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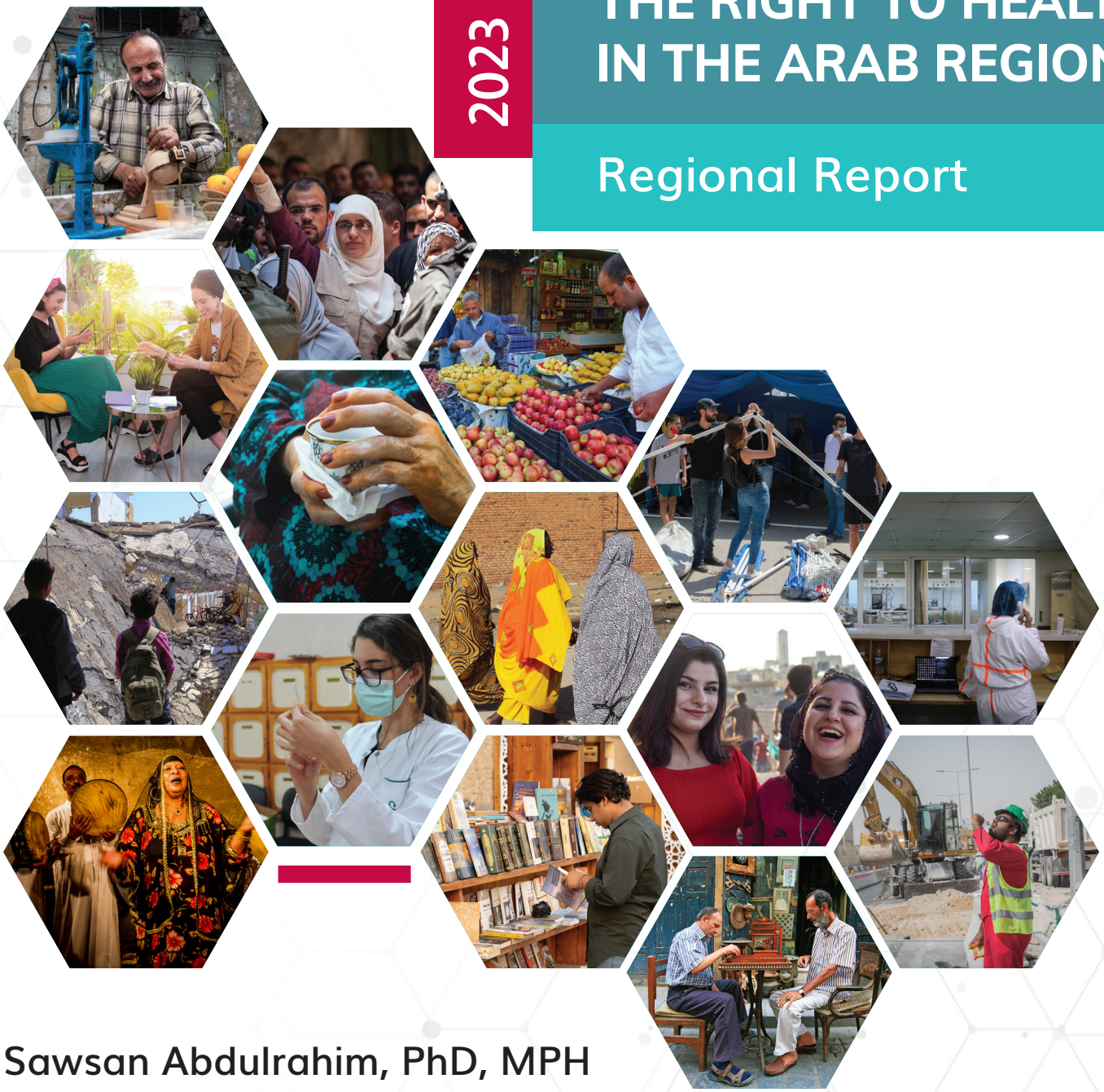
PROMOTING THE RIGHT TO HEALTH IN THE ARAB REGION

2023

Regional Report



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This report is published as part of the Arab NGO Network for Development's Arab Watch Report on Economic and Social Rights (AWR) series. The AWR is a periodic publication by the Network and each edition focuses on a specific right and on the national, regional and international policies and factors that lead to its violation. The AWR is developed through a participatory process which brings together relevant stakeholders, including civil society, experts in the field, academics, and representatives from the government in each of the countries represented in the report, as a means of increasing ownership among them and ensuring its localization and relevance to the context.

This 6th edition of the AWR focuses on the Right to Health. The AWR 2023 on the Right to Health is a collaboration between the Arab NGO Network for Development and the Faculty of Health Sciences at the American University of Beirut. Through this report we aim to provide a comprehensive and critical analysis of the status of the Right to Health in the region and prospects in a post COVID-19 era. It is hoped that the information and analysis presented in this report will serve as a platform to advocate for the realization of the right to health for all.

The report is published by the **Arab NGO Network for Development** (ANND). It can be obtained from ANND or can be downloaded from the following website: **http://www.annd.org**

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Regional Report

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Sawsan Abdulrahim is Professor of Public Health in the Faculty of Health Sciences at the American University of Beirut. Her research centers human rights principles to illuminate social inequities in health across the life course, with a focus on the wellbeing of refugees and labor migrants in the Arab region and beyond. Abdulrahim's substantive areas of interest include gender, migration, and health; aging and care; and the wellbeing of women migrant care workers.

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INTRODUCTION

The right to health is codified in numerous international conventions such as the Constitution of the World Health Organization (WHO 1946), the International Covenant on Economic, Social, and Cultural Rights (ICESCR 1966), and the Alma-Ata Declaration on primary healthcare (Declaration of Alma-Ata 1978; Appendix A). It is also recognized in the sustainable development goals (SDGs). In the Arab region, with increasing attention by governments and WHO to achieving universal health coverage (UHC), the right to health continues to be understood narrowly as the right to access healthcare services. The concept of the right to health, however, is much broader and demands integrating human rights-based approaches and linking health with an agenda of eliminating social inequities and achieving justice. Thus, moving the discourse in the region from its focus on healthcare services to recognizing health as a fundamental human right is a major challenge that this sixth Arab Watch Report (AWR-2023) sought to address. Dedicated to the right to health, the AWR-2023 on economic and social rights is a collaboration between the Arab NGO Network for Development (ANND) and the Faculty of Health Sciences at the American University of Beirut (FHS-AUB).

In addition to this regional paper, the AWR-2023 on the right to health includes a set of national papers on Morocco, Tunisia, Mauritania, Egypt, Sudan, Yemen, Palestine, Lebanon, Jordan, Syria, and Iraq. The report also includes thematic papers on neoliberalism, social protection, and COVID-19, and a case study on climate change in Kuwait. The papers, collectively, provide a comprehensive review of the status of the right to health in the region and highlight critical challenges and gaps. Whilst each national paper uniquely reflects the health situation in the country it represents, all papers were developed through a systematic methodology and a collaborative process to address health through a rights lens and to engage with its economic and political determinants.

The methodology followed in national papers was guided by a 2008 evaluation of right to health features of health systems in 194 countries (Backman et al. 2008). The evaluation examined a broad range of criteria related to health through the lens of equity and rights (Appendix B). In addition to the availability of healthcare services, the evaluation addressed the right to

access the determinants of health such as sanitation services, education, housing, and health related information. It further assessed whether a health system includes a national plan to monitor the progressive realization of the right to health and whether this system monitors non-discrimination and community participation. Non-discrimination in the distribution of health resources is a core obligation that is not subject to progressive realization as it implies equitable distribution even when resources are limited.

Working on the AWR-2023 commenced on the heels of the COVID-19 pandemic and at a time when the Arab region was facing enormous economic challenges and protracted civil wars and mass displacements, a context that will bear negatively on achieving the right to health for the majority of the region's 430 million inhabitants in the coming years. The impact of COVID-19 and the ways in which it uncovered inefficient health systems and weak social protection mechanisms is a theme that runs through all papers in the report and that is summarized as a theme in this regional paper. Although COVID-19 is a transient crisis, as infection rates have waned globally, it was a critical moment that exposed the ills of inequitable economic policies, absence of sufficient social protection mechanisms, and inefficient health systems in many countries in the region including high income ones. Under the weight of an expanding neoliberal global economic system and weak health governance structures in Arab countries, realizing the right to health for large segments of the Arab population may remain elusive in a post COVID-19 era.

The AWR-2023 is a political intervention that utilizes the right to health as an entry point to claiming other fundamental social, economic, and political rights. The prominence of health in demands for freedom and justice in the Arab region lies in the fact that violating the right to health impairs attaining other rights. As eloquently stated by one of the AWR-2023's advisory board members in one of the meetings, "violating the right to health is violating the right to life." It is hoped that the analytical summary presented in this regional paper, and the information and evidence expounded on in national and thematic papers in the report, will serve as a platform for civil society groups and activists to advocate for the realization of the right to health in their own countries and the region as a whole. In heading the call to achieve "health for all by all," advocates should prod Arab states to take steps to realize the right to heath for all citizens and non-citizen migrants and refugees within their national borders.

This regional paper provides a theoretical base and a synthesis of evidence delineated in the AWR-2023 papers. It begins with a review of the meaning of the right to health, the historical events that contributed to its rise and transformation, and the connections between the right to health and other rights and entitlements. The second section in the paper presents a sketch of the political economy of the Arab region and the ways in which policies facilitate or impede achieving the right to health. The third and main section in the paper synthesizes the information and evidence presented in national and thematic papers, and the case study, under six cross-cutting themes: state recognition of the right to health versus realities on the ground; health system governance and neoliberalism; the right to health in a COVID-19 era; the impact of war, occupation, and displacement; and climate change. The themes were developed through a careful reading of early drafts of the papers and discussions during two meetings that brought together authors and ANND advisory board members. A seventh theme in this section summarizes a few critical issues that bear on the right to health in the region but that were not sufficiently highlighted in national papers. The report concludes with policy recommendations.

THE RIGHT TO HEALTH: A HISTORICAL BACKGROUND

The right to health has roots not only in human rights discourses and moral philosophy but also in political demands claimed through social movements. The Universal Declaration of Human Rights, drafted in 1948, set basic rights to which every person is entitled, such as the right to life, freedom from torture, equal treatment, the right to education and work, as well as the right to access housing, food, water, and medical services. The concept of health as a right was earlier envisaged in the 1946 WHO Constitution stating that attaining the highest standard of health "is a right of every human being without distinction of race, religion, political belief, economic, or social condition" (WHO 1946). The right to health was further enforced in the 1978 international meeting on primary healthcare that was convened in Alma-Ata, Kazakhstan. Sponsored by WHO and UNICEF, the meeting marked a turning point in the history of public health and brought about the Declaration of Alma-Ata in which health was explicitly defined as a fundamental human right and a responsibility of governments towards their citizens (Appendix A). In stating explicitly that health encompasses more than access to healthcare, the Declaration ushered in a new concept of health that incorporates social, economic, cultural, and political rights (Toebes 1999). In addition to forming the core of the WHO Constitution and the Alma-Ata Declaration, the right to health is enshrined in international law and several international conventions, most notably Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which explicitly recognizes the importance of physical and mental health. ICESCR obliges signatory states to guarantee, progressively and through legislation, the right to health without discrimination based on "race, colour, sex, language, political or other opinion, national of social origin, property, birth or other status."

Alma-Ata defined the contours of primary healthcare and designated the state as the guarantor of the right to health for its people. The Declaration energized efforts in many countries, particularly those in the global south, to improve access to health equitably; it brought increasing recognition to the notion that social equity is a fundamental component

of health equity and that a strong health system is integral to an equitable society (Lawn et al. 2008). As such, Alma-Ata was deemed a revolutionary moment as it shifted the definition of health from being tied to medicine to one that is determined by social circumstances, and solidified equity and community participation as main health promotion goals. The Declaration was also remarkable in that it called for disarmament to free up resources that can be invested in health and identified the appropriate use of resources as a prerequisite to achieving health for all (Declaration of Alma-Ata 1978).

Within a few years, however, the spirit of Alma-Ata as a rights-based approach to health began to dissipate. The bold vision that the Declaration brought forth, intertwining health with constructs of equity and social justice, was replaced by global discourses on efficiency and cost (Lawn et al. 2008). Increasingly, the concept of health as a right became dismissed as unrealistic, costly, and difficult to achieve. Instead, selective primary healthcare, exemplified through vertical programs and most notably family planning and childhood immunization, received global commitment as a pragmatic and cost-effective approach to improving population health (Rifkin 2018). Importantly, the demise of Alma-Ata signaled the weakening role of WHO and the rising decisional power of the World Bank (WB) and International Monetary Fund (IMF). Increasingly, these multi-lateral financial institutions became chief players in setting global health policies that cohered with neo-liberalism. They forced poor and indebted countries to cut spending on the public sectors and charge fees for services including education and health (Maciocco & Stefanini 2007).

The WB pushed for selective primary care as an efficient approach, despite growing evidence that improving population health goes beyond addressing one disease at a time. In its 1993 Investing in Health report, the Bank introduced the notion of the "package of essential health services" that had an estimated economic value. Moreover, the Bank's policies in support of privatization led to the proliferation of public-private ventures in health, further strengthening the role of the private sector and marginalizing WHO (Maciocco & Stefanini 2007). Over time, the broad and integrated approach to health as a right was replaced by the UHC discourse which guarantees that "all people have access to the full range of quality health services they need, when and where they need them, without financial hardship". Grounded in ethical principles of priority setting, WHO defined three basic tenets of UHC: 1)

coverage should be based on need; 2) contributions should be based on the ability to pay; and 3) the ultimate aim should be to achieve the greatest improvement in population health (Rumbold et al. 2017). Even though UHC incorporates health promotion, prevention, protection, and access to high quality healthcare services as components of a comprehensive public health strategy, it has been critiqued as a departure from comprehensive primary healthcare and the right to health as conceived in Alma-Ata (Hone et al. 2018).

Efforts to link public health with human rights present a parallel thread in the movement towards the right to health that the Alma-Ata Declaration solidified. Human rights are moral values that speak to the dignity of a human being and are enshrined in the Universal Declaration of Human Rights. Mann (1997) drew three types of relationships between health and human rights. The first focuses on how public health policies that do not benefit all social groups equally may inadvertently negatively impact human rights. An illustrative example is when generic policies are put in place without consideration of how different social groups respond differently due to historical and social experiences. The second relationship advances that human rights violations adversely affect physical and mental wellbeing. For example, restricting freedom of association, which is enshrined in the Universal Declaration of Human Rights, interferes with the ability of individuals and communities to participate in decisions that impact their health. The third relationship highlights that "promoting and protecting human rights is inextricably linked with promoting and protecting health" (Mann 1997, p. 10). The socioeconomic risk cross-over in HIV/AIDS during the 1990s is and illustrative example of this relationship; with the maturation of the epidemic and the dissemination of information on how to contain it, the disease began to disproportionately impact marginalized social groups. COVID-19 followed a similar pattern in that, shortly after being declared a pandemic, racial/ethnic and socioeconomic disparities began to appear in high-income countries, thus highlighting that vulnerability is not only biological but is determined by the absence of basic rights and lack of social protections (Afifi et al. 2020). In sum, Mann's writings underscore that the right to health discourse ought to move from abstract legalistic notions toward understanding how violations of this right manifest in real-life situations.

THE RIGHT TO HEALTH IN THE ARAB REGION'S ECONOMIC AND POLITICAL CONTEXT

The Arab region is plagued by the absence of representative democracy in most cases and polyarchy, whereby a population participates periodically in elections governed by a small minority of political elite, in some (Hanieh n.d.). Political authoritarianism intertwines with economic inequality that manifests between and within Arab countries. Although the average GDP per capita in the region is judged to be acceptable by economists, the income shared by the poorest 20% of the population is extremely low (6.8%), indicating intense inequality (Ncube et al. 2014). The combination of political authoritarianism and economic and social inequalities precipitated the waves of revolutions and mass protests that swept across Tunisia, Egypt, and Syria starting in 2010-2011, and later in Lebanon, Iraq, Algeria, and Sudan in 2019. The protesters chanted for freedom but also against social inequities and the corrupt and inept political elite. The discourse on health figured prominently in popular demands for social justice, evidenced by the popularity of the Doctors without Rights during the Egyptian revolution in 2011 and in explicit demands for realizing the social and political determinants of health during the October 2019 Lebanese revolution (El-Agati 2013; Nuwayhid & Zurayk 2019). Yet, the dash of hope people experienced at the onset of the first wave of revolutions, dubbed the Arab Spring, turned to disappointment as revolutions descended to civil wars in some countries and the entrenchment of authoritarian political regimes in others. The failure of mass protests to instigate democratic change reveals deep structural problems in the region and the challenges that human rights advocates concerned with the right to health will continue to face in the coming years.

Writings on the modern history of public health or health systems in the Arab region rarely incorporate a political economy lens or link health to broader social and political transformations. The history of public health in the region intertwines with the history of the establishment of hospitals and the delivery of health services to populations in private, public, and charitable institutions. Under colonialism, health conditions of Arab populations were appalling as colonial practices of land and resource expropriation led to famine and

the spread of epidemics (Longuenesse et al. 2012). As Arab countries began to gain independence, health continued to be conceived as a service, rather than a right, and treatment was provided to the poor as charity (Kronfol 2012). The notion that health is a right arose following World War II when independent states began to finance public sector services like education and health; oil producing, high-income countries used oil revenues to finance a welfare system that included an elaborate primary healthcare system. The new independent Arab countries saw public health as a core component of progress and modernization post-colonialism, extending colonial notions of medicine as a vehicle to civilizing populations (Longuenesse et al. 2012). At present, most health systems in the region are based on a biomedical curative model which is both expensive and not effective in promoting population health (Rawaf & Hassounah 2014). The expansion of a private medical sector, even in countries that publicly espoused social welfare and socialist-style community health such as Syria and Iraq, weakened the role of the state as the duty bearer and the main provider of health.

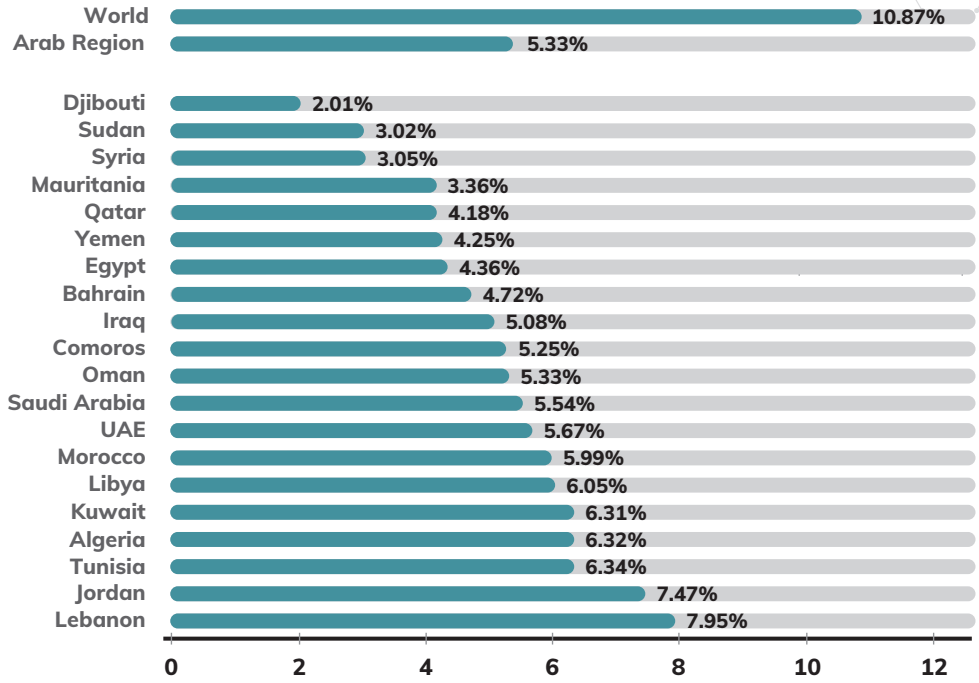
In speaking of the right to health in the Arab region, it is important to first acknowledge that most Arab countries made considerable advances over the past few decades on several key health indicators. This is due in part to the expansion of healthcare services in these countries but mainly a consequence of improvements in the social determinants of health. Historically, improvements outside the healthcare system – such as universal access to sanitation services and electricity, food safety regulations, labor protection guidelines, and the provision of publicly funded education –have had a stronger impact on population health improvements compared to medical advances. Data retrieved from the World Bank data platform shows that the proportion of the population in the Arab region with access to basic sanitation services has climbed from 74% in 2000 to 84% in 2020. The region also made strides in reducing illiteracy and closing gender inequities in educational attainment; some countries in the region have achieved gender parity in primary and secondary education. Moreover, impressive progress has been made on some health indicators including but not limited to increasing life expectancy and reducing child and maternal mortality. In the region, life expectancy rose from 63 years in 1990 to 72 years in 2019 and under-5 child mortality (per 1000 live births) decreased from 82 in 1990 to 36 in 2019 (WB 2023).

Yet, aggregate data hide stark inequities between countries

in the region and within them. A recent report by the United Nations Economic and Social Commission for Western Asia (UNESCWA 2022) claimed that the Arab region is the "most unequal region worldwide." Indeed, data retrieved from the World Bank data platform shows that, in many countries in the region, the income share held by the wealthiest 10% of the population approaches 30% whilst the income share held by the poorest 10% of the population hovers around 3% (WB 2023). Wealth inequity is equally stark in countries at war where a large proportion of the population relies on humanitarian aid for survival. As to education, in countries that had data for 2020, the primary education completion rate ranged from 100% in high-income countries to less than 70% in some low-income and conflict-ridden countries (WB 2023). In Syria, the primary education completion rate in 2013 was lower than it was in 2000 where it stood at 72%. Moreover, despite strides in closing the gender gap in education in some Arab countries, the region registers high education inequities between wealth groups (UNESCWA 2022). Inequalities are not limited to school enrollment and grade completion but also manifest in the quality of education that children receive depending on whether they attend public or private schools. As a result of disinvestment in public education in many Arab countries, children who attend public schools are placed on a disadvantaged social and cognitive development trajectory compared to those who attend private schools, which reduces their chances of school completion and negatively impacts their future job prospects, social mobility, and health.

Health inequities result from social and economic inequities and if both are not addressed through investment of resources and proactive equity-centered policies, they will continue to impede the realization of the right to health. The Arab region spends less on health as percent of GDP (5.3% in 2020) compared to the world average (11% in 2020) and all other world regions (WB 2023; UNESCWA 2022). By contrast, the region spends more on the military as percent of GDP compared to other world regions, even though most Arab countries signed the Alma-Ata Declaration which explicitly calls for reducing military expenditures and investing resources in health instead. **Figure 1** demonstrates inequities in spending on health (as percent of GDP in 2020) between Arab countries. In general, low-income countries (Djibouti and Mauritania) and those mired in conflict (Sudan, Syria, and Yemen) spend the least on health as percent of their GDP. Jordan and Lebanon spend the highest proportion of their GDP on health, although evidence from 2010 shows that half of this spending is private; of that, 75% is out-of-pocket (Salti et al. 2010).

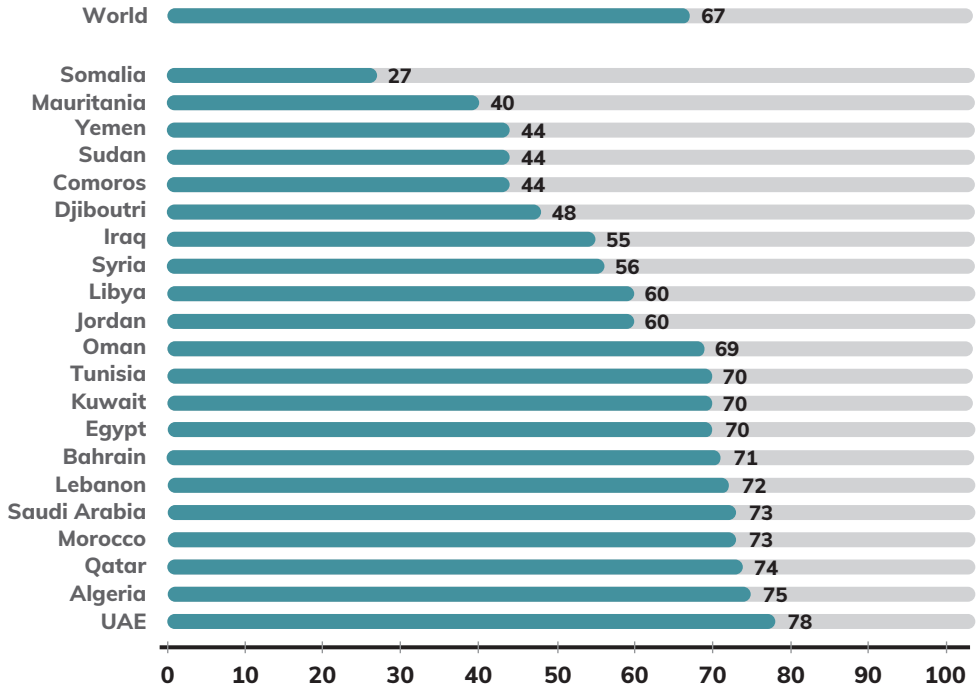
Figure 1. Health expenditure as percent of GDP in 2020 by Arab country



Source: World Bank Data. Note: Data for Palestine and Somalia are not available.

In **Figure 2**, Arab countries are ranked according to their 2019 UHC service coverage index, a measure of coverage of essential health services that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and service capacity and access. Compared to the world average, almost half of Arab countries fall behind in terms of coverage of essential health services. These are primarily low-income or war affected countries, except for Jordan. Conversely, the UHC service coverage index in middle-income and wealthy Gulf Arab countries is similar or even slightly better in comparison to the world average.

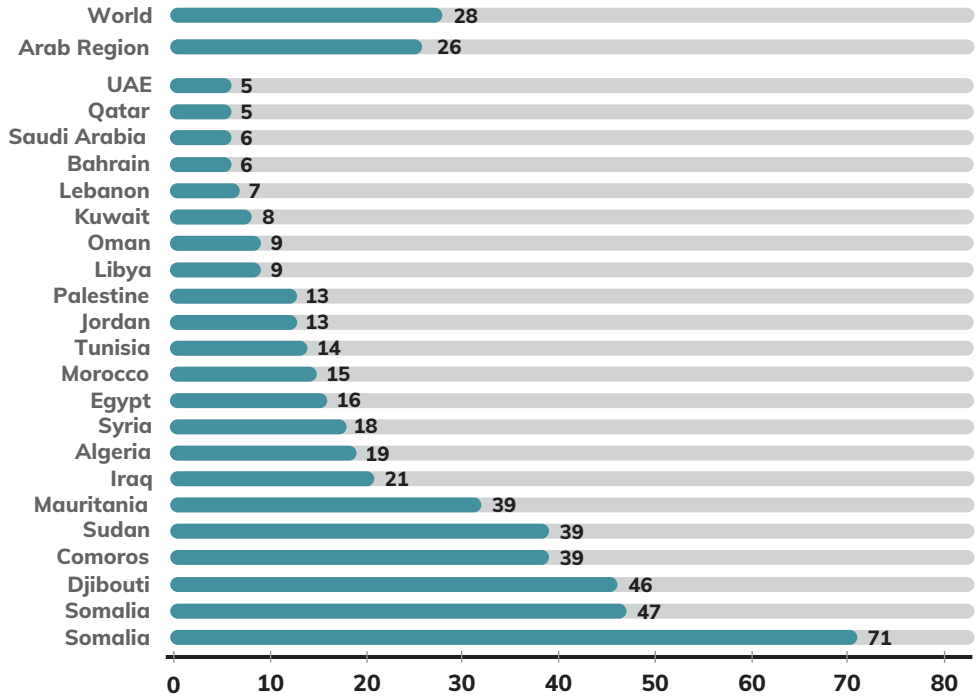
Figure 2. UHC service coverage index in 2019 by Arab country



Source: World Bank Data. Note: Data for Palestine is not available.

Figure 3 shows that infant mortality rate (IMR), which is one of the main indicators used to assess the overall health of a population, varies considerably between Arab countries. IMR is the number of babies who die before their first birthday out of 1,000 live births. In 2021, wealthy Gulf countries in the Arab region had the lowest IMR whilst the poorest Arab countries and those in conflict had the highest. Somalia's IMR of 71/1,000 is one of the highest in the world and Yemen's IMR of 47/1,000 in 2021 was higher than it was in 2013 (45/1,000), highlighting the injustice inflicted by war and militarism on population health in these two Arab countries. Note that because World Bank Data are projections based on earlier data provided by UN agencies, and in some cases governments, the rates presented in Figures 2 and 3 may not be accurate, particularly in war affected countries where available data are very out-dated. Moreover, it is not clear whether estimates in Gulf countries include migrant workers who constitute a large proportion of the resident population.

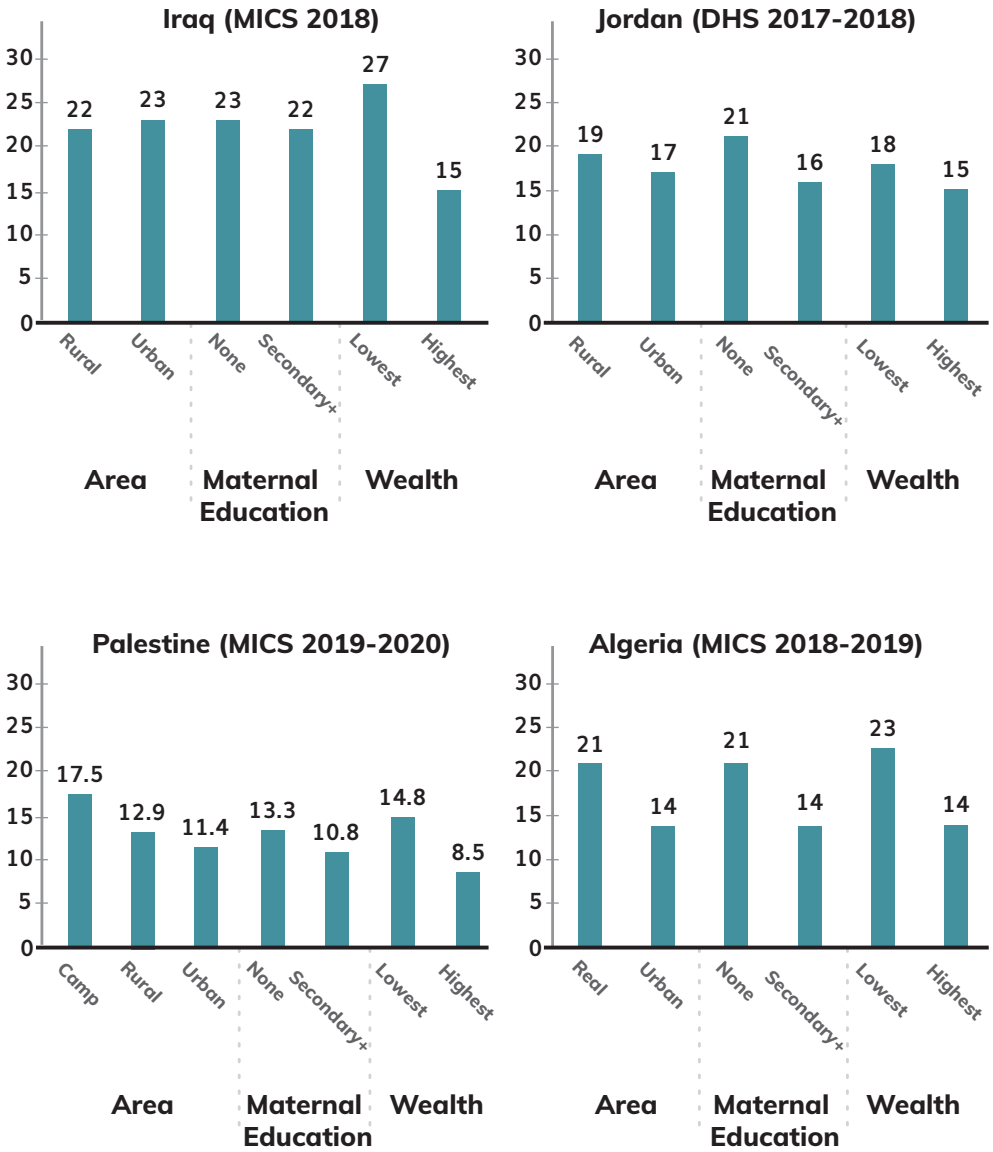
Figure 3. Infant mortality rate (number of infant deaths for every 1,000 live births) by Arab country in 2021



Source: World Bank Data

Health inequities between countries in the region have long been well known. It is also important to draw attention to inequities within countries as they present obstacles to achieving the right to health. **Figure 4** displays IMRs for four countries in the region for which relatively recent population-level data are available through the Multi-Indicator Cluster Survey (Iraq, Palestine, and Algeria) or the Demographic and Health Survey (Jordan). The figure compares, for each country, the IMR by area of residence (rural versus urban, and refugee camp in Palestine), maternal education, and wealth. Except for Iraq, IMR is higher in rural than urban areas in the three other countries and is significantly higher in refugee camps in Palestine. IMR inequities are also determined by maternal education and wealth; infants born to mothers in the lowest wealth quintile in Iraq, Palestine, and Algeria die at a considerably higher rate compared to those born to mothers in the highest wealth quintile. In Iraq, regional inequities in IMR are stark (data not shown).

Figure 4. Inequities in infant mortality rate in four Arab countries by area of residence, maternal education, and wealth.



Source: MICS for Iraq, Palestine, and Algeria; DHS for Jordan

The select data presented thus far show that investments in health in the Arab region are notoriously low and that between and within country inequities in UHC and population health outcomes (IMR representing one of the most vital indicators) are high. Thus, at least two right to health principles are violated – poor investment and non-discrimination in the distribution of health resources. Increasing financial investments is necessary to enhance universal health coverage, a step towards achieving the right to health, and to ensure that all people receive the health services they need, of high

quality, and without financial hardship. In addition to data presented in Figure 2, a recent global analysis showed that only two high-income Arab countries (Kuwait and Qatar) come close to achieving universal health coverage in that their UHC coverage index is 82% and 80%, respectively (GBD 2019 Universal Health Coverage Collaborators 2020). Low- and middle-income countries in the region have a long way to go to achieve universal health coverage, let alone the right to health in its expansive meaning, in part due to limited resources but also social policies and health governance structures that are based on neoliberal models. The impact of uninformed and neoliberal policies on the right to health in the region are summarized in this regional paper and delineated in detail in one of the thematic papers in the report. The right to health also encompasses the right to access other entitlements such as the right to social protection.

Social protection is a critical component of the right to health in a region that is experiencing unprecedented demographic changes due to war and forced displacement, the "youth bulge" in countries that until recently had high fertility rates, and rapid aging in some countries like Lebanon and Tunisia. Yet, spending on social protection in the region is low in general and primarily relies on contributory schemes. This reality favors those who are integrated in the formal economy and leaves a large proportion of the population who either do not work or work in the informal economy unprotected. As a previous AWR focusing on informal labor in the region pointed out, Arab governments struggled for decades to provide social protection to various social groups who fall outside the formal economy (Aita 2016). Indeed, post-pandemic calls to reform social protection systems in the Arab region have advised shifting policies from targeting the poorest social groups to including the "missing middle" such as informal workers (UNESCWA 2021). Limited social protection also impacts older adults, particularly women who do not participate in the labor force in their adult years, persons with disability who have very low employment rates, and non-citizen migrant workers. In a context of dwindling resources within Arab families to provide care to older adult members and those with special needs, rethinking social protection policies to include non-citizen migrant care workers is a priority (Abdulrahim et al. 2014).

The review presented thus far paints a worrying picture of the state of the right to health in the Arab region. Low investment in health as a "resource for everyday life," wide health inequities between countries and between social groups within

countries, and neoliberal health and social protection policies that provide coverage to a small segment of the population highlight insufficient progress towards achieving the right to health in the region over the decades since the 1978 Alma-Ata Declaration. The COVID-19 crisis could have provided a window of opportunity for health and social policy reforms. However, the pandemic presented major challenges to governments to cope with the situation, let alone to rethink policies, and exacerbated inequalities. Civil society activists who want to drive social change in the area of health and human rights are tasked with devising practical strategies to center the right to health in their advocacy efforts and to resist government inertia on this matter. The following sections in the report provide carefully synthesized content that advocates and organizers can utilize as a base to develop new or build on existing strategies. The content draws from evidence and information presented in national and thematic papers and the case study in the AWR-2023. It is grouped under six themes beginning with the theme on the disconnect between legal recognition of the right to health and reality.

SYNTHESIS OF INFORMATION AND EVIDENCE IN NATIONAL AND THEMATIC PAPERS

ARAB STATES' RECOGNITION OF THE RIGHT TO HEALTH VERSUS REALITIES ON THE GROUND

According to Backman and colleagues' (2008) global evaluation, one of the main indicators of a state's recognition of the right to health is whether it has signed on international treaties that protect this right and whether its constitution or other legal statutes explicitly acknowledge this right. Apart from Saudi Arabia and the United Arab Emirates (UAE), all Arab countries are party to the ICESCR including its article 12 that explicitly recognizes the right to health (Appendix C). Most Arab states signed the Alma-Ata-declaration in 1978 and adopted its rights-based primary healthcare principles. A review carried out by Rawaf and Hassounah (2014) shortly following the Arab Spring found that most Arab constitutions recognize the right to health in general statements albeit without an explicit mention of government accountability. The review found that five Arab constitutions did not mention the right to health at all whilst three (those of the UAE, Qatar, and Sudan) included in their national strategies references to achieving universal healthcare access only.

The situation has changed since 2014 with respect to codifying the right to health in the constitutions of Arab countries, notably in Tunisia and Egypt. As described in the Tunisia paper authored by Ines Ayadi and Aida Caid Essebsi, the Tunisian state's discourse on health gradually developed over the years from guaranteeing citizens' access to healthcare services to recognizing health as a fundamental right for all. The 2022 Tunisian constitution consecrates the right to health, holds the state responsible for the provision of health services of adequate quality, and makes explicit references to the importance of addressing the social and environmental determinants of health. Although other Arab constitutions, such as those of Egypt and Iraq, suggest that health is a right, the language remains limited to holding the state accountable for the provision of healthcare services, rather than guaranteeing health as a fundamental human right. The constitutions of Morocco and Mauritania enshrine the right to access healthcare services in the public sector for citizens and

non-citizens alike without discrimination.

Relying on the language of the constitution as evidence of a state's commitment towards the right to health is limited for two important reasons. The first is that some Arab states whose constitutions do not mention the right to health may explicitly guarantee the right to access healthcare services equitably and without discrimination in other legal statutes or national health strategies. An illustrative example is Jordan. As the paper authored by Hamza al-Duraidi suggests, whilst the 2011 Jordanian constitutional amendment does not explicitly stipulate that the state guarantees the right to health, Jordan has numerous regulatory texts that "indirectly influence the realization of the right to health." The second important reason is that there is oftentimes a disconnect between clear and explicit mentions of the right to health in a constitution, or at least the right to access healthcare services, and realities on the ground. This disconnect is stated clearly in the Yemen, Sudan, and Mauritania papers. In these three countries, although citizens have the right to obtain free primary healthcare services as stipulated in national legal statutes, this right is not guaranteed due to myriad factors including scarcity of resources and weak health system governance. In Egypt, the post-revolution Egyptian constitution recognizes health as a right and makes clear references to its social determinants (Rawaf & Hassounah 2014). The author of the Egypt paper, however, argues that the realization of this right is stymied by bureaucracy, health system fragmentation, and weak governance.

HEALTH GOVERNANCE SYSTEMS IN THE REGION ARE MIRED IN NEOLIBERALISM

Health system governance constitutes actions undertaken to promote and protect population health. Irrespective of whether these actions are carried out in the health or non-health sector (economy, education, or migration), they influence health determinants and outcomes. An important question to ask at first is whether any health system is aligned with the primary healthcare model advocated in the Alma-Ata Declaration or espouses neoliberalism as a system of governance. The papers included in this report highlight a few key health system characteristics in Arab countries: 1) health systems are highly privatized, concentrated in urban areas, and are based on a biomedical curative model; 2) they are financed in large proportion through out-of-pocket payments and spend a disproportionate amount of the health

budget on hospitalization and medicine; 3) they demonstrate a contentious relationship between the private and public sector whereby financial and workforce resources are siphoned from the public to the private sector; 4) healthcare service quality is rapidly worsening in the public sector due to financial disinvestment and migration of healthcare workers; and finally 5) health systems constantly undergo restructuring (not necessarily reform in the positive sense) to reduce spending and align more closely with neoliberal models of governance.

Neoliberalism is a set of political and economic policies designed to "liberate" an economy from government regulations. Typical neoliberal policies include lowering taxes, encouraging privatization, eliminating control over trade, and, most importantly, reducing government spending on social services. Neoliberalism is spearheaded by the United States and international financial institutions. As with low-income countries in other world regions, the WB and IMF have for decades imposed on Arab countries neoliberal policy reforms that led to lowering investments in health as a public resource. The region is a hotbed of neoliberal policies whose basic tenets are outlined by Adam Hanieh (n.d.) as follows: 1) to achieve GDP growth; 2) to remove all restrictions on the private sector; and 3) to limit the role of the public sector. These policies contributed to reduced state spending on public services, including education and health, the demise of social protection, and the withdrawal of subsidies on necessities. They have also thwarted tax reforms that could have generated revenues to increase health expenditure and support social protection programs. Indeed, had Jordan, Lebanon, Egypt, and Morocco instituted a wealth tax as low as 2% since 2010, they would have ended their reliance on loans from the WB and IMF and their health systems would have been better prepared to face the COVID-19 crisis (Oxfam 2020).

In the thematic paper on neoliberalism, author Mohammed Said Al-Saadi maintains that neoliberal policies and structural adjustment programs (SAPs) imposed by international financial institutions on low-income Arab countries contradict rights that are guaranteed in the ICESCR such as the right to work, food, education, housing, and the right to health. For years, the WB assumed a prominent role in reforming health systems in the region towards liberalization and expansion of private sector services (Longuenesse et al. 2012). In demanding that an indebted low-income country lift subsidies and disinvest in public services, WB and IMF policies increase food insecurity and limit access to education and other rights, thus directly

impacting health. Moreover, WB and IMF policies undermine health by reducing tax revenues that can be spent on the health sector, increasing the cost of medicines, and hastening the process of healthcare privatization. Rationing spending on primary healthcare services is met with increasing spending on pharmaceuticals, therefore increasing the power of corporations and their control over the provision of healthcare. Al-Saadi's paper on neoliberalism describes how international treaties strengthen pharmaceuticals' hold on intellectual property rights which increases the cost of medicines and impedes the production of generic alternatives.

On a different topic, the paper demonstrates how Arab countries' adoption of SAPs imposed restrictions on the health workforce and increased out-of-pocket spending on health. The sentiment that WB/IMF austerity policies failed to bring countries closer to realizing the right to health but, instead, deepened inequities in healthcare access is reiterated in the Iraq and Palestine papers. Neoliberal financial policies adopted by Jordan in exchange for WB/IMF loans negatively impacted vulnerable social groups and the health sector overall. Similarly, Sudan's adoption of neoliberal policies since the 1970s and adherence to WB/IMF loan requirements reduced citizens' access to free healthcare services whilst the country fell into deeper debt.

The impact of neoliberal policies in health reverberates beyond the healthcare system. In a recently published OpEd, Joe Daher (2022) argues that imposed neoliberal reforms, mainly privatization, austerity, and limited investments in health and other social protections, did not limit the political power of the state but, instead, led to new forms of state authoritarianism. In the Iraq paper, Muntather Hassan argues that the state's adoption of neoliberal policies strengthened the monopoly of political cronies rather than induced private sector competition. In Lebanon, post-civil war reconstruction focused on private sector growth through the promotion of neoliberal policies, resulting in a rentier economy and the proliferation of low productivity sectors (i.e., real estate) at the expense of social development. This strengthened the monopoly of the political elite and entrenched clientelism. Moreover, neoliberal reforms in some Arab countries contributed to the creation of an externally funded non-governmental organizational (NGO) sector to compensate for lack of state protection. Whereas civil society and NGOs fill important gaps, NGO-ization frees the state of its obligations and may lead to further fragmentation and weakening of social protection systems. This has been

the experience in Lebanon, where in the absence of state protection, NGOs provide varying levels of health services, whether through charitable hospitals or primary healthcare centers that are part of the Ministry of Public Health network.

SOCIAL PROTECTION IS A FUNDAMENTAL COMPONENT OF THE RIGHT TO HEALTH

A major consequence of neoliberal policies is the weakening of social protection systems whose role is to safeguard workers but also the poor and vulnerable groups against unforeseen shocks. Social protection is a human right and includes healthcare, maternity leave, unemployment, sickness and disability, and social security in old age. Because labor markets in many Arab countries are characterized by informality, a large proportion of workers, including refugee and migrant workers in construction, agriculture, and domestic service, do not receive health or social security benefits. The high proportion of informal labor has meant that more than half of the populations in Morocco, Mauritania, Sudan, Yemen, Lebanon, and even Saudi Arabia do not have adequate social protection (Aita 2016). The situation is not better in countries that have espoused welfare systems and free public health services since the 1960s. In Egypt, evidence shows that the poor benefit the least and the wealthy benefit the most from public health services (El-Agati 2013). In Syria, marginalized rural women had low access to maternal and neonatal health services in 2000 and even lower access in 2009, shortly before the Syrian revolution and the rise of the Islamic State (Abdulrahim & Bousmah 2019). These examples highlight that Arab states have fallen short of providing adequate healthcare services, let alone achieving the right to health in its full meaning.

The thematic paper by Rana Jawad and Walaa Talaat describes social protection mechanisms in the Arab region explicitly focusing on social health protection defined as: "a series of public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage, or reduction of earnings or the cost of necessary treatment that result in ill health (ILO 2008)." The authors highlight that the region spends significantly lower on social protection (4.6%) compared to the world average (12.9%), which parallels the discrepancy in health expenditures as percent of GDP, as shown in Figure 1. Moreover, only 39.5% of Arab populations benefit from any form of health coverage in comparison to a global average of 66%. In addition to low tax revenue, low investments in social

health protection also reflect: 1) weak social contracts and in some cases the absence of government accountability towards citizens; 2) reliance on contributory schemes in a context where a large proportion of Arab populations are integrated in the informal economy; and 3) a patriarchal approach of conferring protection through traditional social structures (such as religious or tribal institutions, political elite, or members of the monarchy) rather than the state.

The "neo-patrimonial" and "clientelist" approach to social protection is highlighted in the national papers on Mauritania, Jordan, and Lebanon. In Mauritania, as the state is unable to provide protection to all its citizens given limited resources, tribal kinship continues to operate as a form of social insurance. In Jordan and Lebanon, the two countries in the region that spend the highest proportion of their GDP on health, it is common for citizens to seek health services from the political elite. To access expensive treatment for chronic diseases like cancer, Jordanian citizens who do not have health coverage are required to submit a request to the Royal Court to be exempted from payment, a requirement that is clearly at odds with the principle of health as a human right and not a favor. Much has been written about how the provision of health services through sectarian and politically affiliated health centers in Lebanon is used to galvanize patronage for political parties (Cammett 2015). Appealing to tribal, royal, or sectarian elite, albeit necessary for the survival of the poor and those who lack access to social protection, undermines rights and entrenches the power of the "perpetrators of structural violence" (Cammett 2015, p. S76).

THE RIGHT TO HEALTH IN A POST PANDEMIC ERA

The COVID-19 pandemic hit the Arab region following a decade of austerity measures when many Arab states provided little if any social protection to their populations (ILO 2021). Shortly following the spread of COVID-19 in late March and April 2020, evidence began to emerge on the inequitable impact of the deadly virus on various social groups in wealthy countries. Disproportionate vulnerability to the infection and severe complications were not only determined by age and biological risk but by pre-existing inequities along socioeconomic, immigrant status, and racial/ethnic lines, bringing to the fore questions related to the link between the right to health and

vulnerability in the face of an unexpected health crisis. The thematic paper on COVID-19 by Farah Al Shami utilizes the limited data and evidence available on the region to highlight how underlying weaknesses in health and social protection systems exacerbated the impact of COVID-19 in many Arab countries and, in turn, how the pandemic deepened inequities. Indeed, unemployment and poverty increased in the region and wealth inequities intensified post-pandemic. For example, whilst the region's millionaires became richer in 2020 compared to 2019, the average individuals saw a significant decline in their wealth during the same period (UNESCWA 2020). With respect to health, the pandemic revealed pre-existing deficiencies in health systems financing, equipment, and workforce, and highlighted inequities in healthcare access and quality in Arab countries (Hasan 2021).

The COVID-19 moment is an illustrative case study of the ways in which health system privatization and neoliberal policies negatively impacted the right to health in times of crisis. The COVID-19 thematic paper and several national papers (e.g., Egypt, Jordan) highlight how at the beginning of the pandemic the private healthcare sector, which has been thriving at the expense of the public sector, refused to receive COVID-19 patients. As the pandemic prolonged, private hospitals began to take COVID-19 patients but at a very high cost, which meant that public hospitals continued to carry the burden of the pandemic. This situation caused the further entrenchment of health clientelism whereby those with connections received the services they needed whilst the rest of the population had to wait or pay bribes to receive publicly funded health services. As in other countries, COVID-19 impacted frontline healthcare workers in the Arab region, particularly those in the public sector, which accelerated their internal migration to the private sector. Furthermore, the unfolding of the COVID-19 crisis illustrates the power of the pharmaceutical industry in determining access to the right to health. Whereas the development of the COVID-19 vaccine was praised as one of the fastest scientific achievements in modern time, Farah Al Shami suggests that pharmaceutical conglomerates in fact slowed down the vaccine production and actively prevented other countries from developing generics. The power of international pharmaceuticals during the pandemic extended beyond controlling the cost of PCR tests and vaccines and was one of the main reasons behind the price increase of essential medicines.

Although governmental response to the COVID-19 crisis was

judged to be coordinated, dynamic, and effective in some countries covered in this report, such as Morocco, Tunisia, and Mauritania, it was criticized as incoherent and mismanaged in others (e.g., Egypt, Iraq, Yemen). Palestine faced major challenges in combatting the pandemic due to intersecting political and health system factors, the most important of which is Israel's delay in rolling out the vaccine in the occupied territories. In general, control measures to contain the spread of the virus in most Arab countries were militarized and ill-suited for a health crisis. Data presented in the COVID-19 paper show that complete or partial lockdowns in Tunisia, Egypt, Lebanon, and Jordan coincided with social and political events rather than the waning of the spread of the coronavirus.

THE IMPACT OF WAR, OCCUPATION, AND DISPLACEMENT ON THE RIGHT TO HEALTH

Since World War II, the Arab region has witnessed large-scale wars and population displacements, beginning with the Palestinian *Nakba* in 1948 and the displacement of hundreds of thousands of Palestinians following the creation of the state of Israel. In the decades following decolonization and the establishment of Arab nation states, the increasingly ethnic and sectarian nature of conflicts in the region have contributed to a dramatic increase in the number of forcibly displaced populations within and across state borders (Yahya 2015). This increase took place in a context where there has been little if any serious effort to formulate national or regional governance structures for the protection of displaced populations. More recently, the wars in Iraq and Syria have led to catastrophic consequences in the region, depleting resources, heightening sectarianism, displacing millions, and negatively impacting population health. At the writing of this paper, talks between warring parties in Yemen, a country that has been devastated by more than eight years of conflict, brought relative calm, and allowed the delivery of basic health resources (e.g., fuel and food) to internally displaced populations. Around the same time in April 2023, a civil war erupted in Sudan triggering what could have descended into one of the most severe humanitarian crises worldwide. Formerly hosting refugees from South Sudan and Ethiopia, hundreds of thousands of Sudanese are now internally displaced or have flocked into Chad and Egypt seeking safety, food, water, and shelter. Lebanon, which lived through a bloody civil war between 1975 and 1990, and Jordan host large numbers of Syrian refugees. Finally, North African Arab countries, especially Libya, have

become breeding grounds for smuggling networks that feed on the desperation of populations from Sub-Saharan Africa, Syria, and Afghanistan. The presence of large forcibly displaced populations in Arab host states, themselves reeling from economic crises and political upheavals, has exerted tremendous pressures on resources, infrastructure, and health systems. It has also inflamed national anxieties and unleashed a racist discourse that dehumanizes refugees and blames them for the economic and political failures of their host state.

The adverse impact of war and colonization on civilians and the prospect of achieving the right to health figures prominently in the report particularly in the papers on Sudan, Yemen, Palestine, Syria, and Iraq. That the war in Yemen dissipated all aspirations to achieve the right to health was stated by several experts consulted during the writing of the national paper by Dalia Hyzam and Abeer Shaef. Indeed, the conflict in Yemen led to the destruction of water and sanitation infrastructures, food insecurity, interruption of health services, and the spread of infectious disease outbreaks like cholera. Importantly, the civil war fragmented the health system further into a Saudi-led one and a Houthi-led one, not to mention the humanitarian system to which 80% of the Yemeni population relies on for assistance and social protection. Split or dual health systems are also a reality in Syria, where a state and non-state parallel systems operate independent of each other, and in Palestine due to the political fissure between Fatah in the West Bank and Hamas in the Gaza Strip.

The presence of two divided Palestinian authorities, highlighted in the Palestine paper by Ali Shaar, led to the fragmentation of the healthcare system and the deterioration of service quality. The weakening of the system was particularly felt in Gaza after the Palestinian National Authority in the West Bank stopped paying the salaries of healthcare workers in the Strip, which incapacitated the delivery of services and increased population hardship. The implications of the West Bank-Gaza split on Palestinians' livelihood and health notwithstanding, Israeli occupation is the main threat to the realization of the right to health in Palestine. In the context of ongoing Israeli colonization, Palestinians live either as second-class citizens on their own land in historic Palestine, under an air, sea, and land blockade in Gaza, or in segregated cantons in Jerusalem and the West Bank surrounded by an apartheid wall and separated by checkpoints. Access to healthcare services, let alone the right to health, is impossible for Palestinians under these circumstances.

The impact of Iraq's long history of war and violent conflict on the right to health is carefully described in the paper authored by Muntather Hassan. Millions of Iraqis were killed or wounded during the 8-year long Iraq-Iran war in the 1980s, First Gulf war in the 1990s, economic sanctions (2003-2011), and the United States' invasion and occupation. Besides the death, disability, and population displacement, the multiple wars in Iraq caused the flight of large numbers of the country's health workforce, destroyed what used to be praised as one of the strongest health systems in the region, and precipitated poverty-related health outcomes such as infant mortality and infectious disease. Similarly in Syria, armed conflict led to the total destruction of the health system which had an immense impact on health outcomes. Direct conflict strategies adopted by warring parties – both the Syrian regime and militias – did not spare civilians and healthcare workers and led to grave violations of human rights. Each warring party was and continues to be supported by a regional or international actor, which complicates the prospect of ending the conflict and holding violators accountable. Wars and sanctions create new economies and irreversible damage to a country's social system and reverse past achievements toward realizing the right to health. In Iraq, as in Syria, a war structure self-perpetuates, even when direct violence subsides, and normalizes social practices that bear directly on health such as paying bribery in exchange for health services in the public sector. In war-torn Arab countries (Syria, Iraq, Yemen), the normalization of myriad forms of violence against girls and women manifests in increasing early marriage and declining maternal, reproductive, and child health outcomes.

War also affects countries that host those who flee violence. Lebanon and Jordan host the largest proportion per capita of forcibly displaced Syrians and both countries have hosted large numbers of Palestinian refugees since 1948. Health services to Syrian refugees are provided through coordination mechanisms between national ministries of health and the United Nations High Commissioner for Refugees (UNHCR). Although UNHCR and other international aid organizations opt for integrating education and health services for refugees into the host state's public sector, this approach has exerted tremendous pressure on an already overstretched and poorly funded infrastructure in Lebanon and Jordan. Integration has enabled Syrians' access to subsidized primary healthcare services in the public sector, yet financial and other barriers impede their access to secondary and tertiary services such as treatment for chronic disease (Akik et al. 2019). In some cases, however, international

aid for refugees has rescued a public sector institution from financial collapse, an example of which is the takeover of the management and financing of the Rafik Hariri public hospital in Lebanon by the International Committee of the Red Cross since 2016. The hospital, which historically suffered chronic financial problems, currently provides services to refugees and low-income Lebanese citizens alike.

CLIMATE CHANGE

Climate change is an existential threat in the Arab region and impacts citizens and non-citizens alike. As a result of climate change, the region is experiencing declines in water and food resources (El-Zein et al. 2014), a reality that will inevitably impact the health of future generations. Only six out of 22 Arab countries were not classified as water stressed a decade ago and the outlook on water scarcity and food insecurity in the region has grown more pessimistic since then. Food insecurity in low- and middle-income Arab countries will reduce nutritional diversity, change food consumption patterns, and impact the health profile of their populations (El-Zein et al. 2014). Climate change and drought have been hypothesized to contribute to internal displacement and competition over land and water resources, with inter-ethnic conflict in Darfur, Sudan, and civil war in Syria presenting important analytical case studies (Selby et al. 2017). Due to climate change and drought, food insecurity has reached record levels in Mauritania according to a 2019-2020 living conditions survey. As a result, Mauritanians are emigrating from rural areas to the capital city in search of livelihood, a situation that is exerting pressure on urban infrastructure and health services. In Sudan, climate change is projected to change the patterns of communicable and non-communicable disease and poses a serious threat to the right to health.

Even Arab countries that were relatively water secure until the recent past are currently reeling from the effects of climate change and global warming. The drop in water levels in Iraq's two major rivers (the Tigris and Euphrates), due to heat but also the construction of dams upstream by Turkey and Iran, led to poor water quality and reduced access to potable water for a large proportion of the Iraqi population. In Iraq, but also in Tunisia and Lebanon, the privatization of water heightens inequality as the rich can afford to purchase safe drinking water whilst the poor consume contaminated water at the risk of contracting water-born infectious diseases such as cholera. Also related to climate change, Tunisia and Lebanon

experienced forest fires in recent years that destroyed arable land and threatened the livelihood of citizens. In Iraq, high temperatures and drought precipitated numerous sandstorms in spring 2022 and an epidemic of respiratory disease. The fires in Lebanon and water and energy scarcity in Iraq aggravated citizens' anger towards failed governments and contributed to instigating revolutions in both countries in 2019.

Extreme heat, a consequence of the larger problem of climate change, threatens the livelihood and health of populations in the Arab region, and is the focus of the case study on climate, migration, and health in Kuwait by Barrak Alahmad. The impact of extreme heat on the health of migrant workers in the Gulf region became the subject of attention by researchers and human rights groups during the build-up to the 2022 World Cup hosted by Qatar. High-income Gulf countries host large numbers of labor migrants from Asia and Africa who are recruited and hired through the notorious sponsorship (Kafala) system that deprives them of labor protections or legal recourse in cases of exploitation. Male migrant workers who work in construction and agriculture are exposed to extreme heat for long hours. Research in Nepal has uncovered an epidemic of chronic kidney disease among returnee Nepali construction workers who built FIFA stadiums. The case study addresses the link between exposure to heat and migrant workers' health in a country where temperatures touch 50°C in summer. Modeling different scenarios of the impact of rising number of days of extreme heat per decade on population health, the author presents a pessimistic outlook particularly for migrant workers whose health will be affected by the compounded impact of socioeconomic stressors and exposure to heat. The case study presents a critique of current occupational policies (merely banning work for a few hours mid-day during the summer months) which do not consider emerging scientific evidence on heat standards. Instead, it calls for accountability and equity-based policies to mitigate the harm of heat exposure on migrant workers.

OTHER CRITICAL ISSUES THAT BEAR ON THE RIGHT TO HEALTH IN THE ARAB REGION

Despite the richness of information provided in the report's papers and case study, a few critical issues that are deemed necessary to address in the context of the right to health in the Arab region have not been sufficiently covered. These are: scarcity of publicly available data to assess the state of, and monitor progress on, the right to health; gender inequities;

the neglect of mental health; and, finally, a discussion of state responsibility towards the health of non-citizens.

The first issue to address in this section is the challenge that most authors encountered in the process of preparing national papers due to limited data availability. Recognizing that equity and accountability constitute the social justice component of the right to health, national authors followed a methodology of compiling and synthesizing indicators on health services and resources and examining whether these are provided to all social groups equitably and through an integrated and accountable system. During the development and review of national papers, however, it became apparent that data availability posed a serious challenge to assessing a country's achievement of the right to health. In some cases, data published in national reports were outdated; in other cases, they were not available in a form to allow disaggregation by gender, region, and other socioeconomic indicators to be able to assess equity. For the most part, data were extracted from government reports or based on national data gathered through the Demographic and Health Surveys (DHS, USAID) or the Multiple-Indicator Cluster Surveys (MICS, UNICEF). Whilst data provided by governments on healthcare expenditures and workforce were recent, data on healthcare access or health outcomes from national household surveys were outdated in some cases. For example, the most recent national household survey reports are from 2018-2019 and are available only for Iraq, Jordan, Palestine, Tunisia, and Algeria. Important maternal and child health indicator data presented in the Egypt and Sudan national papers, for example, are from 2014. Other countries' data are older and thus do not reflect the impact of recent economic and political changes, not to mention the impact of COVID-19, on population health.

Lack of availability of reliable and up-to-date data constitutes a serious limitation to monitoring progress on the right to health. The challenges posed by data scarcity in the region and fragmentation of data systems due to the privatization of the healthcare system intensified during the first few weeks of the COVID-19 pandemic when access to real-time valid data was critical to response. Data unavailability in many Arab countries is due in some cases to limited resources but also to the absence of political will. Advocating for open data access is a first and a critical step towards monitoring progress and holding governments accountable.

Gender equity is another issue that has been touched upon in various national papers but deserved to be further highlighted

as a central component of the right to health. Despite progress on closing the gender gap in educational attainment in many Arab countries, women and girls in the region face major challenges that directly impact their health and wellbeing. Improvements in Arab women's education have not translated into higher participation in the labor force, which is the lowest worldwide – 18.4% compared to a global average of 48%. This has kept Arab women vulnerable to poverty and dependency and limited their access to health and other social protections that are accessed through employment, such as pension in old age. Women who work receive lower wages compared to men in the same sector and insufficient family care leave (UNESCWA 2019). Only Egypt, Iraq, Kuwait, and Syria provide a maternity leave duration that meets the international recommendation. On the other hand, Arab women are disproportionately burdened by care work within the nuclear and extended family, including care for older adults and family members living with a disability, with little formal support services.

Arab women's and girls' attainment of the highest level of health is stymied by a host of patriarchal norms, social structures, and laws. The overwhelming majority of women in the Arab region do not have the right to abortion or divorce on demand or child custody and, in many countries, women's decisions and actions are regulated by a male guardian. Some countries in the region have invested in mainstreaming gender in national policy development, budgeting, and data-driven evaluation of progress, which is expected to enhance their ability to assess progress on gender equity and the achievement of the SDGs and the right to health for all women and men. On the other hand, millions of Arab women live in countries where they are impacted by multiple forms of structural violence in addition to patriarchy, such as poverty, war, and displacement. Women in the poor and war-affected countries of Comoros, Mauritania, Somalia, Sudan, and Yemen have the highest maternal mortality ratios in the region and some of the highest worldwide (WB 2023). The national papers on Yemen and Sudan in this report highlight the impact of two practices – early marriage and female genital cutting, respectively – on the status and health of women and girls in the two countries. Early marriage, which predominantly impacts girls in poor families, increases during war and in displacement because of insecurity and fear of sexual violence. Early marriage and other forms of gender-based violence intertwine with the feminization of poverty in many Arab countries and result from state neglect and lack of mainstreaming gender in national policies. In Tunisia, services for survivors of

gender-based violence, who are predominantly poor women, are provided by NGOs since the public sector does not dedicate financial resources to these matters. In the context of the Arab region, it is important for civil society activists to emphasize that the right to health can only be realized through advocacy efforts that center SDG5 that calls for achieving gender equity and empowering all women and girls.

Several national papers in the report brought up mental health as an essential element of overall health and well-being. Authors of the Morocco and Sudan papers highlighted health system deficiencies, in that mental health services are hospital based and concentrated in urban areas and more affluent governorates, and recommended health system restructuring to address the mental health needs of the population. The authors of the Mauritania, Jordan, and Iraq papers stated that addressing mental health has become a pressing need in these countries and specifically underscored the unprecedented rise in substance use among youth. They delineated several challenges to an informed policy response to mental health including stigma, insufficient financial and professional resources, and lack of implementation even when a mental health strategy has been prepared. Mental health is determined by social, economic, and political factors such as high rates of youth unemployment and a pessimistic outlook towards political participation. Thus, an approach to advocate for the right to health that incorporates mental health as a main pillar ought to address other fundamental rights, such as the right to work and participate in public life.

Finally, although a few national papers in the report (e.g., Sudan, Yemen, Lebanon, and Jordan) expounded on the impact of hosting high numbers of internally displaced populations and refugees on the functioning of a country's health system, and the climate change case study highlighted the plight of migrant workers in Kuwait, a discussion of the right to health for refugees, migrant workers, and other groups who should be citizens such as the children of citizen mothers and non-citizen fathers deserved more attention. The Alma-Ata Declaration and other international treaties vest the responsibility of realizing the right to health within state governments. This raises critical questions as to who is responsible to ensure the universal right to health for all individuals in a national territory irrespective of their citizenship status. An examination of the right to health in the Arab region would be severely limited if it focused on the realization of this right for citizens only, and ignored the rights of refugees, labor migrants, and others excluded from

citizenship rights because of patriarchal discriminatory policies. In a region where most states have not signed on the 1951 Refugee Convention (Appendix C), discussions around the integration of refugees in host countries and granting them full social and economic rights are taboo. Refugee host states such as Lebanon and Jordan insist that the protection and service provision for refugees are the sole responsibility of the international community represented by UNHCR and other United Nations entities. Moreover, although the Kafala system violates basic tenets of human rights and excludes migrant workers from labor protections, it has proven to be resilient in the face of multiple campaigns to abolish it by local and international human rights groups.

Thus, even though the right to health is indivisible from other human rights, health advocates may find it strategic in the short term to focus on health only but frame it as a universal right rather than a right of citizenship. The WHO Eastern Mediterranean Regional Office has provided support to states to integrate service delivery for refugees and migrants into their national health systems and has recently convened a meeting to review initiatives and highlight good practices. This is an important first step. However, as one of the aims of the AWR-2023 is to move the discourse in the region away from the right to access healthcare services only, the concept that health is not merely a service but a fundamental human right should be emphasized in all future advocacy efforts.

POLICY RECOMMENDATIONS

The following three constellations of recommendations emanate from the challenges identified in the national and thematic papers in the AWR-2023 but also align with policy recommendations outlined in reports by UNESCWA on social protection reforms and universal healthcare coverage (UNESCWA 2021; UNESCWA 2022).

The first set of recommendations highlights the role of social policies in creating a culture of health based on rights, centering equity as an outcome, and strengthening social protection systems to enhance social solidarity and alleviate risk. Framing health as a fundamental human right requires a different orientation than what citizens (and non-citizens), policy makers, and even public health professionals are used to. This framing means that health is not a service or a commodity to provide to individuals in a manner that is detached from the social, economic, or political contexts in which they live. Instead, it means linking the right to health to other fundamental rights and freedoms and promoting a culture whereby individuals and communities have an equal opportunity to live healthy lives. Equity should be at the center of all social policies as economic growth alone is neither sufficient nor a prerequisite of equity. Monitoring mechanisms should assess not only improvement is social indicators such as education, access to infrastructural services, and other forms of social protection, but also reductions of inequities in access between social groups. Relatedly, strengthening social protection is fundamental to achieving the right to health and has the potential to address weak social contracts between people and governments in many Arab countries. Arab governments should devise universal social protection schemes that are not solely based on contributions and do so through increasing tax revenues. They should also move away from targeting the very poor only as this approach misses a large segment of the population such as informal workers. Social protection should also mainstream gender equity and proactively address the rights of older adults and persons with disability. New policies to transform social protection systems and make them sustainable necessitate political will and restoring trust, but also building solidarity and ensuring government accountability.

Secondly, the most important policy recommendation at the

level of the health system is to increase health expenditure in Arab countries and align it more closely with the global average of 11% of GDP. Channeling additional resources to the health system will increase the proportion of the population covered and the number of services included. A critical aspect of health system strengthening is to increase funding to public institutions and improve their quality of services. An anti-public sector paradigm in many countries in the Arab region is a result of neoliberal policies that, through deregulation of the private sector, created an imbalance and siphoned publicly funded resources. Proactive policies are needed to reverse the damage that these policies have inflicted over the years and to promote better use of public resources. Like the point raised about gender mainstreaming in social protection policies, health systems in the Arab region ought to also center gender equity in the distribution of healthcare resources beyond the provision of sexual, reproductive, and maternal health services to women. This means, for example, gathering focused data that illuminate gender differences in access to chronic disease services. The importance of strengthening health data infrastructure in the Arab countries cannot be underscored enough. Gathering data and making it publicly available is critical to assessing and monitoring progress towards the right to health.

Some of the global threats that will continue to hinder the achievement of the right to health in the Arab region – war and displacement, climate change, and unpredictable health crises – may seem beyond the capacity of what any government, let alone public health professionals or civil society groups, can address. Nonetheless, Arab civil society groups should not pass on the opportunity to urge policy makers to introduce legislation and take proactive action to at least protect the most vulnerable during conflict or in the face of climate change, and to advance the rights of refugees and the internally displaced. Groups and individual advocates can utilize the evidence synthesized in this regional paper and other papers in the report to lobby for social change and the recognition of the right to health for all.

Finally, in a context of multiple challenges and limited resources in the Arab region, future actions and advocacy efforts in national and regional contexts should also draw from past experiences. The lessons learned from the COVID-19 pandemic, for example, highlight the need to dismantle health and social policies that promote privatization and deregulation and prioritize social and labor protections in national strategies. Specifically, COVID-19 was a lesson to policy makers in all Arab

countries without exception that neglecting infectious disease preparedness and investing in high-tech medical technology at the expense of basic health services and protections will inevitably lead to a slow and ineffective response to a public health crisis and erode even small progress towards achieving the right to health.

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APPENDIX A: ALMA-ATA DECLARATION

Principal Themes and Essential Interventions (Backman et al. 2008)

PRINCIPAL THEMES

- The importance of equity
- The need for community participation
- The need for a multi-sectoral approach to health problems
- The need for effective planning
- The importance of integrated referral systems
- An emphasis on health-promotional activities
- The crucial role of suitably trained human resources
- The importance of international cooperation

ESSENTIAL HEALTH INTERVENTIONS

- Education concerning prevailing health problems
- Promotion of food supply and proper nutrition
- Adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning
- Immunization against major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

APPENDIX B: INDICATORS OF THE RIGHT TO HEALTH

(BACKMAN ET AL. 2008)

RECOGNITION OF THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

- Number of international and regional human-rights treaties recognizing the right to health ratified by the state
- Does the state's constitution, bill of rights, or other statute recognize the right to health?

NON-DISCRIMINATION

- Number of treaty-based grounds of discrimination that the state protects out of: sex; ethnic origin, race, or color; age; disability; language; religion; national origin; socioeconomic status, social status, social origin, or birth; civil status; political status, or political or other opinion; and property
- Number of non-treaty-based grounds of discrimination that the state protects out of: health status (ex) HIV/AIDS); people living in rural areas; and sexual orientation
- General provisions against discrimination

HEALTH INFORMATION

- Does the state law protect the right to seek, receive, and disseminate information?
- Does the state law require registration of births and deaths?
- Does the state have a civil registration system?
- Does the state disaggregate data in the civil registration system on grounds of: sex, ethnic origin, rural or urban residence, socioeconomic status, or age?
- What proportion of births is registered?
- Does the state regularly collect data, throughout the territory, for the number of maternal deaths?
- Does the state centralize these data for the number of cases

of maternal deaths?

- Does the state make publicly available these data for the number of cases of maternal deaths?
- Does the state regularly collect data, throughout the territory, for the number of neonatal deaths?
- Does the state centralize these data for the number of cases of neonatal deaths?
- Does the state make publicly available these data for the number of cases of neonatal deaths?

NATIONAL HEALTH PLAN

- Does the state have a comprehensive national health plan encompassing public and private sectors?
- Has the state undertaken a comprehensive national situational analysis?
- Before adopting its national health plan, did the state undertake a health impact assessment?
- Before adopting its national health plan, did the state undertake any impact assessment explicitly including the right to health?
- Does the state's national health plan explicitly recognize the right to health?
- Does the state's national health plan include explicit commitment to universal access to health services?

PARTICIPATION

- Is there a legal requirement for participation with marginalized groups in the development of the national health plan?

UNDERLYING DETERMINANTS OF HEALTH

- What percentage of the rural and urban population has access to clean water?
- What are the CO2 emissions per capita?
- Prevalence rate of violence against women
- Access to health services
- Proportion of women with a livebirth in the last 5 years who, during their last pregnancy, were seen at least three times

by a health-care professional, had their blood pressure checked, had a blood sample taken, and were informed of signs of complications

MEDICINES

- Is access to essential medicines or technologies, as part of the fulfilment of the right to health, recognized in the constitution or national legislation?
- Is there a published national medicines policy?
- Is there a published national list of essential medicines?
- What is the public per capita expenditure on medicines?
- What is the average availability of selected essential medicines in public-health facilities?
- What is the average availability of selected essential medicines in private-health facilities?
- Percentage of 1-year-old children immunized against measles
- Percentage of 1-year-old children immunized against diphtheria, tetanus, and pertussis

HEALTH PROMOTION

- Does state law require comprehensive sexual and reproductive-health education during the compulsory school years for boys and girls?
- Proportion of 15–24-year-old boys and girls with comprehensive HIV and AIDS knowledge

HEALTH WORKERS

- Does the state have a national health-workforce strategy?
- Does the state law include provision for adequate remuneration for doctors?
- Does the state law include provision for adequate remuneration for nurses?
- Do the state's workforce policies or programs include a plan for national self-sufficiency for doctors?
- Do the state's workforce policies or programs include a plan for national self-sufficiency for nurses?
- Do the state's workforce policies or programs provide

incentives to promote stationing in rural areas of doctors?

- Do the state's workforce policies or programs provide incentives to promote stationing in rural areas of nurses?

NATIONAL FINANCING

- Is the per capita government expenditure on health greater than the minimum required for a basic effective public-health system?
- What is the proportion of households with catastrophic health expenditures?
- Total government spending on health as percentage of gross domestic product (GDP)
- Total government spending on military expenditure as percentage of GDP
- Total government spending on debt service as percentage of GDP
- Proportion of national health budget allocated to mental health

INTERNATIONAL ASSISTANCE AND COOPERATION

- Does the state's international development policy explicitly include specific provisions to promote and protect the right to health?
- Does the state's international development policy explicitly include specific provisions to support the strengthening of health systems?
- Proportion of net official development assistance directed to health sectors

ADDITIONAL SAFEGUARDS

- Does the state law require protection of confidentiality of personal health data?
- Does the state law require informed consent to treatment and other health interventions?
- Does the constitution protect freedom of expression?
- Does the constitution protect freedom of association?

- Does the state have a patients' rights charter?
- Is the patients' rights charter available in all official languages?

AWARENESS RAISING ABOUT THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

- Does the state have a national human-rights institution with a program of budgeted activities to raise awareness of the right to health among the public?
- Does the state have a national human-rights institution with a program of budgeted activities to raise awareness of the right to health among doctors?
- Does the state have a national human-rights institution with a program of budgeted activities to raise awareness of the right to health among nurses?
- Are human rights a compulsory part of the national curriculum for the training of doctors?
- Are human rights a compulsory part of the national curriculum for the training of nurses?

MONITORING, ASSESSMENT, ACCOUNTABILITY, AND REDRESS

- Infant mortality rate
- Mortality rate of children younger than 5 years
- Maternal mortality ratio
- Life expectancy
- Does the state have a national human-rights institution with a mandate that includes the right to health?
- Number of judicial decisions, nationally, that considered the right to health during 2000–05
- Does the state have a national human-rights institution with a mandate to monitor international assistance and cooperation?
- In the past report submitted by the state to the UN in relation to the International Covenant on Economic, Social, and Cultural Rights, was there a detailed account of the international assistance and cooperation in health that the state is providing?

APPENDIX C: ARAB STATES' RECOGNITION OF THE RIGHT TO HEALTH

Country	International Covenant on Economic, Social and Cultural Rights, art. 12*	The 1979 Convention on the Elimination of All Forms of Discrimination against Women	The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c)	The 2006 Convention on the Rights of Persons with Disabilities: art. 25.	The 1951 Convention Related to the Status of Refugees and its 1967 protocol
Algeria	State Party Signed 1968	State Party Accession 1996	State Party Accession 2005	State Party Signed 2007	State Party to both
Bahrain	State Party Accession 2007	State Party 2002	**Not ratified**	State Party Signed 2007	**Not ratified**
Djibouti	State Party Accession 2002	State Party 1998	**Not ratified**	State Party 2012	State Party to both
Egypt	State Party Signed 1967	State Party Signed 1980	State Party 1993	State Party Signed 2007	State Party to both
Iraq	State Party Signed 1969	State Party 1986	**Not ratified**	State Party 2013	**Not ratified**
Jordan	State Party Signed 1972	State Party Signed 1980	**Not ratified**	State Party Signed 2007	**Not ratified**
Kuwait	State Party Accession 1996	State Party 1994	**Not ratified**	State Party 2013	**Not ratified**
Lebanon	State Party Accession 1972	State Party 1997	**Not ratified**	Signatory	**Not ratified**
Libya	State Party Accession 1970	State Party 1989	State Party 2004	State Party Signed 2008	**Not ratified**
Mauritania	State Party Accession 2004	State Party 2001	State Party 2007	State Party 2012	State Party to both
Morocco	State Party Signed 1977	State Party 1993	State Party Signed 1991	State Party Signed 2007	State Party to both
Oman	State Party Accession 2020	State Party 2006	**Not ratified**	State Party Signed 2008	**Not ratified**
Palestine	State Party 2014	State Party 2014	**Not ratified**	State Party 2014	**Not ratified**
Qatar	State Party Accession 2018	State Party 2009	**No action**	State Party Signed 2007	**Not ratified**
Kingdom of Saudi Arabia	**Not ratified**	State Party Signed 2000	**Not ratified**	State Party 2008	**Not ratified**
Somalia	State Party Accession 1990	**Not ratified**	**Not ratified**	State Party Signed 2018	State Party to both
Sudan	State Party Accession 1986	**Not ratified**	**Not ratified**	State Party Signed 2007	State Party to both
Syrian Arab Republic	State Party Accession 1969	State Party 2003	State Party 2005	State Party Signed 2007	**Not ratified**
Tunisia	State Party Signed 1968	State Party Signed 1980	**Not ratified**	State Party Signed 2007	State Party to both
United Arab Emirates	**Not ratified**	State Party 2004	**Not ratified**	State Party Signed 2008	**Not ratified**
Yemen	State Party Accession 1987	State Party 1984	**Not ratified**	State Party Signed 2007	State Party to both

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