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Thanks to Ruth María Abril Stoffels for her valuable comments

Governance and the right to health in north-western Syria

Abstract

This article highlights i) the lack of respect for the right to health that is being experienced during the Syrian conflict, and ii) the impact of its political significance on the medical humanitarian response, whose mission is precisely that of assisting the people in health matters and thus guaranteeing the minimum standards required by the right to health.

We will focus on two issues: 1) non-fulfilment of the right to health in the Syrian conflict, and 2) clarifying the capacity of the existing medical humanitarian response system to uphold the right to health. The confirmed hypotheses are: first, that the right to health is suffering from a serious lack of respect due to the highly politicised nature of the conflict; and second, that the political influence placed on the system of governance of the health response prevents it from lessening the level of non-compliance with the right to health.

Keywords

Governance, health, Syria.

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¹ My grateful thanks to Ruth María Abril Stoffels for her valuable comments.

Methodology

The confirmation of both hypotheses is the result of a methodology that combines direct observation and the author's knowledge of the terrain. His work for two years as a humanitarian agent in the Syrian crisis allowed him to clearly identify and observe the issues. In addition, five specialists in public health and humanitarian aid were interviewed, all of them working at the time for donors, United Nations agencies and NGOs involved in the response to the crisis in north-western Syria. The interviews were conducted in an unstructured and confidential manner, given the political and sensitive nature of the content of the questions and answers provided. Finally, a review was conducted of academic/scientific literature on human rights, international humanitarian law (IHL) and the right to health as well as public health and public health governance, especially in crisis situations.

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Introduction

Generally speaking, armed conflicts result in a serious deterioration of health systems, affecting both the provision of services and respect for the right to health. The ongoing conflict in Syria for over seven years is no exception. The official figures from public and private bodies, as well as information provided by the media, speak for themselves: almost half a million dead, around five million refugees – the majority in neighbouring countries – and more than six million people who have been internally displaced. With public and social infrastructures severely damaged, health personnel are scarce and the quality of health structures is rather poor and survives largely thanks to the external support of multilateral institutions or non-governmental organisations of all kinds. In addition, the right to health is not respected and continues to be severely violated. On the one hand, there is a lack of availability and access to health services, and on the other, attacks on both structures and health personnel are incessant, the latter being one of the most horrendous practices of modern warfare².

A feature of the humanitarian response in Syria is its fragmentation, with several 'hub' or coordination centres, both formal (Gaziantep, Damascus, Amman), and informal (Beirut and Erbil). This system has resulted in a unique operational response model. Validated following an official resolution of the United Nations Security Council – 2139 February 2014³ – it is a system of cross-border aid, with assistance reaching north-western Syria⁴ across the border from Turkey, as the region is not accessible from the rest of the country⁵.

The actors responsible for healthcare in northwest Syria – young and fragile 'opposition' health authorities, medical humanitarian NGOs born out of the Syrian diaspora and regular humanitarian crisis agencies (international NGOs, UN agencies and donors) – struggle to coordinate generous resources and efforts, and to collaborate on health issues as well as to accommodate different political interests. The result is a complex and rather dysfunctional health governance system unable to meet basic health needs and ensure respect for the right to health. In this case, governance in the health sector – according to the World Health Organisation (WHO)– refers to a wide range of functions related to policy-making and standard-setting carried out by governments responsible for decision-making as they seek

2 HAMPTON, Tracy. «Health care under attack in Syrian conflict». *Jama*, vol. 310, no 5. 2013, pp. 465-466.

3 UNITED NATIONS SECURITY COUNCIL. Security Council Unanimously Adopts Resolution 2139 (2014) to Ease Aid Delivery to Syrians, Provide Relief from 'Chilling Darkness', 2014.

4 For the purposes of this study, the northwest of the country refers to the governorate of Aleppo, the governorate of Idlib and the northern governorate of Hama which remains under rebel control.

5 UNITED NATIONS SECURITY COUNCIL. Security Council Adopts Resolution 2393 (2017), Renewing Authorization for Cross-Border, Cross-Line Humanitarian Access to Syria, 2017.

to achieve national health policy objectives that are conducive to universal health coverage⁶.

Because of its particular model of operational response and governance, as well as the intensity of the violations mentioned above, health care in north-western Syria deserves due attention. Thus, this article, by way of a brief review of scholarly literature and interviews with humanitarian workers and health professionals currently in charge of health care in north-western Syria, exposes and highlights non-compliance and violations of the right to health enshrined in international standards. Following a brief review of the historical milestones of the right to health in order to understand both its importance and its very constitution, we take a glance at its place as a basic right within human rights on the one hand, and IHL on the other, in order to situate the study within its corresponding legal framework. Once the concept of the right to health has been established, the violations of the right to health are listed within the IHL framework, and the reasons why the right to health in the northwest of Syria is far from guaranteed as it should be, are described and analysed.

Further on, we examine more closely the dysfunctional nature of the health governance system and the role it plays in guaranteeing the right to health in the Syrian crisis. In doing so, we approach the issue from two perspectives, one that looks at the existing situation and the other that focuses on the institutional system of health governance prevailing in the region and its applicability in humanitarian crisis situations such as that of north-western Syria. Since at this point there is a lack of literature on reference models for these cases, we use our own, thus creating a research area that can be added to in the future.

Next, we describe the original health governance system developed for health care in northwest Syria. And lastly, the shortcomings of this system are highlighted, thus demonstrating its complexity and considerable political weight, all of which hinder its effectiveness. Accordingly, the relationship between a health governance model and the effective recognition of the right to health is explained. Once analysed theoretically, this case study, although limited due to the scale of the conflict, demonstrates the impact of dysfunctional governance on the effectiveness of the enjoyment of the right to health care.

By way of conclusion, we make a series of minimally specific recommendations to all key actors involved to a greater or lesser extent in health governance in response to the humanitarian crisis in north-west Syria.

This paper also opens the way for comparative studies in other current or upcoming crises, and by extension the development of more efficient health governance systems for future humanitarian crises.

6 DODGSON, Richard; LEE, Kelley; DRAGER, Nick. *Global health governance. A Conceptual Review*. London/Geneva, 2002.

The right to health in north-western Syria

The right to health as a human right and within international humanitarian law

The right to health as a human right; a historic perspective

The right to health, like most basic rights, was explicitly conceived and assumed in the mid-twentieth century. The right to the enjoyment of the highest attainable standard of physical and mental health was first expressed in the WHO Constitution of 1946⁷. Two years later, the 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (article 25 of the Universal Declaration of Human Rights)⁸. And two decades later, it was again recognised as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. More recently, in 2002, WHO and the Commission on Human Rights created the mandate of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health. This mandate includes monitoring the effectiveness of the right to health in certain parts of the world through several annual visits to certain countries in need of evaluation⁹. The Special Rapporteur's last official visit to Syria was in 2010. The mission was considered relatively successful. On the one hand, he focused on problems of access to health, especially for detainees, and was able to gain access to a prison. On the other hand, he focused on sexual and reproductive health issues, where an improvement in epidemiological indicators was observed within a few years¹⁰.

In a recent statement the director of the WHO underscored a fundamental principle of the right to health: impartiality. He said that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”¹¹. Thus, impartiality, understood as the universality of basic health, is in effect the essential driving force of any fair and inclusive health system. In a system that is fair, the right to health includes timely access to, and acceptable and affordable availability of

7 WHO. *Constitution of the World Health Organization*. Basic Documents, Supplement to 45th Edition, 2006.

8 UNITED NATIONS. *Universal Declaration of Human Rights*, 1948.

9 ACNUDH. *Overview of the Mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 2002.

10 GROVER, Anand. *Syria Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Office of the High Commissioner for Human Rights, 2011.

11 WHO. *Health is a fundamental human right*. Declaration by Dr. Tedros Adhanom Ghebreyesus, Director General of the WHO, December 10, 2017.

health care services of sufficient quality. In terms of inclusiveness, the right to health must guarantee essential services for good health such as safe, drinkable water and adequate sanitation, and access to education and health-related information.

The right to health under international humanitarian law

In times of armed conflict, IHL provides rules to protect access to health care, i.e. the right to health. These rules bind States and non-State armed groups. The right to health within international humanitarian law consists of three fundamental principles. The first of these is assistance, i.e. the obligation to provide health services – in accordance with the Geneva Conventions – for civilians, combatants and persons out of combat, including the sick and wounded of armed forces on the field, and shipwrecked members of armed forces at sea, prisoners of war, or assimilated persons who, being placed *hors de combat* are no longer military targets. Secondly, the protection of the medical mission, the wounded and sick, medical personnel, medical ethics and health structures. Thirdly, the principles of distinction and proportionality. First, the principle of distinction provides that in times of conflict combatants have the right to participate directly in hostilities in order to achieve a military objective as effectively as possible; such acts of war shall be directed only against enemy combatants and military objectives and shall avoid unnecessary and excessive harm to civilians and non-combatants. According to the second principle of proportionality, the parties shall avoid causing incidental loss of civilian life, injury to civilians or damage to civilian objects that is excessive in relation to the specific and direct military advantage anticipated. In order to comply with the restrictions and prohibitions on attacks, all parties to an armed conflict must take specific precautions¹².

Violations and non-fulfilment of the right to health in north-western Syria

Violations of the right to health

The Syrian conflict is characterised by the intensity and frequency with which all parties, and especially the Syrian Government and extremist armed groups, have violated human rights and international humanitarian law¹³. Such violations have also occurred in the area of health. Thus, health care and the protection of victims, the respect for and protection of the medical mission and in general, the distinction between military and non-military objectives –in this case the health mission– have not been guaranteed. Proof of this are the examples described below, which constitute the most flagrant violations of the right to health during the conflict and contribute to a

¹² ICRC. *Methods and means of warfare*, 2010.

¹³ IDRIS, Iffat. *International humanitarian law and human rights violations in Syria*. 2017.

clearer understanding of the gravity of the issue, as well as the reasons for such transgressions and their implications.

Attacks on health facilities and the violation of the integrity of the medical mission. Hospitals, medical centres and clinics have been intentionally and systematically attacked. It would appear that these are IHL violations committed for the most part by the Syrian government and Russian forces¹⁴. These attacks destroy vital infrastructure and result in an exodus of medical personnel, severely limiting the capacity of those who remain, thus depriving the wounded of their basic needs¹⁵. Attacks on health facilities are not only a violation of IHL by targeting the medical mission but also¹⁶, since May 2016, of the resolution adopted by the United Nations Security Council (UN) number 2286 in a bid to once again prevent and condemn these attacks¹⁷.

On the other hand, non-state armed groups have made inappropriate military use of medical structures in violation of the integrity of the medical mission and IHL¹⁸. In effect, the conflict in Syria presents unprecedented challenges to medical neutrality. The politicisation of medical care through severe and direct violence against missions and health facilities –the violent deprivation of humanitarian assistance for military advantage, with the flight of civilians, the destruction of infrastructure, terror and even the death of non-combatants– has made Syria the most dangerous place in the world for health service providers¹⁹.

Harassment and denial of humanitarian access. Up until mid-2018, the government persisted with a campaign of protracted sieges²⁰ in predominantly civilian areas, such as the north of Homs or the east of Guta, the rural area of Damascus²¹. Similarly, armed opposition groups maintained prolonged sieges targeted at predominantly ci-

14 PHYSICIANS FOR HUMAN RIGHTS. Issue Brief: Attacks on Health in Syria, 2018.

15 ARMSTRONG, Justin. *Changes in medical practice in Syria; Dilemmas and adaptations in medical facilities continually threatened by attack*. Centre for Applied Reflection for Humanitarian Practice, Médecins Sans Frontières, 2016.

16 SA'DA, Caroline Abu; DUROCH, Françoise; TAITHE, Bertrand. «Attacks on medical missions: overview of a polymorphous reality: the case of Médecins Sans Frontières». *International Review of the Red Cross*, vol. 95, no 890. 2013, pp. 309-330.

17 UNITED NATIONS SECURITY COUNCIL. Security Council Adopts Resolution 2286 (2016). Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations, 2016.

18 RELIEFWEB. «SAMS condemns violations of medical neutrality in Idlib». SAMS, 2018.

19 FOUAD, Fouad M., *et al.* «Health workers and the weaponisation of health care in Syria: a preliminary inquiry for The Lancet–American University of Beirut Commission on Syria». *The Lancet*, vol. 390, no 10111. 2017, pp. 2516-2526.

20 RELIEFWEB. Siege era in Syria ends. PAX, 2018.

21 AMNESTY INTERNATIONAL. *The Unfolding Humanitarian Catastrophe in Eastern Ghouta*, 2018.

vilian areas in the towns of Kefraya and Fua, in the governorate of Idleb²². In both cases, the local population was deprived access to medical care, other basic goods and services and humanitarian aid. In the case of Guta and Homs, they subjected the population to repeated aerial and artillery bombardment. In such cases, IHL is clear; Article 17 of the Fourth Geneva Convention stipulates that when a locality or area is besieged, the passage of medical and health care personnel and the evacuation of civilians, the wounded and the sick requiring treatment must be allowed²³.

Torture and ill-treatment. Torture and other ill-treatment of detainees by government security and intelligence agencies and in state prisons remains systematic and widespread resulting in a high incidence of detainee deaths. For example, large numbers of detainees at Saydnaya Military Prison died after being repeatedly tortured and systematically deprived of food, water, ventilation, medicine and medical care²⁴. This is contrary to the fundamental guarantees recognised in article 3 common to the four Geneva Conventions, which states that all persons taking no active part in hostilities or who fall into the power of the adversary must be treated humanely and it specifically prohibits torture and cruel treatment, outrages upon personal dignity, in particular humiliating and degrading treatment²⁵.

Non-fulfilment of the right to health

For the right to health to be complete, we previously cited the importance of impartiality, fairness and inclusiveness. To this end, availability, accessibility and quality are essential, but a brief review of the status of these three variables shows that the right to health in north-western Syria is far from being fully fulfilled/respected.

First, there is a lack of available services for the provision of adequate care in both primary and secondary health. This occurs mainly:

- i) in non-infectious diseases where there is a lack of continuity and medicines for treatment ²⁶,
- ii) in reproductive health, where fully equipped maternity wards offering 24-hour delivery capacity are scarce ²⁷, and

22 *Report Syria Events of 2017*. Human Rights Watch, 2018.

23 INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC). IV. Geneva Convention on the protection of civilians in times of war, 1949.

24 AMNESTY INTERNATIONAL. Annual report, Syria 2017/2018.

25 ICRC. *The Geneva Conventions of 1949 and its additional Protocols*, 2014.

26 COUSINS, Sophie. «Syrian crisis: health experts say more can be done». *The Lancet*, vol. 385, no 9972. 2015, pp. 931-934.

27 AL-DIMASHQI Youmna; MASSENA, Florence. «Syria's Women: Policies and Perspectives. For Many Syrian Women, Healthcare is a Matter of Geography». *Syria News Deeply*, 2017.

- iii) in the area of vaccination where coverage is insufficient and where, as a result of the arrival of displaced persons from areas where access to basic health did not exist, measles epidemics have broken out and cases of polio have been reported²⁸.
- iv) However, it is interesting to note that the humanitarian response – although insufficient – brings with it the development of services that barely existed before the conflict, such as raising an awareness of mental health services²⁹. Even so, in terms of mental health, in the whole of north-western Syria there are only two psychiatrists and a few psychologists for millions of people³⁰.

On the other hand, the availability, accessibility and quality of water and sanitation are insufficient, which has a clear impact on health. This situation has been aggravated by the arrival of hundreds of thousands of displaced persons throughout 2017³¹.

Second, there is a lack of access to public health services due to constant attacks on medical facilities that either destroy them and render them inoperative, or discourage their use for fear of further attacks. In addition to the quantitative decrease, there has been a qualitative decrease in public health services, as a consequence of the exodus of health personnel and the lack of training facilities for new professionals. Thus, for years the population has been treated by students, specialist doctors who have ventured to practise different specialisations to their own or general practitioners who have become specialist doctors on the basis of practice.

Finally, the lack of education and promotion of good health practices is almost non-existent in a context where more than half of the population is displaced, poorly educated and after years of stress under war has been forced to understand a rather phantom and dysfunctional health system³².

Third, the poor quality of health services is notable. On the one hand, the quality of primary health services has been shown to be quite low in terms of clinical services and health centre management. Problems such as the lack of certain basic services, as well as incorrect and exaggerated prescriptions, are common, according to studies carried out by the WHO³³. On the other hand, the quality of reproductive health is similarly poor with a high level of Caesarean sections and a lack of availability of places

28 WHO. *Reaching out with mental health services for displaced Syrians*. WHO Regional Office for Europe, 2018.

29 WHO. *Reaching out with mental health services for displaced Syrians*. WHO Regional Office for Europe, 2018.

30 BRADFORD, Alexandra. «In Syria's War, 'Mental Health Is the Last Priority'». *Syria News Deeply*, 2017.

31 Interview no. 5. Head of international medical-humanitarian NGO, February 2018 in Gaziantep (Turkey).

32 Interview no. 1. Official A of the WHO, February 2018 in Gaziantep (Turkey).

33 Interview no. 1. Official A of the WHO, February 2018 in Gaziantep (Turkey).

and personnel for twenty-four hour deliveries as well a high number of non-free-of-charge home deliveries carried out by false midwives (often poorly trained nurses)³⁴. In this context, we should highlight the inadequacies in terms of accountability, since there are no mechanisms or processes whereby patients can seek explanations in the event of medical error, all of which generates mistrust and impunity. This in turn has repercussions on access to health services and clearly impacts on the provision of these services.

While in Syria, as the report of the visit of the Special Rapporteur indicates *inter alia*³⁵, these elements (availability, accessibility and quality) were adhered to partially –but not entirely– satisfactorily, the conflict has turned Syria into a historic example of human rights and IHL violations. At the same time, in just a few years it has destroyed the existing health system and, with it, the past achievements of the Syrian state. Thus, as we shall see, difficulties of access, quality and accountability deriving from the conflict can be explained as resulting from both quantitative (lack of health governance bodies) and qualitative (lack of quality of the existing bodies in terms of an effective and coordinated response) governance problems.

Health governance in north-western syria

Health governance, and its application in crisis situations

According to the WHO³⁶, where governance is understood as a political process that involves balancing competing influences and demands, governance in the health sector refers to 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 including:

- maintaining the strategic management of policy development and implementation;
- detecting and correcting undesirable trends and distortions;
- regulating the behaviour of a wide range of actors, from health care financiers to health care providers; and
- establishing transparent and effective accountability mechanisms.

Beyond the formal health system, governance means collaborating with other sectors, including the private sector and civil society, to promote and maintain population

³⁴ Interview no. 2. Official B of the UNFPA, February 2018 in Gaziantep (Turkey).

³⁵ GROVER, Anand. *Syria Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Office of the High Commissioner for Human Rights, 2011.

³⁶ Health System. Governance. Website WHO. Accessed at <https://www.who.int/healthsystems/topics/stewardship/en/>

health in a participatory and inclusive manner³⁷. Health governance in humanitarian crisis situations is clearly affected and often faces difficulties in fulfilling the functions envisaged by the WHO in an efficient manner. In addition, it becomes a significantly relevant part of humanitarian governance, since health is usually one of the most important sectors in the response to a humanitarian crisis.

At the end of the twentieth century, since the end of the Cold War, humanitarian governance, and consequently health care, acquired a human rights and health protection perspective. As the landmark crises in the history of humanitarian aid –from Rwanda to Syria– demonstrate, this perspective has not meant infallible improvements in respect for human rights³⁸.

Despite this protective framework, health governance faces a number of challenges that affect both its functionality and the legal protection framework. The most important challenge concerns the magnitude of the involvement and the role of external actors (private or institutional donors, international non-governmental organisations (INGOs), UN agencies), among which the WHO often stands out for its role as guarantor of protocols and the coordination of health care. Given the scale of the challenge, governance faces the daunting prospect of managing these resources in ways that promote national, regional and local leadership and strengthen national health systems. And it is the local actors who, despite crises, must remain the guarantors of the functioning of governance for the entire period from the outset until post-crisis.

The remaining challenges relate to issues that are also of concern in stable situations in terms of sustaining an efficient system of governance and guaranteeing the quality of services and care, but whose shortcomings may become more acute in times of crisis. These include, among others, transparency, corruption, health education, a tendency towards over-politicisation, the inability to include all sectors of society and a response to the dilemmas of public decentralisation versus hospitalised and privatised systems^{39,40}.

Despite historical developments in the regulatory and legal protection framework, and despite knowing most of the common challenges faced by humanitarian governance in the area of health, there are currently no default master governance models for all crises. Much has been said about the challenges of the global health system –major pandemics such as Ebola, increasing politicisation, the effects of cli-

37 DODGSON, Richard; LEE, Kelley; DRAGER, Nick. *Global health governance. A Conceptual Review*. London/Geneva, 2002.

38 LAUTZE, Sue, *et al.* «Assistance, protection, and governance networks in complex emergencies». *The Lancet*, vol. 364, n.º 9451, 2004, pp. 2134-2141.

39 REPULLO, José R.; FREIRE, José M. «Gobernabilidad del Sistema Nacional de Salud: mejorando el balance entre los beneficios y los costes de la descentralización». Informe SESPAS 2008. *Gaceta Sanitaria*, vol. 22, 2008, pp. 118-125.

40 ARENAS, Carlos A. *La nueva gobernanza de las instituciones sanitarias*. Redacción Médica, 2015.

mate change— but not so much about ideal solutions at either global or specific levels, whether geographical or thematic. While this is not surprising given the particularities that characterise each crisis, it shows that there is still much room for research into models of standard and optimal health governance systems for specific humanitarian crises⁴¹. However, it is possible to have certain guidelines and principles. The following is an account of what can be extrapolated and learned from the case of Syria.

Health governance in north-western Syria

The socio-political situation in north-western Syria

Since the beginning of the conflict, northwest Syria has been an area controlled by opposition and/or rebel forces. Despite the fact that as a result of various offensives the Syrian government has recovered part of the territory of both the Idlib and Aleppo governorates, to this day a large part of both governorates is still under the civil-administrative control of the opposition Syrian government and under the military control of the rebel forces, or under Turkish-Syrian military control, as is the case in the so-called Euphrates shield area, located in the north of the Aleppo governorate^{42,43}. We are talking about approximately four million people, the vast majority of whom are in need of humanitarian assistance, half of whom are internally displaced persons and who clearly constitute the most vulnerable part of the conflict. Access to these areas not controlled by the Syrian government —much of the governorates of Idlib, Aleppo and Hama— from and to Damascus is officially closed for commercial and humanitarian purposes, with obvious exceptions that have to do with the business of war^{44, 45}. As a result, basic needs are not being addressed because there is no infrastructure or public investment, and the economy is being maintained due to the humanitarian industry and, paradoxically, war.

41 BLANCHET, Karl, *et al.* *An evidence review of research on health interventions in humanitarian crises*. London: London School of Hygiene & Tropical Medicine, 2013.

42 In August 2016 Turkey launched an offensive in northern Aleppo to regain a border area that was in the hands of Kurdish armed groups with troops remaining on Syrian territory under the pretext of self-defence. Likewise, under the same pretext protected by Article 51 of the UN Magna Carta, it launched another offensive in January 2018 in the Afrin region northwest of the Aleppo Governorate, where forces have also remained. Furthermore, following the Astana agreements signed by Russia, Iran and Turkey in May 2017 aimed at reducing violence and guaranteeing humanitarian access through the military intervention of each of the signatory countries, Turkey has introduced new troops in the Idlib governorate.

43 BARNES-DACEY, Julien. *What Turkey's intervention means for Syria, the Kurds, and Ankara. What it means for the Syrian war*. European Council on Foreign Relations, 2018.

44 SINJAB, Lina. *How Syria's war economy propels the conflict*. Chatham House, 2017.

45 LUND, Aron. *The Factory: A Glimpse into Syria's War Economy*. The Century Foundation, 2018.

The lack of access to northwest Syria from the onset of the conflict was the result of the deployment of humanitarian aid agencies in eastern Turkey from where they still today assist the people in need through the crossing of the Syrian-Turkish border by experienced personnel and humanitarian equipment. In spite of the validity of resolution 2139 (2014) on «border-crossing»⁴⁶, assisting and coordinating assistance from the neighbouring country with limited access is far from evident⁴⁷. The conflict or crisis following the failed Turkish state coup often leads to blockades. In addition, the lack of visibility and proximity has led, on the one hand, to the inability of humanitarian actors to adequately monitor the delivery and provision of aid, and, on the other, to opportunities for corruption and internal political strife among the various Syrian power actors (civil society, NGOs, authorities, armed groups). These operational and political limitations are reflected in the medical humanitarian arena and, consequently, a health governance system has been developed that is exemplary in theory, as we shall see, in terms of its suitability to respond to such challenges, but somewhat complex and dysfunctional in practice.

The system of political-administrative governance in north-western Syria

Before describing the health governance system, it is important to talk about political governance in north-western Syria because healthcare somehow represents an extension of it. With the *de facto* collapse of the extremely centralised Syrian state and its contemporary institutions, other authorities emerged to fill the gaps in governance and the sovereignty divide⁴⁸. These are local councils and religious authorities, as well as clan structures⁴⁹. Each administrative unit in northwest Syria has developed with varying degrees of autonomy, forming a system of decentralised governance. As mentioned above, despite the existence of an opposition Syrian government and even a second recently declared self-government⁵⁰, local authorities in the form of local councils, religious authorities or armed groups –often represented by political and civil offices– manage the issues that concern their various areas of control with greater or lesser interaction and collaboration. Obviously the involvement of armed groups in any kind of public stewardship, though often invisible, is a concern for the neutrality and legality of the humanitarian response as it is considered to be high.

46 UNITED NATIONS SECURITY COUNCIL. Security Council Unanimously Adopts Resolution 2139 (2014) to Ease Aid Delivery to Syrians, Provide Relief from «Chilling Darkness», 2014.

47 RELIEFWEB. Fact Sheet: United Nations Cross-border Operations from Turkey to Syria (as of 31 Jan 2018). UN Office for the Coordination of Humanitarian Affairs, 2018.

48 DOBBINS, James; GORDON, Philip; MARTINI, Jeffrey. A Peace Plan for Syria II. Rand Corporation, 2016.

49 O'DRISCOLL, Dylan. Governance in Syria. K4D Helpdesk Report. University of Manchester, May 2017.

50 Syria opposition groups form new government in Idlib. Middle East Monitor, November 3, 2017.

In terms of local governance, the body most visibly respected by the people is that of the local councils, corresponding to the administrative legal framework – based on Legislative Decree 107– that existed prior to the conflict⁵¹. It is extremely difficult to get a clear picture of the make-up of the councils, the influences received, the allies they have made, their transparency and efficiency, their sources of funding and their ability to deliver. Even so, it is generally acknowledged that local councils are clearly involved in the provision and coordination of direct services, including health care.

Despite the existence of a system, INGOs, the UN and donors play a decisive role in the development of local governance through their control over flows of capital, knowledge, equipment and goods. However, while on the one hand they reinforce local capacity, on the other they create conflicts over access to resources, power and influence. Local actors, who benefit directly and indirectly, can distort the reality of the crisis in terms of needs and response in order to gain resources and power. As the external support actors are so diverse, a coherent and coordinated approach –within the region and also with the rest of the country where possible– in providing technical support to local governance actors is essential.

The health governance system in north-western Syria

The role of external actors is therefore essential in the governance of health care, as they finance it almost entirely⁵². In order to understand its complexity and resulting inefficiency, the following is a description of the actors that compose it –at local and international level– in which we outline the governance platforms that have been created in order to improve the efficiency of the response and face the changing challenges. We also discuss what it means to approach governance from different perspectives: from the domestic perspective comprised of the civilian sector –which is not always the same as the opposition– and the military side - which generally corresponds to the armed opposition– as well as the international perspective composed of the humanitarian response and efforts towards stabilisation.

The actors

These are the main actors responsible for health governance in north-western Syria. On the one hand, we have local and state health authorities, both with limited resources and capacity until European state donors start funding their governance bod-

⁵¹ ARAABI, Samer. *Syria's Decentralization Roadmap*. Carnegie Endowment for International Peace, 2017.

⁵² Interview no. 3. European humanitarian donor official, February 2018 in Gaziantep (Turkey).

ies as part of their stabilisation programmes. In parallel, we have the medical NGOs that also receive international resources from the early Syrian diaspora. For a few years these played the role of pseudo-authorities in terms of the provision of services, because the health authorities did not have the structure or know-how to absorb resources from international funding. While the Ministry of Health of the opposition government continues to face many of these limitations, the health directors of the governorates, as they are more operational due to the proximity and size of the entities and population to be covered, have seen their resources and capacity grow thanks to donors and their interaction with different expert organisations. As a result, and for reasons that reflect the evolution of the conflict and associated policies, local health directors do not respond or report to the Ministry, but rather to the guidelines of donors, most of whom are European⁵³.

Aside from the health authorities, there are still independent and autonomous medical facilities whose directors sometimes form part of local governance bodies, together with health authorities or local councils.

The WHO also plays an essential role in coordinating response at operational and institutional levels, and in raising and distributing funds. Its obligation as a UN agency to respect the sovereignty of states, while at times limiting, at other times results in a key actor playing the role of a nexus/bridge between the Syrian government and areas controlled by the opposition. But the health NGOs coordinated by WHO are both Syrian and international. The Syrians represent an unusual phenomenon in the panorama of humanitarian crises. Created and managed by the Syrian diaspora from both Western and neighbouring countries, they have been funded to respond to the crisis ever since the outset of the conflict. Nowadays, they still hold political power based on their considerable resource and implementation capabilities, and even the design of policies and strategies. While on the one hand, they have been reacting and taking risks from the outset, on the other, they respond to a clearly political profile –as they are the result of a political revolution– that sometimes calls into question their neutrality.

Finally, top of the list are the traditional donors - commonly belonging to European and North American governments and represented by their development and cooperation agencies. Secondly, the non-traditional donors, who, in the case of the Syrian crisis, generally come from the countries of the Arabian Gulf and are both private and confidential donors –the most obscure and difficult to follow– and institutional and visible donors who participate in large donor meetings.

Traditional donors clearly represent the foreign policies of the governments they represent. This does not always guarantee a neutral response as it is well known how many ‘western’ governments have positioned themselves vis-à-vis the Syrian govern-

⁵³ Interview no. 4. Head of a Syrian medical humanitarian NGO, February 2018 in Gaziantep (Turkey).

ment throughout the conflict⁵⁴. As for non-traditional donors, the phenomenon of a potential lack of neutrality is not eliminated. Transparency and coordination with traditional donors has increased, but it is still not total, so dysfunctionality is often generated by the lack of information generated by duplication and gaps. However, there are a number of private donors from Gulf countries (Qatar and Saudi Arabia mainly), who have continued to fund health programmes and other types of activities in support of the population and influential actors in northwest Syria⁵⁵. The lack of transparency of these donations has often made it difficult to identify duplication and has even generated mistrust leading to the discontinuation of support to health structures by international actors because of suspicions that non-neutral actors –non-traditional non-private & confidential donors– were funding them as this would go against donation principles and even raise concerns about anti-terrorist laws.

Governance platforms

At the same time, there are a number of governance bodies or platforms seeking to maximise coordination, inclusiveness and transparency.

On the one hand, there is the health working group organised by the WHO since 2014 (Syria Health Cluster Turkey Hub⁵⁶). This is the main platform in terms of legitimacy, credibility, coordination capacity, and political influence. It meets on a weekly or twice-weekly basis to give visibility to health needs and challenges, so that medical humanitarian stakeholders can coordinate their interventions, and to address issues of shared importance or to present relevant epidemiological information.

Although donor meetings are not exclusively focused on health, they can be considered as health governance platforms since they allocate exclusive time to address health issues. Finally, at national level there is the so-called Health Sector Strategic Advisory Group; for the ‘whole of Syria’⁵⁷, for the purpose of coordinating the different technical working groups of the different humanitarian coordination centres; for monitoring, evaluating and reviewing healthcare; and for developing the global health strategy for Syria. It is composed of a mix of members of the Syrian opposition Ministry of Health, national and international NGOs, UN agencies and donors.

⁵⁴ RANKIN, Jennifer. «EU at odds with Trump administration over Assad’s role in Syria». *The Guardian*. 3rd April, 2017.

⁵⁵ LUND, Aron. «How Assad’s Enemies Gave Up on the Syrian Opposition». The Century Foundation, vol. 17. 2017.

⁵⁶ *Health Cluster Turkey Hub*, 2018. Accessed at <https://www.humanitarianresponse.info/fr/operations/stima/health>.

⁵⁷ *Whole of Syria Health Cluster*, 2018. Accessed at <https://www.humanitarianresponse.info/en/operations/whole-of-syria/whole-syria-health-cluster-4w>.

In addition to the international platforms, there are the following local governance platforms. First, the Coordination Committee composed of all the Governorate Directors, focuses on designing and updating policies and protocols –always in coordination with Damascus as far as possible and with the mediation of the WHO offices in Gaziantep and Damascus– and establishes standard operational procedures, or coordinates the management of resources such as the establishment of fair salaries for health personnel. A platform run by local health directors, it has been gaining legitimacy as capacities have improved.

Second, there is the Health Authority composed of the health directors of the governorates controlled by the so-called opposition, and by the Minister of Health of the Syrian interim government, which represents an update for the latter. And thirdly, by way of an informal platform, there is a kind of health care oligopoly made up of the most powerful Syrian NGOs in terms of resources, capacity and seniority. They meet with greater or lesser frequency and sometimes end up having greater decision-making capacity than any other platform since they are the actors with the greatest reach, proximity, impact and knowledge. Increasingly, the most influential health directors work in coordination and/or play a role that counterbalances this so-called informal platform.

Various response approaches

Finally, we should point out that various approaches to medical humanitarian response –domestic (civil or military) and international (humanitarian or stabilisation)– coexist, interact with each other according to their interests and sometimes even overlap resulting in a certain systemic lack of functionality. Thus, the health governance system can be viewed from different perspectives.

- The governance approach to domestic and civil health represented by local health directors together with the local council and generally in collaboration with Syrian NGOs. Although they have gained independence, these actors often act with external partners who finance and advise them either in the humanitarian response arena (e.g. with INGOs or UN agencies) or in the stabilisation arena (e.g. with state development agencies and European donors).
- The domestic and military health governance approach represented by the civilian branches of armed groups, usually in conjunction with the local council and/or health directorate, acting independently. The reasons why the civilian branches of armed groups act alongside international actors –generally INGOs or even UN agencies– relate to gaining political legitimacy towards key actors in the conflict or the population under their territorial control⁵⁸.

58 MARTÍNEZ, José Ciro; ENG, Brent. «Stifling stateness: The Assad regime's campaign against rebel governance». *Security Dialogue*, vol. 49, n.º 4. 2018, pp. 235-253.

- The governance approach to international humanitarian health –represented by the WHO health working group, i.e. the UN and NGOs– focuses on responding to urgent, immediate needs arising from an ongoing humanitarian crisis. Although the vertical approach of certain INGOs may generate imbalances due to their unilateral nature, the UN and INGOs are generally coordinated and governed in conjunction with NGOs and local authorities as they depend on them entirely to access beneficiaries and understand their needs.
- The governance approach to international health stabilisation –represented by ‘Western’ donors– has, in parallel to a certain foreign policy outreach, as previously mentioned, a vision of reinforcing and stabilising governance structures such as the Board of Directors or the Coordination Committee through funding, training and advice. This approach somehow assumes that the crisis is coming to an end and that it is therefore time to stabilise in order to rebuild. Despite differences of opinion with respect to other more short-term approaches, there is interaction –and coordination– with local governance actors (local health directors, local councils and NGOs) and with international actors such as the UN and INGOs.

In terms of the dimensions of international governance, it is interesting to note that while some argue that the coexistence of the two is natural and a sign of a certain process of conflict evolution⁵⁹, others criticise the fact that, by focusing on stabilisation, immediate priorities are set aside to concentrate on a political agenda⁶⁰. The truth is that, although the dilemma of the usefulness of applying both approaches is more a question of seeing the glass as half full or half empty, health governance has witnessed certain misunderstandings and frustrations resulting from this systemic parallelism, which we will see shortly. Preventing them clearly involves maximising coordination between the different areas mentioned above.

In conclusion, while there are no health governance models applicable to humanitarian crises– surely due to the complexity of each of these –the case of the crisis in north-west Syria does not offer an ideal model. Like the political governance system, health governance is complex and dysfunctional as a result of the diversity of actors with varying interests (the stance of the international powers, territorial control on the part of the various Syrian parties to the conflict, centralisation and the monopolisation of resources and influence and assistance to the population). These interact to a greater or lesser extent through different governance platforms, formal and informal, which strive to collaborate rather than compete. The multiplicity of actors and governance platforms can be seen through the different approaches to health care, defined according to the type of actors involved and their objectives and interests. The result is again a dysfunctional system in which, in parallel, the medical humanitarian response

⁵⁹ Interview no. 4. Head of the Syrian medical-humanitarian NGO, February 2018 in Gaziantep (Turkey).

⁶⁰ MUGGAH, Robert (ed.). «Stabilization operations, security and development: States of fragility». Routledge, 2013.

is approached from different angles according to different interests –usually political – and in which the population’s right to health is not always prioritised.

The dysfunctionalities of governance and its impact on health

In order to understand the dysfunctionalities of the health governance system in north-western Syria, we will refer again to the functions envisaged by the WHO for a healthy and efficient governance system. We will also add a malfunction briefly mentioned above, which has to do with the phenomenon of ‘anti-terrorism’.

The strategic management of public health

The strategic management of public health has been affected mainly by the political instability that has caused the collapse of the bodies responsible for it. Despite the creation of new institutions, these have limited strategic capacity and are framed within a system of humanitarian governance rather than public health, which continues to hinder comprehensive strategic management. The public health strategy is constantly hindered by funding problems, the multiplicity of actors wanting to do – or not do – the same thing, and the difficulty of making the minimally designed strategies operational either because of their lack of coherence with respect to strategies that existed in the past, the lack of access or because of the lack of legitimacy and credibility of the authorities in charge of their implementation.

On the other hand, the fact that donors initially funded health care through NGOs rather than (pseudo) public agencies prevented the development of strategic health management with a public focus. In this sense, this dysfunctionality is accentuated *a priori* by the fact that the opposition Ministry of Health is barely financed, and therefore there is no health authority in charge of proper strategic management, but rather several health directors who design strategies for their respective governorates. Moreover, it is worth noting that the majority of health personnel who have ended up in public (or pseudo-public) positions were formerly practitioners and not public health managers or administrators, which again undermines the capacity to design and oversee the strategic management of health⁶¹.

Undesirable trends and distortions

While undesirable trends and distortions have been detected in the public health system thanks to the data collection, analysis, and coordination systems established

61 Interview no. 1. WHO Official A, February 2018 in Gaziantep (Turkey).

by WHO and other agencies, there is a problem with their prevention and correction. Once again, this is due to the difficulty of making a health system work properly in a region of armed conflict. Two of the most relevant distortions would be the low vaccination coverage and the constant attacks on medical facilities⁶².

Another distortion would be the fact that the maintenance and reconstruction of the system has been oriented more towards a hospital-based approach, although geographically decentralised to maximise access, but not decentralised in terms of service provision. That is, many small hospitals, but without the full range of services, especially primary health care. This is explained by the lack of resources, the need to maximise services that seemed to be of greater need (secondary health), and the profile of specialised practitioners among the medical staff in charge of these structures⁶³.

The regulation of funding and the provision of services

The regulation of funding is an arduous task when there are not enough resources, nor total coordination and transparency in relation to their origin and destination. As in any crisis, the fight to secure funding is constant throughout the year, and the appropriateness of its allocation is by no means self-evident⁶⁴. Furthermore, despite the regular meetings of major donors, attended by both traditional and non-traditional donors, it is not uncommon for traditional donors to experience difficulties in coordinating and monitoring funds, especially non-traditional ones⁶⁵. Besides, in the absence of a collection system, funding is provided by international agencies such as the UN, development and humanitarian offices and donors. These often reflect political agendas, which complicates the coordination of their plans and coherence in the governance of the system⁶⁶.

Regulating the provision of relevant, orderly, constant/sustainable and acceptable quality services is almost impossible without access and proximity. Such a model entails reporting defects and hence potentially erroneous diagnoses. A good example is the inadequate functioning of epidemiological monitoring. At the height of the mea-

62 Interview no. 5. Head of the international medical humanitarian NGO, February 2018, in Gaziantep (Turkey).

63 Interview no. 5. Head of international medical-humanitarian NGO, February 2018 in Gaziantep (Turkey).

64 EUROPEAN COUNCIL. «Supporting the future of Syria and the region». Brussels conference, 24-25/04/2018.

65 Interview no. 3. Official of a European humanitarian donor, February 2018 in Gaziantep (Turkey).

66 Interview no. 5. Head of international medical-humanitarian NGO, February 2018 in Gaziantep (Turkey).

sles epidemic in March 2018 in Idlib and Aleppo, instead of reporting cases identified according to the specific structure and the origin of patients, the report was restricted to the locality - where there is usually more than one medical unit. Thus vital accuracy in the analysis of the origin of the epidemic was lost and consequently in the efficiency of the response⁶⁷.

Another interesting example of disruption in the provision of services affecting governance occurs in areas controlled by armed groups considered to be terrorists. There, medical structures have been used for military purposes on more than one occasion by armed groups, thus violating the integrity of the medical mission and in turn that of IHL. This resulted in a break in the provision of services, both at the time and *a posteriori*, either out of fear of patients or staff, or because of a possible cessation of funding by donors who do not wish to finance activities in territory controlled by armed groups that are classified as terrorists⁶⁸.

Terrorism and health care in north-western Syria

This example allows us to open a parenthesis in which to deal with a subject that is very present in the humanitarian response in north-western Syria: anti-terrorist policy. In recent decades, an international policy perspective has developed that defines health and humanitarian aid in crises as security issues⁶⁹. This has challenged the ethos of human rights and IHL –politicising it– and influenced the way in which states, and therefore international organisations and non-state actors, understand governance in times of crisis, often directing it to prioritise responding to alleged security threats rather than humanitarian needs⁷⁰.

Thus, in north-western Syria there is concern about assisting people in territory controlled by terrorist groups, and some wonder if this is not replacing humanitarian logic. Donors are obviously not comfortable with funding projects in environments controlled by terrorist groups. While in every crisis there is a price to pay for assisting the public, be they warlords or corrupt governments, the current anti-terrorist environment raises greater doubts about the issue, as there is talk of criminal consequences⁷¹.

67 Interview no. 5. Head of international medical-humanitarian NGO, February 2018 in Gaziantep (Turkey).

68 Interview no. 1. Official A of the WHO, February 2018 in Gaziantep (Turkey).

69 WHITTALL, Jonathan. «The Politics of Health in Counterterrorism Operations». *Website MSF Analysis, Reflections on humanitarian action*, 2018.

70 FIDLER, David P. «Governing catastrophes: security, health and humanitarian assistance». *International Review of the Red Cross*, vol. 89, no. 866. 2007, pp. 247-270.

71 PANTULIANO, Sara, MACKINTOSH, Kate, ELHAWARY, Samir, *et al.* «Counter-terrorism and humanitarian action». *Policy*, 2011.

In view of this, it is important that the right to health and the guarantee of the right to war should prevail over the international anti-terrorist agenda. To this end, IHL in Article 3 common to the four Geneva Conventions applies the term «party to the conflict» to non-state armed groups and obliges them to respect fundamental humanitarian guarantees. In this way it creates space for humanitarian actors assisting populations in areas controlled by these groups to be under the protection of the law by dealing with a party to the conflict and not with a terrorist group⁷². Thus, anti-terrorist concerns should avoid impeding humanitarian assistance, which is always protected under international law.

Mechanisms of accountability

In terms of accountability mechanisms, the authorities and institutions responsible for the design and implementation of public health strategies for north-western Syria are accountable to each other – though apparently not in the best possible way. But there are still a couple of elements that guarantee minimal standards for this accountability: on the one hand, the possibility of accessing the beneficiary's opinion in terms of satisfaction, and on the other, greater capacity to verify the quality of medical activities⁷³.

This analysis indicates that, in the case of north-western Syria, despite the coordination and governance programmes that both donors and multilateral institutions have developed with such commitment together with key Syrian actors, the health governance system does not achieve the expected efficiency due to the difficulties mentioned. The conflict and its political weight impede the necessary transparency and coordination. As a result, it does not contribute to improved availability, access, quality of services and accountability to beneficiaries, including millions of displaced persons in critical situations⁷⁴. Ultimately, the right to health is not achieved in its entirety.

Conclusions

In the northwest (and a large part) of Syria the right to health is not respected and is frequently and severely violated. On the one hand, if the right to health is to be guar-

72 BOUCHET-SAULNIER, Françoise. Le consentement à l'accès humanitaire : une obligation déclenchée par le contrôle du territoire et non par les droits de l'État. *International Review of the Red Cross*, Volume 96, French selection, 2014/1.

73 Interview no. 5. Head of the international medical humanitarian NGO, February 2018 in Gaziantep (Turkey).

74 AKBARZADA, Sumaira; MACKEY, Tim K. «The Syrian public health and humanitarian crisis: A 'displacement' in global governance?». *Global public health*, vol. 13, no. 7. 2018, pp. 914-930.

anted as a human right, it must be impartial, fair and inclusive. For this to happen, the following requirements must be met: availability, accessibility and quality of health services, as well as the existence of accountability mechanisms. Unfortunately, this is not the case. On the other hand, within the framework of IHL, the right to health consists of three main elements: assistance, protection and respect for the principles of distinction and proportionality. But the constant attacks on medical infrastructures, the sieges and the denial of humanitarian access, demolish these elements. While IHL violations are a direct consequence of the armed conflict, the lack of respect for the right to health as a human right is further explained by governance problems which are both quantitative – lack of adequate bodies – and qualitative – lack of quality of the existing bodies in terms of efficiency and coordination. This leaves millions of people particularly vulnerable and especially the displaced, who suffer exacerbated consequences arising from the conflict.

Thus, the Syrian crisis is a very relevant case to examine not only because of its sad and evident violation and lack of respect for the right to health, but also because of the special nature of the medical humanitarian response model based on the UNSC resolution of border crossing, and its resulting health governance system.

Whereas, according to the WHO, governance in the health sector refers to a wide range of functions related to the management and standard-setting of health policy issues leading to universal health coverage, in humanitarian crisis situations these functions are deficient. This is the case in the crisis-ridden north-west of Syria, where, in keeping with the absence of standard and optimal models of health governance in humanitarian crises, no formula has emerged capable of developing a model that would guarantee efficient health governance.

That said, health governance in north-western Syria is a projection of the socio-political system of conflict governance that has developed throughout the conflict. As such, its complexity lies in the diversity of actors with different interests who interact to a greater or lesser extent through different platforms and within each of the different perspectives according to their own particular interests. These interests and their resulting heavy political burden all contribute to a series of system failures that impede the achievement of the expected efficiency according to WHO criteria; a lack of strategic leadership for efficient public health, an inability to correct undesirable trends and distortions in the health system, a lack of transparency and coordination in the regulation of the provision of funds and services, and a lack of effective accountability mechanisms. Although in terms of resources, actors and platforms, the health governance system is sound in theory; in practice political tensions as well as the omnipresent direct consequences of conflict undermine this robust framework. As a result, it does not contribute to improved availability, access, quality of services and accountability to beneficiaries, including millions of displaced persons in critical situations. Ultimately, the right to health is not fully achievable.

While political-military and socio-political instability is a key destabilising factor and the main cause of human rights violations, health governance in north-western Syria is somewhat dysfunctional and therefore unable to guarantee the right to health.

In times of conflict and with such high levels of violence, it is almost impossible to maintain robust and capable governance. Thus, on the one hand, for the violations of IHL and the right to health as a human right to cease, it would be necessary for the conflict to cease. On the other hand, a solid governance system with the necessary number of structures/agencies capable of effectively, transparently and inclusively coordinating health care would address the right to health compliance gaps and contribute to guaranteeing the right to health for the most vulnerable population in the conflict, and especially for displaced persons.

Recommendations

Finally, the following recommendations are proposed to the stakeholders who play a key role in the governance of the medical-health response and in guaranteeing the right to health.

To donors and implementing organisations for better governance in healthcare:

- Maintain levels of investment in both the response and the governance bodies, developing parallel and coordinated strategies capable of fostering governance while responding to immediate needs, and devoting resources to local capacity development.
- More control mechanisms for sending and using resources to avoid the damages in terms of corruption and legal dilemmas caused by a wartime economy.
- Greater attention to the displaced and most vulnerable members of the population, especially in the area of access to primary and preventive health (vaccines) and in secondary health (reproductive health, mental health and infectious diseases).
- Governance platforms should try to distance themselves as far as possible from political issues that do not prioritise and focus attention on public health. They must also maximise coordination among themselves, and with the platforms of other operational centres and the 'Whole of Syria'.
- Maximise the channelling of resources through health authorities in order to strengthen the governance and response bodies that should and must guarantee the fulfilment of the right to health.
- Maintain a careful balance between the energy focused on responding to immediate health needs and the attention given to anti-terrorist concerns.

To the warring parties and neighbouring countries to increase respect for and compliance with the right to health:

- Awareness, knowledge and respect for international law, specifically IHL and human rights, and especially the neutrality and impartiality essential for assisting the people.
- Understanding that access and proximity to the patient is essential for quality healthcare operations, and therefore prioritising and enabling it.

- Facilitating coordination between the different stakeholders, be they humanitarian or political-administrative professionals.

While war is obviously a factor that impedes health governance and the guarantee of the right to health, there is room for improvement at the hands of donors, practitioners and policymakers. Although limited in their ability to prevent violations of IHL and the rights that are a direct consequence of armed conflict, these stakeholders could increase the efficiency and effectiveness of governance and therefore the right to health and its fulfilment: impartial, fair and inclusive health care.

Annexes

Annex. 1. Aspects of the non-structured interviews

In the context of preparing a paper that the author presented in March 2018 as part of a Panel on the Migration Crisis in the Mediterranean, for the 9th Conference on Global Health, held at Columbia University in New York and organised by the Consortium of Universities for Global Health (CUGH), in February 2018 the author conducted five interviews with specialists in public health and humanitarian aid, working at that time on the response to the crisis in north-western Syria for donors, United Nations agencies and NGOs.

The interviews were conducted in an unstructured and confidential manner, given the political and sensitive nature of the content of the questions and answers provided. The aim of these interviews was, together with these specialists, to analyse the situation concerning the fulfilment of the right to health –seen from various perspectives– and the impact of the political toll of the Syrian conflict, both local and international, on the work of each of the interviewees and on the regional medical humanitarian response. The interviewees were previously made aware that the information discussed would have an academic purpose with conversations centering on the perception and lack of respect for the right to health, as well as on the shortcomings and political weight of the health governance system in northwestern Syria.

1. Interview no.1. WHO Official A , February 2018 in Gaziantep (Turkey).
2. Interview no. 2. UNFPA Official B , February 2018 in Gaziantep (Turkey).
3. Interview no. 3. Official from a European humanitarian donor, February 2018 in Gaziantep (Turkey).
4. Interview no. 4. Head of a Syrian medical humanitarian NGO, February 2018 in Gaziantep (Turkey).
5. Interview no. 5. Head of an international medical humanitarian NGO, February 2018 in Gaziantep (Turkey).

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