INDEPENDENT HEALTH-POLICY RESEARCH

Syrian National Health Reform Strategy
2027–2035

VOLUME IV

Primary Healthcare Reform

Rebuilding the foundation of universal, integrated and people-centered care

Dr. Sami Aita, MD
Briefing deck · Independent research edition

Aita Consulting
November 2026

OPEN IS NOT THE SAME AS WORKING

Fewer than one in three public health centers is fully functional

1,728
public health centers in Syria

513
fully functional (30%)

599
partially functional (35%)

616
not functioning (36%)

Source: WHO Syria, HeRAMS data, Q3 2025 (December 2025).

A facility may be nominally open yet lack medicines, trained staff or opening hours. Coverage should be measured by **availability, use, quality and affordability**, not by the number of facilities open.

THE STRATEGIC PROPOSITION

Primary care as the organizing foundation of universal health protection

A progressive shift from facility-centered, episodic services to a population-based model: accessible teams accountable for defined communities, delivering a standard essential package, following patients over time and coordinating referrals.

01

Universal essential PHC

A defined entitlement with standards for availability, quality and financial protection.

02

Population-based care

Catchment planning, flexible registration and continuity of care.

03

Integrated clinical delivery

Multidisciplinary teams, prevention, chronic care, mental health, referral.

04

Workforce and infrastructure

Rehabilitation tied to staff, medicines and readiness, not buildings alone.

05

Sustainable financing

Predominantly public financing; payment that rewards access and quality.

06

Digital and measurement

Longitudinal records, interoperability and transparent indicators.

MEASURING WHAT MATTERS

From facility availability to effective coverage

Facility
Exists and is reachable

→

Readiness
Staff, medicines, tools

→

Access
Affordable and inclusive

→

Quality
Safe and appropriate

→

Continuity
Follow-up and referral

A functioning building alone does not guarantee effective care.

SIX DIMENSIONS OF A NATIONAL DIAGNOSIS

Population and access

Catchments, travel time, displacement, use, affordability, unmet need

Facility readiness

Buildings, power, water, infection control, equipment, diagnostics, medicines

Clinical services

Services actually delivered, opening hours, protocols, referral, follow-up

Workforce

Staff by cadre and location, competencies, vacancies, retention, supervision

Financing and purchasing

Public budgets, donor support, household payments, contracting

Information and governance

Facility registry, reporting quality, supervision, partner coordination

THE PROPOSED NETWORK

A network, not a collection of buildings

Level	Proposed role	Core requirements
Community and outreach	Community health workers, mobile outreach, home visits, targeted prevention	Supervision, referral criteria, reporting, follow-up
First-contact PHC team	Routine and acute care, prevention, mother and child services, chronic care	Named clinical lead, essential medicines, basic diagnostics, records
Network coordination hub	Clinical support, enhanced diagnostics, training, quality review, referral coordination	Shared protocols, escalation channels, information exchange

Functional roles, not new building categories: existing public, private and NGO facilities can perform them if accredited and contractually integrated.

A CLEAR PROMISE

An essential package, introduced in tiers

1. **Tier A — immediately essential**
   Urgent triage, common acute care, immunization, maternal and child priorities, essential medicines and referral

2. **Tier B — standardized longitudinal care**
   Chronic disease registries and follow-up, risk-factor management, scheduled prevention, mental health

3. **Tier C — network-enhanced services**
   Expanded diagnostics, rehabilitation and specialist outreach as workforce and funding permit

Each entitlement needs a delivery standard, an accountable provider, a financing source and a monitoring indicator. The package should not promise what cannot be funded, staffed or delivered safely.

CONTINUITY OF CARE

A team that knows its patients

- **Registration** is a tool for follow-up and planning, never a condition for emergency care
- **Health identifier** aligned with Volume III, with safe provisional records
- **Choice:** a transparent way to select or change a regular team
- **Family medicine** built from today's GPs through structured upskilling
- **Longitudinal pathways** for diabetes and hypertension, from screening to specialist referral
- **Community health workers** tracing missed vaccinations and interrupted treatment
- **Records** that work with intermittent connectivity
- **DHIS2** for monitoring, not as the national patient record

INTEGRATED REFERRAL

Referral as a closed-loop clinical process

PHC assessment
Clinical indication
→
Referral
Urgency and transfer
→
Receiving service
Specialist or hospital
→
Feedback
Results or discharge
→
PHC follow-up
Reconciled care plan

Pathway	Operating principle
Emergency	Immediate stabilization and direct transfer; no gatekeeping delay
Urgent specialist	Time-bound escalation using explicit red-flag criteria
Routine specialist	Structured request with the clinical question, relevant history and results
Diagnostics and rehabilitation	Order tracking, result return and integration into the PHC care plan
Hospital discharge to PHC	Summary, medicines reconciliation, follow-up appointment

RESOURCES AND ENABLING SYSTEMS

Buildings alone do not deliver healthcare

Workforce

A verified inventory of staff by cadre and location; competency-based transition to family medicine; retention through predictable pay, safe workplaces and rural support.

Infrastructure

Refurbishment authorized only against an agreed service profile and a recurrent operating plan; maintenance funded from the start.

Medicines and diagnostics

Essential formulary, transparent procurement, stock monitoring, specimen transport and result turnaround standards.

Digital PHC

The clinical record supports care; national shared services enable exchange; DHIS2 supports selected monitoring.

FINANCING AND PAYMENT

Pay for access, continuity and quality

Mechanism	Potential role	Risk and mitigation
Line-item or input budget	Early stabilization and essential fixed costs	May reward inputs; add readiness review
Risk-adjusted capitation	Population responsibility and continuity	Under-service; protect access and quality
Targeted fee or case payment	Specified services or diagnostics	Volume incentives; limits and audit
Quality-linked component	Verified improvement and reporting	Gaming; balanced indicators, equity safeguards

A transitional blend keeps a stable operating budget while gradually adding population-based and quality-linked payments, piloted before scale. Consistent with Volume II.

ON THE COMMON PATH TO 2035

Evidence-based gates, not a nationwide rollout

2027
BASELINE

Facility mapping, workforce and medicine readiness, urgent service restoration

Gate: Reliable baseline

2027–28
DESIGN

Package specification, governance, costing, referral standards, PHC digital blueprint

Gate: Pilot protocols, funded inputs

2028–30
PILOT

Urban, rural and high-vulnerability pilot networks; clinical and financial evaluation

Gate: Safety and feasibility shown

2030–33
EXPAND

Expand accredited networks, workforce training and digital exchange

Gate: Verified readiness, equitable gains

2033–35
CONSOLIDATE

Outcome improvement, payment refinement, quality benchmarking

Gate: Sustained performance

Planning windows, not commitments validated by government.

STRATEGIC RISKS

What could go wrong, and how to guard against it

Risk	Potential consequence	Mitigation
Insufficient recurrent funding	Facilities reopen but cannot sustain services	Multi-year operating envelopes, phased commitments
Workforce shortages and migration	Lower quality, geographic inequity	Training pathways, supervision, retention incentives
Medicine supply disruption	Interrupted essential treatment	Tracer stock monitoring, diversified procurement
Exclusion of vulnerable groups	Nominal coverage without access	Outreach, provisional registration, equity audits
Donor transition shocks	Service interruption when grants end	Sustainability plans, budget integration

THE AITA CONSULTING RESEARCH SERIES

The NHRS series

I — Volume I — Strategic Architecture
Vision, system functions, governance, financing and the transformation sequence

II — Volume II — Health Insurance Reform
Universal health protection, pooling, the essential package and strategic purchasing

III — Volume III — Digital Health Transformation
Health information architecture, the health number, interoperability and data governance

IV — Volume IV — Primary Healthcare Reform
Frontline services, population-based care, referral networks and primary care performance

Four volumes, one common path to 2035. Each can be read alone; together they set out one direction and the order in which to travel it.

Full volumes available under license, in English and Arabic

Single copies, organization licenses and executive briefings.

LICENSING AND BRIEFINGS

info@aitaconsultingsy.com

+963 952 600 716

aitaconsultingsy.com

Independent research based on public sources. Not an official policy of the Ministry of Health or any public institution.