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Public health in the Arab World: At a crossroads

The Arab World refers to the 22 countries of the Arab League and, arguably, also to communities that identify with it (migrants residing in other regions). Despite long use in History, Political Science, and Economics, the term is not commonly used in international health literature and statistics where the terms 'Middle East and North Africa' or 'Eastern Mediterranean' are in wider use. As these do not include all Arab countries, approaching the Arab World as a *unit of analysis* becomes a new domain for public health scholarship.¹

The region is markedly diverse and inhomogeneous; its characteristics have profound implications for health status and public health. These include countries with the highest and lowest GDP per capita in the world:² Qatar, Kuwait, and United Arab Emirates rank 2nd, 5th and 10th, respectively, whereas Comoros ranks 176th and Somalia is suspected to be at the bottom. The population has more than tripled since 1970, to over 354 million, although growth and fertility rates have been falling. The region is youthful with 31 per cent of the population under the age of 15 and over 50 per cent under 25 years of age. About 57 per cent live in urban areas, including an estimated 43 million slum dwellers. Estimates of poverty vary considerably but exceed 50 per cent in the poorest countries and in some countries engaged in active conflict. Demand for natural resources (water, food, and energy), or ecological footprint, average twice the available resources, or biocapacity.³ This gap is the worst in the world,

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thereby raising a challenge of sustainability, especially under climate change. Water and food insecurity, and drought-related population migration continue to be immediate concerns.

Despite high incomes from energy and trickle effects to non-carbon economies, overall economic performance has been disappointing, and typically volatile, with fluctuating global energy prices and political instability. This situation has created a challenge in job creation. Women's labor participation rate is the lowest in the world. The region struggles with substantial foreign interventions and influence, oppressive political systems, poor governance, and low quality of institutions. Inequalities, exclusion, and non-participation have undoubtedly contributed to recent uprisings.

Multidisciplinary and historical perspectives of development of the post-colonial Arab state and societies, building on what we have already introduced, are needed to illuminate our understanding of public health as a field, of population health indicators, and of determinants of health and health inequities. Development indicators illustrate substantial improvements: between 1970 and 2010, life expectancy increased from 51 years to almost 70, the largest gain among world regions.⁴ Five countries (Oman, Saudi Arabia, Tunisia, Algeria, and Morocco) ranked among the top ten world leaders in development gains, mostly due to achievements in health and education. This reflects major social investments of both republics and monarchies in the second half of the twentieth century. Many of these have been rolled back under neoliberal reforms since the 1990s.

Despite incomplete mortality and poor morbidity data, important health inequalities have been documented. Between-country inequalities are profound: Life expectancy ranges from 50 and 57.1 years in Somalia and Sudan to 78.2 and 81.5 in Qatar and Lebanon, respectively.⁵ Maternal mortality ratio, per 100 000 live births, ranges from 1044 and 1107 in Somalia and Sudan, respectively, to fewer than 15 per 100 000 live births in several Gulf countries. Under-5 mortality ranges over 20-fold from 8.5 per 100 000 live births in Qatar to 180 in Somalia. Within-country health inequalities are also widespread. Measles immunization among 1-year-olds increases considerably from the poorest one-fifth to the wealthiest, from 51 per cent to 86 per cent in Comoros and from 42 per cent to 86 per cent in Mauritania, respectively.⁵

The epidemiological profile varies across countries. Non-communicable diseases (NCD) have become dominant causes of mortality causing more than 50 per cent of deaths, at least a third of which are premature, occurring before the age of 70. This decade, the region will see the second largest increase in NCD deaths (15 per cent) after Africa. This situation does not only merely reflect increasing 'affluence' but also poor political and socioeconomic development choices that are contributing to a risk profile of high tobacco use (of both cigarette and waterpipe), increasing calorie consumption, and decreasing

physical activity. Today, 3 of the top 20 countries with highest prevalence of overweight or obesity and 4 out of the top 10 countries in the world with the highest prevalence of diabetes are in this region.⁶

Even as NCDs burden people and economies, Type 1 conditions (infectious diseases, maternal and child conditions, and malnutrition and related disorders) remain uncontrolled, referred to as a 'double disease burden'. These conditions disproportionately afflict poorer countries, the most disadvantaged in all countries, and populations in conflict. For example, among children under 5 years of age, 57.7 per cent had stunting in Yemen and 21 per cent had wasting in Sudan.

War, occupation, sanctions, civil strife, and insecurities are key determinants of health status and of health system (mal)functioning as many countries are in active or post conflict or suffer instability. This region has the largest number of refugees and of internally displaced and stateless people in the world and the numbers are swelling – even if underestimated by international statistics.⁷

Public health and health systems have progressed but suffer important limitations.^{8–10} Some commentators have questioned use of 'systems' to describe the fragmented structures in place today. Activities to reduce health inequities are not a visible priority. Even in well-endowed health systems in high-income countries, coverage for migrants is inadequate. Work on social determinants, from human rights to trade policies to environmental engineering, is either in infancy or not at all part of health system mandates. The health-in-all-policies approach to health promotion has not taken root – or perhaps not even been planted across the region.

Funding for public health and health systems is insufficient in low- and middle-income countries, and critically so in the first where total annual health expenditure per capita is under US\$50, clearly inadequate to meet basic population needs. This makes universal health coverage a distant goal. Much of this funding goes to curative care with limited funding for core public health functions. Out-of-pocket health expenditures average 57 per cent and 42 per cent in low- and middle-income countries, respectively, raising the risk of impoverishment.

Several low-income countries are in a 'human resources for health crisis', with low density of physicians, nurses, and midwives (near or below 1 per 1000 population). Health systems have built reasonable, although variable, curative services but concerns regarding variable access to, and quality of, care remain. Many countries have large primary care networks. However, these commonly lack the Alma Ata primary *health* care emphasis on social development and community mobilization. Responsiveness to population needs challenges current health systems; systems built during an era of high burden of Type 1 conditions are slow to adapt to the rise of NCDs, and despite chronic conflicts and recurrent emergencies, preparedness and response strategies are not well developed.

Data about the public health workforce are very limited reflecting inadequate attention. Much of public health education remains biomedical in nature. There are fewer than 10 independent/stand-alone graduate schools of public health, only one of which in the entire region offers a doctoral program. Thus, public health is weak, both in institutional capacity and human resources, undermining its leadership potential.

In addressing these challenges, and responding to the dramatic changes that have engulfed the region in the past 2 years, public health stands at a crossroads today. The first path continues the current trajectory but progress may be slow and piecemeal. On the second path, public health acquires a stronger sense of its ethos and mission and seeks to enact change purposefully. Working with other social forces, public health professionals lay the foundation for a new vision for public health in this region based on the values of justice, ethics, and joint responsibility. Thus, a new public health for the Arab World is comprehensive with a population health lens and prioritizes work on determinants and equity. It contributes to strengthening public health nationally but promotes currently weak cross-country work based on regional solidarity and shared destiny. This is the challenge for public health if it is to meet the aspirations that have motivated the unspeakable sacrifices of Arab uprisings and of peoples in other countries.

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