitarian access through specific border crossings. However, these resolutions were subject to periodic renewal and to the UNSC states' refusal to vote in favour of the resolution.[37] Notably, Russia's repeated use of its veto power constantly threatened to shut down the cross-border mechanism entirely, creating cycles of precarity and operational anxiety among humanitarian actors.



Map 2. The United Nations border crossing points into Syria from Turkey, Iraq, and Jordan.
Photo credit: NordNordWest License: https://creativecommons.org/licenses/by-sa/3.0/

Compounding this legal fragility were domestic Turkish policies alongside the heavily militarised Syrian-Turkish border[38], which further shaped the landscape of cross-border health governance. The Turkish government played a decisive role in regulating the flow of humanitarian goods and personnel, framing these movements within its broader national security and border control priorities. These policies have sometimes resulted in delays or disruptions, especially for critical patients requiring cross-border referral for specialised treatment or surgical procedures.[39] Many patients dealing with chronic conditions or disabilities faced heightened administrative and legal barriers to crossing into Turkey for treatment.[40] Humanitarian convoys were also frequently delayed or rerouted due to violence, checkpoints, or bureaucratic bottlenecks, further disrupting operations. The situation was aggravated by the temporary suspension of Bab al-Hawa by the Turkish government in the aftermath of the February 2023 earthquake, which severed a critical artery of care at a time of extreme vulnerability.

Other challenges were multifaceted and structural, including the absence of a unified governance framework inside Syria exacerbated these issues, leading to fragmented coordination, duplication of efforts, and reduced accountability, due to disparate mandates, funding streams, and logistical barriers. Moreover, sanctions imposed on Syria—particularly those affecting dual-use technologies—have hindered the importation of advanced medical equipment such as MRI machines and CT scanners, deemed sensitive due to their potential for military repurposing.[41] Even life-saving items like vaccines, including during the COVID-19 pandemic, encountered delays and restrictions. These barriers have significantly impacted the capacity of healthcare actors to deliver high-quality care or conduct proper diagnostics. This is especially the case as even their own mobility across the Syrian-Turkish border was restricted. Humanitarian teams had to notify the Turkish government at least 72 hours before their missions, before then having to wait for clearance and approval. Additionally, employees with temporary protection from the Turkish government were limited even in their ability to travel within the country, which limits their ability to supervise projects, attend training, or engage in needs assessments. Anxieties linked to legal precarity also further cause psychological and emotional stress to people often contenting with vicarious trauma, navigating the emotional toll of displacement and conflict while operating in under-resourced settings with little psychosocial support.[42]

Looking ahead: Healthcare reconstruction amid transition

With the fall of the Assad regime, the existing Gaziantep-based humanitarian cross-border infrastructure offers a vital interim mechanism to support Syria's health system reconstruction. As the country enters a fragile post-regime phase marked by institutional uncertainty and uneven territorial transitions, the Gaziantep hub can serve as a stabilising logistical backbone, facilitating the continued flow of medical supplies, technical expertise, and personnel into areas where healthcare systems have collapsed. Its embedded networks of international agencies, Syrian NGOs, and trained cross-border health workers provide an already functional architecture that can bridge the gap between emergency response and early recovery.

Transitional use of cross-border infrastructure. Rather than dismantling this infrastructure prematurely, it can be strategically repurposed to support the rehabilitation of local health directorates, guide capacity-building programmes, and coordinate decentralised service delivery while new national institutions are being formed. Moreover, maintaining the Gaziantep mechanism in the short to medium term ensures that critical care and disease surveillance do not lapse, particularly in underserved regions still vulnerable to outbreaks, displacement, and political instability. Used judiciously, the cross-border framework can act as a transitional governance tool, supporting a more accountable and inclusive reconstruction process until a unified, post-Assad health governance system is firmly established.

Balancing local responsiveness and system coherence. To avoid a fragmented recovery, Syrian transitional authorities and their partners must adopt a recovery model grounded in both localised responsiveness and centralised coordination. Building on the strengths of localised governance models, regional health authorities should be empowered to manage resources, tailor interventions to local epidemiological and social realities, and maintain close engagement with communities. At the same time, a national coordination body is essential to ensure coherence across regions by setting unified policy standards, harmonising data collection and surveillance systems, and guiding equitable resource allocation. This hybrid model balances the flexibility of decentralised governance with the oversight necessary for long-term system integrity.

Sustainable financing. A large number of health facilities are expected to face closure due to funding shortages and suspensions from main donors, including USAID, if external support continues to decrease.[43] This risk is further compounded by the anticipated increase in demand linked to return movements. Over 400,000 Syrians have returned from neighbouring countries between December 2024 and April 2025[44], and more than one million are planning to return shortly.[45] To reduce dependency on unpredictable international aid, Syria authorities, with

support from international financial institutions and development partners, must explore diversified and sustainable financing mechanisms. These could include public-private partnerships, community-based health insurance schemes, and targeted international development funding aimed not just at relief but at system-building. Transparent financial management, bolstered by public reporting and independent audits, will be critical to maintaining donor confidence and ensuring equitable distribution, especially in historically underserved areas.

Equity and inclusion. Crucially, health reconstruction efforts must go beyond clinical care. A narrow focus on food baskets or cash assistance must evolve into a livelihood-centred recovery strategy, which addresses social determinants of health such as employment, housing, and sanitation. Improving living conditions is essential to reducing risk factors for disease and mitigating long-term health vulnerabilities. International donors and national planners should prioritise marginalised populations—including women, children, the elderly, and persons with disabilities—in all planning efforts. Health infrastructure projects should incorporate universal design standards to ensure accessibility, while inclusive public health campaigns must challenge stigma, particularly around mental health, gender-based violence, and disability. Embedding equity and inclusion at the heart of reconstruction will be key to preventing the replication of pre-war inequalities and fostering a resilient, rights-based health system.

By leveraging the adaptive capacities of cross-border mechanisms and localised governance models developed during the conflict, Syria can lay the groundwork for a more resilient, inclusive, and rights-based health system. The coming years will test the country's ability to move beyond emergency responses and fragmented aid toward a nationally coordinated yet locally responsive system. One that does not merely repair what was broken but ensures the right to health is guaranteed for all in a post-authoritarian future.

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