

# THE ARAB WATCH REPORT ON ECONOMIC AND SOCIAL RIGHTS 6

## The Right to Health

2023



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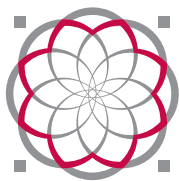
Arab NGO Network for Development  
شبكة المنظمات العربية غير الحكومية للتنمية



AMERICAN  
UNIVERSITY OF BEIRUT  
FACULTY OF HEALTH SCIENCES

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### The Arab NGO Network for Development

works in 12 Arab countries, with 9 national networks (with an extended membership of 250 CSOs from different backgrounds) and 25 NGO members.

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aims since its inception to shape the public health discourse by preparing professionals to be agents of change, and producing research that impacts practice and policy, and thus the health of populations.

American University of Beirut  
P.O.Box 11-0236 / Faculty of Health Sciences  
Riad El-Solh / Beirut 1107 2020  
Lebanon

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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.

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The views expressed in this document are solely those of the author, and do not necessarily reflect the views of the Arab NGO Network for Development, the American University of Beirut, Brot für die Welt, Diakonia, or the Norwegian People's Aid.

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# REPORT TEAM



## **| ANND TEAM**

Ziad Abdel Samad, Executive Director  
Maysa Baroud, Senior Program & Research Officer, Arab Watch  
Report Coordinator  
May Hammoud, PhD, Senior Program & Research Officer  
Adib Nehme, Senior Policy Advisor  
Zahra Bazzi, Programs Advisor  
Diam Abou Diab, Senior Program & Research Officer  
Olga Jbeili, Senior Program & Research Officer  
Marie-José Saade, Program & Research Officer  
Aida Younis, Finance, Admin & HR Manager

## **| LEAD RESEARCHER**

Sawsan Abdulrahim, PhD, Professor of Public Health  
Faculty of Health Sciences, American University of Beirut

## **| TRANSLATION**

Ghassan Makarem  
The Language Platform

## **| COPY-EDITING**

Imane Chammas  
The Language Platform

## **| COMMUNICATIONS, PRODUCTION, AND DESIGN**

Adham Al-Hassanieh, Communications Manager  
Diala Abdelsamad, Communications Officer  
Jocelyne Abi Gebrayel, Producer  
Nataly Berjaoui Lahoud, Graphic Designer  
Gladys Doumit, Graphic Designer  
Nadine Berjaoui, Graphic Designer

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This report is the result of the cooperation between ANND and the Faculty of Health Sciences at the American University of Beirut. It is a collaboration that brings together civil society, which defends and advocates for human rights in the field of public policies, especially at the economic and social levels, and the academic field, which provides knowledge and scientific analysis. This cooperation is beneficial to both parties: On the one hand, academic efforts are supported and find their way toward practical implementation, and on the other, civil society deepens its experiences, concepts, and tools, further improving its advocacy efforts.

The report is the outcome of more than a year's worth of efforts in research, deliberation, exchange of information and ideas, discussion, drafting, and review, by a team of specialists, professionals, and experts from the Arab region and some of the most prominent experts in the health field. The team was highly dedicated to its work and produced 12 national reports on the situation of the right to health and states' commitment to achieving the right to health, four thematic reports on the most notable issues and characteristics of our region pertinent to the right to health, such as neoliberal globalization (Mohamad Said Saadi), the nature of social protection systems (Rana Jawad & Walaa Talaat), political economy, governance mechanisms and health (Hani Serag), and the deficiencies in health systems uncovered by COVID-19 (Farah Al Shami), in addition to the regional report aiming to consolidate concepts, analyze the current reality in the region, and compare the situations in Arab states based on expert reports (Sawsan Abdulrahim).

The expert Maysa Baroud oversaw the content, coordinated the experts and researchers' work, allocated tasks, assigned roles, and followed up on the daily progress and production of the report. Our colleagues Adib Nehme, Zahra Bazzi, May Hammoud, Diam Abou Diab, Olga Jbeili, and Marie-José Saade from the ANND program teams contributed to reviewing and developing the content and providing observations and remarks. Finally, we would like to express our gratitude to the communications team that supported the production of this work, and we specifically thank Adham Al-Hassanieh, Diala Abdel Samad, and Jocelyne Abi Gebrayel and her team.

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We would like to thank each and every person who contributed to the success of this publication.

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# FOREWORDS

# INTRODUCTION TO THE 6TH EDITION OF THE ARAB WATCH REPORT ON ECONOMIC AND SOCIAL RIGHTS: RIGHT TO HEALTH

*Ziad Abdel Samad*

*Beirut, June 30, 2023*

## INTRODUCTION

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The world is witnessing dangerous transformations at various levels that expose a new world order that has yet to see the light and whose features have yet to be fully formed. The current crisis taking the world by storm has affected all countries, regions, and peoples without exception. It confirms the system's unsustainability, generating constant and destabilizing economic, financial, and climate crises and security and military tensions in most regions and continents. These crises, in turn, cause significant disparities in the distribution of benefits and wealth, with unprecedented rates of inequality recorded among Arab states. In fact, the "world's ten richest persons have more wealth than the poorest 3.1 billion people" (Oxfam 2022).<sup>1</sup> Inequality is widespread in all Arab states, where wealth is concentrated among the few and unevenly distributed. These inequalities have aggravated tensions and led to armed conflicts in several regions worldwide. Subsequently, spending on armament reached a new record of USD 2.24 trillion, or 2.2% of the world's gross domestic product (GDP) (SIPRI 2022)<sup>2</sup>, not to mention the

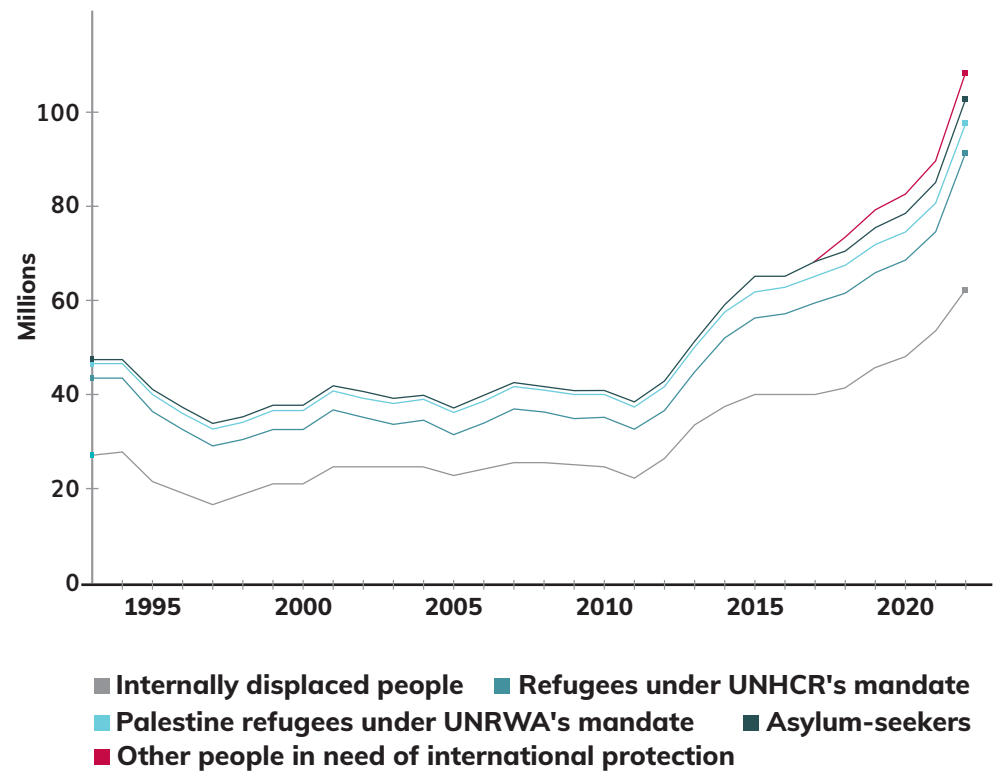
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<sup>1</sup> Oxfam. 2022. "Pandemic creates new billionaire every 30 hours — now a million people could fall into extreme poverty at same rate in 2022." [Link](#).

<sup>2</sup> SIPRI. 2022. "SIPRI Update April 2022: New Military Expenditure Data, Stockholm Forum Registration, Impact of War in Ukraine on Food Security, and More." [Link](#).

number of refugees and the forcibly displaced, which has exceeded 110 million persons, after reaching 80 million in 2021, as shown in **Figure 1** below (UNHCR 2022).<sup>3</sup>

**Figure 1. People forced to flee | 1993 - 2022**



| Source: UNHCR 2022

<sup>3</sup>UNHCR. 2022. "Global Trends Report." [Link](#)

# ARAB WATCH REPORT ON ECONOMIC AND SOCIAL RIGHTS: RIGHT TO HEALTH

The right to health ranked first among fundamental rights these past few years after COVID-19 caused severe economic and social repercussions worldwide. These repercussions affected the right to work and education. They highlighted the core deficiencies of health, education, and social protection systems and governments' inability to provide for their citizens basic services that are proper and fair. Hence, The Arab NGO Network for Development (ANND) took a significant interest in the right to health, adopting it as the topic for the 6th edition of its Arab Watch Report in an attempt to critically analyze health policies, or rather health systems, in both their institutional and structural dimensions on the one hand and their policy dimensions on the other.

## THE REGION AT THE HEART OF CRISES

Arab states suffer from numerous, multifaceted crises resulting from a combination of factors: the implementation of neoliberal policies and inadequate economic and social decisions for decades; and the near-total surrender to the recommendations of the international trade and financial institutions in return for loans and funding to reduce the deficit in budgets, public finances, and the trade balance. As a result, states have abandoned their social responsibilities and economic role, opting instead for privatization – of health services in particular – where health is treated as a commodity rather than a fundamental human right and one of the main components of the social contract. In addition, governments or lower-level decision-making authorities have adopted these policies and programs without any participation and accountability from the political, judicial, and popular levels. The numbers published by international organizations, including United Nations (UN) agencies, reveal unprecedented poverty and unemployment rates and significant inequality between the citizens of Arab

states and within each state regarding wealth distribution and access to fundamental rights. In this context, the 2022 ESCWA report on inequality in the Arab region revealed that only 10% of the population owns 58% of the wealth in the Arab region. In contrast, the most disadvantaged 50% of society share around 8% of wealth (ESCWA 2022).<sup>4</sup>

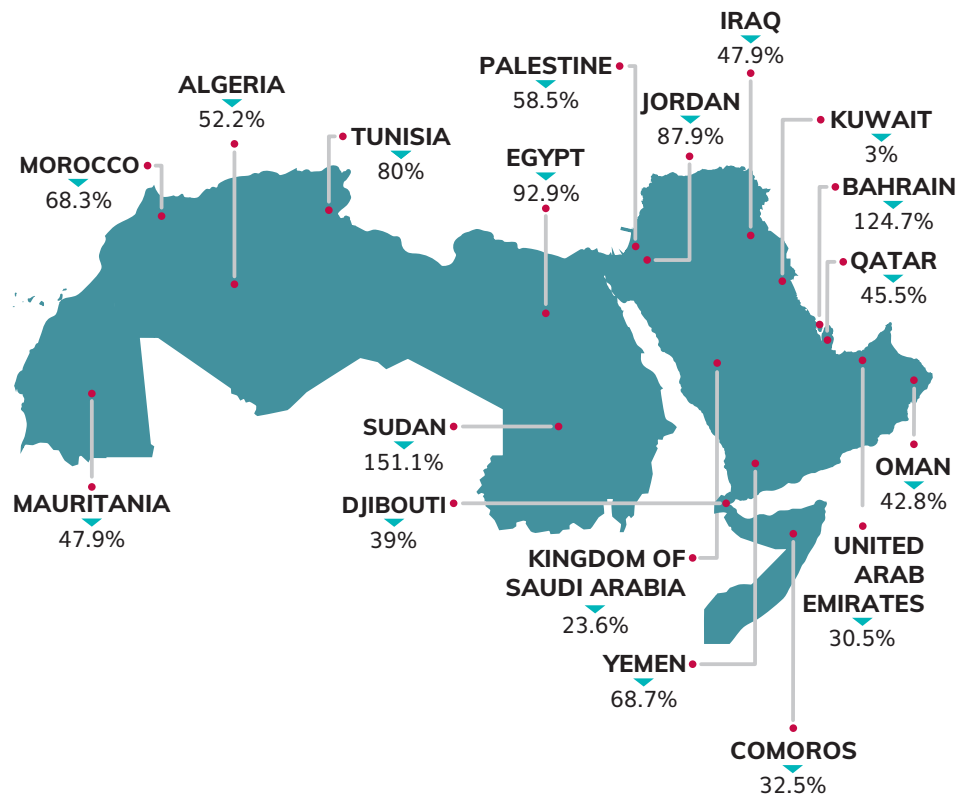
This challenging reality facing the region and its populations has led to popular protests that are still ongoing since the end of 2010 in most Arab states. The responses of the authorities and counter-revolution forces, as well as foreign interventions in the Arab Spring, have caused further disruptions and armed conflicts as a result of the ruling parties' refusal to give up power or any of their privileges, as well as their reluctance to implement necessary reforms that take into account the interests of the people and address the ever-deteriorating conditions. According to the World Bank, military spending in the Arab region reached around USD 2.03 trillion in the two decades between 1999 and 2018. This massive figure is equal to 5.6% of the GDP of Arab states during the same period. In 2022, military spending in the Middle East alone reached around USD 184 billion, a 3.2% increase compared to the previous year. Moreover, amid the security, economic, political, and climate turmoil, over 110 million people were forced to leave their homes, becoming displaced or refugees and asylum seekers, 30 million of whom are in the Arab region (UNHCR 2022).

**Figure 2** below shows the volume of debts incurred by Arab states, constituting an economic burden with serious and long-term social repercussions. The internal and external public debt is now over 50% of GDP and even exceeds 100% of GDP in some cases.

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<sup>4</sup>ESCWA. 2022. "Inequality in the Arab Region: A Ticking Time Bomb." [Link](#).

Figure 2. Arab countries' debts 2023



Note: Internal and external debt as a percentage of GDP: Data for Lebanon, Syria, Libya, and Somalia are unavailable.

Source: International Monetary Fund

In an attempt to maintain the dominance of armed forces or the totalitarian, security, and populist regimes in positions of power, the region is currently witnessing a string of countercoups eroding the few humble victories achieved during the past decade in democracy and the rule of law.

This reality confirms two main issues:

- First:** It is necessary to conduct a critical, bold, and thorough review at all levels concerning the responsibilities of the competent government authorities, including state institutions, security, military, and administrative bodies, and international, national, and local non-governmental actors, including the UN and financial, developmental, and trade institutions. Each of these parties holds a share of the responsibility. In this context, we must stress the need to give due consideration to the standards of "citizenship," namely the balance between rights and obligations, including the right to active political participation, the respect of freedoms, and the adoption of the principles of transparency, accountability, social justice, and equality

among citizens.

- **Second:** Partnership is paramount to overcome these crises, and all the relevant parties should be involved in the development and political process through cooperation and complementary action. Here the growing role of civil society organizations (CSOs) is of utmost importance, especially in advocacy and the defense of human rights, which are universal, interlinked, and indivisible. Despite this growing and important role, it is not an alternative to the state's role and its political and social responsibilities toward society. The same applies to all other development partners. By partnership, we mean genuine collaboration rather than pro forma and unbalanced measures and relationships between the different parties or the ideology of public-private partnership, and we certainly do not mean any other type of commercial or profit-oriented partnership outside the scope of development and human rights.

## OVERVIEW OF THE HEALTH SITUATION IN THE ARAB REGION

The pandemic revealed many challenges that had been smoldering for decades, most notably violence, armed conflicts, and inequality; unemployment; weak social security networks; human rights violations; insufficient response from governments and their institutions; and the economic model which has failed to fulfill everyone's aspirations (ESCWA 2022).<sup>5</sup>

In most Arab states, health systems are hampered by structural issues, including the focus on treatment, amid the lack of universal social protection, primary health care, health awareness programs, and other preventive programs based on the concepts and principles of the World Health Organization (WHO). Moreover, there is a lack of commitment to rights, particularly the right to health and its requirements, in favor of vertical programmatic approaches. COVID-19 exposed the adverse outcomes of these trends and the ineffectiveness of current health systems' funding and material and human resources (Sawsan Abdulrahim).

<sup>5</sup> ESCWA. 2022. "Inequality in the Arab Region: A Ticking Time Bomb." [Link](#).

ANND considers health a fundamental human right enshrined by the 1948 Universal Declaration of Human Rights and the 1978 Declaration of Alma-Ata (the International Conference on Primary Health Care). Similarly, the 1947 WHO Constitution stipulated that health is a fundamental right and includes a comprehensive approach to health. It also included key principles confirming the universality of this right, meaning it cannot be fragmented or divided. It is a right that humans should enjoy regardless of gender, age, religion, race, color, and affiliation. The state is responsible for providing this right to all citizens and ensuring its enjoyment. As such, the Declaration of Alma-Ata emphasizes equality among citizens and social justice, as well as the need to end wars and armed conflicts and direct essential spending toward building solid and consistent health systems capable of responding to the requirements needed to respect the right to health as a precondition to achieve security and social cohesion (Sawsan Abdulrahim).

The world order that emerged during and after the Cold War adopted neoliberalism as an economic model, marginalizing various economic and social rights, including the right to health, especially after the Bretton Woods institutions (International Monetary Fund and World Bank) started playing an important role in managing economic, financial, and development policies internationally. Financial and economic stability thus became the top priority. Structural Adjustment Programs (SAPs) were implemented, favoring austerity measures over social spending, leading to selectivity in applying the right to health while emphasizing certain simple aspects and neglecting other essential ones, contrary to international principles. This situation was aggravated by the World Bank, which became a primary funding and consultancy actor. The World Bank essentially promotes privatization, including health services, further reinforcing the role of the private sector and marginalizing that of the WHO and other international organizations (Mohamad Said Saadi).

Needless to say, the adoption of neoliberal policies over the past decades has undermined the International Covenant on Economic, Social, and Cultural Rights (1966) and led to a reduced commitment to fundamental rights, especially the rights to work, food, education, housing, and health. It is common knowledge now that all rights are interlinked and that the absence of one affects all others. What would the world come to if all these rights were absent?

As a result of these policies, the WHO noted that half of the Arab region's population is not covered by a primary health



care system. Social spending in the region is estimated at 4.6% of GDP, compared to 12.9% internationally (Rana Jawad & Walaa Talaat). Jawad & Talaat add that 39% of the population in Arab states is covered, while this rate reaches 66% globally.

## THE RIGHT TO HEALTH AT THE CORE OF INTERNATIONAL AGENDAS

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The concept of the right to health has evolved in recent decades from the quantitative approach reflected in the Millennium Development Goals (MDGs) to the more universal qualitative approach of the Sustainable Development Goals (SDGs) defined in the 2030 Agenda. SDG 3 focused on the quality of life at the social, economic, and environmental levels, including governance and engagement. These changes were a direct result of the efforts made since 2000 to expand the concept of the right to health, which led to adopting the social determinants of health (SDOH) in 2003.

Interestingly, the right to health was no longer limited to measuring mortality rates of children and life expectancy at birth, as evidenced by Target 3.7, which includes sexual and reproductive care and family planning. Target 3.8 also addresses universal health coverage, including financial aspects, quality health care services, and access to medicines, treatments, vaccines, etc.

The notion of the right to health has also expanded to include ways to integrate it with the right to education and mental health and link it to certain forms of deprivation of freedom, accountability, the right to choose adequate health patterns, and so on.

This confirms the importance of viewing SDGs holistically, as stated in the SDG Summit Political Declaration, whereby achieving the goal related to health is contingent on achieving the goals related to education, decent work, food security, the environment, and equality, particularly gender equality.

The pandemic also highlighted the deficiencies of health systems, given the speed with which the virus spread despite the advanced scientific, technical, and early warning and

prevention systems, as well as the risks resulting from the inaction of states who are responsible for fostering and protecting rights and who play a critical role in developing public policies. Furthermore, the pandemic emphasized establishing rights-based and fair social protection systems.

## PARTNERSHIP FOR THE RIGHT TO HEALTH

Partnership is one of the main pillars of development. It is based on equal opportunity among development partners. Actual partnership, however, is based on citizenship and the principles of rights and freedoms, particularly the right to expression, assembly, association, access to information, and participation. A critical review of development partners and their roles addresses the shared but varying responsibilities of each and the levels of transparency and accountability.

Therefore, to achieve equal partnership, an adequate environment should be provided to the different development partners, especially civil society, which lacks civic space due to the oppressive practices of political powers. Restricting public freedoms is at the top of these practices, particularly the freedom of expression, assembly, and association, access to financial resources, and the right to access information. Moreover, a critical review of civil society's role should be conducted as it aims to fill the gap resulting from the state's absence or poor contribution to providing basic rights to citizens. However, holding civil society responsible for the state's shortcomings and inability to respond to societal needs due to its fragmentation or ineffectiveness is an ill-conceived approach because it only considers the service aspect of civil society, neglecting other aspects such as advocacy, defense, and participation in developing, implementing, evaluating, and assessing the impact and effectiveness of public policies. The absence of the state means the absence of public health policies, which are closely related to other sectors such as environmental protection, quality education for all, housing, food, decent work, and social protection, among others. In addition, the absence of the state and the lack of accountability mechanisms diminish the commitment to rights and hamper their achievement.

*Ziad Abdel Samad is Executive Director of the Arab NGO Network for Development*

# ACCOUNTABILITY FOR A HEALTHY SOCIETY

*Roberto Bissio*

A thousand years ago, the physician, mathematician, and philosopher Ibn Sina, known in Europe as Avicenna, defined health as a balanced state and disease as the result of not maintaining such equilibrium. In his monumental work *Al-Qānūn fī al-tibb* (The Canon of Medicine), Ibn Sina, set the basis of modern medicine and established seven principles for the preservation of health: “moderation of temperament; choice of food and drink; depuration of superfluity; protection of the body; purity of the inhaled air; proper clothing; balance of physical and psychic movements, sleep and wakefulness.”

In the 14th century, Ibn Khaldun offered in his “Muqaddimah” insights about the nexus between population pressure, weather variation and environmental degradation, food security, and public health that are surprisingly relevant today. He wrote that the principal reason for diseases is the corruption of the air by overpopulation, and the putrefaction and the many evil moistures with which the air had contact (in densely populated cities).

Those views are at the basis of modern medicine and Avicenna’s Canon was used in European schools of medicines well into the 17th century. The notions of health as a balance of physical and psychic aspects, the emphasis on prevention to avoid disease and the need to balance urban life (civilization) with a healthy environment (purity of food, water and air) are still relevant today.

The postulations made by these early philosophers are consistent with the Right to Health (established in 1948 as a Universal Human Right), the International Covenant on Economic, Social and Cultural Rights (1966) and also the more recent recognition, in July 2022, by the General Assembly of the United Nations that a clean, healthy, and sustainable environment is a human right. In 2015, the 2030 Agenda committed all governments to achieve a set of goals, including SDG3, that promises to “ensure healthy lives and promoting well-being at all ages.”

But despite this solid body of international law, and policy commitments, the reality of health in the world is far from those standards. While in the 46 countries classified by the UN as “least developed” more than four children out of one hundred born alive die before their first birthday, in the developed countries that rate is five per thousand: eight times smaller! More than eighty per cent of the population has been vaccinated against COVID-19 in OECD countries as of March 2023, but only 58% in the Middle East, and barely 37% in Africa (The New York Times 2021).<sup>1</sup>

And yet the health performance of countries does not correlate strictly with their income. Chile, Costa Rica and even the now bankrupt Sri Lanka had higher life expectancy than the United States in 2021.<sup>2</sup> Chile and Costa Rica achieved those results with per capita expenditures on health of around one thousand dollars a year each. Sri Lanka spent 151 US dollars per capita in 2020, while the United States had surprisingly poor results while spending 11,702 US dollars per capita on health in 2020.

The reason for this paradox would be obvious to anyone remembering the seven principles of Ibn Sina. You cannot expect better health results out of more money spent on medicines and hospitals when your air and water are polluted, your food is of poor nutrition and quality, and your daily life lost its balance with nature. To make matters worse, in the past few decades, health budgets have displaced prevention and primary care in favor of expensive treatments of diseases that could have been avoided with healthier food and lifestyles.

The COVID-19 pandemic dramatically showed the inadequacies of policies that dismantled public health services and substituted them for privatized facilities in the name of efficiency. Instead of supporting public services, which is the recognized way of ensuring the realization of economic and social rights, the World Bank has argued that universal health systems unfairly subsidize the rich. As a result of World Bank

<sup>1</sup> The New York Times. 2023. “Tracking Coronavirus Vaccinations Around the World.” [Link](#).

<sup>2</sup> World Bank. 2023. “Data Bank – Health Nutrition and Population.” [Link](#).

conditionalities, instead of being a common public good, health and education become services provided for profit to those that can afford them and through “focalized” subsidies for the poor. Without proper accountability, those services for the poor become poor services.

During the pandemic, the weakened health systems were overburdened, and the real cost was dramatically shifted onto the shoulder of women, that constitute all over the world the absolute majority of paid and unpaid care providers. A recent study by the Economic Commission for Latin America and the Caribbean of the UN has shown that “investment in care is not only necessary, but also economically viable and sustainable” and the multiplier effect of such investment in the economy can be even greater than that of the construction of physical infrastructure, generating more tax returns and jobs, particularly for women.<sup>3</sup>

But investment in care and prevention, even when it makes economic sense, is not a profitable business for corporations and thus requires to be pursued with active public policies. The pandemic dramatically exposed the failure of global markets. Inequalities have grown between countries, as evidenced by the blatantly unfair distribution of vaccines, and within countries, as shown by the impoverishment of the majorities and a simultaneous increase in the number of billionaires everywhere.

This Arab Watch report contributes to the ongoing global debate on health and care policies and exposes multiple policy failures at national and regional level, resulting from domestic tensions and global trends. As the sixth report on Economic and Social Rights, it is a valuable source of information and analysis from practitioners, academia, and civil society organizations.

But the main value of this report goes beyond its content and lies in its process. The Arab Watch is the result of the invisible history of consultations, networking, and coalition building that made it happen. And in that regard, the public launching of the report is not its end, but the beginning of its life as an advocacy tool. By strengthening civil society in its key role of making the powerful accountable, this report is contributing to better health policies, and making governance more democratic and healthier.

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*Roberto Bissio is Coordinator of the Social Watch*

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<sup>3</sup> Scuro, L., Alemany C., & Coello Cremades, R. (Coords.). 2022. “Financing Care Systems and Policies in Latin America and the Caribbean: Contributions for a Sustainable Recovery with Gender Equality (LC/TS.2022/134), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC)/ United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women).” [Link](#)



# REGIONAL REPORT



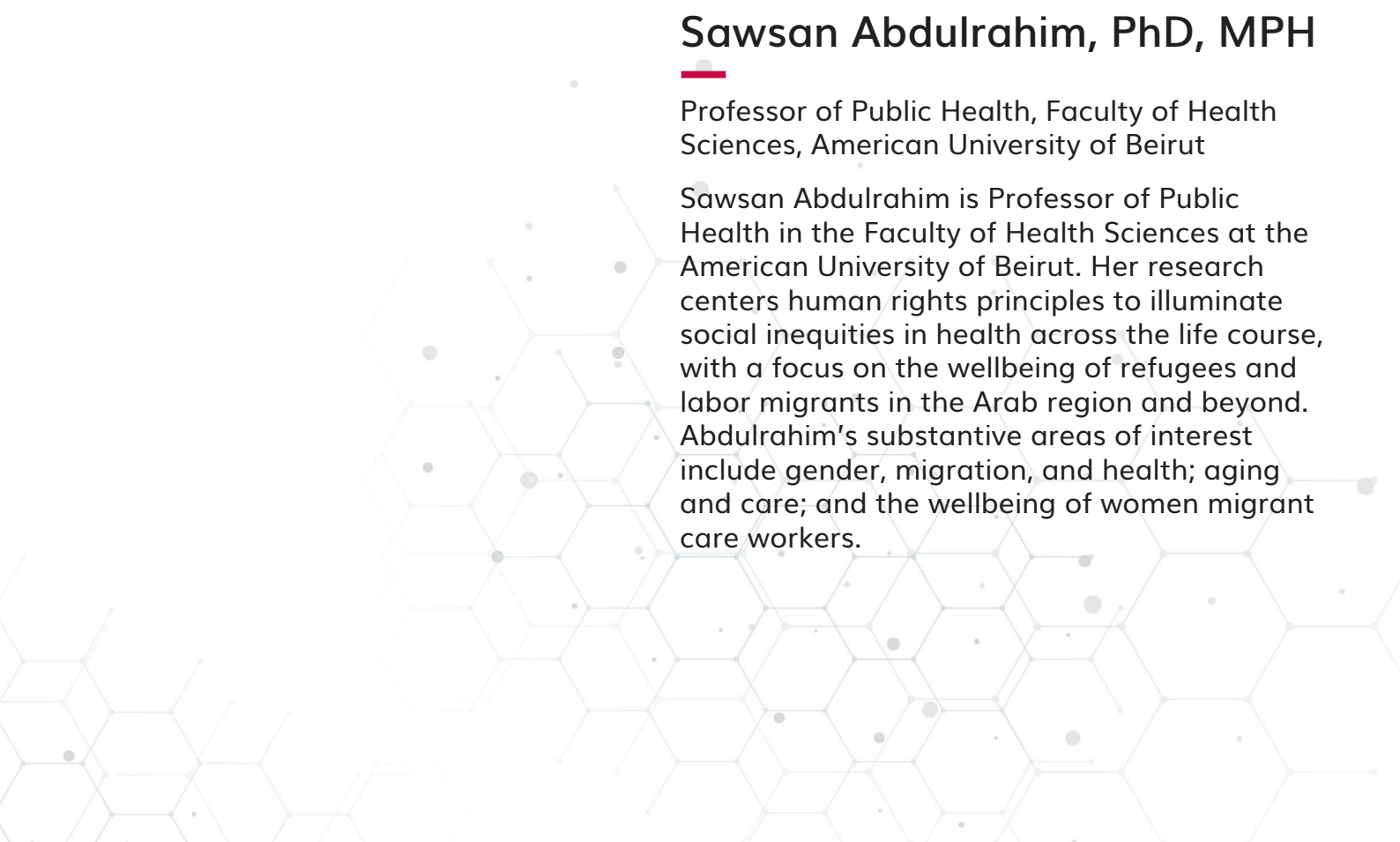
# PROMOTING THE RIGHT TO HEALTH IN THE ARAB REGION

## Sawsan Abdulrahim, PhD, MPH

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Professor of Public Health, Faculty of Health Sciences, American University of Beirut

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.



## 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 health 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

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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 (Toebe 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 or 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 an 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).

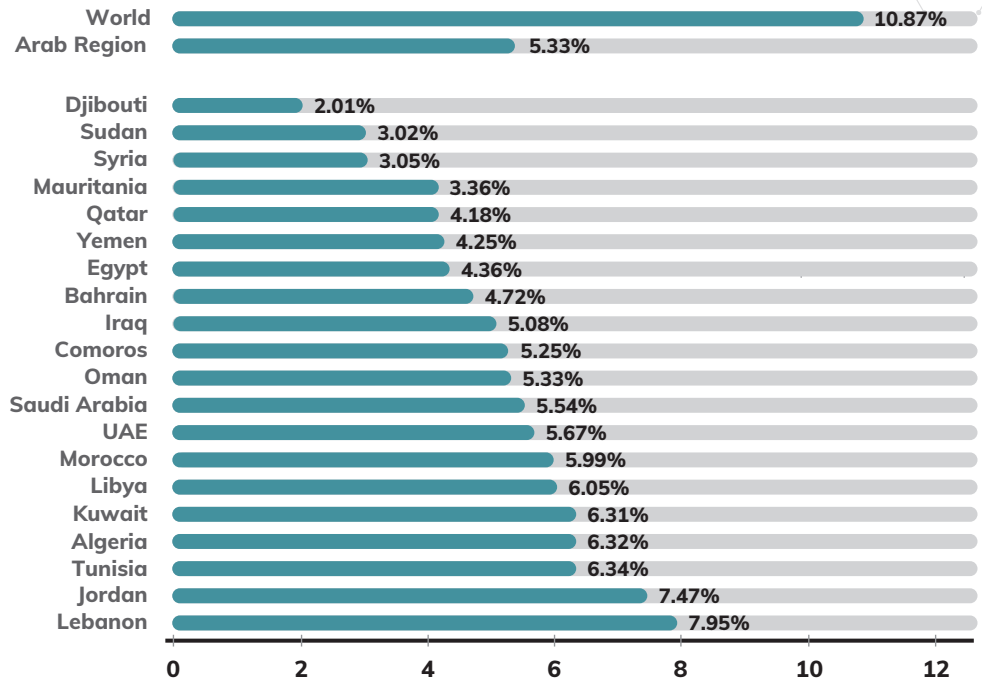
Yet, aggregate data hide stark inequities between countries

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).



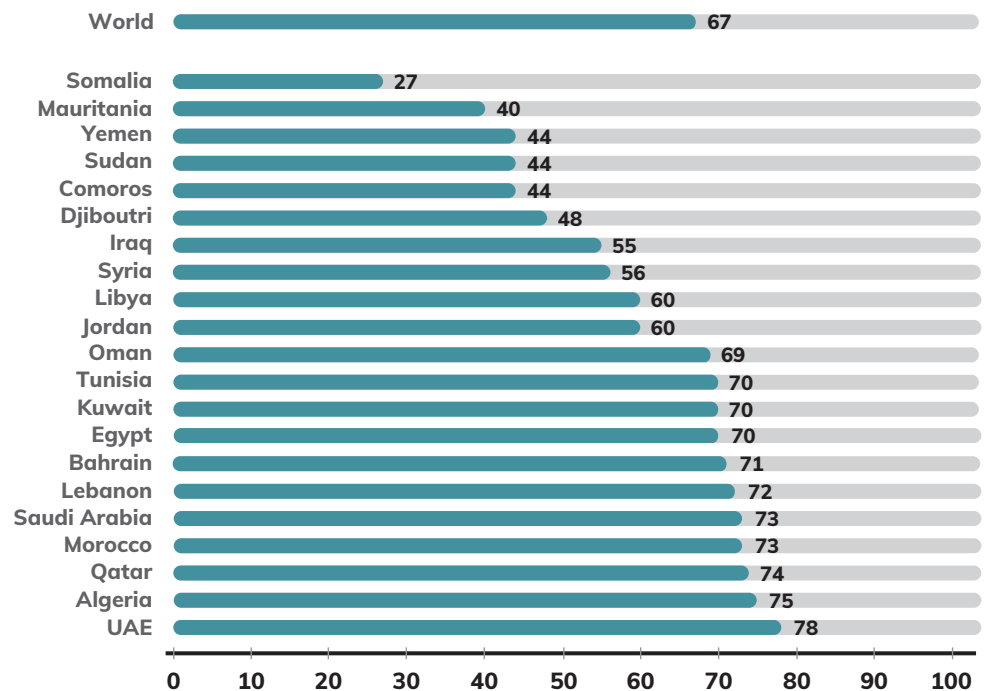
**Figure 1. Health expenditure as percent of GDP in 2020 by Arab country**



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.

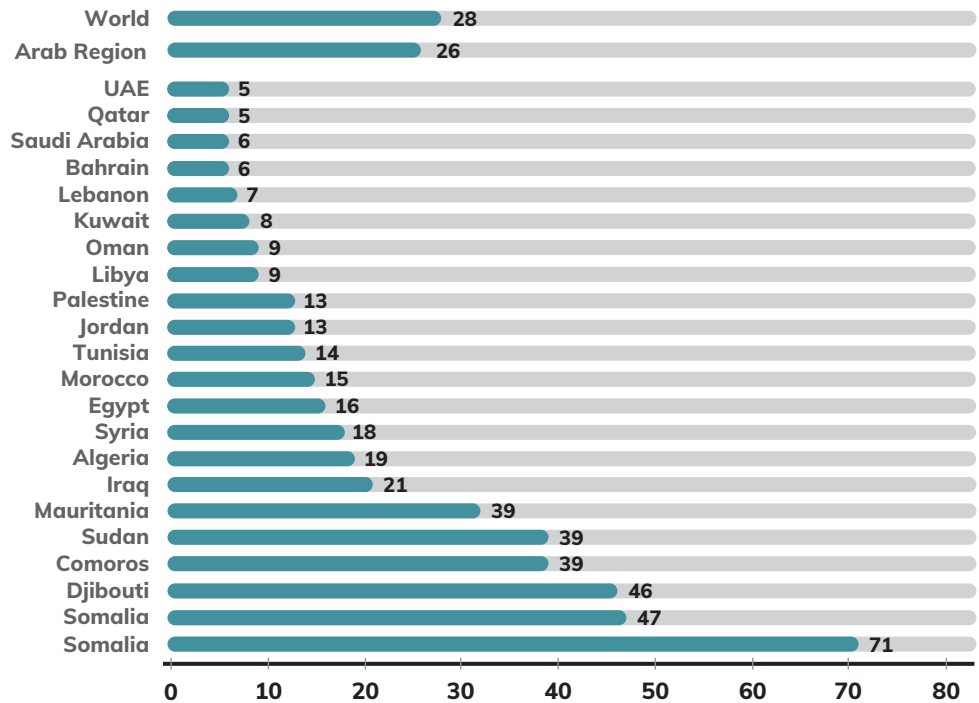
**Figure 2. UHC service coverage index in 2019 by Arab country**



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.

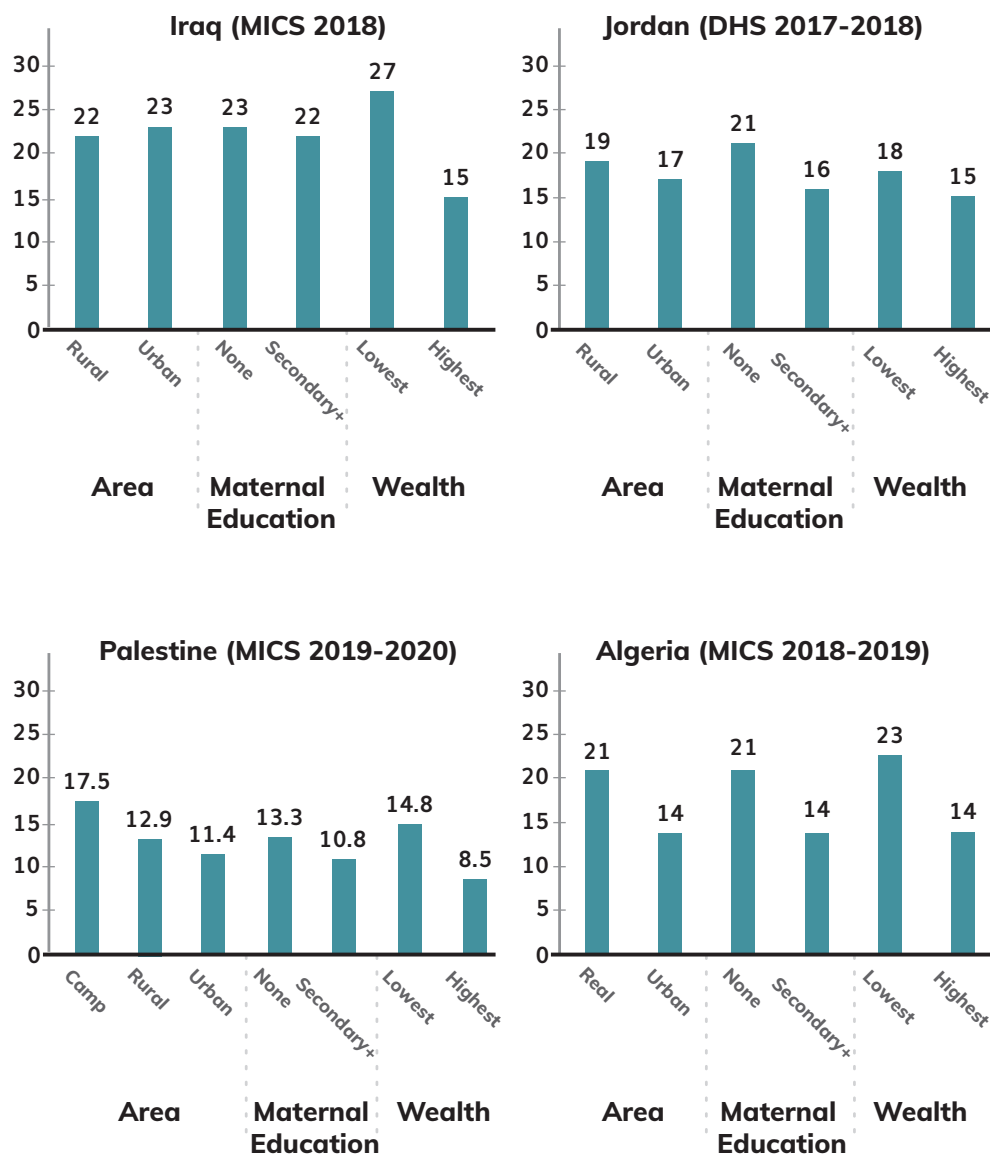
**Figure 3. Infant mortality rate (number of infant deaths for every 1,000 live births) by Arab country in 2021**



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, Mauritians 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-borne 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 in 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)

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## ■ 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?
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# 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	<b>Not ratified</b>	State Party Signed 2007	<b>Not ratified</b>
Djibouti	State Party Accession 2002	State Party 1998	<b>Not ratified</b>	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	<b>Not ratified</b>	State Party 2013	<b>Not ratified</b>
Jordan	State Party Signed 1972	State Party Signed 1980	<b>Not ratified</b>	State Party Signed 2007	<b>Not ratified</b>
Kuwait	State Party Accession 1996	State Party 1994	<b>Not ratified</b>	State Party 2013	<b>Not ratified</b>
Lebanon	State Party Accession 1972	State Party 1997	<b>Not ratified</b>	Signatory	<b>Not ratified</b>
Libya	State Party Accession 1970	State Party 1989	State Party 2004	State Party Signed 2008	<b>Not ratified</b>
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	<b>Not ratified</b>	State Party Signed 2008	<b>Not ratified</b>
Palestine	State Party 2014	State Party 2014	<b>Not ratified</b>	State Party 2014	<b>Not ratified</b>
Qatar	State Party Accession 2018	State Party 2009	<b>No action</b>	State Party Signed 2007	<b>Not ratified</b>
Kingdom of Saudi Arabia	<b>Not ratified</b>	State Party Signed 2000	<b>Not ratified</b>	State Party 2008	<b>Not ratified</b>
Somalia	State Party Accession 1990	<b>Not ratified</b>	<b>Not ratified</b>	State Party Signed 2018	State Party to both
Sudan	State Party Accession 1986	<b>Not ratified</b>	<b>Not ratified</b>	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	<b>Not ratified</b>
Tunisia	State Party Signed 1968	State Party Signed 1980	<b>Not ratified</b>	State Party Signed 2007	State Party to both
United Arab Emirates	<b>Not ratified</b>	State Party 2004	<b>Not ratified</b>	State Party Signed 2008	<b>Not ratified</b>
Yemen	State Party Accession 1987	State Party 1984	<b>Not ratified</b>	State Party Signed 2007	State Party to both



# THEMATIC REPORTS

# GOVERNANCE FOR HEALTH

## Hani Serag

Assistant Professor and Public Health Researcher

Hani Serag is a physician and public health researcher. He is an Assistant Professor at the Department of Internal Medicine – Division of Endocrinology, University of Texas Medical Branch (UTMB), Galveston, Texas. He holds positions as an Adjunct Assistant Professor at the Department of Paediatrics and the Department of Global Health and Emerging Diseases. Serag's previous work includes serving as global coordinator of the People's Health Movement and currently is the Co-Chair of its Steering Council.

## INTRODUCTION

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The conceptual framework for action on the social determinants of health of the World Health Organization (WHO) recognized 'governance' as one of the main components that shape the socioeconomic and political context that, in turn, determines the socioeconomic position of individuals and communities and thus their access to conditions for health (Solar & Irwin 2010). Major components of governance, including influential actors (decision-makers) and decision-making processes and procedures, change over time following a change in the nature of societies and governing bodies and change in dominant ideologies, dominant economic policies, and power dynamics (Kickbusch & Gleiche, 2012; Bennett et al. 2012). During the last few decades, governance for health changed from state-driven decision-making dominated by governments and using constitutional and legislative platforms at the country level and multilateral organizations at the international level to multi-stakeholder decision-making. Those stakeholders included market disciplines and corporations representing the domination of neoliberal economic policies. The change in governance for health was also associated with a more significant role for monetary institutions like the International Monetary Fund (IMF) and the World Bank (WB) over the United Nations specialized health organization, WHO. At the national level, ministries of finance gained greater influence on health policies than ministries of health – here, referring to health policies in a broader sense and not just health budgets.

The current paper is an attempt to highlight the linkage between governance for health and the change in dominant economic policies during the last five decades. It will also provide definitions and identify the influential actors in global and national health decisions and discuss how they practice their influence. The analysis in this paper is supported by some case studies from the Arab region.

## DEFINITIONS

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**Governance** refers to actions and processes formally adopted or informally used to rule decision-making over common goods. Formally adopted decision-making processes or procedures are usually embedded in constitutions of multilateral organizations, international treaties, or national or local constitutions and legislation. Informal governance includes uncodified, non-institutional means of decision-making where power relationships and dynamics would determine the final decisions or influence the course of negotiations. This definition focuses mainly on the process rather than the goals or outcomes of the governance.

To highlight the process, goals, and values of governance, governance can also be defined as the rules and procedures for managing resources, making decisions, and structuring accountability. It applies to a country, institution, or group of people (Center to Eliminate Health Disparities (CEHD) 2016); or structures, policies, norms, and processes designed to ensure accountability and transparency (Atiku 2019).

**Governance for Health** refers to actions and processes adopted to promote and protect people's health. With this definition, these actions and processes are directly or indirectly linked or have the capacity to influence health determinants, status, and outcomes (Garson & Khosrow-Pour 2008). This definition incorporates decision-making processes in non-health sectors or domains that may directly or indirectly influence people's health, including but not limited to policy, economy, trade, education, urban development, and immigration.

The World Health Organization (WHO) recognizes two components of the governance for health (Kickbusch & Gleiche 2012):

1. Health system governance in terms of existing policy frameworks and processes and procedures for oversight, coalition-building, regulation, system design, and accountability. In this component, WHO recognized three stakeholders (World Health Organization 1978):
  - The State, represented by central and sub-national authorities and governmental organizations;

- The health service providers, including public, private, and not-for-profit clinical, para-medical, and non-clinical health services providers; professional associations; networks of care or services); and
  - The citizen, including population/community representatives, patients' associations, community-based organizations (CSOs), non-governmental organizations (NGOs)
2. Joint actions of health and non-health sectors to address health determinants (Kickbusch & Gleiche 2012).

This definition focuses on the interaction among users, providers, and regulators of healthcare services in addition to joint actions between health and non-health sectors while ignoring the influence of international bodies, including multilateral organizations, agencies affiliated with other governments, and international donors. It also failed to recognize the role of power structures that shape the decision-making process at national and sub-national levels.



# MILESTONES IN HEALTH DEVELOPMENT AND DECISION-MAKING

## THE WORLD HEALTH ORGANIZATION (WHO) CONSTITUTION (1946-48)

Entered into force on April 7th, 1948, the World Health Organization (WHO) constitution defined health as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”* (United Nations 1946). This revolutionary definition of health untied health from the provision of healthcare services, though it is one of the key determinants, and indicated the necessity of multidisciplinary effort and multisectoral collaboration.

In its preamble, the constitution considered that *“the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”* and *“governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures”* (United Nations 1946). The recognition of health as a fundamental human right means that there is a right-holder and duty bearer. Every human being is a right-holder for their health and is entitled to the State as a duty-bearer, with no discrimination. This recognition provides a tool for progressive civil society groups to advocate for people's right to health. It may also suggest that the action agenda of these groups should include the following:

1. empowering individuals and communities to claim their right to health;
2. advocating for clear provisions in the national and local constitutions and legislation to protect the right to health before the law, defining means to realize this right (including adequate financial resources), and defining procedures individuals and groups can use to claim their rights; and
3. building the capacity of state authorities and organizations to fulfill their duties to protect the right to health, including creating conditions of health and providing health and social interventions.

In terms of governance for health at national and local levels, the WHO constitution considers States as the duty bearer of people's right to health. This means that States, not stakeholders, are responsible for the decision-making and provision of adequate measures to fulfill this right. The State may involve other actors in supporting the decision-making process, informing a proper planning process, or providing health and health-related services. However, these non-state actors are not decision-makers, and they are not duty-bearers.

Regarding governance at the global level, article 2 of the constitution requires WHO *"to act as the directing and coordinating authority on international health work"* (United Nations 1946). The same article also mandates that the WHO *"establish and maintain effective collaboration with other UN organizations, governmental health administrations, and professional groups."* The constitution clearly considers WHO the directing and coordinating authority for global health, not one of the multiple stakeholders.

In conclusion, the WHO constitution considers governments at national and local levels and WHO at the international level as the authorities and coordinating bodies for health. It does not recognize the concept of a multi-stakeholder decision-making modality.

## **THE DECLARATION OF ALMA ATA (1978)**

The Declaration of Alma-Ata was adopted by 134 countries at the end of the International Conference on Primary Health Care held in Kazakhstan, one of the Soviet Union republics (6 - 12 September 1978), sponsored by WHO and UNICEF. The Declaration is one of the major public health milestones of the twentieth century. The Declaration affirmed the WHO constitution's definition of health and the recognition of health as a fundamental human right. It emphasized the principles of universal accessibility and coverage based on need (equity), comprehensive care (promotional, preventive, curative, and rehabilitative care), community and individual involvement and self-reliance, the intersectoral action for health, and the appropriate technology and cost-effectiveness in relation to available resources. It adopted Primary Health Care (PHC) as an essential tool to achieve health for all (World Health Organization 1978).

The Declaration stated the need for a *"New International Economic Order"* to realize health for all and achieve equity between developed and developing nations (World Health Organization 1978). This statement provided a solid basis for

dealing with health governance as a sub-domain of political and economic governance at international and national levels. This assumption is aligned with understanding health as an outcome of the interaction between biological factors and social, economic, political, and environmental determinants. It is worth noting that the Declaration of Alma Ata was adopted within the context of the Cold War, the oil price crisis that followed the 1973 Arab-Israeli war, and it was only possible with the leadership of Dr. Hafdan Mahler, the Director-General of WHO at that time (Cueto 2004).

At the national level, the Alma Ata Declaration reaffirmed the central role of governments by giving them full responsibility for the health of their people. Globally, the Declaration considered health for all peoples of the world a shared responsibility between governmental and international organizations and the international community (Exworthy 2008).

In conclusion, the Declaration of Alma Ata consolidated the social model of health (Exworthy 2008), provided a solid basis for health governance as a sub-domain of political and economic governance, and innovated the notion of collective responsibility of governments, international multilateral institutions, and the international community at large to achieve health for all peoples of the world by 2000 as a social target (World Health Organization 1978).

## **SELECTIVE PRIMARY HEALTH CARE (1979)**

One year after the vast adoption of the Declaration of Alma Ata, two researchers from the United States, Julia Walsh and Kenneth Warren, backed by the Rockefeller Foundation, published an article in the *New England Journal of Medicine* titled "Selective Primary Health Care — An Interim Strategy for Disease Control in Developing Countries" (Walsh & Warren 1979). The article argued that comprehensive PHC, as articulated in the Declaration of Alma Ata, is costly to implement and that there is a need for an interim strategy that is feasible for the majority of developing countries. Their suggested interim strategy included four interventions focusing on children: growth monitoring, oral rehydration, breastfeeding, and immunization. These interventions were selected based on an analysis of the leading causes of death in early childhood. Later, three more interventions were added to the list, including family planning, food supplements, and female education.

During the same year, the Rockefeller Foundation sponsored a small meeting on its premises in Bellagio, Italy, to discuss what they considered to be the crisis to Alma Ata Declaration

(i.e., being too broad, idealistic, costly to implement, and unrealistic to achieve by 2000). The meeting organizers included the leaders of Western, mainly North American-based organizations and donor agencies, as well as the World Bank (Cueto 2004).

The four 'selective' interventions appealed to donors as they are easy to monitor and evaluate, measurable, and have numerical targets. The international monetary institutions, especially the World Bank, and the big Western donors used this argument to adopt, fund, and promote this strategy among developing countries. The Selective Primary Health Care (SPHC) approach led to donor-driven, donor-dependent, vertical, and non-sustainable programs in developing countries (Obimbo 2003). For example, the coverage of immunization programs in Kenya fell from 60% in 1987 to 32% in 1997 when donors withdrew their financial support (Obimbo 2003).

The Rockefeller-hosted meeting in Bellagio sought to examine the potential for a decision-making process in global health that does not use the platforms offered by the UN. The movement of the SPHC introduced a gradual change to the landscape of global governance for health with a growing role of Western donors in driving the health system agendas in developing countries and the weakening role of the WHO.

## **THE WASHINGTON CONSENSUS AND STRUCTURAL ADJUSTMENT PROGRAMS (1990S)**

The Washington Consensus refers to a set of ten market economy principles presented initially by John Williamson in 1989, which gained wide adoption by prominent economists who are supportive of market economy ideas, big powers (the United States and European Union), and monetary institutes (the World Bank and the International Monetary Fund) (Pettinger 2017). The ten principles were low government borrowing, redirection of public spending, tax reform to broaden the tax base, market-determined interest rates, competitive exchange rates, trade liberalization, openness to direct foreign investment, privatization, deregulation, and secure property rights (Rodrik 2006). Since the 1990s, international financial institutions have been providing low-interest loans to developing countries with conditions of implementing the principles of the Washington Consensus, known as structural adjustment programs (SAPs). In the health sector, SAPs translated into the following health sector reform (HSR) policies:

- Withdrawal of the State from health service provision;
- Reduction of health spending and adopting a low-cost, basic package of interventions;
- Decentralization; and
- Mobilization of multiple sources for healthcare financing.

These measures reinforced the bio-medical oriented, curative, and selective approach to healthcare and initiated a massive wave of privatization. Studies have shown that SAPs policies have slowed down improvements in, or worsened, the health status of people in countries implementing them through, for example (Loewenson 1993):

- Worsening of nutritional status of children;
- Increased incidence of infectious diseases; and
- Higher infant and maternal mortality rates.

SAPs have further consolidated the domination of global governance for health by rich countries (primarily the United States and the European Union) and affiliated financing mechanisms or donors. At the country level, they concentrated the decision-making power in finance rather than health ministries.

### **The Impact of SAPs: The Case of Sudan**

In 1992, the government of Sudan (before it was divided into Sudan and South Sudan) adopted major structural economic reforms under the name of 'liberalization policies.' The impact of these reforms on the health sector was reported in several areas:

- **Decreased healthcare financing:** Governmental spending on health services declined by 83% in seven years from 1.4 Sudanese pounds (SPG.) per capita in 1986/87 to 0.24 SPG in 1993/94. This severe decline was not justified by the limitation of financial resources as the general domestic product increased by 21.6% in the same period (Babiker 1996). The reduction of public health spending and gradual withdrawal from the health (and social) services provision was aligned with standard measures of the International Monetary Fund (IMF) and the World Bank (WB) at that time. They were also favorable to the political priorities of Sudan during the war in the south of the country in the early 1990s.

- **Introduction of a user fee at the time of service:**

In the early 1990s, the Sudanese government implemented some “closing the gap” measures in healthcare financing associated with the reduction of public spending. It innovated the ‘self-help system.’ A change from the dominant free health services system before the 1990s to a ‘cost-sharing’ system under which the public facilities began to collect higher fees at the time of health service provision in outpatient and inpatient settings. The ‘self-help system’ was followed by presenting the ‘economical treatment’ program in selected healthcare centers in Khartoum. The healthcare services provided by these selected centers were considered upgraded services compared with those offered by regular public facilities. The fees were mid-way between the ‘self-help’ fees at the regular public healthcare facilities and the cost of private facilities (OSSREA 1999).

The two models of collecting fees from users at the time of service provision were presented under the name of ‘promotion of healthcare services,’ which attributed the deterioration of healthcare services in the country to the lack of financial resources and the overuse of services. The government justified the direct fee-for-services as one of the measures to regulate the utilization of healthcare services and secure financial resources to improve their quality.

- **Decreased access and utilization of public healthcare services:** This period in Sudan witnessed a high burden of infectious disease and malnutrition due to low living standards, poverty, and the consequences of the war in Southern Sudan (UNICEF 1996). Despite the high disease burden, the utilization of public healthcare declined. A study by the Organization for Social Science Research in Eastern and Southern Africa (OSSREA) attributed this decline to the increase in the cost of public healthcare services associated with deterioration in the quality of care which directed users to the private healthcare sector (OSSREA 1999).

Governance-wise, the 'health sector reform' in the early 1990s in Sudan was a sub-domain of economic liberalization and was informed by the liberalization agenda of the IMF/WB and the military agenda of the government of Sudan rather than responding to a well-studied reform based on systematically assessed needs.

## GLOBAL INITIATIVES (1990s AND 2000s)

In the 1990s through the 2000s, more than 100 global financial mechanisms were established to fund different aspects of health development. This resulted in the following features:

- **Donor-driven priorities:** Further fragmentation of health systems at the national level (more vertical programs).
- **Financial mess:** Excessive demand on government time and loyalty to donors.
- **Concentration of health personnel in funded projects:** Neglected places and neglected areas of healthcare.
- **Creating dependency:** No serious sustainability plan.

In addition to the international monetary institutions and governmental organizations affiliated with rich countries (primarily the United States and European Union), the global initiatives consolidated the role of transnational corporations and business fronts as key players in global health decision-making. This was natural since the majority of these financing mechanisms were heavily funded by corporations or private foundations.

### **The Case of the Child Survival Project in Egypt**

In the early 1980s, the U.S. Agency for International Development (USAID) developed a donor strategy for child survival in Egypt (Tumavick et al. 1990). While describing it as a donor strategy, the donor, USAID, reported that the strategy was developed in collaboration with the Government of Egypt, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO). The project adopted two interventions: (1) Extensive use of oral rehydration therapy (ORT) to limit the severe consequences of childhood diarrhea, and (2) Expanding the childhood immunization program against six communicable diseases (tuberculosis, diphtheria, pertussis, tetanus, polio, and measles).

The Child Survival Project is a demonstrative example of a vertical program that follows the notion of SPHC that was widely adopted by Western donors. The use of ORT continues to be a cost-effective best practice in the initial management of diarrhea among children under five years (Mosegui et al. 2019). However, it deals with the disease (diarrhea) when it occurs and does not address the causes or the risk factors of the disease; that is, ORT reduces the incidence of diarrhea but only treats it after it occurs. National surveys concluded a positive change in the awareness of the importance of ORT, while the national statistics showed a decline in infant mortality. A formal USAID report claimed that both changes were due to the National Control of Diarrheal Diseases project (NCDDP) in Egypt (Tumavick et al. 1990). The same report indicated that there was no evidence of a decline in the severity of diarrheal attacks in infants and children or a decrease in prevalence of cases of dehydration attributed to NCDDP. In other words, available data at this time could not establish evidence on the role of NCDDP in decreasing the prevalence nor the severity of dehydration cases. In addition, data available at this time did not indicate any significant impact of the NCDDP on the incidence of diarrhea among infants and children. It is likely because the NCDDP does not address the root causes of the disease, e.g., access to safe drinking water and a proper sanitation system.



Werner and Sanders (1997) compared comprehensive primary healthcare versus selective primary healthcare in child diarrhea in their book, "Questioning the Solution: The Politics of Primary Health Care and Child Survival (with an in-depth critique of Oral Rehydration Therapy)" (Werner & Sanders 1997). It clearly showed the limitation of selective primary healthcare in affecting the occurrence of diarrhea or assisting with improving child outcomes by only adopting selective curative approach.

**Table 1. Comprehensive versus selective primary health care in addressing diarrhea in children**

Rehabilitative	Curative	Preventive	Promotive
▼ Nutrition Rehabilitation	▼ ORT	▼ Education for personal & food hygiene	▼ Water
	Nutrition support	Measles vaccination	Sanitation
		Breastfeeding	Household food security

| Source: Werner & Sanders, 1997

## WHO MAKES HEALTH DECISIONS?

### THE MOVE FROM STATE-CONTROLLED GOVERNANCE TO MULTI-STAKEHOLDERS (STAKEHOLDERIZATION)

As described in the previous section, during the last four decades, global governance for health has been changed from the domination of United Nations specialized organizations, especially WHO and partially UNICEF, UNDP, UNFPA, UNAIDS, etc. to the domination of Bretton Woods Institutions (International Monetary Fund, World Bank, and World Trade Organization) to the domination of transnational corporations and private foundations (e.g., Bill and Melinda Gates Foundation), as demonstrated in **Figure 1** below.

#### ■ SOURCES OF WHO FUNDING

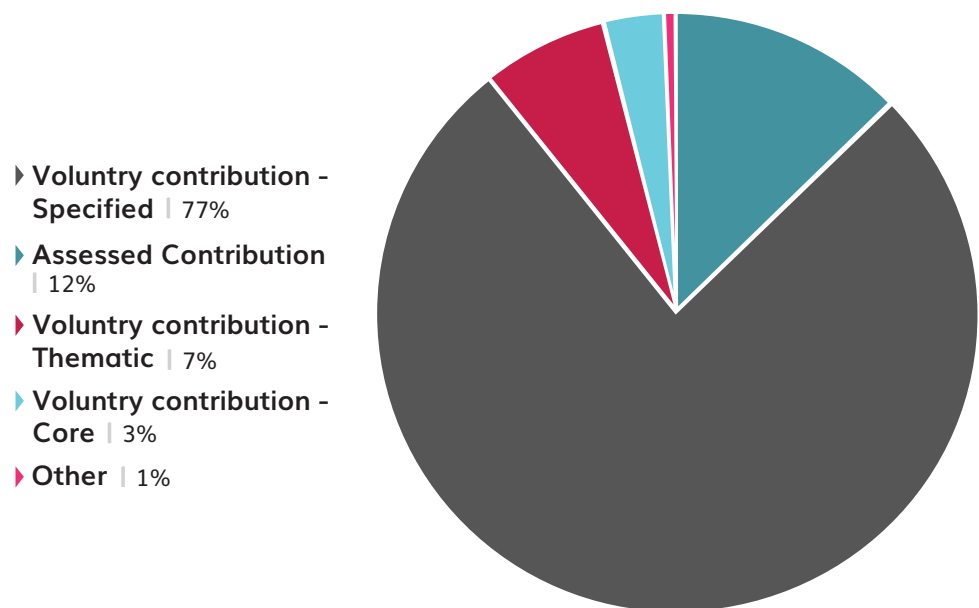
In addition to its immense underfunding, WHO faces four crises in relation to its financing. It suffers misalignment between program budgets and financial commitments from member states, financial unpredictability, lack of transparency in financing and distribution of available funding, and inefficiency in managing the available financial resources (Reddy et al. 2018). To put this in context, the total WHO program budget in 2020-2021 was less than 7.6 billion, which is less than one-fifth of the healthcare budget of the State of Texas, USA, for the same fiscal year (Texas Health and Human Services 2021). Sources of WHO funding can be categorized as:

- Assessed contributions are a percentage of a country's gross domestic product (the percentage is agreed upon by the United Nations General Assembly). Member States approve them every two years at the World Health Assembly.
- Voluntary contributions are largely from Member States as well as from other United Nations organizations, intergovernmental organizations, philanthropic foundations, the private sector, and other sources.

In the WHO budget for 2020-2021, the assessed contribution accounted only for 12% of the total budget, while voluntary contributions represented 87% (refer to Figure 1). The WHO's dependence on voluntary contributions enables external donors

to dictate the WHO's institutional priorities and action agendas (Reddy et al. 2018). **Table 2** and **Table 3** show the impact of voluntary contributions on re-orienting the WHO priorities. One of the clear examples is how the generous funding of the Bill and Melinda Gates Foundation to polio eradication made polio eradication a second priority of WHO even during the COVID-19 pandemic.

**Figure 1. World Health Organization revenue by type, 2020-2021**



| Source: WHO, Contributions 2020-2021: Funding by Contributor. [Link](#).

**Table 2. Distribution of the voluntary contribution of Bill & Melinda Gates Foundation**

Program	%	Program	%
Polio eradication	64.37%	Reduced number of people suffering from financial hardship	0.55%
Improved access to quality essential health services	13.43%	Financial, human and administrative resources managed in an efficient, effective, result-oriented and transparent manner	0.50%
Strengthened country capacity in data and innovation	5.92%	Strengthened leadership, governance and advocacy for health	0.48%
Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	5.21%	Health emergencies rapidly detected and responded to	0.19%
Endemics and pandemics prevented	3.14%	Proven prevention strategies for priority pandemics / epidemic-prone diseases implemented at scale	0.17%
Acute health emergencies rapidly responded to, leveraging relevant national capacities	2.47%	Health settings and health in all policies promoted	0.15%
Special program of research, development and research training in human reproduction	0.86%	Countries prepared for health emergencies	0.03%
Risk factors reduced through multisectoral action	0.85%	Countries operationally ready to assess and manage identified risks and vulnerabilities	0.03%
Social determinants of health	0.84%	Fast tracked delivery for pandemic-causing pathogens	0.01%
Special program for research and training in tropical diseases	0.80%		

Source: WHO Official Program Budget Portal

Table 3. Distribution of WHO overall budget

Program	%	Program	%
Acute health emergencies rapidly responded to, leveraging relevant national capacities	40.52%	Social determinants of health	1.47%
Polio eradication and transition plans implemented in partnership with the global polio eradication initiative	15.56%	Countries operationally ready to assess and manage identified risks and vulnerabilities	1.38%
Improved access to quality essential health services	14.82%	Risk factors reduced through multisectoral action	1.22%
Epidemics and pandemics prevented	5.14%	Strengthened leadership, governance and advocacy for health	1.18%
Proven prevention strategies for priority pandemics / epidemic-prone diseases implemented at scale	3.61%	Reduced number of people suffering from financial hardship	0.85%
Improved access to essential medicines, vaccines, diagnostics and devices for primary health care	3.34%	Fast tracked delivery for pandemic-causing pathogens	0.75%
Health emergencies rapidly detected and responded to	2.48%	Special program for research and training in tropical diseases	0.68%
Strengthened country capacity in data and innovation	2.17%	Financial, human and administrative resources managed in an efficient, effective, result-oriented and transparent manner	0.41%
Countries prepared for health emergencies	2.14%	Health settings and health in all policies promoted	0.39%
Special program of research, development and research training in human reproduction	1.52%	Pandemic influenza preparedness framework	0.39%

| Source: WHO Official Program Budget Portal

## THE CURRENT GOVERNANCE STRUCTURES FOR GLOBAL HEALTH AND THE CHANNELS THROUGH WHICH THEY INFLUENCE DECISION MAKING

Legge (Legge 2023) recognized six categories of actors in global governance for health:

1. Multilateral organizations and international treaties (U.N. system – WHO, UNICEF, UNDP, UNAIDS, ECOSOC; Bretton Woods system – IMF and WB; trade agreements, etc.)
2. Inter-governmental bodies and big powers (G8, G20, OECD, E.U., U.S.A., etc)
3. Transnational corporations (big pharma and food industry)
4. Market disciplines (demand and supply and how it applies in health)
5. Social movements
6. Knowledge flow

### ■ TRANSNATIONAL CORPORATIONS (T.N.C.S)

Transnational organizations have been growing in size, increasing in number, and carrying an increasing proportion of global trade. They play a dominant role in mobilizing funds and technologies for investment. For example, the role of big pharmaceuticals in global governance for health is a good example of the growing influential role of corporations in governance for health at both global and national levels. The story of the interaction between the Egyptian government and Gilead is an illustrative example, and is described below.

#### Back to 2015: The Case of Hepatitis C and Big Pharmaceuticals in Egypt

Despite the recent and ongoing advancements in curative treatments for Hepatitis C Virus (HCV), access to the antiviral treatment remains limited in Egypt. In 2008, the National Committee for the Control of Viral Hepatitis (NCCVH) published a 5-year strategy (2008-2012). It estimated that in 2008 the number of HCV patients who would be eligible for antiviral treatment was 600,000 (Dalglish 2008). However, from 2008-2011, only 190,000

patients received the treatment. The number of patients receiving treatment was 22,000 in 2008, increased to 65,000 in 2009 and then declined gradually to 58,000 and 45,000 in 2010 and 2011, respectively (Centers for Disease Control and Prevention 2012). In a more recent survey, 38% of HCV patients between 15-59 years in a nationally representative sample self-reported receiving HCV antiviral treatment. The percentage was 29.7% for women and 41.7% for men. However, the majority of them self-reported receiving the old treatment regime (interferon) with a 51% cure rate while only 4.8% reported receiving new antiviral medicines (Sofosbuvir or Olysio) with a 79-96% cure rate (Ministry of Health and Population, Egypt 2015).

The strategy, which the Egyptian health authorities continue to follow, tied expanding the access of HCV antiviral treatment to the distribution of a relatively low-priced course of the antiviral treatment through governmental medical facilities based on strict guidelines. During the last decade, the Egyptian government has repeatedly adopted the approach of negotiating with pharmaceutical companies for a reduced price-HCV antiviral treatment for use within the public sector. For example, in 2008, the government reached an agreement with two transnational pharmaceutical companies (Merck and Roche) to produce locally-packed Pegylated Interferon at US\$2,000 (to be paid by the patients) instead of US\$12,000 (the international price) for a 48-week treatment course (as cited in Kaplan and Swan 2012). The reduced price represented 47% of the average annual Egyptian family income and 56% of the annual income of rural households in the fiscal year 2010-2011.

In 2014, the Egyptian Government repeated a similar deal with Gilead Sciences (a US-based pharmaceutical company) to purchase a preparation of Simeprevir (as a part of the currently recommended triple therapy) at US\$900 (to be paid by the patients) instead of US\$84,000 (the original price in the US market) (Fick & Hirschler 2014). This significant reduction in the cost was not reflected in a corresponding expansion of the HCV treatment coverage. This suggests that cost is still beyond the affordability of patients and/or there are

a broader range of barriers (Dalglish 2012; Ministry of Health and Population, Egypt 2015). Such uncertainties reflect a knowledge gap in identifying the barriers to HCV antiviral treatment and/or the ability of the limited existing knowledge to guide an informed decision making process.



## CONCLUSION

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Governance for health is a sub-domain of economic governance. As the case studies in this report demonstrated, the domination of neoliberal policies, financialization of the economy, and stakeholderization have influenced the governance structure for health. This paper also provided some definitions and an overview of some of the financing mechanisms for health.

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# NEOLIBERAL GLOBALIZATION AND HUMAN RIGHTS

## A right to health model

### Mohammed Said Al-Saadi

Political Economy Researcher

Mohammed Said Al-Saadi is an economist and independent consultant. He has written numerous books and publications on Business groups and Development, the Moroccan Economy, Gender and Euro-Mediterranean Partnership, and is a social activist. His research topics cover rethinking development models and developmental states, the impact of the neoliberal and global crisis on Arab countries, industrialization and industrial policies.

## INTRODUCTION

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The past four decades of human history have witnessed the expansion of neoliberal globalization across a large portion of the globe. In its economic dimension, this expanse was based on the postulate that focusing on macroeconomic stability (particularly by controlling inflation and reducing government budget deficit), liberalizing the economy by activating market mechanisms, privatizing public enterprises (or institutions) and facilities, removing obstacles hindering the free flow of goods, services, and capitals, would put an end to rentier activities, promote competition, improve available opportunities for exportation, and help narrow the gap between individual income in poor states and those in wealthy states. These promises never crystallized into tangible reality. They became illusions (السعدي/Al-Saadi 2022), particularly in terms of improving the growth rate and reducing differences between (and within) countries. It gets worse when it comes to the implementation of internationally-recognized economic, social, and cultural rights, most notably the right to health for everyone.

This report attempts to highlight the correlation between neoliberal globalization and human rights with a focus on the right to health. We relied on available academic research and studies as well as outputs and statistics published by international, regional, and national organizations. The report explicates the negative effect of neoliberal globalization on economic rights, particularly the right to health, and sheds light on the mechanisms producing these negative outcomes.

The first section of the study will present the concept of neoliberal globalization and the role of international financial institutions (the International Monetary Fund (IMF) and the World Bank specifically) in its world expansion, especially in the global south, also known as the developing countries. These institutions use conditionality to impose structural adjustment programs (SAPs; also called "economic reform") based on the economic liberalization, privatization, and austerity trifecta. We demonstrate the negative effect of these programs by focusing on the right to health.

The second and third sections will focus on the Arab region as a case study. In the second section, we address the effects of

austerity policies on the implementation of the right to health for all citizens, while the third and final section showcases how privatization of the health sector and business agreements negatively affect the right to health.

# NEOLIBERAL GLOBALIZATION, INTERNATIONAL FINANCIAL INSTITUTIONS, AND HUMAN RIGHTS

## THE EVOLUTION OF THE GLOBALIZATION PHENOMENON AND THE ROLE OF INTERNATIONAL FINANCIAL INSTITUTIONS

Globalization is not a new phenomenon despite the excessive use of this term in scientific, journalistic, financial, business, and public opinion rhetoric. It is an organic by-product of capitalism due to the latter's tendency to spread internally (by dominating the various facets of economic, social, cultural, and environmental life) and geographically, to ensure the continuity of capital accumulation and profit maximization. Three main historical phases can be identified in the evolution of globalization: colonialism, "constrictive" globalization, and neoliberal globalization.

Colonialism was the direct expansion by western major powers across the globe due to their race to occupy different parts of the world for economic and strategic reasons. These powers were seeking new markets for their industrial products and financial investments while controlling the raw material and agricultural resources necessary for their economies. This colonialist phase of globalization ingrained vulnerability and dependency on the fluctuations of raw material prices in the colonized global south. This situation lasted from the last quarter of the 19th century until the end of World War II (WWII).

Constrictive and "negotiated" globalization (meaning that "the governments and peoples of Asia and Africa, the Soviet Union, and the United States and their allies created a multipolar negotiating structure that governs the world order" (العولمة وبدائلها 2018)). The constrictive aspect of capitalist globalization is due to post-WWII circumstances, where labor unions and parties in developed capitalist countries were able to impose a power balance that resulted in the adoption of the welfare state model and the domination of the Keynesian ideology on public policies. Capitalism had to adapt to the requirements of social relations.

Nevertheless, this globalization soon started to lose its luster



in the beginning of the 1970s with the rise of inflation and recession. This flung the doors wide open for the transition to neoliberal globalization with Margaret Thatcher's and Ronald Reagan's ascension to power in Britain and the United States in 1979 and 1980 respectively.

Neoliberal Globalization: this phase was marked by capitalism regaining the upper hand. It imposed its political project and economic agenda that are based on a "liberal economy" and prodded governments to decrease taxes, lift restrictions on the banking and financial sector, and reduce labor costs by creating labor market "flexibility." As a result, capitalist developed countries would adopt the trifecta of economy "liberalization", privatization, and maintenance of macroeconomic balances aimed at creating the appropriate climate for activating market mechanisms. These alone could achieve optimal employment of available resources.

## **INTERNATIONAL INSTITUTIONS AS KEY ACTORS TO IMPLEMENT NEOLIBERAL GLOBALIZATION: STRUCTURAL ADJUSTMENT PROGRAMS**

Following WWII, the Bretton Woods Institutions were established. These comprised the IMF, the World Bank (WB), and the General Agreement on Tariffs and Trade (GATT), which would later become the World Trade Organization (WTO) in 1995. These institutions aimed to ensure the evolution and stability of the global capitalist system led and controlled by the United States through free trade exchange and an international monetary and financial framework. However, in 1971, the United States decided to suspend the dollar's convertibility into gold (one of the most important pillars of the Bretton Woods system). This led to a structural crisis and a transformation in the duties of the two international financial institutions (the IMF and World Bank). Subsequently, these two institutions would approach third world countries drowning in external debt to ensure they pay their creditors, essentially to save developed capitalist countries' banks. These aforementioned institutions would impose harsh conditionality in exchange for loans aimed at having the debtors forsake their state-directed economic model for the sake of a model that is based on liberal markets, free initiative, and a redirection of the economy towards exportation. This is the "structural adjustment" that was imposed on countries, also known as the "Washington Consensus" (between the US Department

of the Treasury, the IMF, and the World Bank) (Stiglitz & Pike 2004), based on the economic liberalization, privatization, and austerity trifecta.

It is worth noting that the main goal of these programs was to integrate the global south into the globalized capitalist system and to respond to the expansion needs and additional capital accumulation, and world domination of major monopolies and multinational companies (Petras & Veltmeyer 2011). Percy Barnevik, CEO of ASEA Brown Boveri, put this reality into simple words in his definition of globalization: "I would define globalization as the freedom for my group of companies to invest where it wants when it wants, to produce what it wants, to buy and sell where it wants, and support the fewest restrictions possible coming from labor laws and social conventions" (Chesnais 1997). Structural adjustment and stabilization programs consist of restoring macroeconomic balance (controlling inflation, balancing the public budget and the balance of payments), gradually liberating industrial, trade, and financial sectors, privatizing public sector companies, and lifting administrative and regulatory restrictions on private sector initiatives. The restoration of macroeconomic balance requires applying strict austerity policies such as reducing public expenditure, wage bill cuts/caps, eliminating subsidies on basic goods, while economy liberalization is conducted through more liberal trade policies, liberalization of the exchange rate and prices in general.

In terms of controlling and rationing, the expected changes mainly aim to "improve the business climate", i.e., government measures regulating private sector activities, including the labor law, to make work relations more flexible.

If the role of the IMF stalled during the first decade of the 21st century, it made a strong comeback with the global financial crisis of 2008, especially after the emergence of the European sovereign debt crisis due to the state's extensive intervention to save the financial and banking sector from collapsing. The most notable measures that were taken to implement structural adjustment programs and austerity policies against the European sovereign debt crisis were: phasing-out or eliminating subsidies on basic goods such as fuel, electricity, food items, and agricultural inputs, wage bill cuts/caps, increasing taxes on sales and value-added tax (VAT), "reforming" pension systems, privatizing public facilities, and applying labor flexibility, etc. (السعدي/Al-Saadi 2022).

## NEOLIBERAL GLOBALIZATION AND HUMAN RIGHTS (PARTICULARLY THE RIGHT TO HEALTH)

### ■ THE EFFECTS OF STRUCTURAL ADJUSTMENT PROGRAMS (SAPS) ON HUMAN RIGHTS

Due to considerations related to the space allocated to this report, we will present the connections between neoliberal economic policies and certain economic and social rights. For a more thorough analysis of these connections see (Balakrishnan & Elson 2011). We will expand more on this subject in the section related to the right to health.

A group of UN experts conducted a careful review of the documents and publications resulting from 20 years of structural adjustment in Africa and Latin America. This review concluded that "these policies were not consistent with the long-term developmental needs of developing countries. The available evidence refutes the claims of the World Bank and the IMF that SAPs reduce poverty and promotes democracy. SAPs use the principles of liberal economic activity to emphasize efficiency and productivity and is biased towards groups that exercise exportation and international trade at the expense of civil freedom and autonomy" (1999 آثار سياسات التكيف الهيكلي / The Effects of Structural Adjustment Policies). This impact is the most evident on the levels of the rights to work, food, and education.

#### **The right to work**

The International Covenant on Economic, Social and Cultural Rights (ICESCR) acknowledges every person's right to "just and satisfactory" work conditions. This means having fair wages and equal pay for equal work that is sufficient to provide a decent life for workers and their families. Article 8 acknowledges the worker's right to form or join unions that protect their right to strike. This article emphasizes safe working conditions, equal opportunity in the workplace, and sufficient periods of rest and free time, including defined working hours and regular paid vacations. The ICESCR also urges the World Bank and the IMF to take into consideration the need to protect the right to work in adopted loan-related policies.

However, it is worth noting that "reforms" recommended by these institutions directly harm the right to work in just conditions by focusing on the flexibility of the labor market,

claiming that the latter is a decisive factor in improving the competitiveness of goods and services in borrowing countries. Critics have highlighted that the IMF and World Bank often underestimate the negative repercussions of "labor flexibility" in relation to human rights. And so, the report of the United Nations Human Rights Committee confirms that policies pushing for "labor flexibility" are considered a violation of human rights (United Nations General Assembly, 2016). Additionally, a number of neoliberal economic "reforms" negatively and indirectly impact the protection of workers' rights. Liberalizing trade and attracting foreign investments are a downward spiral that is heading away from the respect of workers' rights, where local capital pushes decision-makers to reduce wages so they can keep up with global competition. Moreover, severe monetary policies prod governments to abandon wage-related workers' rights (such as minimum wage), using the resulting inflation as argument (Stubbs & Kentikelenis 2017).

### **The right to food**

Applying SAPs resulted in a real threat to food security for large portions of global south societies. UN experts affirm that malnutrition and unemployment have increased among the poor due to the elimination of food assistance. Changing agricultural policies – from production for local consumption to production for exportation, such as coffee beans, cotton, or tobacco – has led to a sharp decline in food production and a rise in malnutrition (1999 آثار سياسات التكيف الهيكلي/The Effects of Structural Adjustment Policies).

### **The right to education**

International conventions consider that every person has a right to education (Article 26 of the Universal Declaration of Human Rights). It was noted that SAPs contributed to the reversal of some of the achievements made by a number of "developing" countries in children's education during the 1960s and 1970s. This is essentially due to reducing spending on education. Primary education was negatively affected as the United Nations Educational, Scientific and Cultural Organization (UNESCO) has registered a decrease in 6- to 11-year-old children's enrolment in schools. This could influence gender equality as parents will refrain from enrolling their daughters in school when having to choose who will receive an education, due to the increase in school fees. This discrimination could have negative, long-term effects on the health of infants and children considering the vital relation between the child's well-being and the mother's level

of education (1999 آثار سياسات التكيف الهيكلي /The Effects of Structural Adjustment Policies).

### **The right to housing**

Low or reduced wages and unemployment due to the implementation of SAPs prevent many households from fulfilling their basic needs, especially in terms of housing. In addition, the elevated interest rates annihilate any hope of purchasing a home. Moreover, as the state refrains from providing housing directly or through assistance to disadvantaged households and lifts the restrictive rental market controls, private property owners are more likely to take advantage of the poor, who often allocate a significant amount of their income—almost half—for rent (آثار سياسات التكيف الهيكلي 1999/The Effects of Structural Adjustment Policies).

## **■ THE EFFECTS OF NEOLIBERAL GLOBALIZATION ON THE RIGHT TO HEALTH**

The International Covenant on Economic, Social and Cultural Rights (ICESCR) includes the most comprehensive article related to the right to health in international human rights law. According to Article 12 of the Covenant, "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", in addition, for instance, it refers to a number of "steps to be taken by the States Parties...to achieve the full realization of this right". However, the "neoliberal reforms" included in the SAPs, namely pressuring public expenditure, lifting regulatory controls, and privatizing the health sector negatively affected the realization of this right according to international legislations. To analyze the negative repercussions of these "reforms", we utilize the conceptual framework developed by Kentikelenis (2017), which looks at the multiple pathways through which SAPs promoted by the IMF and World Bank affect health systems, including through direct effects channels, indirect effects channels (moderated through macroeconomic and institutional reforms), and the impact of SAPs on the social determinants of health. The framework and various channels are described further below Kentikelenis (2017).

### **Direct effects channels**

**First:** Stabilization policy and austerity measures reduce public health expenditure. This may affect investments in particular, and subsequently health services (the available number of health facilities for instance). In turn, we notice that the agreed SAPs between international financial institutions (IFIs)

and Latin American countries have led to decreases in public expenditures on social policy and social security, but increases in health spending.

**Second:** The healthcare workforce is also affected due to redundancies, hiring freezes, and wage bill cuts (by setting maximum wage), leading to the migration of healthcare workers.

**Third:** User fees for access to healthcare services reduce vulnerable groups' ability to access these services.

**Fourth:** Lifting regulatory controls contributes to the growth of the private health sector. This transformation was associated with social class discrimination, as strata of the population able to afford private healthcare can gain access to a broader bundle of services. However, this may be coupled with the state rolling back public provision to a limited array of services for the poor or outsourcing it to non-governmental organizations. As a result of these direct effects on the right to health, non-state actors have often been sought to fill the gap (particularly international organizations and civil society associations).

### Indirect effects channels

**First:** Local currency devaluation leads to increases in prices of exported medications and medical equipment, making them harder to acquire, especially for low-income and vulnerable groups.

**Second:** The removal of tariffs and customs reduces trade tax revenues in the short-run, which can undermine the financial resources for the health sector. However, public revenues may increase if growth rates improve due to more openness.

**Third:** The privatization of public sector institutions increases public revenues. However, these could be harmed in the medium- and long-run once revenues generated by state-owned enterprises are lost.

### Effects on social determinants of health

Social determinants of health: the realization of the right to health does not solely entail an endeavor to eradicate diseases, but also its root causes. Beyond their effects on health systems, neoliberal policies can have a profound impact on the social determinants of health that could outlast the implementation period of SAPs. These four key effects are:

**First:** SAPs can result in a significant decrease in incomes and increases in unemployment and poverty, with follow-on effects

on social class inequalities. These in turn are root causes of health problems that could last a lifetime.

**Second:** Education is a key social determinant of health, as it improves individuals' knowledge about health and how to access health services, and positively impacts social mobility opportunities, which in turn feed into a host of other determinants of health (such as employment and income), yet neoliberal policies do not improve, but rather impede, access to education, especially for women and children. For example, the World Bank and IMF recommended the introduction of user fees for primary education or mandated education workforce reduction, thereby impeding educational attainment for children (1999 اثار سياسات التكيف الهيكلي/The Effects of Structural Adjustment Policies).

**Third:** The implementation of SAPs negatively impacts the environment and environmental policies, including water, sanitation, agriculture, and energy. For instance, IFI-mandated policies can result in environmental degradation, which in turn affects population health. In addition, the privatization of water distribution may render access more difficult for limited-income groups. These are all factors that may aggravate populations' health in the long run. Last but not least, the implementation of SAPs threatens social cohesion, changes cultural norms and societal values, and leads to a retreat to individualism and selfishness at the expense of public interest.

## AUSTERITY POLICIES AT THE EXPENSE OF THE RIGHT TO HEALTH IN THE ARAB REGION

Arab States (we focus in this research on middle-income countries, intentionally excluding Gulf countries), like the rest of the global south, witnessed the implementation of neoliberal policies within the framework of SAPs during the 1980s and the 1990s. These policies negatively impacted the right to health, either directly by marginalizing the public health sector, or indirectly through its repercussions on social determinants of health (unemployment and poverty, aggravated social class inequality, reduced level of education, etc.). Despite adopting the slogan of "health for everyone" and relying on the government to fulfill the majority of essential health needs, most Arab States faced qualitative obstacles such as reduced human resources and decreased levels of professional competence. This was coupled with a limited fiscal basis due to the pressures imposed on public expenditure, privatization policies, and commercialization of social services, leading to disparities in mortality and sickness rates along with inequality between income groups, in terms of gender, and geographical location (الفضيل/Fudayl 2012; بيومي/Bioumi 2016).

What interests us in this section is highlighting the negative effects of the continued implementation of neoliberal policies, and especially austerity measures, in the health sector post-Arab Spring and the resulting unpreparedness of several Arab States to address COVID-19. We will present the austerity policies that were adopted in the wake of the Arab Spring before analyzing its repercussions on the right to health in the Arab region.

### THE CONTINUED AUSTERITY POLICIES POST-ARAB SPRING

#### THE INTERNATIONAL MONETARY FUND POLICIES POST-ARAB SPRING

The IMF justifies the need to resort to austerity policies and its neoliberal components with the deceleration of global growth and economic recession in the Eurozone, in addition to increases of food item and fuel prices and the expansion of the Syrian crisis repercussions to neighboring countries. It



also mentions the post-Arab Spring internal factors marked by uncertainty and the faltering of current political reforms with governments increasing support for basic goods despite the continued significant funding needs (السعدي/Al-Saadi 2022).

As a way out of this situation, the IMF considers it a priority to maintain external and financial sustainability and reduce public debt. This requires activating the instruments of the public financial policy and monetary policy "to provide the conditions for comprehensive growth across all of society's sectors". On the one hand, public financial affairs must be controlled, public investments must be rationalized, and social safety nets for the poor must be strengthened. On the other hand, a cautious monetary policy against inflation must be adopted, currency exchange rate flexibility must be promoted, and structural reforms must be continued (review the labor market regulatory framework, reform, organize the business sector and governance, improve funding acquisition).

By laying out its vision, it is clear that the IMF is adopting the same approach we presented earlier: controlling budget deficit considers austerity policies an important factor to restore confidence in the private sector perceived as the driver for economic growth.

#### ■ **AGREED AUSTERITY MEASURES WITH THE IMF IN RETURN FOR LOANS OR THROUGH MONITORING REPORTS UNDER ARTICLE IV OF THE IMF'S ARTICLES OF AGREEMENT**

Despite the Arab Spring, governments in the Middle East and North Africa (MENA) region adopted an average of three austerity measures per country to control their public budget deficit (Ortiz & Cummins 2013).<sup>1</sup> Furthermore, countries also adopted wage bill cuts/caps and reviewing support programs and tax systems. Eliminating subsidies on basic goods (particularly fuel and food items such as flour, sugar, and oil) was the common measure between all Arab States included in the review by Ortiz and Cummins (2013), with the exception of Lebanon, despite its political and social implications, especially in the absence of comprehensive social protection policies in Arab States. In contrast, there were other "reforms" under study by governments in the region, such as increasing indirect taxes (VAT), decreasing tax exemptions, controlling wage bills, and reducing public institutions' running costs. Moreover, other states were planning on reconsidering "reforms" in pension systems (Tunisia) or reviewing their healthcare policy (Jordan) by rationing health spending and using pharmaceuticals (Ortiz & Cummins 2013).

<sup>1</sup> This average is based on an analysis conducted by Ortiz & Cummins, who analyzed 314 IMF country reports published between January 2010 to February 2013. Their study of 181 countries covered the following 10 countries in the Middle East & North Africa: Algeria, Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, Tunisia, and Yemen (Ortiz & Cummins 2013).

A study of the adopted measures between 2012 and 2015 has shown that promoting austerity harms development and social progress (Ortiz et al. 2015).<sup>2</sup> An analysis of the study findings offers the following conclusion: all governments in countries in the MENA region covered by the study focus on “reforming” the state’s subsidies on basic goods, particularly fuel, and food items sometimes, among others. Other common measures among all MENA countries covered by the study include: wage bill cuts/caps and “reforming” the labor market. On the one hand, Egypt has taken the decision to implement wage bill cuts, comprehensively review public wages system, and reduce pensions. Other countries followed suit, such as Algeria, Morocco, and Jordan. On the other hand, Algeria, Egypt, Jordan, Morocco, and Tunisia opted for introducing labor market “flexibility” by reducing regulatory controls and improving education programs (Ortiz et al. 2015).

## EFFECTS ON THE RIGHT TO HEALTH

IFI-imposed conditionality in the form of “fiscal adjustment” negatively affects the right to health through the numerous channels it is applied, most notably reducing government budget deficit, imposing restrictions on workforce employment, and exerting pressure on public investment in the health sector. We shall discuss the effects of these respective three channels on Arab States.

### LIMITING PUBLIC EXPENDITURE ON HEALTH AND CHARGING THE CITIZEN WITH A LARGER PART OF MEDICAL AND TREATMENT BILLS

**Figure 1** demonstrates the evolution of the “per capita total expenditure on health” between 2000 and 2019 in selected Arab States, excluding the Gulf states, for numerous considerations, most notably financial wealth, population size, and their ability to import foreign medical expertise. This indicator has witnessed considerable growth in countries such as Jordan, Tunisia, Algeria, and Egypt, and not as much in Lebanon, Morocco, and Iraq between 2000 and 2008. The same applies to the growth rate curve of “total health expenditure in relation to growth domestic product (GDP)” (**Figure 2**). The curve of this indicator rose between 2000 and 2008 in Tunisia, Morocco, and Egypt while it rose to a lesser degree in Morocco, Lebanon, and Iraq. The global economy witnessed

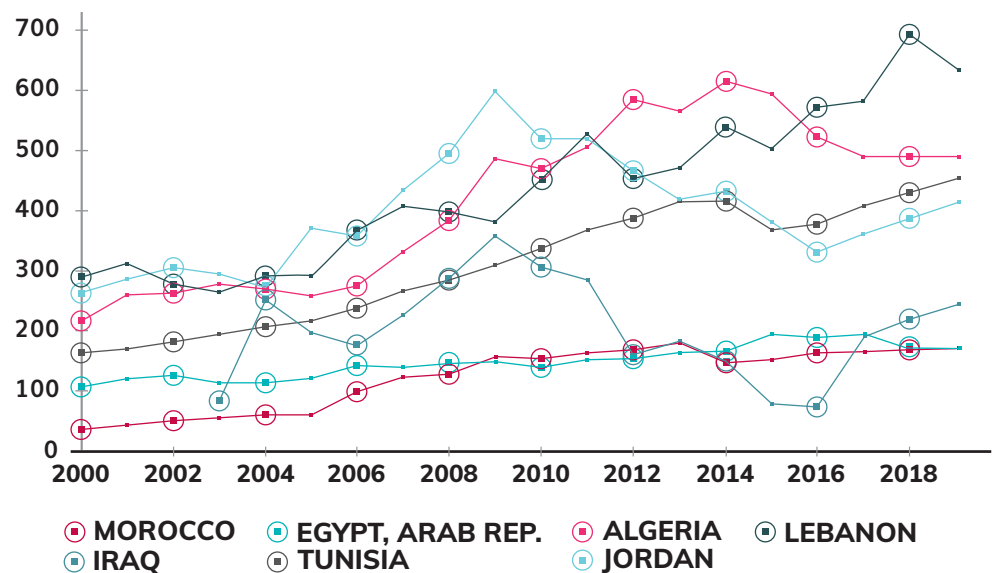
<sup>2</sup> The study by Ortiz et al. (2015) offers an analysis of 284 IMF country reports published from September 2012 to February 2015. Their study of 187 countries covered the following eight countries in the region: Algeria, Egypt, Iran, Jordan, Lebanon, Morocco, Tunisia, and Yemen.

significant recovery during the reported period, marked by "financialization" and the emergence of real estate and financial bubbles in the United States and Europe.

However, these bubbles exploded in 2008 leading to a global financial crisis that would cast its shadow on a number of countries across the world as of 2010. Subsequently, the European Union and many Arab States adopted austerity policies that would negatively impact their economic and social situations, including the health sector as of 2011-2013. The "total health expenditure per capita" tangibly decreased in varying percentages from one Arab country to another between 2012 and 2019. The same decrease was noted in the growth curve of "public health expenditure in relation to GDP" with significant dwindling in countries such as Egypt, Tunisia, and Algeria.

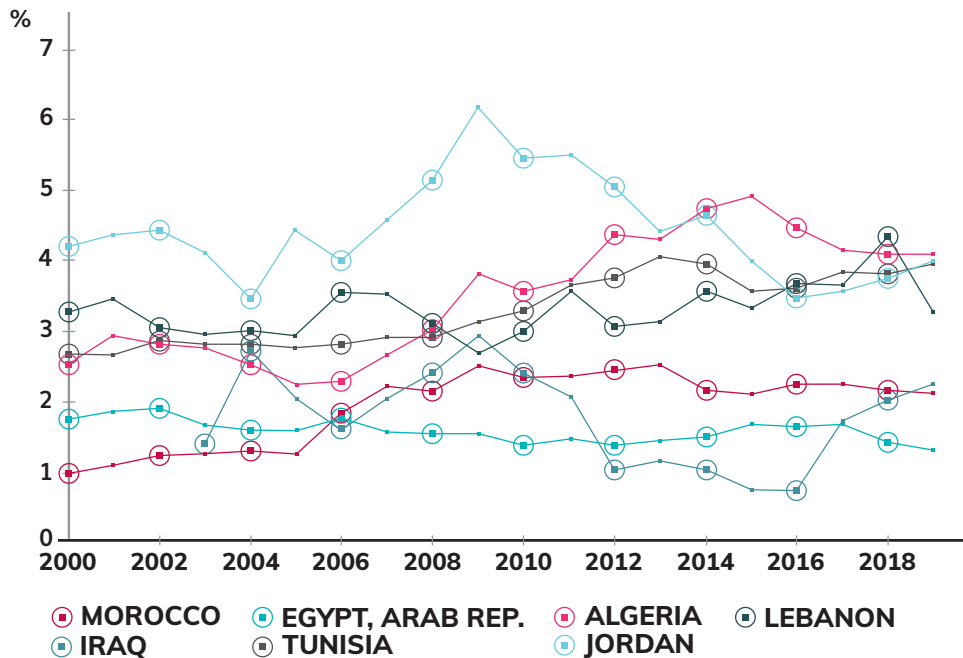
To make the picture clearer, we chose the "the general increase in health expenditure" in Morocco as an example, which registered a tangible decrease from 2010 to 2016 (**Figure 3**).

**Figure 1. Domestic general government health expenditure per capita, purchasing power parity (current international dollar): Morocco, Egypt, Tunisia, Algeria, Lebanon, Jordan, and Iraq**



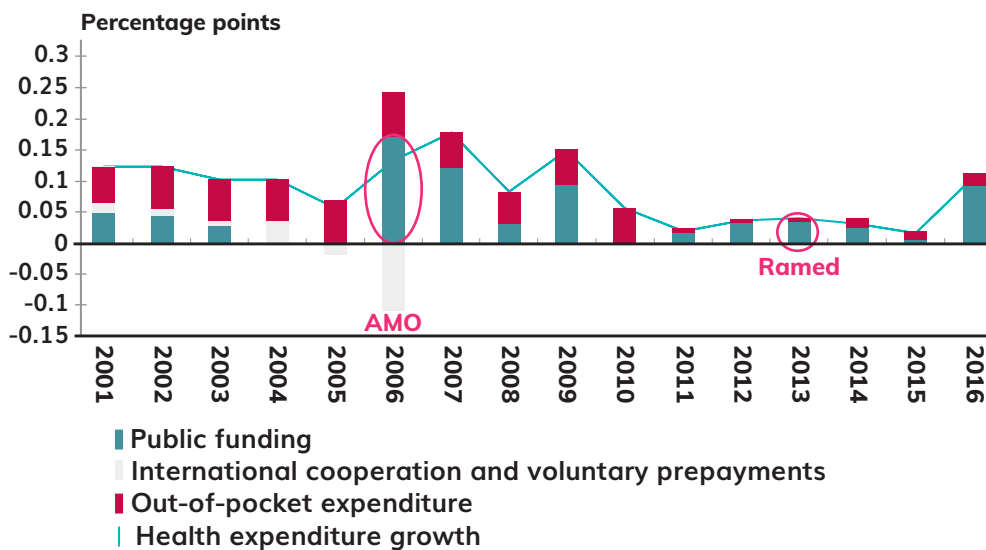
| Source: World Bank, World Development Indicators

**Figure 2. Domestic government health expenditure (% of GDP): Morocco, Egypt, Tunisia, Algeria, Lebanon, Jordan, and Iraq**



Source: World Bank, World Development Indicators

**Figure 3. Detailed growth of health expenditure in nominal terms in Morocco**



Source: Mobilizing tax revenues to finance the health system in Morocco, OECD: Global Health Expenditure (WHO), 2020.

Given the reduced total expenditure on health, citizens are forced to carry the larger part of their medical and treatment

needs. If we exclude the Arab Gulf region where state contributions cover at least 60% of these needs, the citizen pays the more significant share of medical needs in several countries in the region, especially in Egypt, Yemen, Syria, Iraq, and Morocco (**Table 1**).

**Table 1. Financial health indicators (out-of-pocket (OOP) spending)**

Country	OOP as % of health expenditure		
	2006/08	2015	2020
Egypt	57.4	58	62
Iraq	22.2	36.5	78.5
Jordan	42.9	23.5	30.4
Lebanon	41.2	34.3	33.1
Libya	28.3	29.7	26.5
Morocco	57.2	58.4	-
Sudan	70.2	75.8	73.9
Syria	52	53.9	-
Tunisia	45.6	35.3	39.9
Yemen	47.5	74.1	-

Source: WHO EMRO Health Indicators

## ■ EFFECTS ON WORKFORCE IN THE HEALTH SECTOR

Reducing total expenditure on health as part of austerity measures that prioritize macroeconomic balances, at the top of which is reducing budget deficit to 3% of the GDP, exerts pressure on wage bills, thus blocking or reducing employment to the maximum limit and/or eliminating pensions, as well as favoring fixed-term employment contracts (also known as contracting in certain Arab States such as Morocco), or wage cuts/caps.

### Reducing employment

No data reflecting the evolution of the public health sector workforce in the Arab region was found. This is due to the fact that the World Health Organization (WHO) does not segregate statistics according to gender and sector (private or public). Taking this reservation into consideration, **Table 2** indicates that the average number of physicians for every

10,000 people has decreased between 2014 and 2019 in five countries (Algeria, Egypt, Iraq, Morocco, and Syria) out of 10 or has remained the same in Tunisia and Libya, while registering an increase in three countries (Jordan, Lebanon, and Sudan). Similarly, and over the same period, the rate of female and male nurses (**Table 3**) decreased in six countries out of 11 (Algeria, Egypt, Libya, Sudan, and Syria), while it increased in five others (Iraq, Lebanon, Morocco, Tunisia, and Yemen). In general, the public health sector funding issue, further aggravated by austerity policies, remains a major obstacle hindering the improvement of health services in Arab States. These countries are falling behind in terms of medical and nursing human resources compared to the global average and the Gulf region (see **Figures 4 and 5**).

**Table 2. Health sector workforce (Physicians)**

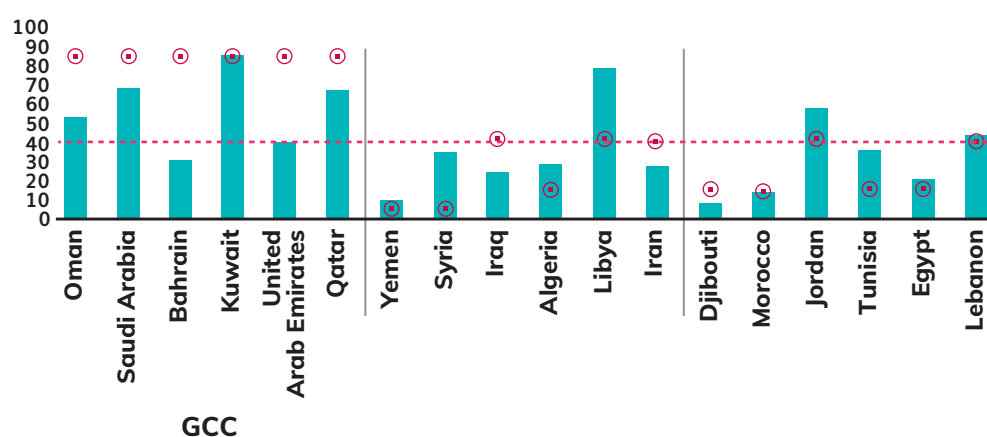
Country	Medical Physicians					
	2014	2015	2016	2017	2018	2019
Algeria	-	-	18.42	-	17.32	-
Egypt	7.45	7.77	7.77	7.57	7.3	7.09
Iraq	9.71	-	8.08	7.94	6.7	9.13
Jordan	22.7	27.4	-	22.2	-	25.13
Lebanon	20.6	21.4	21.5	22.6	24.25	26.17
Libya	21.4	19.6	-	21.5	-	-
Morocco	9.1	-	-	7.3	-	-
Sudan	-	4.15	-	-	11.4	-
Syria	14.4	-	11.8	-	-	-
Tunisia	12.3	12.6	12.4	12.6	-	-
Yemen	2.9	-	-	-	-	-

| Source: WHO EMRO Health Indicators

**Table 3. Health sector workforce (Nurses)**

Country	Nursing Personnel					
	2014	2015	2016	2017	2018	2019
Algeria	-	-	22.5	22.3	13.45	-
Egypt	18.49	18.3	18.2	18.2	18.27	-
Iraq	17.24	15.54	16.2	16.2	19.3	21.1
Jordan	31.8	-	-	28.6	26.8	28.14
Lebanon	14.3	14.4	15.6	16.6	17.4	-
Libya	70.8	-	-	65.7	-	-
Morocco	8.6	-	-	12.7	-	-
Sudan	12.3	8.4	-	-	-	-
Syria	21.5	-	14.1	-	-	-
Tunisia	23.8	25.3	25.7	24.9	-	-
Yemen	6.7	6.7	6.9	7.1	7.2	-

| Source: WHO EMRO Health Indicators

**Figure 4. Number of qualified health professionals per 10,000 people**

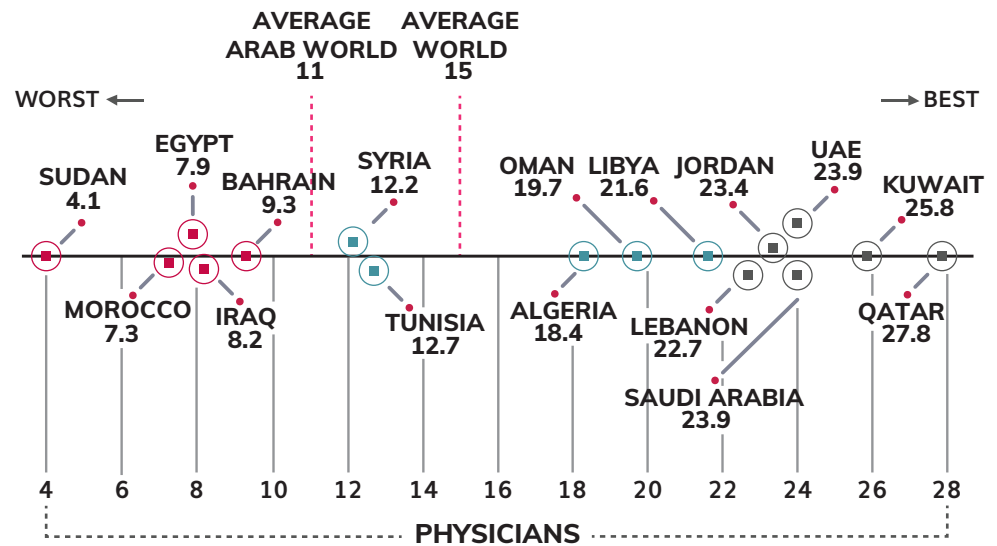
■ National value

⊙ Comparison to the median value of the income bracket

📅 2014 data, except for Oman, 2016; Kuwait, Bahrain, Jordan and Tunisia, 2015; Algeria, 2017. GCC countries are compared to the median value of high-income countries; all other countries are compared to the median of middle-income countries.

| Source: Organisation mondiale de la santé, Observatoire mondial de la santé

**Figure 5. Number of physicians per 10,000 people**



Richer Arab countries are doing better in terms of physician density, but they are still below the global average of high-income countries, which stands at 30.

| Source: From World Bank

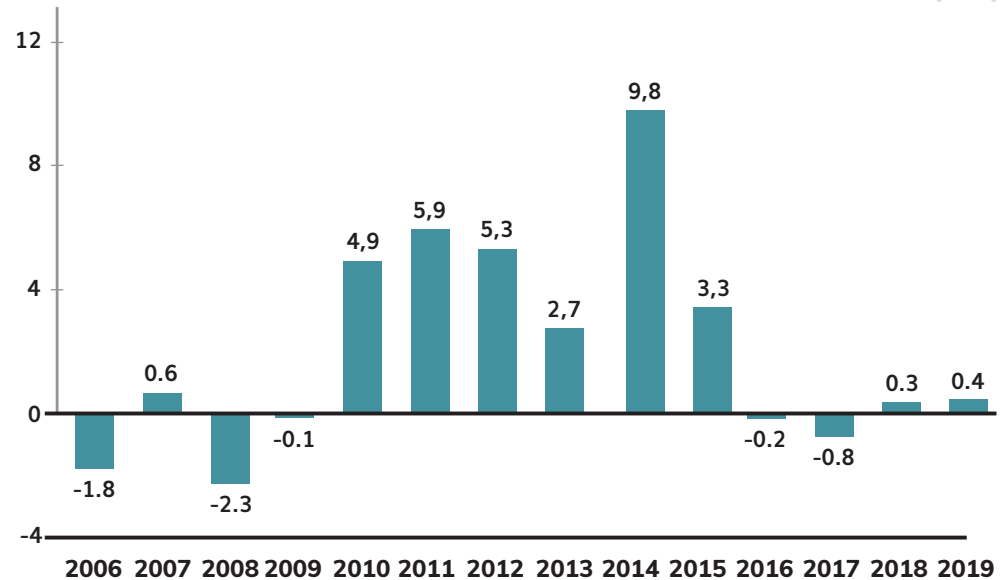
### Pressure on wages

Arab region governments prioritize the implementation of international institutions' instructions to control inflation and reduce budget deficit. This leads to their resorting to wage reduction as a mechanism to achieving these two objectives. **Figure 6** indicates the reduced purchasing power of the Arab region's workforce in general. The annual average real wage growth decreased significantly in 2015, registering a percentage of 3.3% (compared to a growth rate of 9.8% in 2014), before slipping to 0.5% in 2016 and 0.8% in 2017. 2018 and 2019 witnessed a slight increase of 0.3% and 0.4% respectively.

Moreover, wage bill cuts or caps have negative repercussions on human development. Many middle- and low-income Arab States suffer from a major deficiency in available human resources such as male and female physicians, nurses, teachers, and social workers. For instance, the shortage in health professionals in Morocco is estimated at "97,000 professionals in the medical and paramedical fields, and the country needs 25 years to fill the gap in human resources in the health sector" (24poum/Alyouwm24 2021). The reduced purchasing power of health sector workers is expected to affect their morale, decrease their productivity, increase absence from work and work in the informal sector, and aggravate human capital and competencies flight. This reflects negatively on public services offered to citizens, especially in the popular areas of rural and urban regions.



**Figure 6. Annual average real wage growth in the Arab region (2006-2019)**

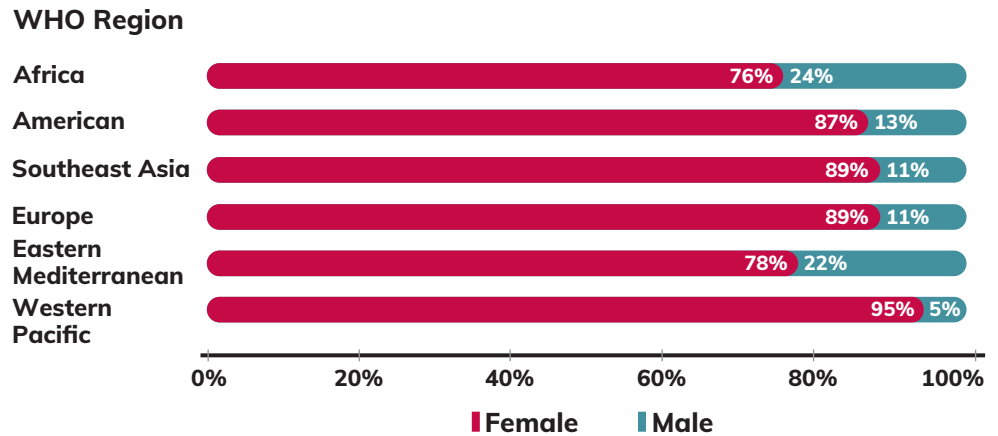


| Source: Global Wage Report, 2020-2021

### **Female health workers are the most affected by the deterioration of work conditions due to austerity policies in the health sector**

The global health sector depends on the services of female workers more than male workers. **Figure 7** shows that women form 78% of nursing staff in the Middle East (this region includes all Arab States except Algeria) compared to 22% of men. In contrast, few women occupy leadership and responsibility positions as nurses or physicians. WHO data indicates that women are paid less than men, along with facing other forms of workplace gender-based discrimination (Organisation Mondiale de la Santé 2020).

**Figure 7. Percentage of female and male nurses by region**



Source: Organisation Mondiale de la Santé (OMS), 2020

#### ■ NEGATIVE EFFECTS ON INVESTMENT IN THE PUBLIC HEALTH SECTOR

Given the lack of consolidated data on investment in health in the Arab region, the number of available hospital beds and the number of primary healthcare units and centers provided in WHO reports were used to measure the evolution of investment in the health sector over the past decade. It is worth noting that the two mentioned indicators do not reflect the share of each of the private and public sectors in health investments.

**Table 4** shows the evolution of the hospital beds and primary healthcare units and centers indicators for every 10,000 people between 2008, 2015, and 2020. The hospital beds indicator for every 10,000 people decreased in nine countries out of 12 (excluding Gulf countries for previously explained reasons). Egypt, Jordan, Lebanon, and Libya witnessed a significant dive in this field.

As for the primary healthcare units and centers indicator, it decreased in nine cases out of 10. It is worth noting that the number of hospital beds for every 10,000 people in Arab countries remains below the global limit set at 18 (WHO, SDG Indicator Metadata, 20-12-2021).

Moreover, researchers have noticed that austerity policies in the health sector reflect negatively on preventative care spending compared to curative care despite the former's importance in pandemic prevention (Jacques & Noël 2022).

**Table 4. Health-related material resources' indicators (% for every 10,000 people)**

Country	Hospital Beds				Primary Healthcare Units and Centers			
	2006/09	2015	2020		2006/08	2015	2020	
Bahrain	19.7	20.3	17.8		0.2	0.2	0.2	
Djibouti		20.3				0.6		
Egypt	20.8	14	14.3	↘	0.7	0.6	0.6	↘
Iraq	12.6	15.6	12	↘	0.6	0.7	7.1	↗
Jordan	18	13.8	14	↘	2.4	2.3	7	↗
Kuwait	18	20.4	19.3		0.4	0.3	0.2	
Lebanon	34.3	28.5	27.3	↘		2.3	0.5	↘
Libya	37	37	32	↘	2.6	2.3	2.1	↘
Morocco	11	11	10	↘	0.8	0.9	0.8	↘
Oman	20.2	15.8	14.8		0.9	0.6	0.5	
Palestine	12.8	13.9	12.9	↗	1.8	1.3	1.6	↘
Qatar	25.2	12	11.2		2.7	2.3	3.2	
Saudi Arabia	22.1	26.5	22.5		0.8	0.7	0.7	
Sudan	7.3	80.1	6.6	↘	1.6	16	1.5	↘
Syria	15.4	15	13.9	↘	1	0.9	0.9	↘
Tunisia	20	21.8	24	↗	2	1.9	1.9	↘
UAE	18.6	0.12	17.9		0.3	11	3.8	
Yemen	7	7.1	5.7	↘	2	1.5	1.4	↘

Source: WHO EMRO Health Indicators

### ■ AUSTERITY POLICIES IN THE HEALTH SECTOR DID NOT HELP RESPONDING TO COVID-19

If COVID-19 revealed the key role of socio-economic determinants in the spread of the virus, it also highlighted the unpreparedness of health systems to respond to such crises considering the noticeable shortage in human resources, insufficient medical equipment and facilities, the limited number of intensive care units, and the marginalization of preventative care at the expense of curative care. It also accentuated the weakness of the universal social protection system in the Arab region as an effective means to respond to the various, particularly health-related risks, that individuals may face throughout their lives. The repercussions of the pandemic were

more severe on vulnerable groups, especially in the informal sector and for vulnerable workers. This is confirmed by Alami (2022) as she writes that “the impact of the pandemic was aggravated by the weak health funding systems and the inadequacy of public sector social protection at the expense of the poor and vulnerable groups of society...[moreover], if the lack of medical oxygen and intensive care units was in itself an issue in responding to the pandemic, having a solid and evolved public health sector is considered a stronger line of defense to prevent this issue” (Alami 2022).

# PRIVATIZATION, COMMERCIAL AGREEMENTS (INTELLECTUAL PROPERTY RIGHTS), AND THE RIGHT TO HEALTH

The neoliberal approach to health is considered a commodity regulated by the supply and demand “law” rather than a basic human right, as stipulated by international conventions. As per the approach, the government must allow the domestic and foreign private sector to develop this sector that is vital for society, as demonstrated by COVID-19. There are three key factors that contributed to the development and expansion of healthcare privatization: governments’ narrow fiscal space (the outcome of anti-tax and social justice policies), the pressure exerted by multilateral international institutions, namely WTO and IMF, and bilateral trade agreements. We shall present the risks incurred by the expansion of the private sector in Arab States in terms of achieving comprehensive fairness and justice in the health sector. Then, we shall address international and bilateral agreements and their measures that could affect realizing the right to health, while focusing on the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in the Arab region, considering its direct impact on this context.

## THE PRIVATIZATION OF THE HEALTH SECTOR AND ITS REPERCUSSIONS ON THE RIGHT TO HEALTH

The privatization of the health sector takes many forms. We cite private health insurance (the liberty to pay for customized services according to a contract that allows the insured to benefit from a set of services limited by a specific financial ceiling) at the expense of public funding or one that is based on social solidarity, the wide range of private healthcare offers, the refund of provided health services and the adoption the rules of “the new public management” (applying private sector work methodologies to public sector institutions while focusing on competencies, achieving flexibility, heading towards decentralization, and fixating on results), and importing certain services (such as cleaning and laboratory testing) (André et al. 2016).

The following section will focus on the expansion of private healthcare offers and financialization at the expense of the public sector while highlighting its negative effects on the right to health.

### ■ THE EVOLUTION OF HEALTH SECTOR PRIVATIZATION IN THE ARAB REGION: TOWARDS THE “FINANCIALIZATION” OF THE PRIVATE HEALTH SECTOR

The data on the expansion of the private health sector in the Arab region is not sufficient. The main data used to address this subject were extracted from a relatively recent World Health Organization (WHO) study (WHO 2018). We also relied on a recent study by the Moroccan Competition Council on private hospitals and similar entities (وكالة المغرب العربي للأنباء 2022). The World Bank defines the private health sector as “the official profit-oriented health service providers” (Harding & Preker 2003; mentioned in WHO 2018).

The private sector evolved exponentially during the 1990s due to numerous factors, including: the rise in demand for health services paralleled by a marginalization of the public health sector. In addition, increased profitability and poor enforcement of the tax system led to an increase in private investment in the health sector, especially by doctors.

The private health sector covers a variety of activities that are linked to inpatient and outpatient healthcare services, investment in infrastructure, medication production, and the importation and use of health technologies, with the exception of preventative healthcare which does not interest the private sector. In middle- and low-income Arab States, this sector provides between 33% and 88% of inpatient and outpatient healthcare services. Table 5 indicates the number of public and private sector hospital beds in several countries in the region. We notice a clear contrast between country Groups 1 and 2. Public hospitals in Group 1 are prevalent due to the large financial capacities of the Arab Gulf states, whereas private hospitals outnumber public hospitals in Group 2, which includes middle-income countries.

The private sector owns between 60% to 100% of the pharmacies in middle-income countries, while this percentage ranges between 22% and 98% in low-income countries. There is also a significant concentration of the private health sector in urban areas where the social groups who can afford it are present.

**Table 5. Distribution of hospital beds in the private and public sectors**

Country	Hospitals		Hospitals beds		Total	Percentage of private hospital beds	Hospital beds per 10 000 population
	Private	Public	Private	Public			
<b>Group 1</b>							
Bahrain	13	10	384	1 702	2 086	18	17
Kuwait	15	15	1 247	6 703	7 950	15	22
Oman <sup>a</sup>	10	55	360	5 499	5 859	6	16.7
Qatar	4	6		1 694			12
Saudi Arabia	137	298	14 165	46 871	61 036	23	21.4
United Arab Emirates	33	54	2 557	7 024	9 802	26	20
<b>Group 2</b>							
Egypt <sup>a</sup>	1 351	646	31 653	96 820	128 473	25	16
Islamic Republic of Iran <sup>a</sup>	170	682	17 323	114 232	131 555	13	17.5
Iraq <sup>a</sup>	231	96	2 886	40 182	43 068	7	13
UAE	18.6	0.12	18.6	0.12	0.12	0.12	0.12
Jordan <sup>a</sup>	61	45	4 041	8 065	12 106	33	18
Lebanon <sup>a</sup>	189	30	12 000	2 500	14 500	83	34.5
Libya	103	97	2 088	20 689	22 777	9	37
Morocco <sup>a</sup>	NA	141	7 973	21 734	29 707	27	9.3
Palestine <sup>a</sup>		40	1 174	5 183	6 357	18	15.2
Syrian Arab Republic	376	124	8 962	22 858	31 820	28	15.5
Tunisia <sup>a</sup>	116	174	3 400	19 632	23 032	15	23.0

(a): Data confirmed by WHO country office or Ministry of Health

Source: From WHO EMRO 2014.

### ■ TOWARD THE “FINANCIALIZATION” (THE PREVALENCE OF FINANCIAL PROFITABILITY AND ITS MECHANISMS) OF THE PRIVATE HEALTH SECTOR IN THE ARAB REGION

Foreign and domestic investment in the health sector is one aspect of health commercialization and its transformation into a lucrative service. Several Arab States are seeking to attract

private financial funds to join this “dynamic” by amending laws and legislations. As such, Law No. 131-13 on the practice of medicine in Morocco underwent significant amendments relating to the conditions of establishing and using private hospitals and similar entities and their regulating laws. In this context, the law allows for non-physicians to invest in these hospitals (particularly investment funds and insurance companies). Ever since, “hospital groups”, also known as “health groups”, appeared in the profit-oriented sector. These groups are mostly managed as a corporation. They include several private hospitals, different in size and geographic location, falling under one management.

We provide an example of two groups under foreign capital which are currently in the region: Elsan, the French group specialized in hospitalization, and the group of testing and treatment centers owned by Alta Semper the English private equity firm providing specialized treatments in Morocco and Egypt. The Ministry of Health announced the privatization of five public hospitals last year (الشارع السياسي / Political Street 2022). There is also a possibility to bring businessmen from the Arab Gulf states to benefit from this project, taking into account the Saudi experience in this field (مجلة الأبحاث 2012 (الاقتصادية)). This program falls under the liberalization of health services by allowing foreign doctors to compete with Egyptian doctors in terms of employment. This is part of the service liberalization plan under the WTO General Agreement on Trade in Services (GATS). Moreover, “mergers and acquisitions in the private health sector increased. This sector has become a magnet of investors from the Arab Gulf due to significant profits and revenues generated by private hospitals. Financial acquisitions in this sector are ranked second among the Egyptian economic sectors.”

The same study showed an increased “concern over monopolizing groups in the private medical sector, raising complaints from most Egyptians due to the outrageous increase in service rates, after Emirati group ‘Abraaj Capital’ acquired a group of major hospitals such as Cleopatra, the Cairo Specialized Hospital, and El Nile Badrawy Hospital, as well as the two largest chains of laboratories in the country: Al Borg (926 branches and 55 biological laboratories) and Al Mokhtabar (826 branches).”

Furthermore, the Saudi Elaj Medical Group acquisitioned 9 major hospitals, the “Cairo Lab” medical laboratories spread across Egypt, and “Techno Scan” radiology centers, which in turn owns 24 branches across different governorates



(العربي الجديد/Al-Araby Al-Jadeed 2022). On the other hand, the Egyptian government resorted to the implementation of health projects under the Private-Public Partnership (PPP) Law. In this context, we cite the alliance between Al-Bareeq for investment and project development, Dar for Construction & Trading (DETAC), Siemens for Medical Devices and Pharmaceuticals, and G4S Facilities Management (English company) to implement and partially manage two projects: the Samouha Hospital for Maternity and Blood Transfusion and the Specialized Mouwasat Hospital (Private Sector Partnership or Public Service Privatization? n.d.).

### ■ RELIANCE ON PRIVATE SECTOR TO GUARANTEE THE RIGHT TO HEALTH FOR EVERYONE: THE RISKS

In terms of the health system's response to citizens' expectations, privatization increases discrimination against those who cannot afford private insurance and are, subsequently, not prioritized, as well as health disparity between rural and urban areas. Healthcare coverage is reduced in rural areas, leading to higher infant mortality (كالوتي/Kaloti 2021).

On the other hand, one study shows that service quality indicators are not significantly affected by privatization despite the improved productivity in the Kingdom of Saudi Arabia. In addition, access to healthcare services was reduced due to privatization (Almutairi & Al Shamsi 2018).

In terms of healthcare affordability, privatization promotes the "cream skimming" or "cherry picking" phenomenon. The private health sector essentially (and purposefully) concentrates services on low-cost or low-risk clients, as well as high-value clients, to increase profit. Evidence has shown that privatization increases these practices. People who are disease-free or patients with mild health issues (reduced cost) or are younger are often given priority in the private sector for more profit (Kaloti 2021).

In terms of improving efficiency, Kaloti (2021) notes that excessive diagnosis and treatment are "common in private healthcare systems, often considering patients as revenue sources rather than patients. This leads to ineffective allocation of money and resources. In other parts of the world (India, to be specific), increased privatization led to an excessive use of diagnostic testing, antibiotic prescriptions, and unnecessary surgeries. Doctors tend to service business stakeholders instead of patients, leading to major financial waste" (Kaloti 2021).

## TRADE AGREEMENTS AND INTELLECTUAL PROPERTY RIGHTS HINDER THE REALIZATION OF THE RIGHT TO HEALTH FOR EVERYONE

The World Trade Organization (WTO) affects healthcare through two main agreements: the General Agreement on Trade and Services (GATS) and The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). In addition, adopting bilateral or regional trade agreements which include TRIPS-Plus provisions is a real threat for access to treatment for everyone.

### ■ THE OUTLINES OF THE GENERAL AGREEMENT ON TRADE AND SERVICES (GATS)

The liberalization of trade and investment which the WTO endeavored to expand and embed exceeds the movement of goods and capital, reaching trade in essential services such as education, health, water and housing, and all others that have a direct effect on health. **Table 6** includes the ratified WTO agreements that directly impact the right to health. These are: the Agreement on the Application of Sanitary and Phytosanitary Measures (directly impacts food safety); the Agreement on Technical Barriers to Trade (impacts the production of pharmaceuticals, biologicals, and foodstuffs); the Agreement on Trade-Related Aspects of Intellectual Property Rights (impacts pharmaceuticals); and the General Agreement on Trade in Services (impacts health services). Services are produced, distributed, promoted, and sold through four means: services crossing international borders, users moving from one state to another, foreign service suppliers entering a certain state to start a business that provides a certain service, and individuals from one member state moving to provide a certain service to another member state. The first means is people moving abroad for consumption (patients moving for treatment or students for education); the second means is professionals moving abroad to provide a service (health professionals); the third means is service providers moving abroad (direct foreign investment in the health sector); and the fourth means is cross-border services (telemedicine: healthcare, diagnosis and treatment, medical education and training, technical expertise in telemedicine).

We would like to note that the liberalization of service trade by the movement of highly-skilled users and professionals will aggravate the shortage of health sector workforce through "brain drain", which will reflect negatively on access to

healthcare in the global south. Moreover, the movement of service providers abroad will deepen inequality in accessing treatment and create a double-standard health system at the expense of vulnerable and destitute social groups.

**Table 6. The most significant WTO agreements and their implications for the health sector**

Agreement	Health area concerned	Related provisions
Agreement on the Application of Sanitary and Phytosanitary Measures	Food Safety	Stipulates use of Codex Alimentarius standards, guidelines and recommendations as the international reference
Agreement on Technical Barriers to Trade	Production of pharmaceuticals, biologicals, foodstuff	Setting and applying international quality standard
Agreement on Trade-Related Aspects on Intellectual Property Rights	Pharmaceuticals	Patent protection for inventions in all fields of technology
General Agreement on Trade in Services	Health services	Regulation of trade in services

| Source: From Kinnon, *World Trade*, 1998

### ■ THE AGREEMENT ON TRADE-RELATED ASPECTS OF INTELLECTUAL PROPERTY RIGHTS (TRIPS)

Signatory states of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) commit to adopting the minimum standards of intellectual property rights while leaving the members the liberty to choose the implementation of the laws that increase protection compared to the text of the agreement, as long as this additional protection does not interfere with the agreement's provisions. The WTO TRIPS, negotiated during the Uruguay Round, incorporated intellectual property rules into the multilateral trade system. TRIPS provisions allow a relative and restrictive flexibility in the drafting of national laws and legislations to ensure an appropriate balance between providing incentives for future inventions in pharmaceuticals and facilitating access to current ones (including but not limited to: the ability to use "flexibility clauses in the agreement" – such as parallel import

and compulsory licenses – allowing low- and middle-income countries to benefit from generic pharmaceuticals, i.e., medication that is the same as a brand-name drug in form, dosage, quality, effect, and purpose. These are produced without a license from the inventor company, with guaranteed quality and at lower cost. However, this experience revealed the disadvantages of TRIPS when applied in Malaysia for instance, as prices of pharmaceuticals increased by a yearly rate of 28% between 1996 and 2005. Also, two billion people are still deprived of basic medication due to the main obstacle of elevated prices (Nations Unies - Haut Commissariat aux Droits de l'Homme 2015).

### ■ THE TRIPS-PLUS PROVISIONS AGREEMENT

The United States bypassed the TRIPS agreement under the pretense that it does not provide sufficient protection for American pharmaceutical companies, thus creating the TRIPS-Plus Provisions Agreement, allowing free trade agreements that maximize protection for their benefit. This pertains to adopting stricter intellectual property laws than required in WTO's conditions. Moreover, this agreement aims to limit the ability to use and neutralize flexibility clauses stipulated in TRIPS. Examples include: extending the term and life of a patent,<sup>3</sup> granting patents for new usage or formulas that already exist, and data exclusivity.<sup>4</sup> Rarely do the negotiations of these agreements ensure transparency and stakeholder participation from civil society organizations (CSOs) and social movements that fight for the right to health for everyone, away from trade- and profit-related considerations.

According to the advocates of Big Pharma's hold on intellectual property rights, the prospects of making large profits within temporary monopolies protected against illegal imitation stimulate investment in research and development to innovate new pharmaceuticals and production methods. For this reason, the state must support these companies for high profitability (or "rent" in the economic meaning of the concept) that compensates for the cost of research and development, by enabling them to monopolize the market for a set period of time (at least 20 years). However, studies have shown that TRIPS-Plus standards increase medication prices to hold off or limit competition from generic drugs, thus directly affecting access to medication (تعزيز وحماية حقوق الإنسان / Promoting and Protecting Human rights 2009). Analysis has also shown that there isn't any conclusive evidence that applying TRIPS and TRIPS-Plus in developing countries promoted research

<sup>3</sup> See Definitions

<sup>4</sup> See Definitions

or development of treatment (because having an adequate market is the deciding factor). The claim that protection systems of intellectual property rights are essential for direct foreign investment and the transfer of technology was also proven to be faulty (تقرير ممثل وفد المنظمات غير الحكومية/Report of the Representative of the NGO Delegation 2014).

## ■ THE IMPACT OF TRIPS-PLUS ON THE REALIZATION OF THE RIGHT TO HEALTH IN THE ARAB REGION

### **Morocco: Strict laws limiting access to healthcare**

In 2004, Morocco and the United States signed a TRIPS-Plus free-trade agreement (FTA) with strict provisions related to intellectual property protection. A comparative study of legal frameworks that guarantee access to medicines (ITPC MENA 2017), including patent laws, pharmaceutical regulations, medicine-related decrees, free-trade agreements, and others, showed the lack of flexibility of these laws in Morocco, compared to Egypt and Tunisia. And thus, the study concluded that: "the provisions in Egypt provide more flexibilities. In Morocco, the conclusion of an FTA with the United States led to the inclusion in the laws of additional constraints. Meanwhile, Tunisia contains some interesting provisions but could better make use of the TRIPS flexibilities, in particular on the grounds to issue compulsory licensing."

### **Jordan: Monopolization and increase of medicine prices**

The Jordan-US FTA signed in October 2000 includes the TRIPS-Plus provisions. The incorporation of these provisions in Jordanian intellectual property laws was a main condition on the US's part for Jordan's adherence to the WTO. However, the constrictive nature of these provisions, particularly those related to the extension of patentability beyond the initial 20 years set by TRIPS and "data exclusivity," negatively affected the right to healthcare. As a result, medicine prices in Jordan registered a 20% increase in 2001. Moreover, the implementation of the data exclusivity condition led to the monopolization of the market to prevent competitors from marketing their products, thus delaying or preventing the availability of generic drugs at a lower cost for citizens (اوكسفام/Oxfam 2007).

Furthermore, no direct foreign investment by foreign pharmaceutical companies relating to the manufacturing of generic medicine in partnership with domestic companies has been registered in Jordan since 2001. The new products that were introduced to the market were only a fraction of the total products introduced to the US and European Union (EU)

markets (اوكسفام/Oxfam 2007).

**Deep and Comprehensive Free-Trade Agreements (DCFTA) threatens access to healthcare**

The European Union seeks to follow the same US strategy benefitting European Big Pharma through “Deep and Comprehensive FTAs” proposed to Morocco and Tunisia at an initial stage, than Egypt and Jordan within the framework of “Euro-Mediterranean Partnership.”

The main lever for trade liberalization in the proposed FTAs is to achieve a kind of convergence at the regulations and legislations level through the gradual incorporation of community *acquis* (*Acquis Communautaire*), namely the set of legislations, standards, and regulations forming the EU laws, by the targeted southern Mediterranean countries (Morocco, Tunisia, Egypt, Jordan). This regulatory agreement does not only concern the trade of goods, aiming to ensure the compliance of products with industrial standards, technical specifications, and human and plant health-related measures, but also includes the trade of services, government procurement, competition rules, intellectual property rights, and investor protection.

In this regard, the EU proposes incorporating TRIPS-Plus provisions into the health standards stipulated by domestic laws in Tunisia and Morocco (especially the extension of patentability and data exclusivity). This measure will make access to healthcare even more challenging for middle- to low-income social groups. In Tunisia for instance, where generic drugs production covers 70% of the demand, extending patentability beyond the initial 20 years stipulated by WTO’s TRIPS-Plus would deprive the Tunisian pharmaceutical industry from producing generic drugs that could replace European pharmaceuticals for the new generation (Haddad 2019).

Pharmaceutical sector professionals in Tunisia confirm that major European companies are ready to use all means necessary to extend patentability to 40 or 50 years compared to the current 20 years. As such, if Tunisia agrees to the EU-proposed DCFTA, the cost of healthcare for Tunisians will increase and the survival of the domestic pharmaceutical industry will be threatened.

## CONCLUSION

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This report addressed the effects of neoliberal globalization on human rights, particularly the right to health. It demonstrated the key role of international financial institutions (IFIs) in disseminating neoliberal policies that are based on economy liberalization – privatization – macroeconomic balances prioritization through structural adjustment programs (SAPs), taking advantage of the debt crisis in the global south. The mechanisms used by neoliberal economic policies to impact the right to health, be it directly or through their repercussions on social determinants of the right to health, were analyzed. The negative effects of neoliberal globalization on the right to health in the Arab region were highlighted by demonstrating the negative outcomes of public spending austerity measures, then privatization policies, and finally free-trade agreements (FTAs).

On the one hand, austerity measures in middle-income Arab States led to a significant decrease of growth rates in “total health expenditure per capita”, to varying degrees across Arab States post-Arab Spring, and burdening citizens with a larger share of medical and treatment expenses. Public health sector employment also decreased and pressure was exerted on the wages of the sector’s workforce. Lastly, pressure on public expenditure negatively affected investment endeavors in the health sector, especially in hospitals and primary healthcare units.

On the other hand, privatization gave a strong push to the private health sector, allowing foreign capital to provide an array of health services. This aggravated the risks of health financialization in Arab States and limited the access of vulnerable groups to the right to health.

Finally, contrary to the promises made by multilateral financial and trade organizations to encourage investment and innovation, signing trade agreements that include the protection of intellectual property rights, particularly TRIPS-Plus provisions, reinforced market monopolization by European and American pharmaceutical companies and prevented Arab States from benefiting from the production of generic drugs, particularly in Jordan and Morocco.

## DEFINITIONS

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**A patent:** gives the owner of the invention the legal right to exclude others from making, using, or selling an invention for a limited period of time. It may be granted for the invention of a certain product or process.

**Data exclusivity:** gives the inventor the right to prevent third parties from using data presented by the inventor to the regulatory committee to receive a marketing license for the pharmaceutical product for a set period of time.

**Compulsory licensing:** a license to use a patented invention issued by the state at the request of a third party. It is considered one of the flexibility aspects provided by the WTO through TRIPS.

**Parallel import:** buying a patented medicine from a legitimate source in an exporting country and importing it without the approval of the "parallel" patent holder in the importing country.

**Linkage between patent and marketing authorization:** a link between the granting of marketing approval and patent protection. The marketing of a generic version of a medicine could only take place once the patent protection is over.

**Experimental use – Bolar provision:** it is possible to allow the experimental use of an invention under patent protection as it does not violate the patent nor the protected market. Certain states allow the experimental use of the patented drug, including clinical trials and experimentation, to certify the effectiveness of the generic product so that it can be put on the market once the patent protection period expires.

**Note:** These definitions are extracted from ITPC MENA, Assessment of national intellectual property landscapes and their impact on access to medicines, September 2017.



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# THE RIGHT TO HEALTH THROUGH A SOCIAL PROTECTION LENS

## Rana Jawad

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Reader in Social Policy at the University of Bath

Rana Jawad is Reader in Social Policy at the University of Bath. She specialises in the social policies and welfare systems of the Middle East and North Africa region and has published widely on the topic in a range of academic and international reports. She is co-founder and convener of the MENA Social policy network.

## Walaa Talaat

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Lecturer of economics at Faculty of Business, Ain Shams University

Walaa Talaat is a lecturer of Economics at the Faculty of Business, Ain Shams University. Walaa has a PhD in Development Economics and International Development from the University of East Anglia, United Kingdom. Her main areas of research looks at social policy, social protection, poverty, and health in the MENA region. She has a more general interest in social policy and climate change.

# INTRODUCTION: THE EVOLUTION OF THE CONCEPT OF SOCIAL PROTECTION IN INTERNATIONAL AND ARAB DEBATES ON DEVELOPMENT

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The link between health and socio-economic outcomes, not least poverty, is well recognized in international policy and research debates (IMF 2020; ILO 2008), taking center stage in both the Millennium Development Goals (MDGs) and Sustainable Development Goals (SDG) frameworks (ILO 2008). In social protection discourse, health is the first contingency of the lifecycle, making affordable, adequate, and accessible health services not only an indicator of well-being but also an outcome of successful economic growth in high-income countries and a vital pathway to development in low and middle-income countries (ILO 2008). Social protection, in particular, has a key role in mitigating ill health and addressing the social determinants of health (ILO 2022). Against this background, the main aim of this report is to provide a critical analysis of the current status and future prospects of the right to health through a social protection lens in the Arab region. The report focuses on the main social protection measures and strategic reforms driven by austerity measures and budgetary considerations in the post-COVID-19 era, in the context of weak regional social protection policies.

Given the assumptions of universality and adequacy of benefits in the right to health, the report covers the targeting and universal coverage dilemma in the region, including, actual responses during and post-COVID and Arab government philosophies of social protection. It does so by examining how Arab populations access health protection services through the following modalities: government-provided public health systems (which rely on taxation and government revenues); social insurance for formally employed private and public sector workers; social safety nets that include a health component (such as cash transfers); out of pocket expenditure (which is known to be very high in the region); and, finally, private medical health insurance (such as through occupational programs or market-bought services). To this end, the report distinguishes its focus from standard public health analysis by referring to Social Health Protection (SHP), defined below (ILO 2008).

The countries covered in the report are the 22 countries of the Arab League which fall into three categories according to their gross national income (Mokdad et al. 2014): low-income countries (LICs; Comoros, Djibouti, Mauritania, Yemen, and Somalia), middle-income countries (MICs; Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Sudan, Syria, and Tunisia), and high-income countries (HICs; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates). The region is quite diverse economically and socially, resulting in different health status and public health outcomes. Poverty estimates vary considerably but exceed 50% in the poorest countries and in some countries engaged in active conflict (Mokdad et al. 2014).

Before proceeding, it is important to note the two main limitations in the analysis presented in this report. First, this report provides data about SDG 1 ("No poverty") and SDG 3 ("Good health and well-being"), particularly in the context of indicator 1.3.1 ("End poverty in all its forms everywhere"), and 3.8.1 (Coverage of essential health services). The most comprehensive and reliable data source we could find for this is International Labor Organization (ILO) World Social Protection Database (WSPDB) using ILO STAT. Measuring social protection effectiveness through effective coverage is a complex task that requires considering several dimensions to arrive at a comprehensive assessment. In practice, few Arab countries have available national statistical data necessary for such an assessment of coverage, and where available, data is often outdated. Furthermore, only partial information is available for some of them. As such, for consistency, this report relied on WSPDB using ILO STAT as the main source of global data on social protection, which is reported or imputed. The regional average of Arab countries is calculated for the available reported data for countries found at ILO STAT as shown in each figure.

Second, the concept of universal social protection applied in this report focuses on coverage and adequacy of benefits. As it has developed in policy and conceptual debates worldwide, the concept does not address intangible aspects of deprivation such as dignity, trust, and freedom which are indeed a core part of people's protection and empowerment but only assumed to be outcomes of effective social protection policies. There are studies worldwide that provide evidence of the beneficial effects of social protection on economic and social well-being, but here in this report, the focus is on mapping the existing systems and coverage in Arab countries and assessing ways in

which these might be improved. Hence, the report emphasizes the issue of access to social protection for all population groups throughout their lifecycle to achieve universality.

## DEFINITIONS OF KEY TERMS

**Universal Social Protection:** is achieved through a nationally defined system of policies and programs that provides equitable access to all people and protects them throughout their lives against poverty and risks to their livelihoods and well-being. This protection can be provided through a range of mechanisms, including in cash or in-kind benefits, contributory or non-contributory schemes, and programs to enhance human capital, productive assets, and access to jobs (USP2030 2015).

**Social Health Protection:** is 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 can result in ill health (ILO 2008, p. 3)

**Social protection:** there is a wide set of definitions ranging from focus on marginalized groups to a right to income protection for all members of society. This report adopts the wider definition advocated by the ILO whereby social protection is a human right to income security and healthcare. Hence, it includes all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups (UNDP 2016, p. 15). For the rest of society, social protection is intimately connected with the lifecycle and the contingencies that may cause economic or social distress, such as maternity, retirement, and sickness.

**Social protection floor:** The Social Protection Floor (SPF) approach promotes access to essential social transfers and services in the areas of health, water and sanitation, education, food, housing, and life- and asset-saving information. It is an approach that emphasizes the need to implement comprehensive, coherent, and coordinated social protection policies to guarantee services and social transfers throughout the life cycle, with particular attention to vulnerable groups (ILO 2008).

**Contributory schemes:** are those where beneficiaries make regular contributions to a scheme that protects them in the

event of, for example, maternity, unemployment, or illness. Sometimes costs are matched or subsidized by the government. Insurance can be provided through public social insurance, insurance companies, or through mutual funds. Given that formal sector employment is usually male-intensive across the world, many existing contributory schemes perpetuate or reinforce gender inequalities, yet many social insurance schemes contain provisions that work towards closing gender gaps (UNDP 2016).

**Social assistance (and non-contributory schemes):** refers to targeted, state-financed schemes that extend a range of poverty relief services to poor populations who are often informal workers and/or self-employed. Such schemes include cash transfers, pensions, and health coverage to men and women with low incomes not covered by any formal contributory scheme such as work-based employment (UNDP 2016).

**Social contract:** As noted by Loewe and Zintl (2020), this concept refers to the “entirety of explicit or implicit agreements between all relevant societal groups and the sovereign (i.e., the government or any other actor in power), defining their rights and obligations towards each other.”

## GLOBAL FUNDING STATUS OF SOCIAL PROTECTION, REFLECTING PRIORITIES OF ARAB COUNTRIES

As outlined in Ortiz et al. (2017), there are various funding mechanisms for social protection around the world:

- i. **Re-allocating public expenditures:** this includes assessing ongoing budget allocations through formal mechanisms like Public Expenditure Reviews (PERs) and other types of thematic budget analyses.
- ii. **Increasing tax revenue:** this is achieved by changing different types of tax rates – e.g., on consumption, corporate profits, imports or exports, or natural resource extraction.
- iii. **Expanding social security coverage and contributory revenues:** increasing coverage and, therefore, collection of contributions frees up space for government spending on social protection.
- iv. **Lobbying for aid and transfers:** this requires engaging with either different donor governments or international organizations.



- v. **Eliminating illicit financial flows:** this requires better control of money laundering, bribery, tax evasion, trade mispricing and other financial crimes.
- vi. **Fiscal and central bank foreign exchange reserves:** this includes drawing down state savings and other state revenues stored in special funds, such as sovereign wealth funds.
- vii. **Managing debt (borrowing or restructuring existing debt):** this involves active exploration of domestic and foreign borrowing options at low cost.
- viii. **Adopting a more accommodating macroeconomic framework:** this entails allowing for higher budget deficit paths and/or higher levels of inflation without jeopardizing economic stability.

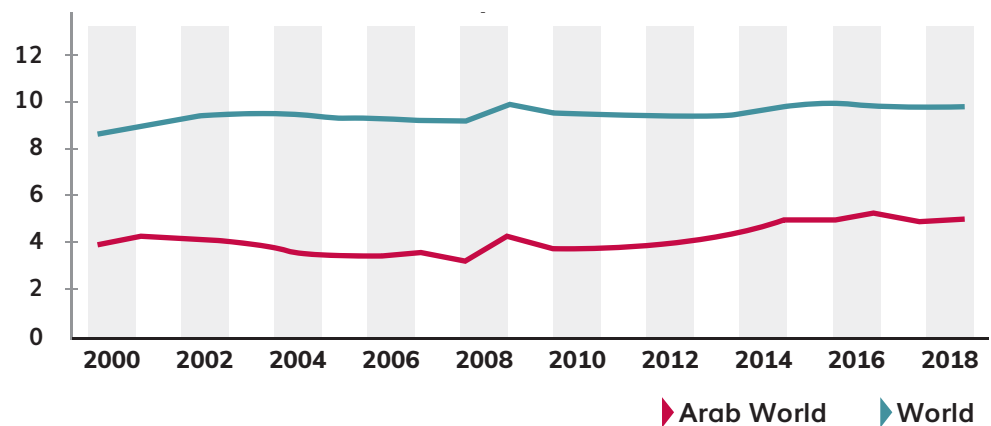
Comprehensive data on the patterns of financing social protection in the Arab region is patchy. We know that public expenditure on social protection (excluding health) averages 4.6% in the Arab region compared to a world average of over 12.9% (ILO 2022). Financial protection for healthcare takes three forms in Arab countries: (1) Government Health Insurance (GHI), (2) Private Health Insurance (PHI), and (3) Social Health Protection (SHP) (Alami 2017). SHP covers contributory schemes (typically called social health insurance) and non-contributory schemes, including community-based or social solidarity systems. Households not covered by the above categories must pay Out-Of-Pocket (OOP) or forgo healthcare.

The challenge in Arab countries is that extending coverage of financial protection means an extension of schemes in the formal labor sectors, with SHP targeting informal workers and the poor such as through the work of charitable organizations or international humanitarian agencies. The COVID-19 pandemic revealed some positive initiatives, such as the establishment of unemployment insurance schemes in Bahrain, Kuwait, Oman, and Saudi Arabia and enhanced coverage for maternity protection and informal workers in Jordan. The OECD (2020a) estimated that, on average, 2.7% of GDP was allocated to fiscal measures and 3.4% of GDP in liquidity injections was delivered by Central Banks across the Arab region during the first weeks of the pandemic. The region's fiscal deficit (IMF 2022) was projected to increase to 10.8% of GDP in 2020, raising concerns regarding the sustainability of the countries' economic response given the continued social and economic needs in the recovery period. The Gulf states showed the largest fiscal stimulus package that amounts to 6.9 billion USD,

whereas the LICs accounted for the lowest fiscal stimulus of about 0.27 billion USD (ESCWA 2022).

Coverage levels help to fill the picture of spending priorities. According to the International Labor Organization (ILO 2022), as of 2020, 40% of Arab populations were effectively covered by at least one social protection benefit compared to the global average of 46.9%. These rates hide inequalities and gaps within and between Arab countries, especially in relation to health protection and access: 39.5% of Arab populations have health coverage compared to a global average of 66%. The groups experiencing the highest exclusion rates are people with disabilities, the unemployed and mothers with newborns (all below 12%). Only 8.6% of women are legally covered by social protection compared to men (36.1%). The region also has the lowest level for maternity protection (12.2%) compared to a world average of nearly 50%. Arab states share the lowest ranking with the African continent on health expenditure (5.2%) compared to the world average (9.8%). **Figure 1** provides data on GDP % spending on health and shows that Arab country averages are well-below global averages.

**Figure 1. Current Health Expenditure (% GDP)**



Source: World Bank Data indicators, available at: <https://data.worldbank.org/indicator>

## GOVERNANCE OF SOCIAL PROTECTION AND THE PATRIARCHAL APPROACH IN ARAB COUNTRIES

According to Batniji et al. (2014), the equitable distribution of public goods, such as healthcare, is so intertwined with accountability that some political scientists use measures of the distribution of these public goods as a measure of government political accountability. In republics, pension plan coverage is

double that in the monarchies of the Arab region (44% vs. 22%, respectively), which suggests that regimes dependent on their social achievements for stability are more likely to provide for their population. Another factor in determining the provision of public goods could be social division, or fractionalization, which can occur on social, ethnic, or religious grounds. Countries with greater social divisions have less access to healthcare, higher child and maternal mortality rates, and less investment in public goods.

Arab states are often described as having weak social contracts through neglect of public services, exclusion of certain population groups, and the use of violence against their citizens. Another distinguishing feature of the Arab region is the extent of external intervention in the form of colonialism, economic sanctions, foreign aid, military assistance, and military conflict that have contributed to, but do not fully explain, the failure to establish accountable and inclusive political systems in the Arab world. These political factors might explain variations in access to health services and health outcomes. According to Jamali et al. (2014), women are particularly disadvantaged in the labor market, which means that they also benefit less from social protection systems because they either have little prior experience of work, are perceived as not having the physical capacity, or have to look for work that fits their responsibilities at home. Hence, Arab countries follow what is called a “male breadwinner” mode of social policy (Alami 2017).

Reform efforts have remained patchy, partial, and contradictory even after the COVID-19 pandemic, with only a handful of countries like Morocco extending health insurance coverage to informal sector workers, which is financed through a combination of contributions and taxes, although OOP spending by households also continued to rise (UN-ESCWA 2022). Inequities continue to be a key feature of Arab health systems, and health sectors are still largely accounted for in terms of fiscal impact rather than for their contribution to welfare and social justice. Such policies are rooted in the non-inclusive macro-economic frameworks that have driven Arab economies, which focused on profiting networks of privilege and with political regimes characterized by cronyism, exclusion, and coercion. In this context, the preservation of power assumes priority over development goals, creating productive employment opportunities, and social protection. The COVID-19 pandemic put further pressure on health systems highlighting years of disinvestment and not even the right to universal

health in some countries, such as in Jordan. War, occupation, sanctions, civil strife, and insecurities have also put pressure on Arab public health systems. This region has the largest number of refugees and internally displaced and stateless people in the world, and the numbers are rising.

The patriarchal approach is evident in a range of patrimonial and authoritarian governance regimes: (1) the residual approach to social protection and social welfare issues, which favors provision through informal societal structures such as clientelism, the family, charitable and religious organizations, and tribal and community structures limits the economic and social freedoms of women, youth and older people as well as more progressive forms of social protection entitlement based on social citizenship; (2) at the national state level, there is a narrow set of dominant political actors such as the monarchy, military, prominent political families and business leaders who control the fundamental structures of decision-making in government that lead to a narrow focus on social protection as a social right.

As noted in Jawad, Walton, and Merouani (2021), Arab countries are neo-patrimonial. This form of political rule is based on "a hybrid that combines practices from the region's pre-modern state-building inheritance with bureaucratic structures partly imported from the West" (Bacik 2008:51). The neo-patrimonial state is usually considered "weak" in the sense of the ability to implement policies (Bill and Springborg 1994), and especially foster economic development, but, at the same time, it is quite robust in its combination of different kinds (personal and bureaucratic) of authority" (Hinnebusch & Gani 2019, p. 4). The neo-patrimonial approach of the region helps to explain the distorted governance of social protection through the concept of "limited access order" (North et al. 2009), which is founded on clientelism and enables rulers to control society and provide services. The most well-known characterization of governance in Arab countries is also the Rentier state model, which helps to reinforce the patriarchal decision-making processes around national wealth and social order. The presence of an allocation state, not based on extraction contracts, thus explains why the process of state formation in the Middle East has not followed a path of economic development, sustained reform, and democratization (Schwarz 2008).

## THE MAIN METHODS OF FINANCING SOCIAL PROTECTION SYSTEMS IN THE ARAB REGION AND THEIR APPLICABILITY, WITH REFERENCE TO BISMARCK AND BEVERIDGE MODELS

According to WHO (2012 briefing), the distinguishing feature between the “Bismarck Model” and the “Beveridge Model” is the basis of entitlement to a benefit. In the Bismarck Model, entitlement is linked to a contribution made by a worker and, as such, membership of a corporate body is important such as affiliation with an employer in the case of workers. In the Beveridge Model, entitlement is based on citizenship or residence and, as such the benefit received is not dependent on previous contributions. Arab states have different strategies to provide social protections to their citizens in cases such as pregnancy and maternity or from the financial consequences of health risks. Countries vary in the extent to which they rely on non-contributory (tax-funded) national healthcare systems (the Beveridge model) or contributory social health insurance systems (the Bismarck model) (Loewe 2013).

In the Arab world, existing public health arrangements have disproportionately burdened Arab populations with high financial costs and hardship when using healthcare, with significant impoverishing and deterrent effects (Alami 2017). Health protection schemes are most comprehensive for those who can afford healthcare; they are mainly based on contributions and formal employment and thus fail to cater for the poor and the rural and informal sectors. Financing systems also lack the operational bases and institutional prerequisites for effective resource pooling and risk sharing, with segmentation and fragmentation worsening horizontal and vertical inequities. The neglect of public health systems has reinforced inequities by widening the gap between needs and provision and emphasizing the ability to pay as a basis for accessing quality care.

The state-centered developmental frameworks that characterized Arab countries after independence initially oriented most countries towards a Beveridge model — a national health system for all citizens financed through general taxation. “Most Arab public sectors were funded through a combination of payroll taxes and government revenues (often from oil), the latter remaining dominant in Iraq, Syria, and Libya. In the high-income Gulf states, it is oil revenues that dominate state social expenditure rather than taxation with the main political support base located among the urban middle

classes and ruling elites" (Alami 2017, p. 164). In trying to expand coverage from this starting point, most Arab systems have emphasized contributions and/or allowed opting out. While this may appear as a shift towards the Bismarckian model (a national health system financed mostly through contributions by employees, employers, and sometimes the government), in practice, most financing structures are mixed. The health systems are in need of upgrading, rehabilitation, and up-scaling, and responding to new shocks, not least the impact of war or in the case of the Palestinian people, occupation. As such, the region's increasing focus on promoting contributory insurance (Bismarck model) without strengthening risk-pooling or solidarity principles (Beveridge model) is likely to face important financial barriers. The gaps in coverage and barriers to financial access to health in the Arab region will further delay preparedness for Universal Health Coverage (UHC).

## OVERVIEW OF HEALTH PROVISIONS IN THE EXISTING SOCIAL PROTECTION SYSTEMS OF THE ARAB COUNTRIES

Coverage and spending of social protection in the Arab countries are not only insufficient, but also inequitably distributed, both across subregions and countries and within the same country. Large segments of the population, including informal workers, unemployed, or those outside the labor force, are excluded from employment-related social protection, particularly women, young people, and non-national workers. Millions of key population groups, such as children, people with disabilities, and older people, have no access to effective mechanisms or social protection floors to protect their incomes, especially to finance their healthcare. Moreover, the protracted conflict-related fragility and humanitarian crises in countries across the region have imposed an additional burden on underdeveloped social protection systems. To obtain social justice in the Arab region, governments should establish universal social protection, including social health, and urgently realize the human right to social security for all. Doing so would contribute to decreasing poverty, containing inequality, enhancing human capital, fostering dignity, fairness, and solidarity, and strengthening the social contract (ILO 2021b).

### A LIFE CYCLE APPROACH TO SOCIAL PROTECTION FOR ALL IN THE ARAB REGION: AN OVERVIEW

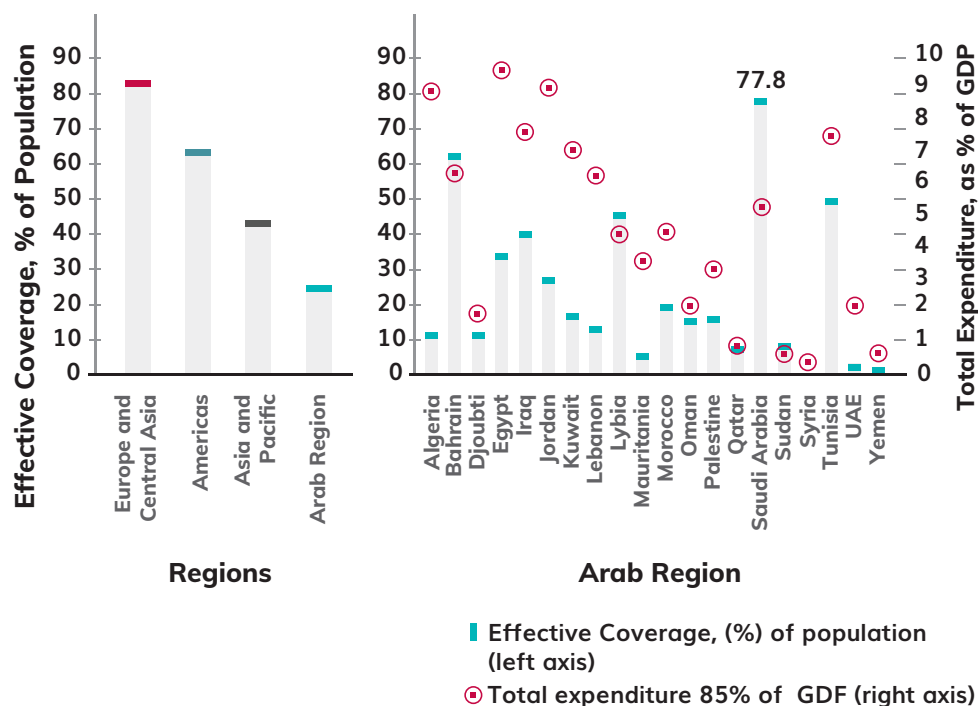
As of 2020, only 46.9% of the world population was effectively covered by at least one social protection benefit excluding health (SDG 1.3.1: including, for instance, child and maternity benefits, support for persons without a job, persons with disabilities, victims of work injuries and older persons.), while the remaining around 4.1 billion people, accounting for 53.1% of the world population, were left unprotected. **Figure 2** shows that there are significant inequalities across and within regions, with the highest coverage rate in Europe and Central Asia and the Americas at 83.9% and 64.3%, respectively, and above the world average, while Asia and the Pacific and the Arab region coverage rates are 44.1% and 26% respectively, with far marked coverage gaps. According to an ILO report (2021a),

only 30.6% of the working-age population is legally covered by contributory schemes that include a full range of benefits, from child and family benefits to old-age pensions, with women's coverage lagging men's by a substantial eight percentage points. This implies that 69.4% of the world's population is only partially protected or not protected at all. Gaps in coverage, adequacy of social protection systems, and inclusiveness are highly associated with significant underinvestment in social protection, particularly in Asia and the Arab region.

**Figure 2** depicts large variations in effective coverage across the Arab region. In the Gulf Cooperation Council (GCC) countries, on average, 31% of the population is protected through some form of social protection, compared to an average of 85.4% in high-income countries. Saudi Arabia and Bahrain display higher effective coverage rates since they provide social insurance coverage to non-national workers with a limited range of benefits. For instance, in Bahrain, social insurance for migrants is provided against old age, disability, and death. Differences in coverage across the GCC countries are a function of the extent of coverage granted to non-nationals and the proportion of non-nationals in each country's population. Spending and coverage in the conflict-affected and fragile countries of the region, such as Syria, Yemen, and Palestine, are very limited where less than 17% of the population are effectively covered through statutory social protection programs. Jordan and Lebanon are hosting refugees with low effective coverage rates, which reflect that they have very limited or no access to statutory national social protection schemes. In some cases, refugees benefit from emergency response. Coverage across upper and lower-middle-income countries in the region ranges from 77.8% in Saudi Arabia and 50.2% in Tunisia to a mere 13.9% in Lebanon and 2.8% in Yemen. These differences are due to the depth of coverage of contributory and non-contributory systems. Investment in social protection, excluding health, in the Arab region is insufficient, at an average 4.6% of GDP, below the world average of 12.9% sector, as indicated in the following figures.



**Figure 2. Population covered by at least one social protection benefit, and public social protection expenditure, excluding health, as a share of GDP, 2020 or latest available year**



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

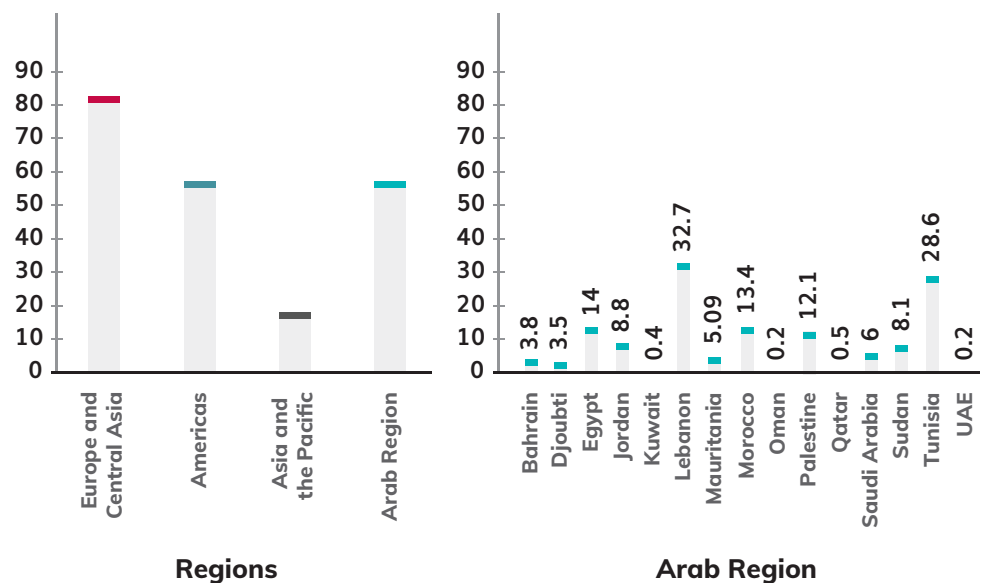
### ■ CHILDREN AND FAMILY BENEFITS

Coverage of children through social protection systems is low in the Arab region, especially in the GCC and other countries, as shown in **Figure 3**. Globally, around 26.4% of children are covered by social protection benefits. Children's coverage in the Arab region ranges from 32.7% in Lebanon to 0.2% in Oman. However, the Arab region lags behind in children coverage which accounts for 9.2% as compared with other regions such as Europe and Central Asia, the Americas, and Asia and the Pacific, which account to 82.3%, 57.4%, and 18%, respectively. Contributory child and family allowance play a critical role in improving children's coverage. These schemes exist mainly in Lebanon, Tunisia, and Morocco, covering 32.7%, 28.6%, and 13.4%, respectively. They contribute significantly to the coverage of children, although the adequacy levels differ greatly. Tunisia has gone through reform to strengthen social protection and increase investment in child well-being, aimed at achieving universal coverage of families with children through a multi-tiered model to extend non-contributory programs to all families not covered by contributory schemes (ILO 2021b).

Non-contributory child benefits are not common in the Arab

region. Whenever they are offered, they are given to certain targeted groups, such as children with disabilities, orphans, and foster children. As such, the vast majority of children are being excluded from these programs, such as in Palestine and Jordan. In Egypt, only 14% of children are covered through the social protection system, with, for example, 4 million children benefiting from the Takaful cash program that targets poor families with children. However, the eligibility criteria are narrow leading to limited coverage. In Morocco, some programs, such as education and healthcare services, are designed to respond to children’s needs. Therefore, the limited social protection coverage of children in the Arab region raises concern, given the importance of investing in human development and protecting them from vulnerabilities (Machado et al. 2018).

**Figure 3. SDG indicator 1.3.1 on effective coverage for children and families:** Percentage of children and households receiving child and family cash benefits, 2020 or latest available year



Source: Author’s compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

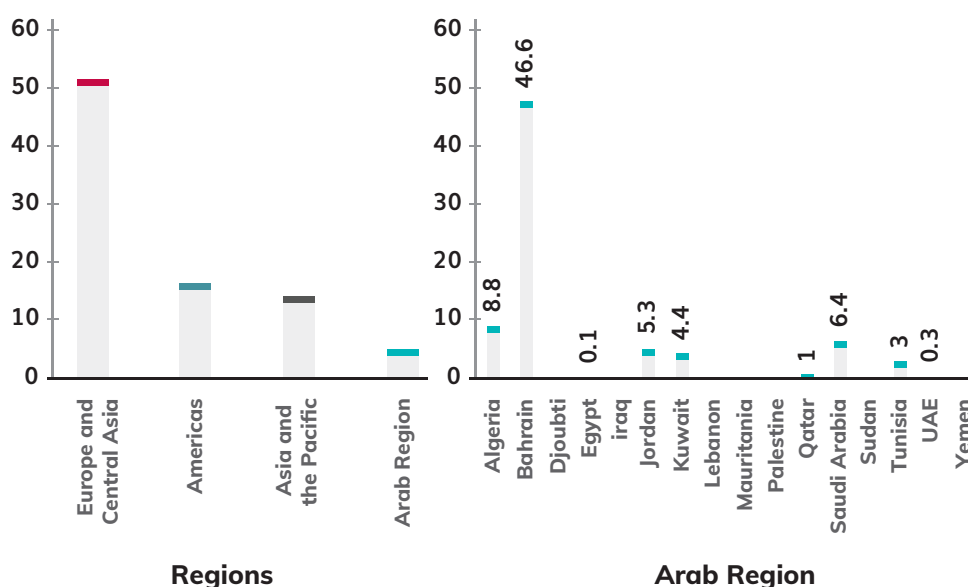
■ **UNEMPLOYMENT BENEFITS**

In the Arab countries, fewer than 10% of the unemployed have access to unemployment benefits, as compared with 18.6% worldwide and in other regions such as Europe and Central Asia, the Americas, and Asia and the Pacific 52.3%, 16.4%, and 14% respectively as shown in **Figure 4**. The unemployed are offered unemployment benefits through contributory and non-contributory schemes in Algeria, Bahrain, Egypt, Jordan, Kuwait, Morocco, and Saudi Arabia. Non-nationals are ineligible

for these benefits in Saudi Arabia and Kuwait or with restricted access in Bahrain and Jordan. In Bahrain, the percentage of unemployed persons receiving cash benefits reaches 46.6%, with non-national workers legally covered by unemployment insurance schemes.

When COVID-19 hit in 2020, it revealed the weakness and underdevelopment in systems of unemployment protection and labor market activation in the region (Bird & Silva 2020). There was a lack of solidarity in financing and risk-pooling across different sectors of the economy. Moreover, employer liability mechanisms suffer from weaknesses in terms of monitoring and legal enforcement of workers' rights, and exposure to bankruptcy and abuse risks. Some initiatives have been introduced in the Arab region to provide unemployment insurance schemes, such as in Lebanon, Tunisia, Palestine, and the United Arab of Emirates. In Jordan, unemployment insurance schemes have been used as a crisis response.

**Figure 4. SDG indicator 1.3.1 on effective coverage for unemployment protection:** Percentage of unemployed persons receiving cash benefits, by region, subregion 2020 or latest available year



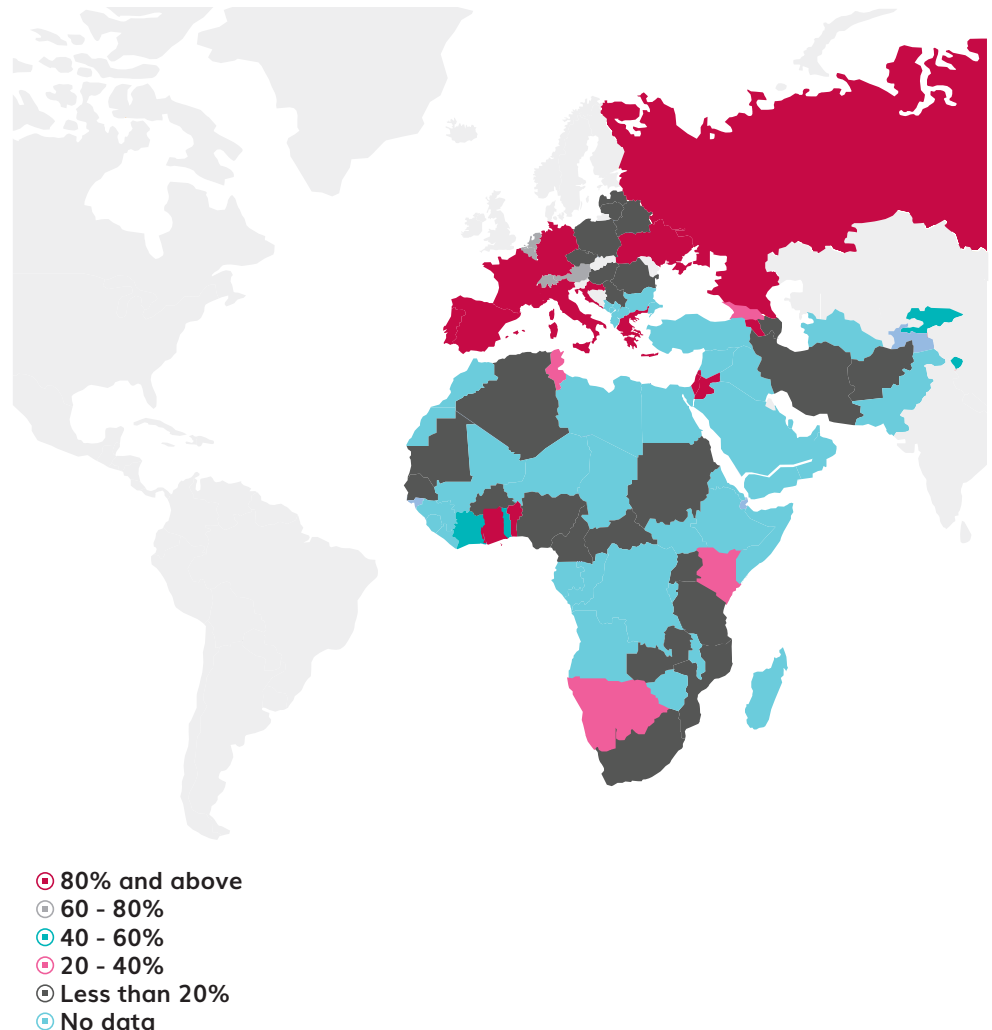
Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

## ■ MATERNITY BENEFITS

Most countries in the world provide maternity provisions in their social insurance schemes. In contrast, countries in the Arab region generally provide paid maternity leave as an employer liability in their labor codes (ILO 2021b). Such arrangements

provide limited maternity protection with weak enforcement mechanisms and may discourage hiring female workers. The adequacy level of maternity benefits and their duration are also often longer and more generous in the public than in the private sector. In Tunisia, as shown in **Figure 5**, 23.5% of women giving birth received maternity cash benefits. Some countries in the Arab region have moved toward introducing social insurance schemes; however, with limited coverage, high informality levels, and low female labor market participation, for example, Sudan, Jordan, and Iraq (ILO 2021a). After COVID-19, Jordan introduced a childcare subsidy as a form of contributory maternity insurance scheme. However, no Arab country provides non-contributory benefits explicitly targeting pregnant women.

**Figure 5. SDG 1.3.1 indicator on effective coverage for maternity protection:** Percentage of women giving birth receiving maternity cash benefits, 2020 or latest available year

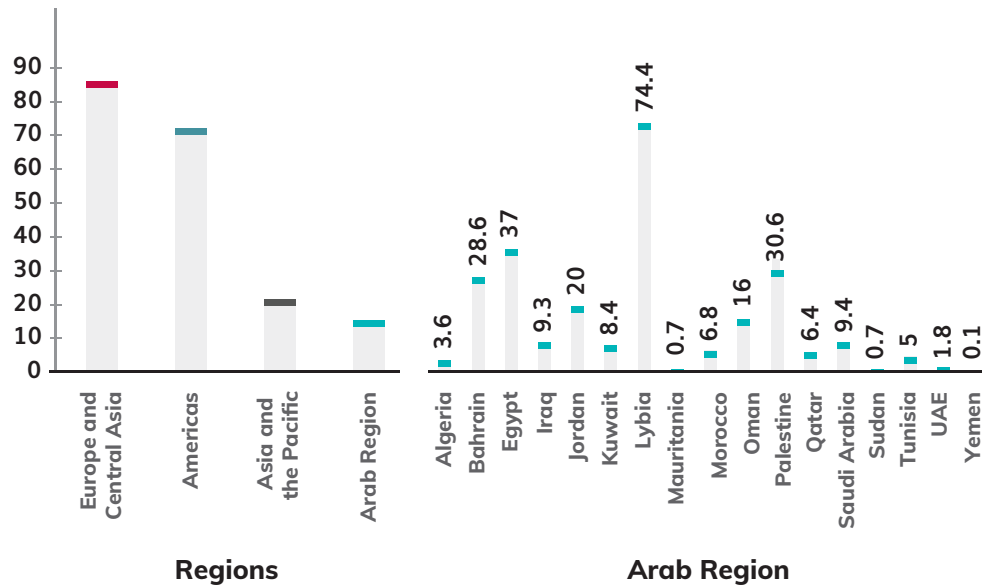


Source: ILO 2020, World Social Protection Database Maps, based on the SSI; ILOSTAT; national sources.

### ■ DISABILITY BENEFITS

Access to social protection benefits among people with disabilities globally reaches an average of 33.5%, as compared with low coverage in the Arab region, which reaches 15%, the lowest among other regions such as Europe and Central Asia, Americas, and Asia and the Pacific as shown in **Figure 6**. This is due to the limited coverage and low adequacy levels of contributory and non-contributory schemes in countries in the region, such as Sudan, Yemen, and Mauritania. Contributory benefits cover a small portion of people with disabilities, rarely in excess of 10%. Bahrain, Palestine, and Jordan have recently increased their coverage of people with severe disabilities using non-contributory benefits. In Egypt, 37% of people with severe disabilities receive disability cash benefits. For example, the Karama cash transfer program is provided unconditionally to people with disabilities. The main source of benefit coverage for people with disabilities is non-contributory schemes provided by ministries of social development. However, these benefits are inadequate and fragmented and do not sufficiently address the exclusion errors due to which the intended beneficiaries are not able to participate in the program, for instance, private cost, targeting technique, administration, and financial barriers. Most countries of the Arab region lack comprehensive and tax-funded schemes offered to those with disabilities. Therefore, some countries in the region, like Palestine and Lebanon, have identified a need to introduce disability benefits as part of a social protection scheme for those with disabilities (UN-ESCWA 2017; ILO 2021b).

**Figure 6. SDG indicator 1.3.1 on effective coverage for people with severe disabilities:** Percentage of people with severe disabilities receiving disability cash benefit, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

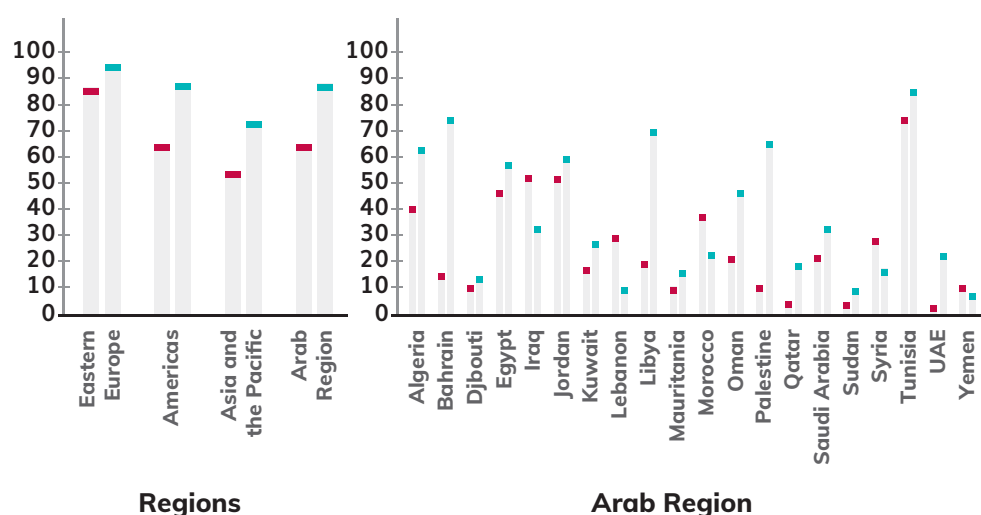
■ **OLD AGE BENEFITS: PENSION SCHEME**

Two important indicators are used to understand the implementation of statutory schemes: the percentage of persons above statutory retirement age receiving an old-age pension and active contributors as a percentage of the labor force. These provide an indication for those benefiting from existing contributory and non-contributory pension schemes and future pension coverage for those who are economically active in the labor force. An important cause for concern is that, at the global level, 53.7% of the global labor force contributes to pension schemes compared to 25.6% of the Arab region. This indicates that limited coverage is expected to receive a contributory pension upon retirement, as shown in **Figure 7**. This is due to the high levels of informality in the region, together with the lack of institutional capacity to ensure the enforcement of laws and fragile governance.

Only around 40% of older people receive a pension in the Arab region, less than the global average of 77.5%. Coverage rates are significantly high in countries with social insurance systems, such as GCC countries, Tunisia, and Jordan. However, Lebanon and Palestine have no scheme that provides periodic pension benefits for workers in the private sector, which is not sustainable (ILO 2021b). Some countries in the region provide

generous retirement conditions for public sector workers and benefit levels for pension schemes. On the contrary, some countries do not offer adequate minimum benefit guarantees in the absence of automatic pension-indexed inflation. Some countries, such as Egypt, Jordan, Oman, and Sudan, conducted reforms in merging retirement systems for public- and private-sector workers through a combination of institutional, systemic, and parametric reforms. However, the process of convergence is slow. Reform in Iraq has been delayed.

**Figure 7. SDG indicator 1.3.1 on effective coverage for older persons:** Percentage of population above statutory pensionable age receiving an old-age pension and active contributors as a percentage of the labor force, selected countries, 2020 or latest available year



■ Labour force covered by pension scheme (active contributors)

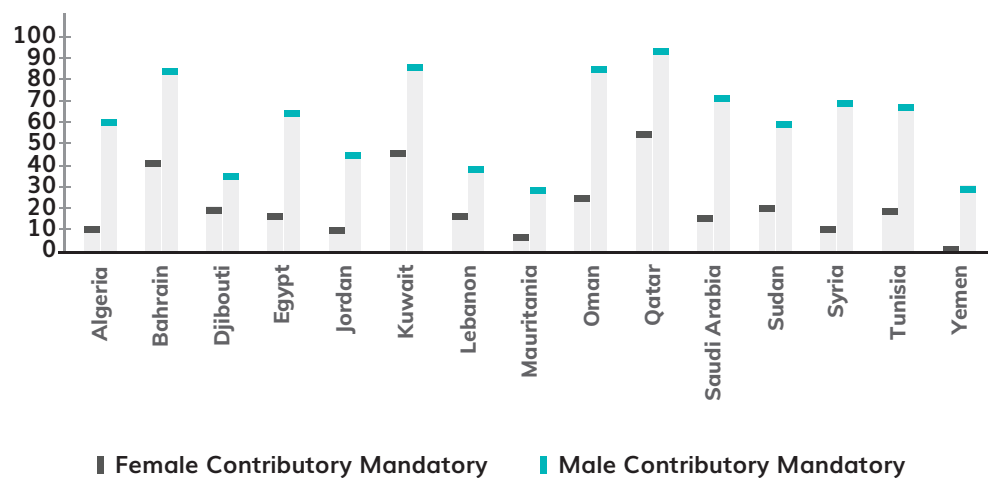
■ SDG indicator 1.3.1 on effective coverage for older persons: Percentage of population above statutory pensionable age receiving an old-age pension, selected countries, 2020 or latest available year.

Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

Contributory pension schemes are also characterized by a significant gender bias, as shown in **Figure 8**. For example, in Kuwait, women are less likely than men to benefit from a selection of contributory pension schemes by at least 40 percentage points. This infers low female labor force participation in the region. Therefore, the design of pension systems is tailored to those in stable, long-term, wage-employed careers (ILO 2021a). Non-contributory benefits for older people are rare in the region. However, Oman and Bahrain provide income security in old age, especially for

women. Non-contributory schemes covering families with older members are generally inadequate and cannot replace individual pensions based on broad coverage and universal entitlement.

**Figure 8. SDG indicator 1.3.1 on effective coverage for older persons:** Percentage of population above statutory pensionable age receiving an old-age contributory pension, by sex selected countries, 2020 or latest available year



Source: Author's compilation, based on ILO 2020, World Social Protection Database, based on the SSI; ILOSTAT; national sources.

## SOCIAL HEALTH PROTECTION SYSTEM IN ARAB COUNTRIES

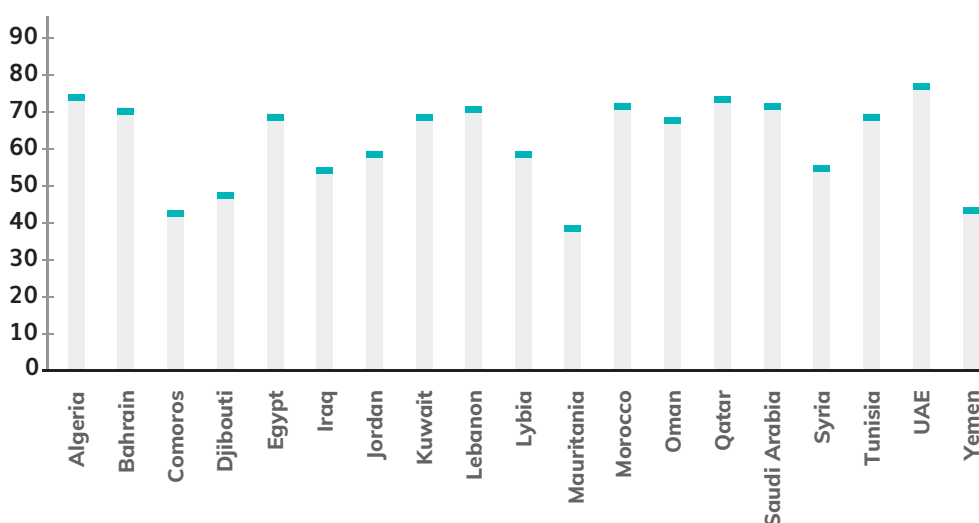
Social health protection is measured by SDG target 3.8 to achieve UHC, including access to quality essential healthcare services, financial risk protection, and access to safe, effective, quality, and affordable essential medicines and vaccines for all; and the ILO Social Protection Floors Recommendation, 2012 (No. 202) that should guarantee first: access to essential healthcare, including maternity care, second: basic income security for children, providing access to nutrition, education, care, and any other necessary goods and services, third: basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability, and finally: basic income security for older persons. This is a key element of the human right to health and social security. The health system in the Arab region is complex and pluralistic, combining public and private providers and financiers. Providers compete, and citizens can choose services based on their needs and ability to pay. Consequently, the system relies on four primary financing



agents delivering health services under contributory and non-contributory schemes: the government sector, the public sector, the private sector, Civil Society Organizations (CSOs), and household OOP payments when adequate coverage is not provided.

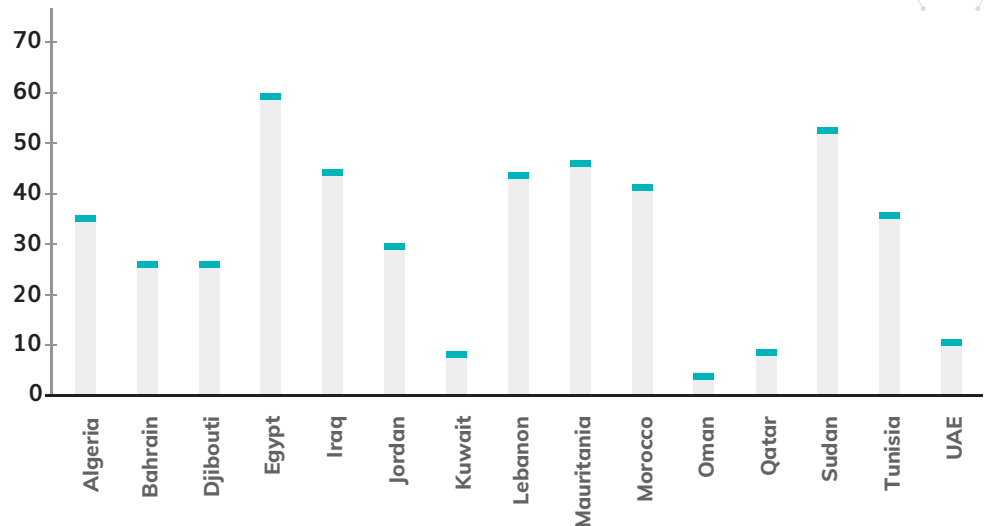
Social health protection in the Arab region is characterized by the low quality of service provided with limited coverage, as shown in **Figure 9**. UHC rates vary significantly among countries in the region, from as high as 78% in the United Arab Emirates to as low as 40% in Mauritania. Limited health access OOP payments are still high in the Arab region, as shown in **Figure 10**. This means that households are responsible for most of the healthcare costs, reflecting inequality in accessing healthcare services between urban and rural areas (ILO 2021). The distribution of spending for OOP payments as a percentage of health expenditure varies markedly across countries in the region. Most GCC countries have low OOP expenditure compared to other Arab countries. The OOP payment in Egypt and Sudan represents around 59.3% and 53%, respectively, of the health expenditure compared to 5% in Oman. Reliance on OOP spending reduces social solidarity and increases inequalities in accessing the healthcare system. After the Arab Spring, many countries prioritized health coverage in the new constitutions and national policy dialogues. However, most of the Arab countries still lagged in achieving the UHC targets. For instance, the region faces outdated national health accounts and poor data sharing across system levels (Alami 2022).

**Figure 9. UHC Service Coverage Index (SDG 3.8.1) (%), 2019**



Source: Data extracted from WHO Global Health Expenditure Database (WHO-GHED); latest available year modified in 2021

**Figure 10. Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%), 2020**



Source: Data extracted from WHO Global Health Expenditure Database (WHO-GHED), latest available year modified in 2021

## MIGRANT AND REFUGEE ACCESS TO SOCIAL HEALTH PROTECTION SYSTEMS IN THE ARAB REGION

Over 40 million migrants and refugees were hosted in the Arab region in 2019, which accounts for 15% of them worldwide. Around 50% originated from Arab countries and stayed in the region (UN-ESCWA 2020). According to the World Bank (2016), conflicts and wars in Iraq, Libya, Syria, and Yemen have led millions of people to leave their homes and flee to countries already suffering from economic burdens, such as Egypt, Jordan, Tunisia, Lebanon, and Djibouti. Despite the resources devoted by host governments and international bodies, they are exposed exponentially to dangers. The more migrants and refugees there are, the higher the percentages of poverty and risk exposure among them. If one looks at individual countries, the picture might become clear: in Yemen, since the beginning of the conflict in March 2015, around 190,000 people have fled the country, nearly 25% of them from Somalia, and over 2.1 million people have been internally displaced, with an estimation of around 80% of the population in need of humanitarian assistance. Many refugees have returned to Somalia, and the rest have moved to other countries in the region, notably Djibouti and Ethiopia, where they are hosted as refugees with limited access to basic services (UNHCR 2019).

With regards to the effect of conflict on the health of forcibly

displaced populations between and within countries, this has resulted in high mortality and morbidity rates from preventable causes, particularly within vulnerable groups either by age or gender. In addition, there are several challenges in providing them with social health protection except in the Gulf area, including those related to policy, programmatic and institutional capacity; for instance, weakened systems, funding, administrative barriers, coordination, and sustainable interventions, among many others. Therefore, providing social health protection for refugees and migrants is a challenge on both the supply and demand sides. On the supply side, limited access to health services is due to weakened health systems that vary across countries in the region. On the demand side, safety, together with epidemiological and demographic issues, lead to a high burden of both communicable and non-communicable diseases and mental illness among them, combined with other common diseases related to poor determinants of health, social status, and lack of access to basic health services. As such, resources devoted to health are unable to meet their needs. Migrants and refugees' situation underscores the urgent need to develop a comprehensive and integrated regional social health protection strategy to support their needs and strengthen and support healthcare systems in host countries. This strategy should aim at increasing the capacity, resilience, and preparedness of healthcare systems to promote a sustainable response that could address the health needs of both migrants and refugees together with the general public. It should also be based on the local legal context of each country in the region while ensuring the rights to access healthcare for migrants and refugees. This is an opportune time for revising the relevant legal frameworks for the rights of social health protection (UNHCR 2019).

The role of international organizations is central in supporting access to healthcare and providing social health protection in the Arab region for migrants and refugees. Some Arab countries incorporate the right for refugees their national laws and policies. In contrast, others have drafted policies such as Memorandums of Understanding (MOU) between international organizations and hosting governments to ensure their access to essential healthcare services. The World Health Organization (WHO) global action plan 2019-2023 identified a set of priorities to guide international organizations (including the WHO itself, the International Organization for Migration (IOM), the United Nations High Commissioner for Refugees (UNHCR)), member states and non-state actors in promoting the health of refugees and migrants. These priorities include: promoting the health

of migrants and refugees through short-term and long-term public health interventions; advocating the mainstreaming of migrants' and refugees' health into global, regional, and country agendas; promoting refugee-sensitive and migrant-sensitive health policies and legal and social protection, which include the health and well-being of women, children, and adolescents, gender equality and empowerment of migrants and refugees women and girls; promoting continuity and quality of essential healthcare, while implementing and developing occupational health and safety measures; accelerating progress towards achieving SDGs including UHC by enhancing capacity to tackle the social determinants of health; strengthening health monitoring and information systems; and supporting measures to improve evidence-based health communication to counter misperceptions about migrants and refugees health (Onarheim & Rached 2020).

Migrants, refugees, and displaced populations require social health protection that mainly focuses on mental health protection and support due to the vulnerabilities they are exposed to, beginning with basic services, such as access to food, water, shelter, healthcare, and other mainstream services. An example is Sphere Project's (2018) mental health standards, cowritten with WHO and is being developed in collaboration with UNICEF and other partners to support migrants and refugees. However, health systems in the Arab region struggle to cope with their needs, and henceforth, women and children mainly face severe challenges. For example, the total number of all deliveries in Lebanon is 73,000 childbirths per year in the Lebanese population, compared to 39,000 deliveries in the Syrian refugee population. Such high numbers of deliveries pressure national health systems, especially reproductive, maternal, and child health services. To end preventable deaths among all women, children, and adolescents and to greatly improve their health and well-being, countries should follow the guidelines and standards for Reproductive, Maternal, Newborn, Child, And Adolescent Health (RMNCAH) services. However, these are non-existent, fragmented, or poorly implemented in displacement settings. Moreover, RMNCAH available data and information among migrants, refugees, and displaced populations, and coordination and integration in humanitarian settings remain insufficient, as does social and financial protection. Possible solutions should lurk in integrating RMNCAH with national frameworks' preparedness plans to ensure healthcare quality services are provided to women, children, and adolescents, which should be sensitive to their needs and situation (WHO 2019).

## RESPONSES FOR CHANGING REALITIES IN THE ARAB REGION: COVID-19

Before the COVID-19 pandemic, less than 30% of the population in the Arab region were covered by social protection programs, including health. Most of these programs were funded through government budgets or external assistance and not through beneficiaries' or employers' contributions. The pandemic spotlighted the problems of the social contract between people and governments. Spending levels on COVID-19 in the Arab region varied largely from one country to another, however it remained lower than global spending. In the region, 3.9% of the GDP was spent on the pandemic compared to a global average of 22.6%. The Gulf countries spent the most, around 69.9 billion USD, compared to 24.78 billion USD spent by all the remaining Arab countries. Not only did the spending levels vary across the region, but the sources of spending differed from one country to the other. In Morocco and Tunisia, the private sector provided funds worth 104.5 million USD and 410 million USD, respectively. While most Arab countries reprioritized their public spending or created special funds, countries in conflict relied mainly on donor funding and humanitarian aid.

Additionally, spending on the pandemic went towards different areas, including social insurance, loan and tax benefits, social assistance, labor market interventions, health-related support, financial and general policy support. In this context, Arab countries devoted nearly 18% of fiscal support for social protection. For example, Somalia allocated around 100%, followed by Lebanon with 96.8% and then Iraq 95%. Oil-exporting countries prioritized temporary tax reductions, extended deadlines for payments and increased other spending to preserve jobs, while oil-importing countries focused their spending on health and targeted social transfers (UN-ESCWA 2021).

Before COVID-19 in 2018, health spending as a percentage of GDP ranged from a low of 1% in Sudan to 4.4% in Kuwait, with a regional average of 2.9%. This level of spending is relatively moderate compared to the global average of 5.87% for the same year. Overall, in the region, health spending between 2015-2018 was relatively steady, accounting to 3% of GDP. Notably, this should have urged policy makers to increase health spending to improve health services, which is essential especially with high levels of poverty and unemployment in the region. After COVID-19 hit the world, it revealed the extent to which health systems in the Arab region are fragmented and

primary care is underserved. It highlighted the health systems' uneven capacity and deep inequalities (UN 2020). According to the Global Health Security Index (2021), one-third of Arab countries have less than 10 healthcare providers per 10,000 people, while the richest third of countries have at least a range of 50 to 70 providers per 10,000 people.

The regional doctor-to-population ratio is 2.9 per 1,000 people, below the world ratio of 3.42 per 1,000. Similarly, this trend was observed in intensive care units, hospital beds and primary care, with a large variation between and within countries for rural and urban areas. On average, 61% of the population in the region can access health services, however, this rate varied significantly among countries and even within individual countries, from 77% in Kuwait to 22% in Somalia. Similarly, OOP expenditure on health varied from 37% of the cost to 88% in poorer countries, threatening the ability of households to meet their basic needs. Moreover, social health protection schemes are often fragmented and do not cover the unemployed and workers in the informal sector. Despite the ongoing emergency health response and efforts undertaken in the region to enhance access to health services, the costs of testing and healthcare, as well as falling ill are likely to have a devastating consequence on poor households with the potential to push tens of millions of people into poor health and poverty (UN 2020).

## **RECENT KEY SOCIAL HEALTH PROTECTION REFORMS IN THE ARAB REGION**

To implement contributory health insurance, governments are challenged to improve the sustainability of health insurance funds and to broaden coverage of these funds, especially to informal workers and low-income groups to better protect them from the impact of lifecycle risks. However, these two goals, fiscal pressure and coverage gap, are hard to achieve, therefore non-contributory schemes are provided to limit the challenges of coverage, sustainability, inclusiveness, and adequacy level of health benefits. Countries in the Arab region have introduced several reforms to overcome the challenges mentioned above.

### **■ CONTRIBUTORY HEALTH PROTECTION**

In Jordan, the government expanded health insurance coverage in 2004 by adopting a civil health insurance law to include older people, starting with those over 80 and then over 70, reaching everyone aged over 60 in 2017 (135,000 persons). Also, the coverage expanded in 2018 to include free access to healthcare

for beneficiaries of the National Aid Fund, children under six, and persons with disabilities. Similarly, in Sudan in 2015, the national health insurance program extended its coverage to subsidize older people, poor households, and people with disabilities (UN-ESCWA 2019).

From 2000 until 2005, the Palestinian government extended free coverage via a health insurance scheme to all unemployed persons and their households. Consequently, the coverage of health insurance increased from 204,350 to 343,318 beneficiaries. In 2007, it was decreed that all households in the Gaza Strip should be exempt from paying contributions. Health insurance is offered to those benefitting from social assistance and imprisoned persons. The number of social assistance beneficiaries in the West Bank benefitting from health insurance on this basis increased from 10,942 in 2008 to 41,198 in 2017 insured households. The number of prisoners' households covered by health insurance increased from zero to 17,882 from 2009 to 2017, respectively. These reforms appear to have worked well in terms of coverage since the proportion of Palestinian households covered by health insurance increased from 48.6% in 1997 to 66.2%.

In 2004, Tunisia adopted a law establishing a new health insurance regime in which social insurance and health insurance are bundled together. This reform resulted in covering both workers from the public and private sectors on the same basis. As such, the coverage of private sector workers has since risen very sharply from 1,162,446 in 2002, meaning that 54% of all such workers were covered, to 2,362,839 in 2017, lifting the coverage rate to 81% (UN-ESCWA 2019).

In Egypt, the 2014 constitution affirmed the universal right to healthcare, safeguarded by building and maintaining an inclusive and effective healthcare system. The government has developed an ambitious long-term plan to reform the national health system, adopted by parliament in 2017. To achieve target 3.8 on UHC, the government must allocate not less than 3% of GDP to health. The increasing cost of healthcare in Egypt is a challenge. In 2018, 62.8% of health expenditures were paid OOP. Fragmentation is another challenge. A member of the same household could benefit from various schemes under different programs, each with its regulations, which makes it difficult to unify health services. Moreover, due to widespread informality, some workers are not covered by any health insurance scheme. This problem is further exacerbated in rural Upper Egypt, where workers are the least educated and most disadvantaged.

In Egypt, Law No. 2 of 2018 on universal health insurance was adopted to address healthcare challenges. Phase one began in five pilot governorates: Port Said, Suez, Ismailia, North Sinai, and South Sinai. It will be expanded to the entire country over ten years. The new law mandates health insurance for all citizens except those living abroad. Employers must contribute 4% of the employee's salary or a minimum of 50 Egyptian pounds, and employees contribute 1% of their wage, adding an additional 1% per child or dependent and 3% for a non-working spouse. Those who receive pensions contribute 2% of their monthly pension. In addition to contributions, universal health insurance will be financed by taxes on cigarettes, highway tolls, corporate revenue, application and renewal fees for various licenses, payments made to join the health insurance system, and external and internal grants and loans. The new law provides a health subsidy for those unable to make contributions, under which the government contributes 5% of the minimum wage per family member. Eligibility for the health subsidy will be determined according to targeting criteria, and the government plans to cover approximately one-quarter to one-third of the population. Nevertheless, the government is expected to face several challenges (Talaat 2022).

#### ■ NON-CONTRIBUTORY HEALTH PROTECTION

Some countries in the Arab region allow certain categories to be covered by contributory health insurance schemes for free or on a subsidized basis. Other countries have established or complemented contributory schemes by providing specific non-contributory healthcare schemes for the poor and vulnerable. These schemes, which share many characteristics with cash-transfer programs, mainly rely on targeting. In Lebanon, since 2011, beneficiaries of the National Poverty Targeting Program (NPTP) can access private and public hospitals at a reduced cost, for which the Ministry of Health can pay around 90% of the hospital tariff.

In Tunisia, a non-contributory health provision scheme is offered to poor and vulnerable households who are enrolled in Assistance Medicale Gratuite I and II Programs that provide free access to care at public hospitals and health coverage on a heavily subsidized basis. The health benefit reached 622,000 households in 2018. In Morocco, the 2002 law mandated that a special non-contributory health provision scheme, named RAMED, must offer free health coverage to the poor while vulnerable households must pay a small contribution. RAMED has been operational in parts of the country since 2008 and covered the whole country in 2012, reaching 11,866,735 beneficiaries in 2018 (UN-ESCWA 2019).



## THE MULTIDIMENSIONAL ROLE OF ARAB STATES AND THE INCREASED RESPONSIBILITY OF CIVIL SOCIETY ACTORS

Arab health systems have undergone similar transformations to other developing countries towards greater reliance on private and charitable sector provision due to the neoliberal economic reforms of the 1980s and 1990s and the austerity measures which followed in the 2000s. What is distinctive about the 'commodification' of healthcare in the Arab region is that most Arab countries went against the international trends of reducing OOP spending by investing in public health. As a result, financial burdens on citizens in the MENA region have not improved even when fiscal space opened up in the 2010s, later to be put to the test by the COVID-19 pandemic, as noted above.

### TYPES OF APPROACHES ADOPTED IN DIFFERENT SUB-REGIONS BY THE STATE AND PRIVATE SECTOR

Most Arab countries have a public healthcare system funded primarily by the treasury. The eligibility criteria and access patterns vary across countries and do not always match political regimes or national income levels. For example, Oman, Sudan, Syria, and Yemen have historically offered free of charge healthcare to all residents. In contrast, in Bahrain, Qatar, Kuwait, Saudi Arabia, and the UAE, free healthcare is only available for nationals and citizens (Loewe 2013). In Jordan and Iraq, only civil servants and military personnel are treated for free; all others must pay user fees, although these are heavily subsidized. Tunisia and the West Bank have social health insurance systems that operate their healthcare systems. These healthcare systems are primarily financed from the premiums of health insurance systems but also receive subsidies from the Treasury (Loewe 2013). They are freely available only to members of the health insurance scheme, while the uninsured have to pay modest user fees. Algeria and Libya both have a public healthcare system and a healthcare system owned by the respective social health insurance organization. The public healthcare system pays for its costs mainly through tax revenues, but it is co-financed by the social health insurance organization from the premiums collected from the members. However, the socially insured and the uninsured are entitled to free medical treatment. The difference between both countries

is that in Algeria, the insured may also go to private healthcare providers, and they are then reimbursed for 80% of the cost.

Egypt also has both a public healthcare system and a social health insurance scheme. The public scheme is run by the Ministry of Health and financed by the treasury from general taxes. It is open to all residents free of charge. At the same time, the health insurance scheme runs its system of healthcare, which is for the benefit of its members only – but not their relatives. It is financed from social insurance contributions, gets funds from the treasury, and has a much higher standard than the public system. Lebanon also has a social health insurance scheme and a public healthcare system. The insured and the uninsured can refer to the public healthcare system and private providers. However, in both cases, they have to pay high user fees. Morocco and Mauritania have public healthcare systems, which are only partly financed by the treasury from general income tax and charge relatively high user fees. Morocco has started building a social health insurance scheme, which takes over the fees paid for healthcare services. It also provides households in need with identification cards that entitle them to free use of the public healthcare system. This effort was accelerated during the COVID-19 pandemic (ESCWA 2022).

Even within government-provided facilities, considerable differences in benefit packages and access to facilities persist, generating horizontal inequalities. For example, Jordan's Civil Health Insurance covers ministers and employees. However, only the former can access first-class services (including private providers) and have a comprehensive benefits package (inpatient, outpatient, diagnosis, rehabilitation, etc.). Likewise, in Lebanon, hospitalization class depends on the health insurance category, with some high officials exempt from contributing but entitled to a comprehensive package (El Khoury 2012). An even higher level of fragmentation is reported in Egypt, with the best state hospitals reserved for the ruling elites, which can also use private care (El Laithy 2011).

## **SOCIAL PROTECTION AND TAX POLICIES: FINANCING STRATEGIES AND FRAMEWORKS**

In recent policy debates, social protection and tax have emerged as two of the key policy instruments available to governments in the pursuit of development goals (Bastagli et al. 2021). Both feature prominently in the Sustainable Development Goal (SDG) and Financing for Development (FFD) processes. Social protection and taxation interact to shape the distribution and redistribution of income and wealth

directly, through the incidence of taxes and transfers. They also interact to shape the resources available for social spending by influencing government accountability and legitimacy processes, the quality of service provision, and people’s willingness to pay taxes. Some key principles are:

1. Taxes and transfers can be a powerful redistributive tool;
2. Tax and transfer design and implementation details matter; and
3. Variations in the levels and composition of revenue, or ‘financing mix,’ have implications for distributional outcomes and policy sustainability.

Below is a summary of the main strengths and weaknesses of taxation in relation to other social health protection funding mechanisms. **Table 1** below shows the different kinds of health financing mechanisms, and **Table 2** shows the strengths and weaknesses of each one, including taxation.

**Table 1. Scope of health financing mechanisms**

Government revenues	Payroll taxes	Premiums/ CBHI	Premiums/ PHI	Out-of-pocket payments
Equity depending on design of tax system	Coverage of formal economy	Resource collection from the non-salaried	Increases fiscal space	Easy to administer
Coverage and outreach	Increased fiscal space	Allows to target public funds to the poor	Allows to target government funds to the poor	
Sustainability	Public support	Increases fiscal space		
Potential for efficiency	Financial soundness	Potential to reach out to those who can pay or are subsidised		
	Allows to target government funds to the poor			

Source: From ILO 2008

**Table 2. Pros and cons of the different funding mechanisms of social health protection**

Mechanism	Pros	Cons
▼ Tax-based health protection	▼ Pools risks for whole population	▼ Risk of unstable funding and often underfunding due to competing public expenditure
_____ Coverage and outreach	_____ Potential for administrative efficiency and cost control	_____ Inefficient due to lack of incentives and effective public supervision
_____ Social health insurance	_____ Redistributes between high and low risk and high- and low-income groups in the covered population	_____ Poor are excluded unless subsidized
_____ Social health insurance	_____ Generates stable revenues	_____ Payroll contribution can reduce competitiveness and lead to higher unemployment
_____ Social health insurance	_____ Often strong support from population	_____ Complex to manage governance and accountability can be problematic
_____ Social health insurance	_____ Involvement of social partners	_____ Can lead to cost escalation unless effective contracting mechanisms are in place
_____ Micro-insurance and community-based schemes	_____ Redistributes between high and low risk and high- and low-income groups in the covered population	_____ Poor may be excluded unless subsidized
_____ Micro-insurance and community-based schemes	_____ Can reach out to workers in the informal economy	_____ Maybe financially vulnerable if not supported by national subsidies
_____ Micro-insurance and community-based schemes	_____ Can reach the close-to-poor segments of the population	_____ Coverage usually only extended to a small percentage of the population
_____ Micro-insurance and community-based schemes	_____ Strong social control limits abuse and fraud and contributes to confidence in the scheme	_____ Strong incentive to adverse selection
_____ Micro-insurance and community-based schemes	_____ Micro-insurance and community-based schemes	_____ Micro-insurance and community-based schemes

<p>Private health insurance</p>	<p>Preferable to out-of-pocket expenditure</p> <p>Increases financial protection and access to health services for those able to pay</p> <p>Encourages better quality and cost-efficiency of healthcare</p>	<p>Maybe associated with lack of professionalism in governance and administration</p> <p>High administrative costs</p> <p>Ineffective in reducing cost pressures on public health financing systems</p> <p>Inequitable without subsidized premiums or regulated insurance content and price</p> <p>Requires administrative and financial infrastructure and capacity</p>
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| Source: From ILO 2008

As Megersa (2019) notes, social protection and taxation are two interrelated policy instruments that have a major role in advancing the capacity of fiscal policy to influence development, equality, and the Sustainable Development Goals (SDGs). Developing countries are faced with the option of raising government revenues for social protection through taxation and social security contributions. However, these remain challenging because tax authorities have weak capacity and lack transparency. At the same time, a large share of the population is informally employed, which makes it difficult and costly to collect social security contributions or tax employees. According to the ILO, these challenges limit the means to redistribute income and develop effective social protection systems (ILO 2016). A key measure for fiscal expansion already being used in Arab countries is the removal of ineffective tax subsidy policies (e.g., Jordan, Egypt, Morocco, Oman, and Lebanon). Moreover, taxes on natural resources in resource-rich countries can support social spending and generate overall economic growth. This approach could be better implemented in the region's oil- and gas-rich states.

Taxes and social transfers are often discussed separately, but they have evident interconnections in practice and influence the distribution and redistribution of income and wealth. As noted by Bastagli (2015), when studies examine social protection independently from tax policy, they generate an incomplete picture of the impact of fiscal policy (Bastagli 2015a; 2015b) since the net effects of government spending and taxes make the poor worse off, hence the need for implementing

a comprehensive approach which includes both taxes and spending (as can be seen in Jordan and other Arab countries below).

Taxation is especially significant – when compared with other social protection financing alternatives, like expenditure reallocation and dependence on external financing – because it has the capacity to redistribute wealth in a much more profound way and support social citizenship. Taxation has the potential to create and strengthen government legitimacy and state-citizen relations (UNRISD, 2019). External financing and revenue earned from natural resources and consumption taxes have been crucial to backing the establishment or enlargement of social protection programs. Arab countries suffer from a relatively low tax-to-GDP ratio, making them more dependent on international aid and financial support. This raises equity and sustainability issues, some of which can be resolved through the transparent management of resources and by creating tax and transfer policies that address equity and broader development concerns (Bastagli 2015a).

Various Arab countries have approached this issue of tax reform in different ways, as can be seen below:

- Jordan: the reduction and, in some cases, removal of subsidies on different types of petroleum products has lowered the government's fiscal burden and supported some improvement in social protection coverage, such as cash transfer schemes to vulnerable households. However, this reform sparked resistance and possibly also increased tax evasion.
- Egypt: the increase in government taxes and the termination of energy tax subsidies (among other policies) has led to targeted social 'solidarity' programs – including pension schemes, healthcare provision, and education. However, rising poverty rates remain an issue, and recent reforms (higher taxes and cuts to subsidies) affected living costs for many households.
- Oman has cut ineffective tax subsidies on different items and focuses on diversifying its economy (and source of tax) – away from oil. The country has also implemented a comprehensive social protection system, including universal medical care, programs for disabled people, children, migrant workers, and free/compulsory education.
- Algeria has sought to enhance social protection provision through taxes on tobacco, alcohol, and pharmaceutical imports.

According to the IMF (2022), improvements in tax policy design can help widen the tax base and increase the redistributive capacity of the state: there are key elements of this perspective that apply to the Arab countries. First is the reduction of tax exemptions on personal and corporate income. This measure can help to expand the tax base by restricting “generous and distortive tax exemptions—including those introduced during the COVID-19 pandemic”, leading to improvements such as greater allocative efficiency, simplification of tax administration, and reduction of non-compliance. A case in point is Egypt, where a reform of income tax law is underway to simplify the legal framework and rationalize exemptions. Second, improving the design of the VAT is another important measure of tax reform. The IMF (2022) argues that exemptions on basic goods and services, including foodstuffs and medication, aimed at lowering the tax burden on vulnerable households, in effect, benefit high-income households and distort market prices. These exemptions can be replaced by better-targeted cash transfers, which may be financed using consumption tax revenues (Warwick and others 2022). VAT progressivity can also be improved if additional revenues are used to finance spending on social programs, education, health, and infrastructure (IMF 2020).

The weaknesses of taxation systems in the Arab countries were brought to the fore following the COVID-19 pandemic response. Although countries in the Arab region, like Morocco and Egypt, were quick to introduce tax-financed cash transfer schemes, the high levels of labor market informality mean that the social insurance base of social protection is small and not well adapted to emergency situations. The productive inclusion of youth can help broaden the base of contributory social protection and the tax base for non-contributory programs.

## **THE ROLE AND CONTRIBUTIONS OF CIVIL SOCIETY AND RELIGIOUS GROUPS**

2015–2025 has been called the “Arab decade for civil society organizations” by the WHO and Arab States (2015) following a region-wide consultation in 2015. The decade provides a platform for strengthening and mobilizing civil society organizations in the Arab region to become effective partners in achieving the SDGs. WHO is cooperating with this initiative by helping to identify the specific role that civil society organizations can play in achieving SDG 3 (the health goal).

Civil society organizations have a key role in the progress of the health-related SDG agenda, including health literacy, advocacy, social mobilization, and service provision, especially

in countries in crisis and emergency situations. Religious welfare movements and organizations already provide health services to poor populations and their membership base (Jawad, 2009; 2019). Their role is controversial due to their wide range of services and the extent to which these exacerbate social divisions and discrimination. This is especially true in the MENA region, where religious divisions are deep and sometimes politically divisive. In the Arab region, the number of civil society organizations per country varies but is increasing in number and influence. Civil society organizations are weakest in the Arab Gulf monarchies and military-ruled states like Egypt and Libya. They play a crucial role in addressing population health problems, providing institutional vehicles to address community needs and expectations, and complementing government action through implementing programs not considered a priority or targeting marginalized groups. Civil society organizations also provide frontline services in countries with acute crises where governments are weakened or partially absent (more than half the countries in the region). They facilitate community interaction with services such as hygiene, water, and sanitation, support access to vaccines and promote health through information dissemination, such as in Ebola virus disease outbreaks and natural disasters, and for smoking prevention and promotion of healthy diet and physical activity. They also influence policy development, for instance, through the Framework Convention on Tobacco Control and HIV/AIDS, and contribute to resource mobilization, including for polio eradication and girls' education.

The role of civil society organizations and the importance of partnership with civil society are not well recognized by governments in the Arab region, except where religious welfare is involved. However, even in the latter case, many governments collect Zakat formally and distribute it in the form of social assistance. In many countries, legal frameworks for establishing civil society organizations are lacking or have become tighter, such as in Egypt. Consequently, low trust exists between governments and civil society, and coordination is difficult. Additionally, there is a weak culture of volunteering in the region and poor understanding of its importance in development. Furthermore, cultural and social norms prevent specific groups from participating in civil society. Specific challenges related to civil society organizations include weak strategic planning, inadequate staff capacity, and weak governance and management, with often limited transparency in funding.



## DISCUSSION

### TOWARD UNIVERSAL SOCIAL PROTECTION SYSTEMS IN THE ARAB COUNTRIES

- i. Before COVID-19, the Arab region fell short of providing adequate and comprehensive social protection to a large share of its population. These systems were characterized by fragmentation, consisting of social insurance for those in formal employment (with limited coverage) combined with narrow targeting of non-contributory scheme programs. This created gaps in social protection coverage, comprehensiveness, and adequacy, including access to healthcare, sickness, and unemployment benefits associated with significant underinvestment in social protection. As a result, the human right to social security in the Arab region remains unfulfilled for most of the population.
- ii. A large percentage of children still have low or no effective coverage regarding social protection worldwide. Globally around 26.4% of children are covered by social protection benefits. Coverage of children in the Arab region ranges from 32.7% in Lebanon to 0.2% in Oman. However, the Arab region lags behind in children's coverage which accounts for 9.2% compared with other regions. This requires policymakers to implement an integrated social protection system, including child benefits and childcare services, parental leave provision, and healthcare access.
- iii. Globally, effective coverage of unemployment protection reaches 18.6% of unemployed workers. In the Arab countries, fewer than 10% of the region's unemployed have access to unemployment benefits, and this has become a matter of concern in the region, especially after COVID-19 highlighted the crucial role of unemployment protection schemes in protecting jobs and incomes.
- iv. Some countries worldwide have achieved notable progress in providing universal or near-universal effective maternity coverage. Despite the positive developmental impacts of supporting childbearing women, some countries in the Arab region provide maternity benefits with limited coverage due to high informality levels and low female labor market participation.

- v. Access to social protection benefits among people with disabilities globally reaches an average of 33.5%, as compared with low coverage in the Arab region, reaching 15%. After COVID-19, several countries in the world introduced universal disability benefit programs. Still, in the Arab region, persons with disabilities are often excluded from contributory social protection. This exclusion illustrates the urgent need to introduce disability benefits as part of social protection schemes for those with disabilities, which should equally be necessary to fulfill other commitments, such as ending poverty.
- vi. Globally, 77.5% of people above retirement age receive old age pension benefits. However, there are still major variations worldwide across different regions, including the Arab region, between rural and urban areas, and between women and men. Only around 40% of older people receive pensions in the Arab region. Some countries in the region provide generous retirement conditions for public sector workers and benefits levels for pension schemes. On the contrary, some countries do not offer adequate minimum benefit guarantees with the absence of automatic pension indexed inflation. The COVID-19 pandemic has placed additional financial pressures on pension systems, but countries have reported that the impact over the long term will be moderate to low. The Arab region faces several challenges to reforming the pension systems, including low levels of economic development, high levels of informality, low contributory capacity, poverty, and insufficient fiscal space.

## TOWARD UNIVERSAL SOCIAL HEALTH PROTECTION SYSTEMS IN THE ARAB COUNTRIES

The challenges and opportunities for extending social health protection coverage in the Arab countries are:

- i. **Highlighting the need to reduce out-of-pocket payments and the limitations of benefit adequacy, especially after COVID-19.** Social health protection in the Arab region is characterized by low service quality and limited coverage. Coverage varies significantly among countries in the region. Limited health access may have a significant effect on households' health, which causes serious health problems. Additionally, OOP payments are still high in the Arab region. This means that households are responsible for most healthcare costs, reflecting inequality in accessing services

between urban and rural areas. Moreover, other barriers to accessing healthcare remain in the form of physical distance, quality and acceptability of health services, and long waiting times.

- ii. Supporting universal social health protection for all in the Arab region is through key conditions:** rights-based entitlements, broad risk pooling, and collective financing using more and better data to monitor progress on equity and coverage. The COVID-19 pandemic revealed the need to invest in the quality of healthcare services, which requires recruiting, deploying, training, and motivating health workers to ensure the delivery of quality healthcare services. There is a strong linkage and coordination between income security and accession to medical care in addressing key determinants of health more effectively. The pandemic highlighted the crucial role of social health protection in shaping behaviors to foster prevention and the complementarity of sickness and healthcare benefit schemes. Additionally, the urgent need for emerging and special needs requires collective approaches for better healthcare service, including population aging, human mobility, and the increasing burden of prolonged and chronic diseases.
- iii. Developing the benefits and advantages of social insurance:** Arab countries should ensure that the entire population (citizens and residents – including migrants and refugees, and especially women, children, poor households, people with disabilities, and agricultural and informal sector workers) are covered by a cost-effective package of services with consumption of services allocated according to people's health needs – not their willingness or ability to pay. This would require an initial focus on providing a package of public healthcare benefits to all residents who are currently not insured, not only the poorest or most vulnerable. It is worth noting the financial pressures faced by the working poor and middle classes in Arab countries, who may be earning wages but remain vulnerable to sudden shocks due to a lack of savings or indebtedness.
- iv. Simplifying procedures for benefiting from social insurance (and making entitlements easier to understand):** Obstacles to effective coverage include administrative or geographical barriers, non-compliance with registration procedures, or lack of awareness (ILO, 2022). The low effective coverage

in Arab countries is affected by a range of factors such as substantial informality, labor and social security inspection mechanisms with low enforcement capacity, low contributory capacity on the part of employers, a lack of understanding of social insurance, a mismatch between benefits and needs, and complex administrative procedures. Hence, Arab countries should address barriers to accessing social protection – such as physical distance, lack of simple and appropriate information, lack of financial inclusion, and cumbersome and complex administrative procedures. Awareness-raising of staff, disability disaggregated data, non-discrimination and accessibility provisions in regulations and standard operating procedures effectively contribute to greater sensitization to better inclusion requirements. Greater public awareness of rights and entitlements and efforts to improve health literacy among local populations are essential to empowering people to demand health services. Such steps should accompany interventions in the political and institutional environment to improve benefit adequacy, scheme accountability, and the associated perceptions of fairness and trust. Migrant workers can play an important role in addressing labor shortages, particularly in economies with aging workforces, thereby contributing to the sustainability of social security systems.

- v. Enhancing the contribution of social insurance fund investments in economic and social development:** Arab countries need to better adapt financing mechanisms and modalities to the disparate situations of workers and enterprises, ensuring a fair sharing of responsibilities between workers and employers, those who benefit from their work and, where necessary, the government. Further investment in social protection is required now to fill financing gaps. In particular, prioritizing investments in nationally defined social protection floors is vital for delivering on the promise of the 2030 Agenda. Fiscal space exists even in the poorest Arab countries, and domestic resource mobilization is key. However, concerted international support is also critical for fast-tracking progress in those countries lacking fiscal and economic capacities, especially in low-income countries affected by conflict like Libya, Yemen, and Sudan, with marked underinvestment in social protection. Without continued support for social protection expenditure and prolongation of emergency measures, many countries face the possibility of the “cliff fall” scenario.

**vi. Extending social protection as a tool addressing crises (armed conflicts, economic and financial crises, COVID-19):**

Efforts on shock-responsive social protection require balancing humanitarian and development perspectives. Therefore it is crucial to work with other partners and leverage each others' strengths to support governments in developing social protection systems that can better prepare and respond to shocks in the country. This collaboration and coordination is needed at different levels: (i) Collaboration with different ministries/departments (social development, disaster risk management, finance, planning); (ii) Collaboration with development and humanitarian stakeholders on a common agenda; working alongside other development partners (e.g., WFP, World Bank, UNHCR) to avoid duplication or gaps in provision; (iii) National-level collaboration with teams working on emergency responses and other sectors is also needed. This would broadly entail mapping of stakeholders, their circles of influence, motivations, and capacities; development of a common understanding of concepts and processes on shock-responsive social protection; identification of a common roadmap with clarity on roles and responsibilities based on interest and capacity; and influencing humanitarian programming to better align with planned and ongoing efforts on shock responsiveness.

**vii. Opportunities and challenges associated with digital social protection:**

In some cases, social protection responses have magnified the challenges in accessing benefits faced by those who were already difficult to reach, such as those without access to digital technologies. The COVID-19 crisis has highlighted the need to build inclusive delivery systems. Arab countries were hard-pressed to identify those in urgent need of additional protection against the health and economic risks facing them – especially informal economy workers – and to disburse benefits to them rapidly and safely. In many Arab countries, digital technologies were crucial to identifying beneficiaries and delivering benefits to them and were used in creative and innovative ways. Countries that had pre-existing digital social registries, like Jordan, Egypt, and the Arab Gulf states, were able to respond faster and more efficiently during the pandemic. However, digital technologies also carry exclusion risks. Where people do not have access to banks and financial services, lack digital literacy, and/or do not have access to smartphones, they may end up doubly excluded. Furthermore, those countries that actively extended provision to reach hitherto uncovered groups of

the population, including through digital technology, and included them in national registries, established a basis that could enable the further extension of social protection. For example, reliance on digital methods of outreach, registration, and payout may have exclusionary effects for women – as for other vulnerable groups – due to the gendered nature of the digital divide, namely the uneven distribution of ownership of, access to, and knowledge of new technologies. The same exclusions apply to people with disabilities and older people.

**viii. Establishing grievance mechanisms that support**

**accountability:** Social protection policies in the Arab region have not been sufficiently sensitive to the circumstances of marginalized groups like women, migrants and refugees, ethnic minorities, older people, and people with disabilities. In many cases, these groups may not have sufficient information about their rights. Transparency, as well as effective grievance and appeal mechanisms, are needed to ensure that all actors are fully aware of their rights and responsibilities; that legal frameworks provide for clear and predictable entitlements; and that administrative procedures are as simple and transparent as possible, fully harnessing the potential of digital technologies while protecting personal data, respecting privacy, and ensuring that non-digital solutions remain in place for those who may not be able to use digital technology. Citizens and residents should have trust and confidence that their appeals are heard fairly and alternative sources of support are made available where eligibility is not established for a social protection benefit.

## FUTURE DIRECTIONS: KEY CONCLUSIONS AND POLICY RECOMMENDATIONS

### CONCLUSION AND POLICY OPTIONS FOR UNIVERSAL SOCIAL PROTECTION

- i. Fundamentally, governments of the Arab region should address the fundamental structural issues and place social protection at the core of a new social and economic paradigm. This requires an urgent need to improve, sustain and expand spending on social protection to ensure its adequacy and coverage and create fairer and more inclusive societies to unlock opportunities for inclusive growth, tackle poverty and inequality effectively, and avoid the progressive impoverishment of the missing middle.
- ii. Social protection floors in the Arab region should guarantee at least basic income security and access to healthcare services for all. To achieve systematic change, rights-based social protection benefits that address life cycle risks have a critical role in filling coverage gaps. Non-contributory schemes should be used to minimize exclusion errors; however, these schemes cannot be seen as a substitute for developing a contributory social protection system. Universal social protection can be achieved by combining social insurance and tax-financed programs through well-designed systems and building more integrated institutional governance and administration models.
- iii. The COVID-19 pandemic has highlighted coverage gaps for temporary, casual, part-time, and self-employment workers, including seasonal workers, agricultural and domestic workers, and those in the informal sector. Governments in the Arab region should provide all workers and their families with access to at least basic income protection to establish a more diversified and sustainable financing base for social protection.
- iv. Migrant workers and refugees, who are subject to discrimination and unequal treatment, must be given special attention to access the social protection system, including healthcare. Efforts should be undertaken to align social protection programs with the humanitarian–development nexus and enhance the shock responsiveness of systems across the region.

- v. Progressive reforms of contributory schemes, including pension systems in the Arab region, should aim at improving fairness across labor market segments and across and within generations. Despite their financial burden, these reforms need to ensure a fair balance between sustainability, coverage, and adequacy.
- vi. Investment in social protection needs structural transformations in the employment and economic paradigms prevailing in the Arab region. Contributory and non-contributory schemes should gear towards promoting formalization and facilitating the labor market participation of young people and women. Furthermore, it is important to strengthen social protection benefits during working life and medical care schemes.
- vii. Expansion in social protection spending requires increasing spending efficiency and designing options to mobilize fiscal resources through enhancing the progressivity of the tax system, reallocating public expenditure to investment in social sectors, and tackling tax evasion and avoidance.
- viii. International support and innovative financing mechanisms for social protection are necessary to avoid fragility, debt sustainability, or capacity constraints.
- ix. Participation and social dialogue of all relevant stakeholders are essential to ensure that a new social protection paradigm is sustainable, fair, and acceptable, particularly for vulnerable workers and groups.
- x. Management information systems and monitoring and evaluation are crucial in building comprehensive social protection systems. This requires establishing central repositories of information and effective data collection to enhance coordination and complementarity in service delivery.

## **CONCLUSION AND POLICY OPTIONS FOR UNIVERSAL SOCIAL HEALTH PROTECTION**

- i. Strategies for implementing universal healthcare will depend on specific country contexts, existing health system arrangements, the country's fiscal capacity and public values. They will have to combine a mix of health financing mechanisms to accelerate the achievement of universal coverage and to balance equity, efficiency, and quality of care (ILO 2008). Arab countries have made some progress



in increasing population coverage; however, significant barriers to accessing healthcare remain in the form of OOP payments on health services, physical distance, limitations in the range, quality, and acceptability of health services, and long waiting times, as well as opportunity costs such as lost working time. The COVID-19 crisis has highlighted the limitations of benefit adequacy and the need to reduce out-of-pocket payments. Hence, a major principle that Arab countries should adopt is that universal access needs collective financing, broad risk-pooling, and rights-based entitlements as key conditions for supporting effective access to healthcare for all in a shock-responsive manner.

- ii. More and better data on legal coverage needs to be collected as a matter of priority to monitor progress on coverage and equity. A second element is that investment in the availability of quality healthcare services is crucial. The COVID-19 pandemic has further revealed the need to invest in healthcare services, improve coordination within health systems, and provide adequate healthcare staff training and recruitment. Transparent and sustainable reforms of social protection systems in Arab countries can lead in the long run to a gradual expansion of social insurance and health coverage, as highlighted in the Social Protection Floor Framework. The starting point for such reforms is comprehensive legal coverage through the right to health in national constitutions.
- iii. A major challenge for Arab health ministries is enforcing policies and laws. Indeed, corruption and tense political situations have enabled many to disregard laws or policies. Prevention should be part of the health reform in the Arab world, and ways in which it can be incorporated into social health protection schemes must be further developed. Unfortunately, many Arab countries invest in treatment rather than prevention and long-term planning. Most Arab countries have weak health information systems. The vital statistics in most Arab countries are non-existent, which produces challenges for sound policy and prevention programs. Indeed, some health information responsibilities are not managed by ministries of health. For example, the Ministry of Interior is in charge of death registries in some countries in the region. A call to establish (in most) and improve (in some) health information systems is necessary.
- iv. Where civil society is concerned, some key recommendations as noted by WHO and the Arab League (2015) are: Arab states should build trust and promote a more enabling

legislative environment for civil society organizations, workshops, and training courses for civil society organizations in Arab states to raise awareness of the SDGs and promote civil society participation in them. Further support is needed in the development of criteria for the assessment of civil society organizations, particularly for those that are health-related. Supporting capacity-building of civil society organizations through organizing training-of-trainers courses to ensure sustainability and building capacities in health priorities, proposal writing, project planning and implementation, and promotional campaigns is also necessary. A further option may be the establishment of liaison offices at ministries of health to act as an interface with civil society organizations.

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# THE COVID-19 CRISIS AND HEALTH INEQUALITY

A reciprocal  
magnification effect  
in the Arab region

## Farah Al Shami

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Senior Fellow – Arab Reform Initiative (ARI)  
Former Program and Research Officer –  
ANND

Farah Al Shami is a development economist. She is currently a Senior Fellow at the Arab Reform Initiative (ARI), leading ARI's social protection program. She has eight years of experience, working with CSOs, academic institutes, and UN entities on advancing policy reforms in the Arab region. Her areas of expertise include conducting and managing interdisciplinary research, coordinating national and international advocacy efforts, facilitating professional consortia/communities, and leading capacity-building programs. She holds an MA in Policy Economics from Williams College (MA-USA), an MA in Economics from the American University of Beirut, and a BS in Economics from the Lebanese American University.

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## INTRODUCTION

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Following the outbreak of the COVID-19 pandemic, the Arab region witnessed an exponential rise in health outcome disparities. The severity of the COVID-19 pandemic was magnified by existing inequalities in chronic diseases and inequities in the social determinants of health. The outbreak of the COVID-19 pandemic in 2019 caused drastic decays in employment, healthcare, education, economic activity, and welfare schemes in the Arab region, all while disproportionately affecting the poorest and the most vulnerable social groups (Kamurase & Willenborg 2021). Being in large part a sanitary crisis, the impact of the pandemic was primarily apparent on health systems and has especially deepened and accelerated health inequality. This translated into uneven infection and mortality rates, uneven access to medical facilities, hospital beds, testing centers and vaccination, as well as discrepancies in the quality of treatments, the competency of medical staff, and the cost burden borne by different social groups, with a direct impact on the right to health (Filip et al. 2022).

The link between income inequality and health inequality was further reinforced by the COVID-19 pandemic. Individuals with lower income often face barriers to accessing quality healthcare such as mobility difficulties and financial constraints, leading to disparities in health outcomes (Kawachi & Kennedy 1999). During the pandemic, these disparities were intensified as individuals with lower income, among others, were more at risk to be exposed to the virus due to correlated occupations or living conditions, and had limited access to healthcare and resources for both prevention and treatment. The pandemic, in turn, worsened income inequality by causing widespread job losses, business closures, and economic downturn, disproportionately affecting the poor. Indeed, the pandemic resulted in approximately 8.8 million people losing their jobs in the Arab region, which further exacerbated economic disparities. Moreover, the pandemic led to an unprecedented increase of 1.3% in the unemployment rate in non-GCC Arab States and left more than 39 million individuals in the region working in hard-hit sectors (Dewan et al. 2022; Abu-Ismaïl et al. 2021). Notably, the wealthiest 10% of the population now possess 81% of the region's total wealth, compared to 75% of wealth prior to the pandemic (ESCWA 2022a). In addition, in 2020, Bahrain, the United Arab Emirates (UAE), Yemen, the

Kingdom of Saudi Arabia (KSA), Oman, and Kuwait have joined the 20 most unequal countries in the world, which only included Lebanon and the KSA in the previous year (ESCWA 2022b).

Inflation also jumped to high levels in many countries like Sudan (269.3%), Lebanon (150.4%), Yemen (45.0%), and Libya (22.3%), largely due to the pandemic (Dabrowski & Domínguez-Jiménez 2021). Yet, the pandemic overlapped with many other protracted and compounding crises in the different Arab contexts, such as the economic and financial crisis and the August 4 Beirut Blast in Lebanon, the political "de-transition" following Kais Saeid's self-coup in July 2021 and the inception of a monetary predicament in Tunisia, the economic and currency crisis in Egypt, the water crisis and its subsequent economic volatility in Iraq, as well as the renewal of conflict in regional hotspots. These developments were coupled with economic fluctuations with severe socio-economic repercussions, especially since they were accompanied by an increased cost of living and a wave of subsidy lifting, affecting the price of fuel, food, and medicines due to exhausted public budgets and depleted foreign reserves, which further accentuated inflation and deteriorated people's purchasing power amid the loss of jobs and livelihood opportunities (Nehmeh/نعمة 2021). While this makes it hard to disentangle the impact of the pandemic on social justice and inequalities, it reinforces the notion of increased inequalities in the aftermath of COVID-19, and especially increased health inequality given its proxy relationship with wealth and income inequality.



# BETWEEN THE NATURAL AND THE DELIBERATE: HEALTH EQUALITY IN LIMBO

## A ONE-DIMENSIONAL RESPONSE, A SHORT-SIGHTED APPROACH

Arab States dealt with the pandemic as merely a health and sanitary crisis, instead of considering it as an economic crisis as well, thus inadvertently overlooking its socio-economic repercussions. Amidst the crisis, the region's average social spending accounted for only 4.6% of total GDP, in stark contrast to the global average of 12.9% of GDP (International Labour Organisation [ILO] 2021). Therefore, while a multitude of economic indicators, such as inflation, poverty rates according to multidimensional indices, unemployment, the deterioration of the business environment, and the striking business closures emerged as telltale signs of an economic crisis, many Arab States exhibited a continuity instead of a rupture in their economic policies and models at large (Ghannouchi 2021; Awad et al. 2021). Regrettably, this approach further magnified the detrimental impact of the pandemic on the right to health, intensifying health inequalities. One-dimensional measures that focused primarily on health overlooked the multifaceted nature of the crisis and the intricate interconnections between livelihoods, income security, welfare, and access to healthcare, treating the health crisis as if it was mutually exclusive from an economic crisis. This counter-intuitive approach was a manifestation of the State institutions' weak preparedness to crises and emergencies, and of the States' socio-economic paradigms that predated the crisis. It also constituted the main factor hindering the effective mitigation of the crisis' consequences.

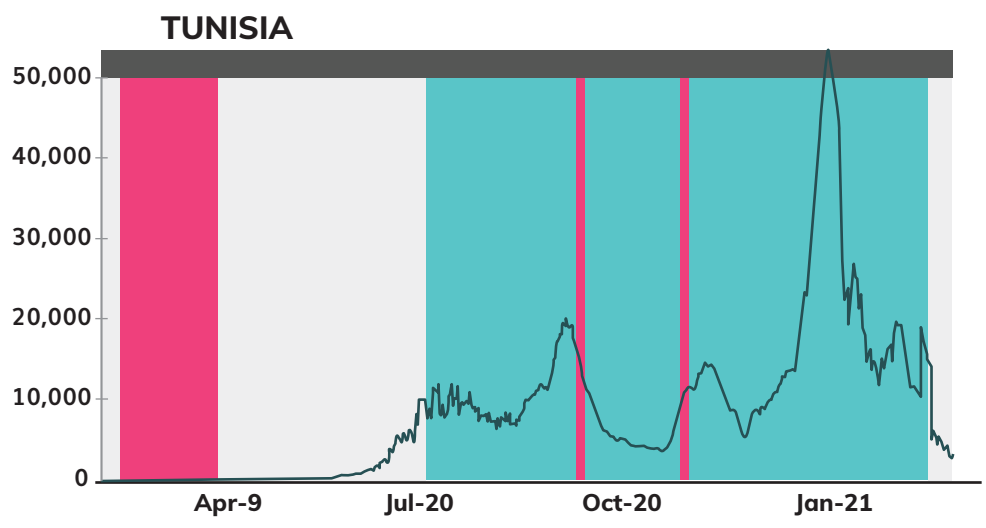
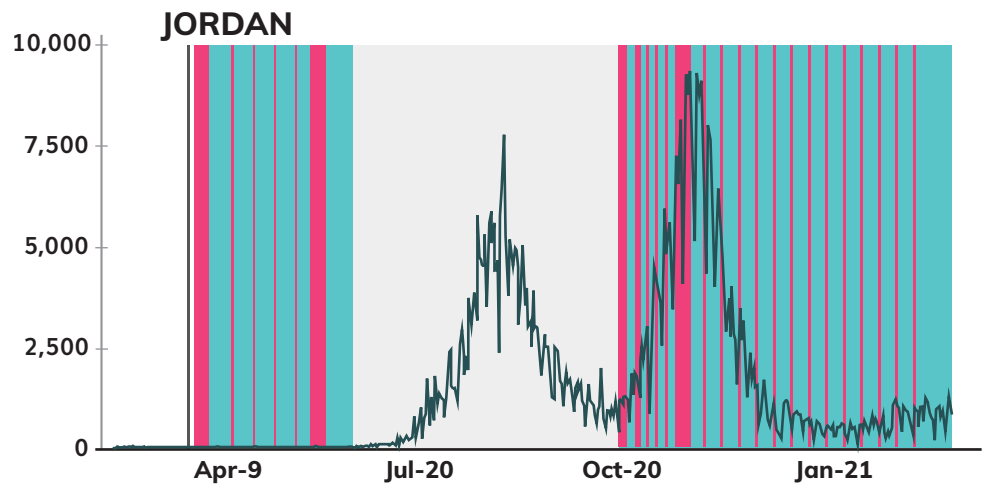
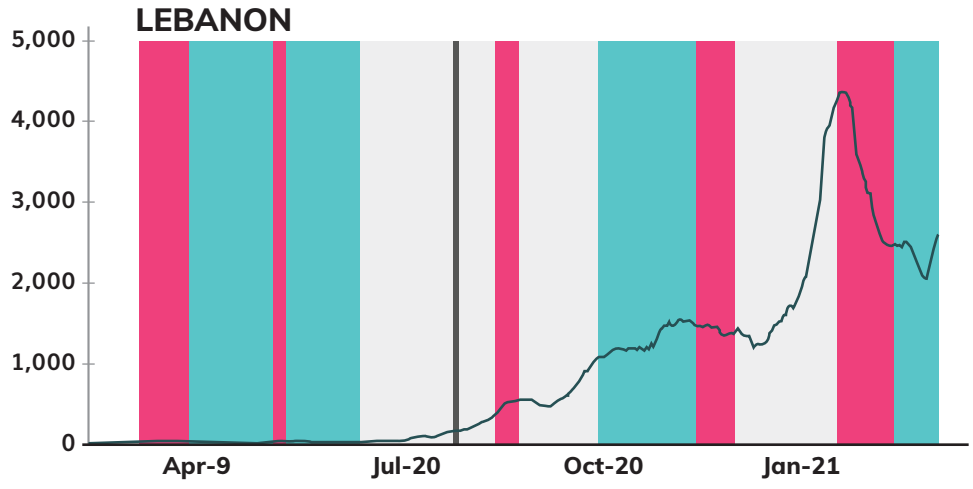
Remarkably, the average total expenditures on health in the Arab region during the pandemic accounted for a mere 3.2% of total GDP, which is significantly below the global average of 5.8%, despite considering COVID-19 to be a health crisis. This disproportionate allocation is further emphasized by the fact that the region spent 5.4% of its GDP on military expenditure, on the other hand (ILO 2021). Even more, subsidy lifting across the region and socially-insensitive attempts such as the one in Jordan, which consisted of making changes to the social security law and shifting to a "modern government" through

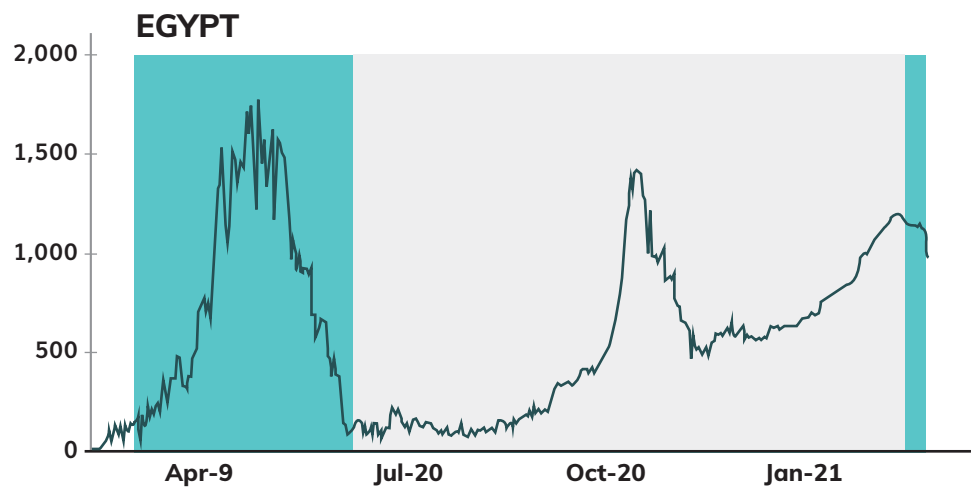
the abolishment of the Ministry of Labor during the pandemic, lend further proof to how flawed the responses of some States were. This reflects a misguided perception of the pandemic that overlooks the need for a comprehensive support and protection system by the States to their people. However, failure to adequately compensate individuals for the loss of jobs and livelihoods due to these restrictive measures immensely exacerbated these health disparities (Nehmeh/أحمد 2021).

Even when viewed as a health response, the measures taken during the pandemic were ill-suited to address “a health crisis” effectively, thus making access to quality healthcare limited and a privilege for the few, for several reasons. The absence of adequate, quality public healthcare and the prevalence of ineffective, non-inclusive social protection systems in several countries in the region, resulted in discrepancies in access to healthcare across income levels. While those with lower incomes were often unable to afford proper, high-quality medical care during the pandemic, the affluent could either protect themselves or overcome the limited capacity of public and even private medical centers by paying for required medical attention and care at home. The affluent were also often able to afford frequent PCR tests as well as blood and radiology tests prior, during, and after a COVID-19 infection episode, thus increasing their chances of survival compared to those who did not have the same financial means (Jamal & Robbins 2023). Studies showed that severe complications were not only determined by age, genetic predisposition, and biological risk but by pre-existing inequities along socioeconomic backgrounds, immigrant statuses, 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 crisis (Mishra et al. 2021).

Furthermore, in many Arab contexts, the health response took on a militarized nature, particularly in countries such as Egypt, Jordan, Lebanon, and Tunisia, where total or partial lockdowns and several episodes of State emergency were implemented (Hoffman 2020; Oxford Analytica 2020). As per **Figure 1** below, such securitized measures were frequently imposed and did not coincide with upsurges in infection rates. Instead, lockdowns and curfews considerably coincided with protests and social upheavals, thus indicating their usage by States as tools to repress social movements and food riots (Houry 2020).

Figure 1. Lockdown versus infection timelines during COVID-19





**Total Lockdown** (major closure of non essential services and businesses and major mobility restrictions for civilians, unless based on permissions and exceptional cases)

**Partial Lockdown** (partial opening of non-essential services and businesses and partial loosening of mobility restrictions, as well as curfew hours)

**Normal Mobility** (normal opening hours and minimal or no restrictions)

**State of Emergency**

 Infections

| Source: Figures retrieved from the Arab Region Hub for Social Protection's website (2022)

## POWER AND PROFIT OVER PEOPLE: AN INEFFECTIVE RESPONSE

The level of preparedness across Arab health systems varied, rendering some systems more vulnerable to collapse or shocks like COVID-19 than others. The unequal level of susceptibility was attributed to factors encompassing the resilience of the health infrastructure, from hospitals to medical equipment and health technology, as well as numerous economic, financial, and social variables. For example, prior to the virus outbreak, the average number of hospital beds per 1000 inhabitants was only 1.5 (World Bank 2023). Consequently, the demand for inpatient care necessitated innovative alternatives, such as referring some supposedly in-patient cases to out-patient care modalities or even residential care, with individuals resorting to

personal oxygen generators and self-administering intravenous treatments, which are monopolized by a few private suppliers at overpriced rates. This was especially the case in countries that could not rapidly establish specialty field hospitals or turn public lands into dedicated field facilities, like Lebanon (Haldane et al. 2021). Furthermore, inequalities among medical staff were observed in several countries in the region, ranging from employment hierarchies to disparities between the private and public health sectors' personnel, and comprising variations in qualification, remuneration, access to protective gear, and reception of COVID-19 relief and benefits. Additionally, significant gaps in the coverage of cancer treatment, chronic, and cardiovascular diseases by public health institutions and existing social protection schemes persisted despite the heightened vulnerability to the virus by those with chronic illnesses (Isma'eel et al. 2020). Similar limitations were observed in addressing mental and psychological disorders, despite a drastic increase in such cases during the pandemic, thus further compromising patients' resilience against the virus (Mourani & Ghreichi 2021).

A key reason behind this bleak situation is that healthcare is significantly privatized in the Arab region, and so are health insurance systems (Aïta 2022). Nonetheless, the private sector was unable to accommodate the increased need for healthcare and to treat all citizens and residents equally, therefore highlighting the importance of solid and universal health systems both in disaster management and at baseline. The privatization of health services exacerbated inequality during the pandemic in several ways. First, privatized healthcare services are often more expensive than public healthcare, making them inaccessible to many low-income individuals and exacerbating existing health inequalities. For example, in countries like Egypt where private health centers were allowed to conduct PCR tests, major discrepancies were seen in the pricing across the country. For instance, the test costed between 1,000 and 2,000 Egyptian pounds (in the period spanning end of 2020-mid 2022) (EIPR 2021). Second, privatized health systems may prioritize profit over public health, especially with the lack of corporate social responsibility frameworks, like in the great majority of Arab countries, and in the midst of systematically poor regulatory quality. This leads to inadequate funding for public health measures such as vaccine distribution and testing programs. Third, privatized healthcare facilities may be less equipped to handle surges in demand during pandemics as they focus on profit rather than inclusive public health. This can lead to long waiting times,

intensify nepotistic and clientelist practices, and result in insufficient care for those who are unable to afford substantial out-of-pocket expenses. Finally, the privatization of healthcare can entail a lack of adequate coordination and communication between public and private healthcare providers, which can further exacerbate data centralization and management issues, worsen health inequalities, and widen gaps in the overall healthcare systems (Asfour & Jabbour 2020). As such, while neoliberal policies were shifting resources all along from public to private hospitals, private hospitals often refused to take infected cases at the beginning of the pandemic and the poorly financed public health sector bore the much heavier brunt of the crisis.

The privatization of healthcare in Arab countries manifests in various subtle and indirect ways such as geographic imbalances. Hospitals, both private and public but especially public, are rare and unevenly distributed across geographic areas in Arab countries, deepening the core-periphery and rural-urban dichotomies and mirroring the centralization of governance and development (Bajec 2020). Lebanon, Iraq and Egypt are illustrative of this picture. Despite this, even after the pandemic hit and in the middle of the crisis, deliberations to shift the health model in Egypt from free healthcare to a privatized model, following the Port-Said pilot model, were underway (Gad 2022). Such models and shifts can only increase the reliance on private health facilities and insurances, which only the wealthy can afford. Not only do insurance companies lack the corporate social responsibility frameworks that are necessary for the inclusion of cancer, cardiovascular, and mental and psychological illnesses, they likewise enjoy a striking degree of poor regulatory quality and have no social accountability to the extent that they could omit any COVID-19-related coverage amid the global health crisis. This forced all COVID-19 patients who could not access healthcare through overwhelmed public facilities to seek treatment through private ones, with the latter charging patients on a full out-of-pocket basis. Knowing that private health facilities were also overwhelmed during peak COVID-19 infection waves, this restricted the options for the majority of those who caught the virus and needed medical attention – especially before the vaccine roll-out phase (Abi Rached et al. 2020).

The scarcity of health services during the pandemic put to the fore the importance of a well-established, well-functional, efficient, inclusive, and universal public health system, with an enhanced capacity to accommodate increased demand during

health emergencies. However, it also exposed the deficiencies in the quality of medical care and competencies in existing public health systems in many Arab countries, just like it exposed their relatively limited capacity. In addition to issues of availability of medicines, equipment and hospital beds, the issue of medical staff migration from the public to the private sector (just like their migration abroad) was remarkable. Inequality in medical staff competence between private and public sectors – to the disadvantage of the latter – was evident in the difference in the protocols adopted between the two sectors. In countries like Lebanon and Iraq, these lingering problems and disparities contributed to significantly higher mortality rates due to COVID-19 which were significantly higher in public hospitals compared to private ones (Isma'eel 2020). Nevertheless, the pandemic did not trigger any serious attempts to invest in and improve public health systems, which goes back to a lack of political will to do so, not only because of exhausted public budgets, depleted foreign reserves, irrational government priorities, and misappropriations and embezzlements of public resources, but also because public health is one of the strongest tools in the hands of clientelist and sectarian governments (Tabaqchali 2020). Never-ending wait lists, having to pay bribes, and resorting to cronyism are characteristics of a system normalized by governments in the region, whereby the political class tends to use public health systems (or the provision of services through these systems) to indirectly force the disenfranchised and desperate who have no other recourse to join their constituency bases (Di Peri 2020).

These power dynamics were also witnessed on the level of access to the COVID-19 vaccines, which is a reflection of global inequality as well. Northern countries had access to patents and resorted to bilateral agreements with big pharmaceutical companies to get the COVID-19 vaccines, which undermined multilateral agreements that can provide or aim at providing a more inclusive coverage, thus violating the World Health Organization (WHO)'s Equitable Allocations Framework and the Access to COVID-19 Tools Accelerator (COVAX ACT). As for countries of the global South, most of them were refused patents to produce the vaccines or did not have the ability for such production. Some of them are part of the World Trade Organization (WTO) or the European Union-Deep and Comprehensive Free Trade Agreements (EU-DCFTAs), such as Tunisia and Morocco. These free trade agreements entail a binding "TRIPS" component on intellectual property rights, which has a degree of flexibility that the whole world should have benefited from to allow for the production of the vaccines

beyond the monopolizing big pharmaceutical firms and to open space for more affordable generic productions – like what was the case with the therapeutics of HIV, Hepatitis C, and Tuberculosis – to meet global needs at more affordable rates. Non-GCC Arab countries were victims of this model (Egyptian Initiative for Personal Rights [EIPR] 2020). This considerably slowed the vaccine roll-out in many countries, and prevented the vaccine from being free for everyone in some contexts, including Egypt (EIPR 2021).

## THE HARDEST HIT POPULATIONS: BEYOND EXPECTATIONS

COVID-19 infection rates were expectedly highest among the poorest, as they had disproportionately low access to masks, sanitizers, frequent tests, and in some cases the vaccines, medicines, and treatments. The most vulnerable social groups that are typically marginalized during crises and shocks were indeed the most affected, namely children, women, youth, the elderly, LGBTQ+ communities, rural populations, the urban poor, informal workers, refugees, and people with disabilities, among others (Nehmeh/نعمة 2021). Working women, apart from their initial gender-based vulnerabilities, had to shift to remote working and – at the same time – provide extra care for their families at home, thus having to juggle two careers and endure a wide spectrum of challenges. Many women and LGBTQ+ people could not afford reproductive healthcare or even access menstrual hygiene products and contraceptives. Increased gender-based violence during lockdowns aggravated this problem, to the extent of increasing unwanted pregnancies and sometimes abortion (McGrail et al. 2022). Migrant domestic workers also faced accentuated vulnerability as did precarious workers that are not necessarily informal, but semi-formal or even formal. For example, offline and especially online/platform gig workers who operate on a zero-hour contract, on-demand basis – the numbers of whom surged with digitalization during the pandemic – faced harsh work conditions and lack of social protection when they needed it the most (Alsahi 2020; Maktabi et al. 2022).

More importantly, the pandemic also intensified the vulnerability of people living in slums and informal settlements, under highly unsanitary environments, urban populations who are more exposed to air pollution and are therefore more susceptible to respiratory diseases such as COVID-19, people initially suffering from respiratory diseases, the elderly who are relatively more susceptible to the virus, etc. Notably, workers in



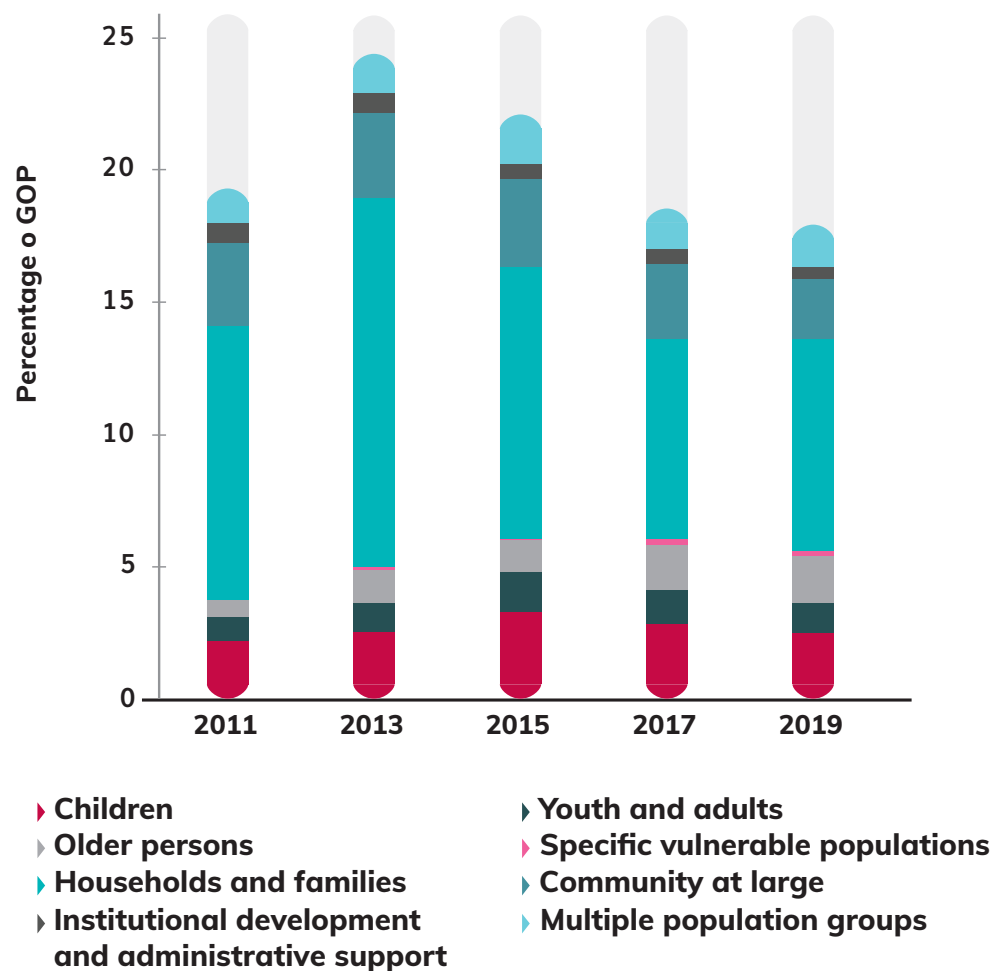
the informal sector were found to be better off in that they had the privilege to circumvent lockdowns, curfews, and business closures as they work independently from any registered employer. Moreover, in Egypt, for example, key government decisions aimed at supporting women through the pandemic were restricted to public sector employees and excluded the private sector. Thus, women working in the private sector, although usually perceived as being better off, were more affected by the crisis than those working in the public sector (Al-Shami 2022).

The pandemic's heterogeneous impact on Arab societies stems from the specificities of the crisis itself as well as the various vulnerable social groups, on one hand, and the fact that vulnerability is a fluid term and a continuously changing phenomenon, which cannot always be captured by typical definitions and indicators, as dictated by international organizations that adopt colonial methodologies, on the other (Al-Shami 2022). However, it is worthwhile to note that, while some social groups benefited from the pandemic and others were harmed by its repercussions, the net social impact of this historical episode was negative, reflecting an overall pattern where the rich got richer or were less affected, and the poor became poorer or were more affected (Nehmeh/نعمة 2021).

COVID-19 responses have left many behind because of the status quo that predates the pandemic and the ineffective redistribution mechanisms of public resources, if they exist. UN-ESCWA's Social Expenditure Monitor for Arab States affirms that personal and corporate income taxes are low in most middle-income Arab countries compared to other kinds of tax that are less redistributive (such as the VAT). The Monitor, as per **Figure 2** below, also demonstrates that the largest share of social expenditure is targeted at households and families, although with a downward trend across the years. It shows as well that youth, children, older persons and other specific vulnerable groups benefit from a relatively smaller share of social expenditure despite being the most in need (Sarangi et al. 2022). The Monitor's results are further validated by ILO's data (2021), which indicates that, in Arab States, only 40% of the population are covered by at least one social protection benefit, 15.4% of children, 12.2% of mothers with newborns, 7.2% of persons with severe disabilities, 8.7% of the unemployed, 24% of older persons, and 63.5% of workers in case of work injury (ILO 2021). The latter number indicates that social protection systems in the Arab region are predominantly employment-based, which goes back to the absence of the needed social protection floors that provide universal health

coverage and minimum income security to all through a combination of contributory and non-contributory social assistance schemes. Arab governments have, among other practices, had cold feet to establish such floors since these floors fundamentally challenge the complex political-economy on which political regimes survive, which is characterized by clientelism (as described previously) and political redlines that exclude specific vulnerable groups like migrants and LGBTQ+ people. The disproportionate impact of these practices rendered only 32.2% of vulnerable persons covered by social assistance in the region (ILO 2021).

**Figure 2. Distribution of social expenditures among different social groups**



Source: Figure retrieved from UN-ESCWA's Social Expenditure Monitor for Arab States (2022)

During the pandemic, international organizations and humanitarian actors had to step in to offset the absence of the State (El-Jardali 2020). Amid one of the most severe

humanitarian crises in recent history, social protection therefore took the form of mere humanitarian relief that does not complement a baseline of universal social protection coverage. In the best-case scenario, it took the form of social safety nets such as Lebanon's Emergency Social Safety Net program (ESSN) and the national aid fund expansion programs in Egypt (expansion to Takaful and Karama) and Jordan (the Takmeely Support Program). These interventions are poverty-targeted and use proxy-means testing as a targeting method, which suffers a large margin of error by definition and excludes many who are in need of aid. The absence of universal social registries that provide the data necessary to respond to the targeting criteria, exaggerates the problem. More so, amid high levels of digital and financial illiteracy, especially in remote areas, and the disproportionate access to finance and telecommunication infrastructure, the adopted delivery mechanisms (e.g., e-wallet in Jordan) for these programs have left many beneficiaries unreachable. In addition, social safety nets are known to provide inadequate protection, and to be transient and non-viable. Humanitarian interventions are also largely disintegrated and ineffective. Their securitization, especially in light of the pandemic, and their politicization, especially in conflict-afflicted countries, have further hampered their ability to meet their purpose. Finally, the fact that non-State and trans-State actors tried to replace the States in providing this support and alleviating poverty in many contexts, has made it easier for States to evade their responsibility on this front while making these governments look good, thus stabilizing their failed systems and decelerating social upheavals.<sup>1</sup>

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<sup>1</sup> This paragraph is in large part informed by research conducted by the author over the course of 2-3 years as well as outputs produced and exchanges undertaken in the framework of the Arab Reform Initiative (ARI)'s Arab Region Hub for Social Protection.

## CONCLUSION AND POLICY RECOMMENDATIONS

The COVID-19 pandemic has exacerbated both income and health inequalities among populations in countries across the Arab region, thus reinforcing the vicious cycle between both types of inequality, which mainly emanates from the interconnectedness between health and socio-economic status. The pandemic exposed structural discrepancies in different aspects of human and economic development, coupled with structural flaws and deficiencies in both health and social protection systems prior to COVID-19, all of which led to a further devolution in health equality, and widened polarization in access to quality healthcare. In addition to poor disaster management, incompetence, and limited or misappropriated resources on the part of Arab States, health equality was victim to nefarious politico-economic factors overlaid by clientelism, political redlines, and a lack of political will to provide universal health coverage and social protection. In other words, in addition to natural channels, deliberate political channels drove up health inequality, among other forms of inequality, during the pandemic.

The pandemic response in many Arab countries was a one-dimensional, reactive, and short-sighted response whereby States dealt with the crisis as merely a health and sanitary crisis, instead of considering it to be an economic crisis as well, thus inadvertently overlooking its socio-economic repercussions. Economic and social policy were unchanged. Even though viewed as a health response, the measures taken during the pandemic were ill-suited to address "a health crisis" effectively. The response was largely securitized and often politicized. Arab governments used overstretched COVID-19 policies (e.g., lockdowns and curfews) as a pretense to repress social upheavals in reaction to economic hardships instead of to suppress the spread of the virus. In some countries, like Tunisia, COVID-19 was seized as a political moment to advance political agendas or even shifts (Daoudi 2023). Instead, pre-existing State policies should have been replaced with transformative, interventionist policies to contain the losses caused by the crisis and hedge its effects in order to avoid the consequential disruptions in economies and societies.

The pandemic response also prioritized power and profit over people's well-being and welfare. With the restricted capacity of health facilities, resorting to private healthcare was at many times the only option. However, private care was not affordable

or accessible to everyone. Amid the absence of universal social protection systems and the exclusion of COVID-19 from private insurance policies, people who could not access public healthcare had to pay significant sums out-of-pocket, despite the rise in the cost of living and the loss of livelihood opportunities. As the pandemic overlapped with other national and/or global political and economic shocks and crises, unexpected adverse measures were seen in many contexts, including subsidy lifting on food, fuel, and medicines, as well as discussions regarding shifts in health systems and government models.

As a result, people's purchasing power and access to health were impaired, and health outcome indicators saw an outstanding deterioration. More importantly, this situation disproportionately affected the poorest and the most vulnerable due to direct channels and indirect ones such as the disparity in infrastructure, personnel, and service quality between public and private health systems. The hardest hit populations were indeed those whose share of public social expenditures as a percentage of total GDP is the lowest. Additionally, new and invisible forms of vulnerability have been engendered, inviting us to rethink our definition, understanding, and measurement of vulnerability, especially during times of crisis. Discrepancies did not only manifest within countries, but also between Arab countries, and between the global North and the global South – as access to vaccines illustrated.

In conclusion, with the differences in health systems in mind, countries in the Arab region need to shift to a rights-based and multi-sectoral approach to health and well-being, including through consolidating public health systems and services into sustainable structures, strengthening the layers of a solid and resilient public health infrastructure, building the capacity of the public health workforce, and addressing the economic dimension of health coverage. To achieve such reforms, Arab States need to:

- Raise awareness and invest in both health promotion and health prevention equally, and refrain from overlooking the latter approach moving forward.
- Develop national strategic visions built around a clear diagnostic of the wider political, institutional, and legislative considerations that ought to be taken into account to ensure the feasibility of desired reforms.
- Develop a disaster management plan drawing on the success stories and lessons learned from the pandemic, taking into consideration the multidimensional nature of crises and emergencies.

- Conceive a continual participatory and consultative process where civil society can weigh in on public health policy design and emergency responses. This process should include the knowledge producing civil society as well as the grassroots civil society who speak to the communities and for the communities.
- Invest in the governance reforms needed to neutralize humanitarian responses from the effects of any political agendas and to finance universal social protection and health coverage, particularly by rationalizing public spending, advancing fiscal reforms, and prioritizing social spending.
- Build the foundations for universal health and social protection systems based on a human-rights perspective.
- Invest in health information systems, indicator enhancement, data collection, and data disaggregation considering the various forms of vulnerability and their intersections.
- Invest in e-government and open government systems, which are key for effective data management and usage. Disclose the data collected during the COVID-19 pandemic and use it as one of the building blocks to establish nation-wide registries.

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# **NATIONAL REPORTS AND CASE STUDIES**



# RIGHT TO HEALTH IN EGYPT

## Health inequity during COVID-19 in Egypt



### Ahmed Azab

Pharmacist and Health Researcher

Ahmed Azab's research interests include access to medicines, the pharmaceutical sector, and health systems. Ahmed is currently pursuing his Master of Public Health at Vrije Universiteit, Amsterdam.

## INTRODUCTION: INEQUITY IN ACCESS TO HEALTH SERVICES IN EGYPT BEFORE COVID-19

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic. The first case of COVID-19 was diagnosed in Egypt on February 14, 2020. The pandemic coincided with the first stages in implementing the new comprehensive health insurance law, Law No. (2) of 2018, launched in Port Said Governorate in late 2019. It was a time of great economic and social difficulties for all citizens. The government had just implemented the so-called economic reforms agreed upon with the International Monetary Fund (IMF) in November 2016, withdrawing fuel and electricity subsidies and raising transportation prices. Waves of inflation followed and impacted many citizens' livelihoods. In fact, the pandemic began to spread a few months after the IMF's economic reform program ended. The combined impact revealed the structural deficiencies in Egypt's current social and health protection system, discussed later in this report (المبادرة المصرية للحقوق الشخصية 2021).

When COVID-19 reached Egypt, the health sector suffered from insufficient government spending, highlighting an urgent need to restructure the health system. Medical staff worked in abysmal conditions, receiving meager wages. In the last few decades, many left the country looking for better working conditions and opportunities, causing a severe shortage of doctors and nurses.

This report begins with a historical overview of the Egyptian health system and the various incomplete attempts to establish a health insurance system. Then, it analyzes Egypt's health situation before Covid-19 and the government policies to address the pandemic. The report also emphasizes that accessing healthcare was always mired with problems, particularly inequality. The pandemic has only deepened them and brought them to the surface. Finally, the report aims to extract practical lessons from the response to the pandemic, which could help implement the new health insurance law and health reform in general.

## METHODOLOGY

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The report is based on a literature review of publications published in Arabic and English on the history of Egypt's health system and general challenges and difficulties. It also relies on news and press articles, especially published during COVID-19, population health surveys, in particular, the most recent survey published in 2014, and the Central Agency for Public Mobilization and Statistics reports. The search engines used to review the literature were Google Scholar and PubMed, in addition to the Egyptian press sites. Other sources include reports and data from international institutions such as the World Bank, the WHO, and the United Nations (UN).

The report also incorporates the findings of the latest population health survey in 2021, issued in 2022 but not yet published in full, except for a news release mentioning the preliminary results. Thus, it was not easy to draw conclusions before the entire survey was published.

The primary challenge faced in the development of the report was the outdated health data. For example, the most recent National Health Accounts were done over ten years ago. In addition, the scarcity of gender-specific data in the health sector was also a challenge.

## A HISTORY OF EGYPT'S HEALTH SYSTEM AND THE INCOMPLETE ATTEMPTS TO ADOPT AN INSURANCE SCHEME

Egypt's health system is well-established and dates back several decades to the establishment of the modern state during the reign of Muhammad Ali in the nineteenth century. At the time, Egypt's ruler sought to develop public health to serve the army, on the one hand, and to improve the health of human resources in the emerging bureaucratic apparatus, on the other hand.

In 1936, the Ministry of Health was established as a separate ministry after being part of the Ministry of the Interior. Since then, the Ministry of Health and Population has managed the health system through various health directorates across the different governorates (Gad 2022).

Notably, 1964 was a turning point in adopting a health insurance scheme. Two critical laws were issued that year:

- Law No. (75) of 1964 stipulated the provision of health insurance to government employees, public authorities, public institutions, and local administration units. In return, a subscription of 3% of the workers' monthly wages would be paid by the employer (the government) and 1% by workers or employees. Based on this law, Presidential Decree 1209 of 1964 established the General Authority for Health Insurance to implement its provisions.
- A year later, another law was issued to control regulations. Law No. (63) of 1964 applied health insurance to workers in the public and private sectors. They were subjected to the Social Insurance Law in exchange for 4% of the monthly wages paid by the employer in addition to 1% of the monthly wage paid by the worker. The law mandated the General Authority for Social Insurance at the time to implement its provisions; however, its role overlapped with that of the General Authority for Health Insurance. Consequently, Presidential Decree 3298 of 1964 was issued to transfer the responsibility of the General Authority for Social Insurance concerning health insurance to the General Authority for Health Insurance (القانونية تاروشنم n.d.).

The 1964 law was part of an attempt by the Nasser regime to establish a health insurance system based on the British

model, where the state controls the service, its facilities, and funding. However, the attempt did not succeed due to financial obstacles. On the contrary, there has been a gradual shift from totally free services to so-called economic services, which entails citizens paying part of the cost upon receiving the service. Private services began to appear in the public system for those who could pay. Their emergence was due to the financial challenges facing the nascent health insurance scheme. Thus, those in charge began seeking other sources of financing to supplement what came from the state's treasury. They chose to provide "distinguished" health services at a fee (Gad 2022).

Another milestone was reached in 1975. Two critical laws were adopted and are still in force today:

- Law No. (32) of 1975 regulated insurance treatment for workers in the government, local administration units, public authorities, and public institutions, to be determined successively by the Health and Population Minister. The law reduced financial burdens on employers from 3% of the monthly wages to 1.5%. It also reduced the burdens on the workers from 1% to 0.5% of the basic wage. On the other hand, it added a small financial contribution from the insured obtaining the service in exchange for the reduction.
- The Social Insurance Law promulgated by Law No. (79) of 1975 adopted five types of insurance: 1) old age, disability, death, and work injury, 2) sickness, 3) unemployment, 4) social care for pensioners, and 5) care for pregnancy and childbirth. The law applies to civil workers in the state's administrative apparatus, public bodies, and institutions. Work injury provisions also apply to workers under 18. The provisions were in return for participating in sickness insurance: the employer pays 3% and the insured 1% of the total monthly wages. Sickness insurance also includes pensioners for 1% of pensioners and 2% of the widows' wages. However, the employer does not pay a share.

In 1992, Law No. (99) introduced a health insurance scheme for students. It applied health insurance to students of all educational levels from kindergarten to secondary school except university, in exchange for 4 pounds per year as a student's subscription and 12 pounds as support from the state's public treasury for each student. Students also contribute to one-third of the price of medicines outside hospitals, except for medicines to treat chronic diseases. The proceeds of a fee of 10 piasters for each pack of 20 cigarettes also went into the fund. In addition to treatment and

rehabilitation services, the law provided the following preventive services: It included a comprehensive medical examination at first enrollment at the start of each educational stage and a qualitative medical examination regularly or for emergency health conditions. It also provided vaccination programs and medical recommendations to the educational authority to provide the necessary health requirements to maintain the level of environmental health, to examine students who practice various activities to determine their fitness to carry out these activities, to spread health awareness among students, and to supervise their nutrition (Nandakumar et al. 2000).

In 1997, the Health and Population Minister issued Decision No. (380) regarding providing health insurance to children from birth to school. Subscription to the scheme involved 5 Egyptian pounds annually and one-third of the price of medicine outside hospitals, except for chronic diseases.

In the 1990s, the Ministry of Health and Population and the donor community initiated health sector reforms to improve indicators and address emerging challenges. The Ministry established the Health Reform Programme, designed to be implemented in 10 to 15 years to shift the healthcare focus from a heavy reliance on “vertical programs” to integrated, less expensive, and sustainable programs based on family doctors and health units (Al Bahnasy 2016). Vertical health programs are a trend in health policy characterized by their specific goals, working on one disease or a small group of health programs and focusing on the short or medium terms. They are administered centrally but separate from the Ministry of Health and Population. The vertical approach is disease-specific, which often makes it easier to get funding.

This pilot reform model relied on primary care/family medicine as a tool for reform and a way to contain escalating health expenditures and reduce out-of-pocket spending. Primary care physicians would handle a large proportion of cases and refer them to secondary and tertiary care levels only when necessary.

However, an evaluation by USAID in 2005 pointed to several weaknesses in the health reform program. These included:

- **Family medicine as the basis of reform:** The model is based on family doctors as an entry point to the system and the first contact between the patient and the service. Family doctors must deal with many cases and refer them to the secondary and tertiary care levels for advanced medical interventions, thus saving money and improving primary healthcare. However, the model is slow in practice.



- **Different needs and expectations for the different population groups (of health service recipients):** Beneficiary satisfaction varied greatly. Patients have often considered specialists to have a higher status than family doctors. One challenge was to convince recipients of the service. Another was the lack of family medicine doctors due to the novelty of this specialization after decades of patients seeking specialists directly.
- **Private sector opposition:** The program did not attract private sector providers as it required investment to convert clinics to a family practice model to obtain accreditation. The private sector was uninterested in the family medicine model, especially after decades of excessive expansion. In addition, the family medicine model would have meant fewer out-of-pocket patients visiting their clinics. Thus, private sector providers risked losing specialized care patients and out-of-pocket profits. This situation exemplified the conflict between the idea of health as a commodity versus health as a right and a public service that must be provided to all regardless of the ability to pay.
- **Financial challenges facing the reform program's continuity and sustainability (Rafeh, n.d.):** The health reform program was piloted in three governorates (Alexandria, Menoufia, and Sohag). However, funding soon became challenging as sponsors failed to create new sustainable funding sources other than international grants. Family health services were funded through traditional public sources, and the poor state budget. The additional costs of operating the family health units and disbursing incentives for service providers were funded entirely by donor grants. Thus, financial sustainability remained a challenge, although the scope of health reforms was small.

However, despite these repeated attempts, attempts to establish a health insurance scheme were inconsistent and lacked complementarity. Almost every decade witnessed a new attempt, but they all lacked the resources, decisions, and directives to carry out the required health reforms. On the other hand, the real political will to deal with health issues and their social determinants was absent. Additionally, actors and stakeholders outside the public health sector had conflicting interests. They depended on out-of-pocket spending as an opportunity to maximize their profits. In general, the matter was not merely technical but also political, linked to the health coverage priorities of various political systems.

## THE NEW UNIVERSAL HEALTH INSURANCE SYSTEM: A NEW ATTEMPT AT UNIVERSAL HEALTH COVERAGE

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The new universal health insurance system aims to cover all citizens in all stages of their lives, where the state ensures financial protection for those unable to do so. The system was introduced through the Comprehensive Health Insurance Law No. 2 of 2018, which adopts the principle of separation between service providers, financing agencies, and the regulation, accreditation, and quality authority. The law established three principal bodies to manage the new system. It also adopted several mechanisms to measure medical service performance, citizen satisfaction, and quality. The three new bodies created by the law are:

- The Universal Health Insurance Authority (UHIA) responsible for financing and purchasing health services for citizens participating in the scheme.
- The Egypt Healthcare Authority responsible for managing healthcare and services and supervising service providers.
- The General Authority for Health Accreditation and Regulation responsible for monitoring and regulating service quality.

Separating service providers, funding bodies, and accreditation and regulation authorities is a new trend in Egypt's health system. However, it aligns with the global trend toward universal health coverage. The other principle in the new law is the obligation to implement and participate in the new universal health insurance scheme. Furthermore, the law aims to achieve community solidarity, as it is compulsory and prohibits opting out. The new system is based on the following principles:

- Households as the basic unit of coverage.
- Primary healthcare and family medicine as a basic entry point.
- Providing healthcare and treatment services at all three service levels (primary healthcare, the secondary care specializing in diagnosis and treatment and provided in hospitals, and tertiary care specializing in special and advanced cases).

The law was drafted in late 2017 and approved by the House of Representatives. It was ratified by the President of the Republic in January 2018. The universal health insurance law will gradually replace the laws currently in force (over six stages) and within a period of fifteen years.

The new system relies on three primary funding arrangements to ensure its sustainability:

The first includes the contributions of households under its umbrella. Subscription rates are based on heads of households' total income, covering them, their children, and non-working wives. On the other hand, working wives contribute 1% of their income. The whole household contribution is estimated at an average of 6% of the head of the family's total income and 4% paid by the employer, whether in the public or private sector. Thus, the total household contribution for two children and a non-working wife becomes 10%. These contributions are paid by groups who can do so and who work in the public and formal private sectors.

The second includes coverage by the state's public treasury for groups that cannot contribute, based on the percentage of such households and individuals.

The third involves other sources, community financing, fees allocated for health on a package of goods and services for some industries, car extraction fees, road transit fees, and cigarette taxes.

The universal health insurance scheme will be implemented over six stages covering all governorates. The last stage will involve Cairo, Giza, and Qalyubia. The first stage began in July 2019 in Port Said Governorate as a pilot and also involved Luxor, Ismailia, South Sinai, Suez, and Aswan. According to the law's administrative regulations, the six stages will be implemented over 15 years:

1. Stage 1: Port Said, Suez, South Sinai, North Sinai, and Ismailia
2. Stage 2: Aswan, Luxor, Qena, Matrouh, and the Red Sea
3. Stage 3: Alexandria, Beheira, Damietta, Sohag, and Kafr El-Sheikh
4. Stage 4: Assiut, the New Valley, Fayoum, Minya, and Beni Suef
5. Stage 5: Dakahlia, Sharkia, Gharbia, and Menoufia
6. Stage 6: Cairo, Giza, and Qalyubia

However, COVID-19 hit the country only a few months after the pilot in Port Said, and the pandemic's global health, economic, and social consequences slowed the implementation process. The pandemic, unprecedented in 100 years, was a significant challenge, and added to the existing and continuing structural challenges to achieving universal coverage in the next ten to fifteen years.

On the one hand, the scheme still needs work at the primary healthcare level. The scheme still lacks personnel, especially family doctors (one million people may need approximately 100 family doctors at a rate of one per 10,000 citizens), and more family doctors are required to staff the units. Their vital role must be explained to citizens and healthcare workers, especially entry-point doctors. Another challenge relates to digitization on the national level, which includes managing patient data, their full registration (some of which is currently in process), and managing financial claims for service providers according to temporary and final contracts.

# THE CURRENT STATE OF EGYPT'S HEALTH SYSTEM

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The following section highlights the current structural defects in Egypt's health system, characterized by fragmentation and lack of integration in performance and the organizational structure. This is in addition to fragmentation of the service providers and the dominance of curative services at the expense of preventive and primary care.

Furthermore, according to the constitution, the Ministry of Health and Population is still responsible for public health in Egypt. However, the Health Ministry's performance has revealed several shortcomings. These include weak intermediate administrative cadres, bureaucratic complexity, overcrowding, and extreme centralization. Moreover, the participation of governorate health directorates in decision-making and health policies is limited. Instead, they follow the central instructions from the Ministry's head office in Cairo.

In addition, the healthcare system in Egypt is fragmented and includes multiple actors. Health services are provided by three sectors: the state, the private sector, and charitable organizations.

## THE GOVERNMENT SECTOR

The state or government sector comprises ministries funded by the Ministry of Finance, such as the Ministry of Health and Population, with its hospitals and agencies and the Ministry of Higher Education, with its collective hospitals. Various other ministries are also involved, including the Ministries of Defense, Interior, Transportation, Electricity, and others that provide health services to their employees. In the Ministry of Health and Population departments and hospitals, the service could be provided in return for a fee paid by patients when receiving the service. Some departments are self-financed either through patients paying out-of-pocket or having to pay for medical supplies required by the intervention. The above is under the umbrella of the public sector and the regulatory and administrative authority of the Ministry of Health and Population. Below is an overview of the main actors comprising the government, or public sector:

- The Ministry of Health and Population has a health directorate in each governorate, headed by a doctor reporting to the minister.
- The General Authority for Health Insurance was established following the Presidential Decree 1209 of 1964. It is state-run and supervised by the Ministry of Health and Population to finance and provide health services simultaneously. The authority's budget is deducted from state employee salaries, pensions, the set amount paid by school students, and the state budget allocations.
- The Medical Services Institution has been an economic body under the Health Minister's supervision since 1964 upon the nationalization of some private and community hospitals. It includes a small number of hospitals in Cairo and some other governorates.
- University hospitals are run by the Ministry of Higher Education and funded by the Ministry of Finance. An additional funding source comes from providing paid services to patients, often at a lower price than the private sector. Managed by the Ministry of Higher Education, these hospitals provide advanced medical care and employ highly skilled and trained doctors compared to those from the Ministry of Health.

## THE PRIVATE SECTOR

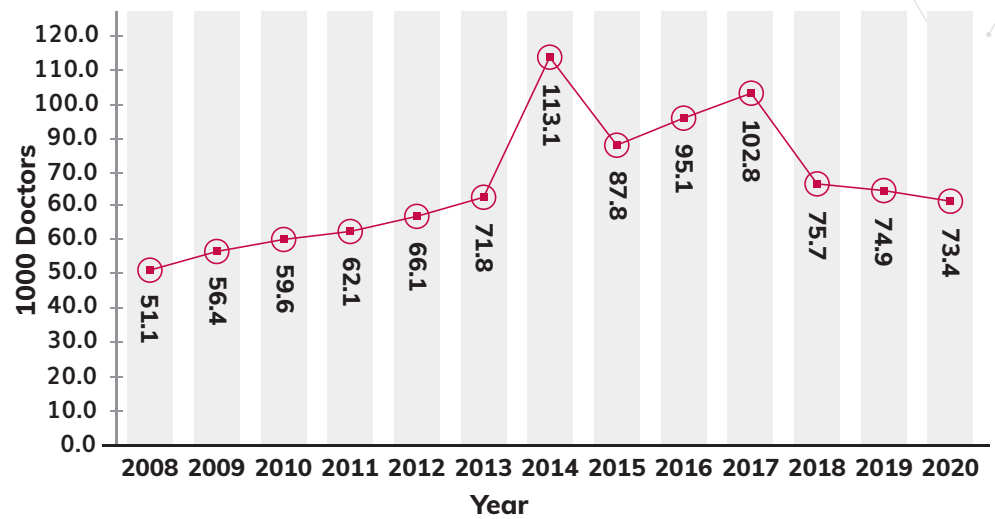
The private sector includes private hospitals, specialized medical centers, laboratories, and pharmacy chains. The private medical sector has spread vigorously in the last twenty years, at least due to the government's reduced spending on health, as detailed below. It should be noted that many public-sector doctors, nurses, and workers also work in private-sector hospitals or clinics, mainly due to the abysmal wages in the public sector.

## CHARITABLE ORGANIZATIONS

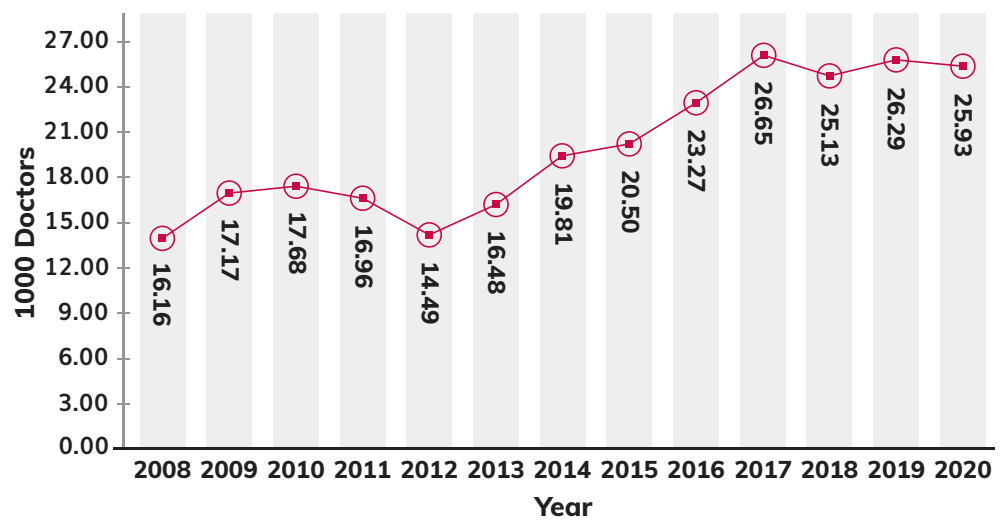
They include religious and non-religious charities.

## HUMAN RESOURCES

The number of physicians in the government health system increased between 2008 and 2014, then sharply declined, as shown **Figure 1** (2014 and 2020). On the other hand, the number of doctors in the private sector has been steadily increasing since 2012.

**Figure 1. Number of doctors in the public sector**

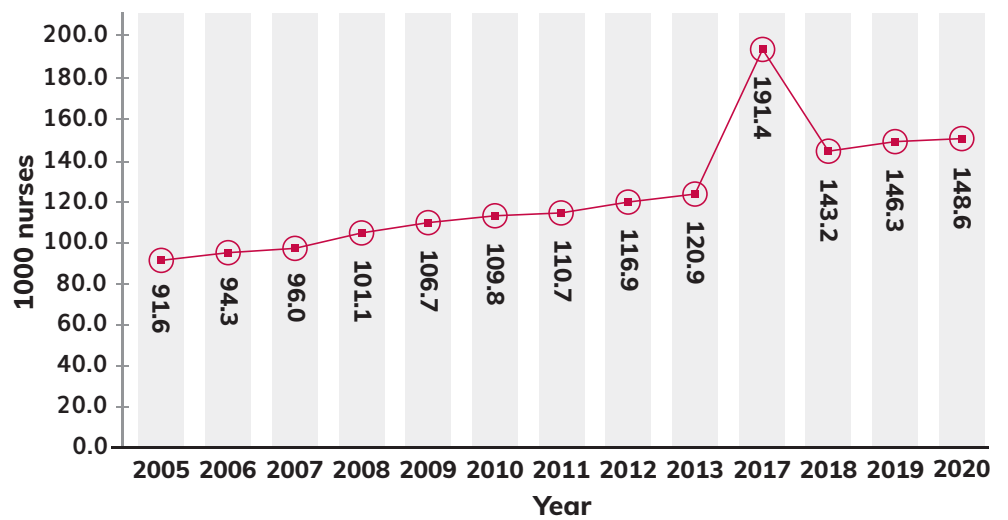
| Source: CAPMAS

**Figure 2. Number of doctors in the private sector**

| Source: CAPMAS

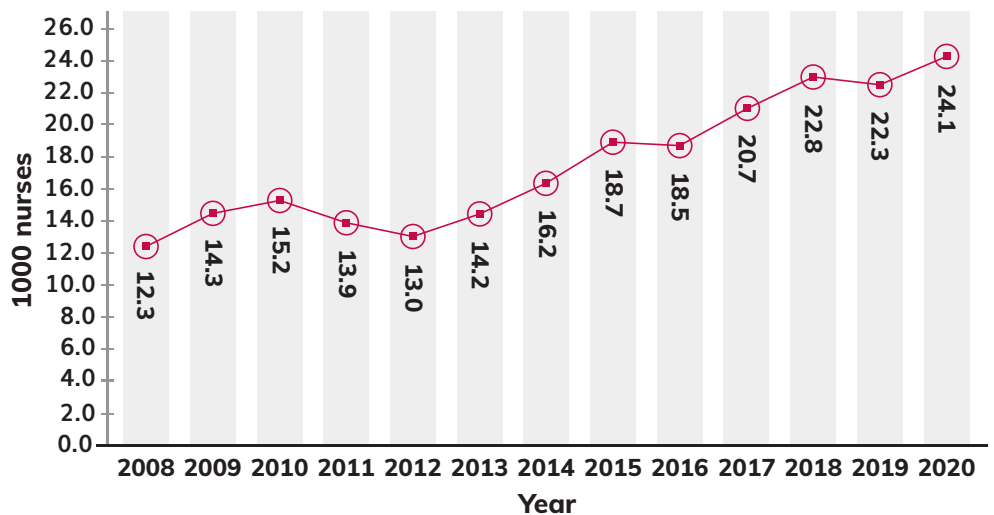
On the other hand, between 2017 and 2020, nursing staff numbers declined in the public sector, and rose in the private sector, as indicated in the following figures.

**Figure 3. Number of nursing staff in the public sector**



Source: CAPMAS

**Figure 4. Number of nursing staff in the private sector**



Source: CAPMAS

However, workers in the public health sector often have additional jobs in the private sector.

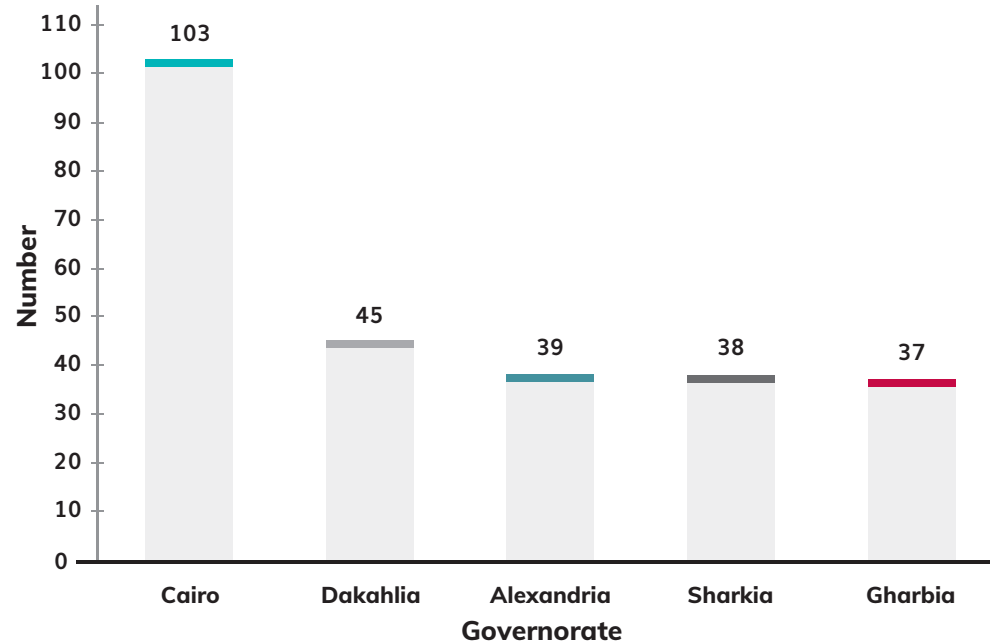


## UNIONS OF MEDICAL PROFESSIONS

The Egyptian Medical Syndicate represents Egypt's doctors. It is often considered the most eminent in the medical sector due to having the most powerful voice in discussions related to the health sector. It continuously provides opinions on health developments, sometimes clashing with the Ministry of Health and Population regarding doctors' conditions or decision-making methods. However, the same cannot be said about other health professionals, such as pharmacists, nurses, and laboratory technicians.

Furthermore, Cairo has the largest share of health infrastructure among the various Egyptian governorates. It also has the highest share of health workers. However, the unjust distribution is apparent in the gap between urban capitals and other governorates and between the north and south of the country, in favor of Cairo and the north.

**Figure 5. Number of public sector hospitals in the five largest governorates 2020**



Source: CAPMAS

**Table 1. Healthcare workers distribution in relation to governorates**

Statement	Governorates	Health Assistants		Nursing Staff		Dentists		Pharmacies		Human Doctors	
		Females	Males	Females	Males	Females	Males	Females	Males	Females	Males
<b>Total</b>		<b>52</b>	<b>10824</b>	<b>133610</b>	<b>12737</b>	<b>10711</b>	<b>10123</b>	<b>32496</b>	<b>14850</b>	<b>35813</b>	<b>39110</b>
Cairo		-	549	8401	251	1936	1472	2510	499	5684	2849
Alexandria		-	432	3958	102	1314	571	3378	345	2113	936
Port Said		2	80	250	15	26	22	163	36	37	35
Suez		-	21	1346	137	74	76	280	58	239	216
Ismailia		-	135	2029	138	111	136	646	144	254	345
Damietta		19	179	5004	277	327	260	1099	19	815	891
Dakahlia		15	1295	11565	461	1197	1100	4190	1112	5754	6305
Alsharqia		-	890	12911	1101	851	430	4385	2305	4964	3152
Kaliobeya		-	459	6755	19	476	446	1792	729	851	1074
Kafr El Sheikh		5	457	6201	544	336	568	2037	734	1341	1844
Algharbia		-	487	12012	899	665	830	1273	1046	2694	3771
Monoufia		-	744	8414	442	441	758	1659	1862	2557	3586
Albuhayra		-	771	13306	286	294	364	1176	306	1320	2301
Giza		6	335	4872	279	871	620	1697	351	1440	1799
Bani Sweif		-	292	3283	108	134	175	853	290	446	553
Fayoum		2	270	3101	139	264	337	466	553	355	899
Menia		-	709	5247	1038	407	459	1189	616	1042	1735
Asyut		-	845	6967	2969	286	496	793	1393	1326	2191
Sohag		-	576	2931	494	289	303	754	705	1165	1523
Qena		-	205	2953	389	71	153	797	489	308	864
Aswan		-	224	5315	600	71	128	306	178	230	500
Matrouh		3	155	1294	128	52	78	120	125	292	639
Elwady El Geded		-	58	1198	587	45	50	66	41	92	176
Red Sea		-	90	481	114	44	33	244	141	134	173
North Sinai		-	206	2312	655	57	103	145	174	94	259
South of Sinaa		-	123	451	364	23	39	104	202	98	205
Luxour		-	237	1053	201	49	116	374	219	168	289

## THE PHARMACEUTICAL SECTOR

Currently, the pharmaceutical sector only does packaging of medicines locally. Any disruption in the import of pharmaceutical raw materials from abroad, whether due to problems in the availability of hard currency or problems in supply chains, such as what occurred due to COVID-19, is considered one of the most important reasons for the occurrence of repeated crises of shortage of medicines and their high prices. The private sector prefers importing manufactured raw materials (production inputs) from abroad. Thus, drug prices are always subject to hard currency fluctuations. According to some estimates, the pharmaceutical sector relies on importing basic materials, manufactured active materials, and the necessary raw materials from abroad, by more than 90%. Thus, any administrative change or financial savings resulting from standardized procurement would not address the root of the problem, which is close to complete dependence on imports (Egyptian Center for Economic Studies 2020).

## HEALTH INDICATORS: MANIFESTATIONS OF INEQUALITY AND INEQUITY

Inequality is a prominent feature of the Egyptian health system, specifically with regards to access to health services and shouldering the burden of health spending.

Health protection is an essential component of social protection. Its absence may lead to poverty as a result of the out-of-pocket financial costs incurred by individuals due to illness, especially in cases of catastrophic spending on health.

Reduced government spending on health and excessive reliance on the private sector in providing health services led to a rise of at least 60% in out-of-pocket spending. As a result, the private sector has dominated the market, and health services are becoming more of a commodity.

### CHILD AND INFANT MORTALITY RATES

The latest Demographic Health Survey issued in 2014 found the under-five mortality to be 27 deaths per 1,000 births in the preceding five years. At this level, one in every 27 Egyptian children will die before age five. About eight out of every 10 early childhood deaths in Egypt occur before a child reaches one year, and just over half of all deaths (52%) occur during the first months of life.

**Table 2** presents neonatal, post-neonatal, infant, child, and under-five mortality rates in the 15 years preceding the 2014 survey. These results indicate the current level of mortality rates and provide an opportunity to assess their development.

**Table 2. Neonatal, post-neonatal, infant mortality, child mortality, and under-five mortality rates in the five-year segments preceding the survey in 2014**

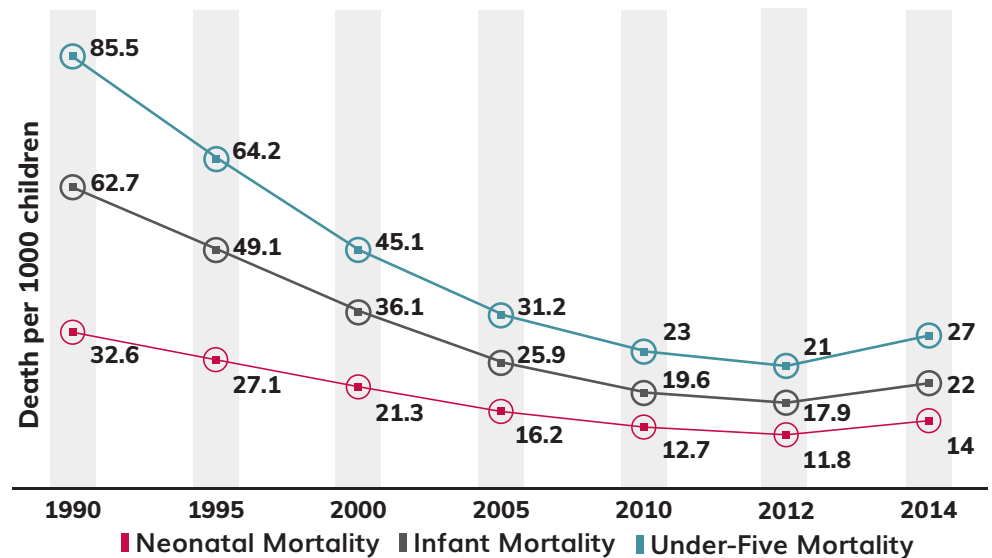
Years Prior to Survey	Neonatal Mortality	Post-Neonatal Mortality*	Infant Mortality	Child Mortality	Under-Five Mortality
0-4	14	8	22	5	27
5-9	19	11	30	3	33
10-14	19	13	33	7	39

\* Calculated as the difference between infant mortality and neonatal mortality rates.

**Table 3. Distribution of under-five mortality rates by cause of death between 2000 and 2012**

Cause of Death	2000	2012
	As a % of total under-five child mortality	
Prematurity	28	29
Congenital disabilities	12	21
Acute lower respiratory tract infections	15	10
Complications during childbirth	13	13
Diarrhea	9	5
Other reasons	36	35

Source: UNICEF (2014) *Children in Egypt: a statistical digest*, June 2014, UNICEF Egypt, Cairo, Egypt; World Health Organization (2014), *World Health Statistics 2014*.

**Figure 6. Child mortality rates between 1990 and 2014**

Source: UNICEF (2014) *Children in Egypt: a statistical digest*, June 2014, UNICEF Egypt, Cairo, Egypt; May 2014.

In terms of geographical distribution, urban children are less likely to die at any stage of early childhood than rural children. For example, the under-five mortality rate in urban areas is 23 per 1,000 births, 32% lower than in rural areas, where it is 34 per 1,000 births. In terms of place of residence, the under-five mortality rate was highest in Upper Egypt (38 deaths per 1,000 births) and lowest in urban governorates (20 deaths per 1,000 births).

Similarly, the difference in neonatal mortality between rural and urban areas is significant but not as large relative to the gap in post-neonatal and infant mortality rates.

On the other hand, according to the new health survey, data from 2014 to 2021 indicates the following:

The preliminary results of the latest Egyptian Family Health Survey 2021 indicate that the infant mortality rate during the five years immediately preceding the survey amounted to 25 deaths per 1,000 births. The neonatal mortality rate was 18 cases per 1,000 births, while the post-neonatal mortality rate reached 18 deaths per 1,000 births. However, the post-neonatal rate was seven cases per 1,000 live births. The under-five mortality rate reached 28 cases per 1,000 live births. Infant deaths represent about 89% of child deaths in Egypt, and about 72% of infant deaths occur during the first month after birth.

Compared to the 2014 Survey, the new data indicates an increase in the infant mortality rate from 22 deaths per 1,000 births in 2014 to 25 deaths in 2021. In addition, infant mortality rates during the first month rose from 14 per 1,000 births in 2014 to 18 in 2021. Nevertheless, the mortality rate for children aged 1-4 years decreased from 5 cases per 1,000 births in 2014 to only 3 per 1,000 births in 2021.

Preliminary data showed discrepancies in mortality rates according to the place of residence. The mortality rate for children under five is higher in rural areas than in urban areas and Upper Egypt compared to urban governorates and Lower Egypt (CAPMAS 2021).

## WOMEN

Women in urban governorates receive more healthcare during pregnancy than in Upper Egypt and border governorates. However, the latest survey in 2021 indicated that almost 20% of pregnancies in the five previous years were unwanted, and 12% were not wanted at all (CAPMAS 2021).

The following barriers to women's access to healthcare were identified:

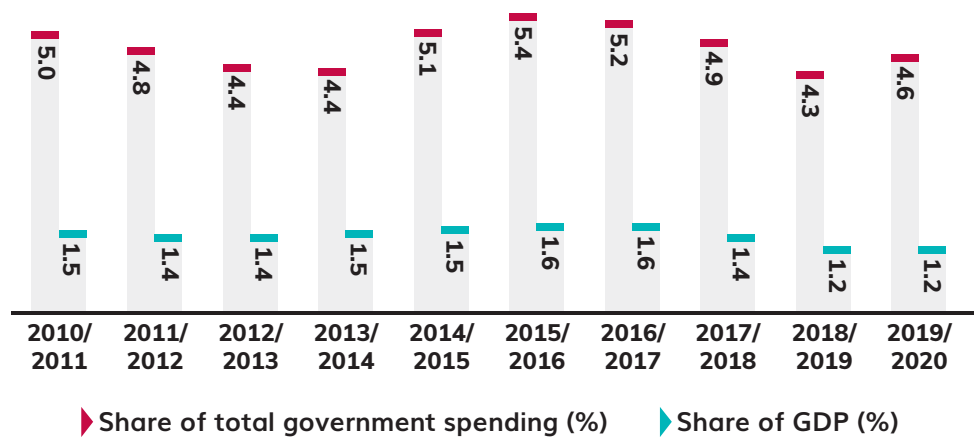
- Medication shortages
- Unavailability of a health service provider
- The distance from the nearest health unit and the need for transportation

## GOVERNMENT SPENDING ON HEALTH

According to the 2014 Egyptian constitution, the state must spend at least 3% of its gross national product (GNP) on health. However, despite a health challenge the size of the COVID-19 pandemic in 2021, health was ranked fifth in government spending priorities. Spending on health in 2021 did not exceed 1.5% of the gross domestic product (GDP). **Table 4** shows that government spending on health is declining. The government sometimes adopts an expanded definition of the meaning of general government spending on health. Instead of the calculation being based on allocations that go to the Ministry of Health and Population only, which are less than the constitutional percentage, the government calculates all health expenditures by government agencies from ministries (such as the Ministry of Interior or Oil) and public bodies (whether

service or economic). It also includes spending on providing drinking water and sanitation services (UNDP 2021). Thus, it gets out of the constitutional impasse stipulating spending 3% on health services. However, while sanitation, for example, is linked to the right to health, calculating the expenditures of other government agencies that go to their employees as part of spending on health is an attempt to evade the percentage.

**Figure 7. Overview of health financing in Egypt**



## THE PRIVATE SECTOR RECEIVES THE LARGEST SHARE OF HEALTH FINANCE IN EGYPT

The private sector receives the largest share of health financing. WHO data shows that private spending represents about 71% of the total current spending on health in Egypt, according to 2018 estimates, compared to 29% of government spending on health. The private sector's share of current spending on health in Egypt is higher than the global average of 41%, and higher than that of several other lower-middle-income countries. In the same context, Egypt is considered one of the countries with the highest direct contributions (out-of-pocket spending) to total current spending on health, which amounted to nearly 62% in 2018, close to double the global average.



**Table 4. Government spending on health**

	2005	2010	2015	2020
Health spending US\$ per capita (CHE)	61	107	174	151
Government health spending % Health spending (GGHE-D%CHE)	32.3%	32.9%	31.2%	31.9%
Out-of-pocket spending % Health spending (OOPS%CHE)	64.6%	62.6%	59.5%	59.3%
Priority to health (GGHE-D%GGE)	5.2%	4.4%	5.1%	5.2%
GDP US\$ per capita	1.39	2.586	3.252	3.457

| Source: World Health Organization Global Health Expenditure [Database](#).

## **MALNUTRITION**

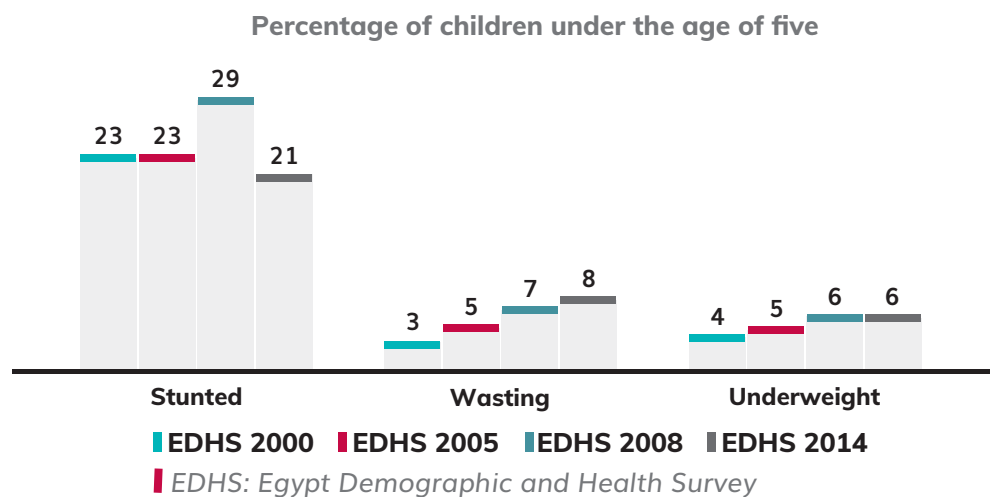
Childhood malnutrition is a persistent problem in Egypt. Malnutrition is the cause of two-thirds of child deaths globally, and Egypt is among the 36 countries where 90% of the global burden of malnutrition is concentrated. Despite a decrease in child mortality in Egypt, malnutrition rates are still high, especially among children under five. Stunting rates among children under five reached 21% in 2014, while rates of wasting and underweight children reached 8% and 6%, respectively. This is in addition to the 'double burden of malnutrition' when undernutrition is coupled with overweight/obesity. The double burden of malnutrition is a significant challenge in Egypt, predominantly obesity and stunting. Thus, appropriate comprehensive measures must be taken to reduce this burden, as 14.2% of children under five are overweight.

Another major challenge is anemia (a deficiency of red cells/hemoglobin in the blood that leads to paleness and fatigue). It affects 27.2% of children under five and 25% of women of childbearing age (15-49 years) (Ministry of Health and Population/Egypt, El-Zanaty and Associates/Egypt, and ICF

International 2015). In addition, more than a third of children and young girls and boys in the age group of 5-19 years suffer from overweight or obesity, and girls in the age group of 5-19 years are more likely to suffer from anemia than boys of the same age group.

Stunting is a sign of chronic malnutrition and varies widely across Egypt. One out of every four Egyptian children suffers from stunting (short stature for their age), while nationally, one in five children under five (21%) is stunted or too short for their age. Among governorates, the percentage of children suffering from stunting ranged from 15% in the three border governorates surveyed to 30% in urban areas of Upper Egypt. Stunting affects children of all income levels, not just the poor. Among the poorest families, we find that 24% of children under the age of five are stunted, which is very similar to the rate of stunting among children in wealthy families (23%). Moreover, the stunting rate remained above 20% between 2000 and 2014, while other measures of malnutrition increased, such as being underweight and thin, which is a sign of severe malnutrition.

**Figure 7. Malnutrition among children under five**



## THE TREND TOWARD VERTICAL HEALTH PROGRAMS

In the few years preceding the pandemic, the Ministry of Health and Population tended to favor vertical health programs (such as the campaign to eradicate Hepatitis C, the women's health campaign, and the campaign for early detection of obesity and malnutrition). Recently, the Ministry launched even more

vertical programs instead of integrating already existing health system functions to implement the first stage of the comprehensive health insurance law: establishing well-equipped basic care units in the governorates.

“Vertical programs” are a trend in health policy. They are goal-specific and address one disease or a small group of health problems, focusing on the short or medium terms. They are administered centrally but separate from the Ministry of Health. The vertical approach is disease-specific, often making it easier to obtain funding and achieve rapid success in dealing with a particular disease. On the other hand, the horizontal approach is more comprehensive and seeks to overcome basic health problems (Cairncross, Periès, and Cutts, 1997).

## HEALTH POLICIES AND PROCEDURES APPLIED DURING THE PANDEMIC

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The pandemic overwhelmed Egypt's already weak health system and posed a major challenge. The first case of COVID-19 was detected on February 14, 2020. However, the virus quickly spread during March, prompting the Egyptian government to issue a night-time curfew from March to June 2020 (Egyptian Cabinet 2020).

The Ministry of Health and Population relied mainly on public hospitals, specifically fever and chest hospitals, as a front line for dealing with cases. These hospitals served as the first line of defense in dealing with suspected cases and referring confirmed cases to medical quarantine. As the number of cases increased, the Ministry began receiving COVID-19 cases in all of its 320 hospitals.

In April and May of 2020, a sharp increase in cases placed tremendous pressure on public hospitals, which lacked sufficient capacity. The private sector stepped in to provide services and care for COVID-19 patients. However, the cost of private care was severely exaggerated and unaffordable for most citizens. Consequently, the state tried to impose a fixed price on such services, amounting to 10 thousand pounds (roughly 323 USD) per night. However, the private sector refused to comply with Ministry of Health and Population regulations. This behavior went unchecked, and the state did not act to implement the fixed price, most likely because it was not serious about it and did not want to impose any form of regulation on the private sector during the pandemic (Gad 2022).

The state established a higher national committee for the urgent response to COVID-19. Headed by the Prime Minister, the committee reports to the President of the Republic. It is generally responsible for major decisions related to total or partial national-level closures. Furthermore, a medical committee was formed to tackle the medical aspect, supervised by the Ministry of Health and Population, in addition to a scientific committee at the Ministry of Higher Education to set scientific guidelines. The bureaucratic administrative structure above addressed the pandemic's administrative, technical, and political aspects.

However, despite efforts by the Ministry of Health and Population, the response to COVID-19 faced significant gaps and challenges, summarized below.

## **SHORTAGE OF HEALTH SECTOR WORKERS**

The poor distribution of skilled and trained health workers and the low quality of care provided by the public sector are among Egypt's major challenges regarding human health resources. These problems existed before the pandemic, but their effects emerged during the spread of COVID-19. As previously explained about the medical staff's working conditions, most healthcare workers receive meager wages, and there is a mass exodus of doctors and nurses, whether abroad or to the private sector. According to estimates, about half of Egypt's skilled physicians work outside the Ministry of Health and Population. As a result, the quality of healthcare in the public sector is low and deteriorating. Nevertheless, despite its weakness, the government placed the primary responsibility for treating most infections on the public sector. It should be noted that public sector doctors, nurses, and other public health staff work long hours and face risks of infection and psychological stress. That is, inequality already existed in the sector and was exacerbated by the pandemic.

Furthermore, the state did not provide any financial or moral compensation to the medical staff for their sacrifices during the pandemic. On the contrary, demands to raise salaries to guarantee a decent life were unmet, and health sector workers faced security and administrative restrictions if they expressed their opinions or criticized the government's measures.

Despite the shortage of doctors, health sector workers were subjected to security harassment and administrative abuse in many cases when they expressed their concerns, declared their needs, or criticized the government's handling of the pandemic. The mistreatment ignored the fact that they endured harsh and unfair conditions for more than a year without a break or interruption (Amnesty International 2020).

During the first months of the pandemic, many deaths occurred among health sector workers. Although the government did not disclose the numbers, a WHO representative stated in April 2020 that 13% of COVID-19 infections in Egypt were among medical workers (Ghanam 2020).

Nevertheless, deaths among doctors were documented by the Medical Syndicate throughout the pandemic. However,

there is no information about other health sector workers, including nurses, technicians, paramedics, pharmacists, and administrators. The Ministry continuously failed to document injuries and deaths among medical staff. On the contrary, it ignored the problem and reduced the number of deceased doctors compared to the number recorded by the Medical Syndicate.

As deaths among health workers increased and societal sympathy for their sacrifices grew, there were more demands for the fair treatment of staff who fell victim to the disease. However, the state only slightly increased doctors' salaries to contain the many demands for fair financial compensation.

The Medical Professions Risk Compensation Fund was established under Law No. (184) of 2020 to cover total or partial disability or provide compensation to the families of those who die due to practicing the profession. In contrast to other entitlements from insurance and pensions, it was in the form of a one-time compensation and not a monthly pension. Furthermore, most of the fund's resources are collected from the contributions of members of the medical profession. However, almost two years after the law's adoption, it still lacks precise implementation mechanisms and procedures for victims' families to apply for compensation. It is likely that the law was passed merely to contain escalating demands.

The pandemic also impacted the daily consumption patterns of food and non-food commodities in Egypt. For example, protein consumption decreased by up to a quarter of what it was before the spread of the virus, mainly due to the decrease in household and individual incomes and the rise in food commodity prices (CAPMAS 2020).

## TESTING

Another problem related to the COVID-19 response by the Ministry of Health and Population was the lack of PCR tests provided by the government since the onset of the first wave. The Ministry's policy aimed to economize in providing and analyzing tests.

The Ministry's policy of limiting tests hurt health workers, endangering the lives of many of those on the frontline and most vulnerable to infection. These policies also reduced the quality of data on the total number of cases since PCR testing was limited compared to infections. The Ministry also

failed to announce the results of tests conducted outside the government's central laboratories and sub-laboratories in the governorates. For example, tests conducted in university hospitals or private sector laboratories did not make it to the daily count and did not reflect the actual situation.

Some other factors contributed to the inaccuracy of official data on the number of infections and deaths due to COVID-19. Many infected persons chose to conduct blood analyses and chest x-rays in the private sector instead of the PCR test, despite their high cost. Others chose home isolation and treatment by following up with a private doctor without notifying the Ministry of Health and Population.

In terms of the availability of PCR tests, the state prevented private laboratories from conducting them in the first months of the pandemic. It made the service exclusive to the Ministry of Health and Population laboratories (central and subsidiary), providing the test for free but though the number of tests was limited. For those who requested the test for travel abroad and similar reasons, the cost was set at 1,050 pounds (63 USD, according to the exchange rate at the time) and later reduced.

The scarcity of PCR testing characterized the response since the first wave. Eventually, the Ministry of Health and Population allowed the private sector and private laboratories to conduct the tests, but without any regulations, especially with regard to pricing, which varied from one place to another. On the other hand, private laboratories were charging between 1000 to 2000 pounds (60-70 USD) , which is beyond the ability of the vast majority of Egyptians.

## **VACCINES**

Egypt initiated its COVID-19 vaccination campaign in January 2021. However, the campaign was haphazard from its inception. It began without a clear plan and specific timeline for making vaccines available. In addition, effective health communication and awareness mechanisms to announce information on vaccine provision and its importance were absent. For a long time, the Ministry of Health and Population addressed citizens through social media alone. The only source of information about the measures taken by the state to provide vaccines was through television statements by Ministry of Health and Population officials or those in charge of managing the crisis. However, the information was often conflicting (EIPR 2021).

There was no clarity regarding the priority of vaccination groups most at risk of infection, with poor transparency and difficulty accessing information related to vaccination rates among the population.

On the other hand, on the first day of the national COVID-19 vaccination campaign, the Ministry of Health and Population announced that most citizens would have to pay for the vaccine. It was only free for medical staff and those registered in the Takaful and Karama programs, which are social support programs for those in need supervised by the Ministry of Social Solidarity. However, government programs such as Takaful and Karama cover less than 10% of the disadvantaged poor in Egypt, depriving disadvantaged citizens who are unable to register or not registered in these programs from accessing vaccines. As a result of broad criticism, the state retracted that step and provided vaccines for free.

The Ministry of Health and Population did not publish vaccination data according to different age groups. There is no data on vaccination rates among the elderly and those with chronic diseases, who are most vulnerable to infection and its complications and have priority in obtaining the vaccine. Announcing these numbers is vital because they indicate the efficiency and fairness of vaccination distribution among citizens (EIPR 2021).

Registration for the vaccine was exclusively through an online portal, and appointments were far into the future. The situation created an obstacle for the elderly with chronic diseases and those unfamiliar with online registration. Vaccination centers were disproportionately distributed among governorates, especially in the south and the Delta, where citizens had to travel a long distance to obtain the vaccine.

Thus, obtaining the vaccine depended on a degree of education and the ability to access the Internet and information due to the Ministry's reliance on a website for registration. A broad segment of citizens unfamiliar with this type of registration method was excluded, mainly from the weakest and most vulnerable groups in society.

On the other hand, pregnant women who wanted to obtain vaccines waited a long time to receive specific recommendations from the Ministry of Health and Population on whether to obtain the vaccine. Again, this failure pointed



to the Ministry's poor communication in conveying health recommendations to citizens.

In some cases, vaccines were distributed based on individual economic and social status, regardless of the order of health priorities. For example, vaccines were distributed to House of Representatives and Senate members after they were given a choice between the Chinese Sinopharm vaccine and the English AstraZeneca vaccine. However, the Ministry of Health and Population announced that citizens do not have the option and shall be vaccinated according to what is available.

Finally, no official information has been announced to this date about vaccine distribution by governorates or gender (EIPR, 2021).

## CONCLUSIONS AND RECOMMENDATIONS

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- Primary healthcare and family medicine must be given priority as the main factor in the success of the new universal health insurance system.
- Working conditions for healthcare teams must be improved, including a review of the poor salaries, to avoid a severe crisis of medical staff shortage, especially doctors and nursing teams in the whole country, specially in the public health system.
- Strengthen the national pharmaceutical industry and the manufacturing of pharmaceutical materials locally, especially basic and non-patented medicines, to contribute to easing pressure and demand for hard currency, on the one hand, and protect drug prices from supply chain disruptions, on the other. This requires policies and action plans by the state or in partnership with the private sector, aiming to reduce the import of pharmaceutical raw materials, which the Egyptian pharmaceutical industry relies on entirely.
- Promote transparency and disclose information to the community, such as the geographical and gender distribution of vaccines.
- Finally, one of the most important lessons learned from the pandemic is the commitment to implementing the new comprehensive health insurance law and working diligently to complete its three phases to achieve comprehensive health coverage for all Egyptians without discrimination.

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# RIGHT TO HEALTH IN IRAQ

Fragile structures and  
growing challenges

## Muntather Hassan

Iraqi al-Amal Association

Muntather has been a dentist since 2017 with a bachelor's degree from the University of Kufa. He is currently a master's student in peace studies and conflict transformation at the University of Innsbruck, Austria. He works for Al-Amal on peace issues supported by volunteering experience with youth groups since 2011. His research interests include equality, identities, communication, and development.

## INTRODUCTION

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Iraq's long history of wars, violent conflicts, economic crises, and social divisions had a direct and indirect impact on its population's health, including lost lives, disabilities, and loss of livelihoods. After eight years of war against Iran in the 1980s and the second Gulf War in 1991, Iraq faced harsh international sanctions that destroyed the health and healthcare infrastructure. After the fall of Saddam Hussein's regime and the US occupation in 2003, neoliberal government policies failed to improve the right to health in the country. The public healthcare infrastructure barely changed due to the ongoing political instability that restricted the system's ability to provide services to the population. Furthermore, the long history of violent conflict has left most Iraqis with varying mental health problems and unhealed trauma. However, the healthcare system, health policies, and government and private sector approaches rarely address such issues.

In addition, Iraq faces serious environmental challenges, including pollution, climate change effects, extreme heat, and drought. In the spring of 2022, thousands were admitted to hospitals due to unprecedentedly intense sandstorms that temporarily brought the country to a standstill. Moreover, eight small rivers and three lakes completely dried up due to generally low water levels and high temperatures, threatening food security and agricultural livelihoods. Vulnerable groups continue to suffer from multiplying effects due to their inability to access appropriate health services and the components of healthy living.

This report consists of three main sections. It begins with a brief historical overview of the context of the right to health in Iraq from the establishment of the modern state to the present day. It then examines and analyzes right-to-health indicators and discusses the leading challenges to the right to health. Finally, it concludes with recommendations for various actors, including civil society, the government, and the international community.

## METHODOLOGY

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This report is based on a desk review of available literature, including government documents such as laws and performance reports, and reports by United Nations (UN) institutions like the World Health Organization (WHO) and the World Bank. Other sources included academic research, press reports, and reports by local and international civil society organizations (CSOs). The conclusions were supported by anecdotal observations from the author's practical experience as a dentist in the Iraqi public sector, where he spent nearly six years. This methodology was chosen after failing to obtain important information from primary sources through key informant interviews with stakeholders in leading positions in the Iraqi health sector. Five directors of departments concerned with public health from three Iraqi Ministry of Health Directorates were interviewed. The research focuses on all governorates except for the Kurdistan region, which uses another health system and has different social and political contexts.

The report builds on a rights-based approach. It adopts the principle of the right to health to understand the situation and challenges in Iraq. However, this right is not limited to obtaining appropriate health services. It includes all the elements of individuals' and groups' well-being. Thus, the report uses systems theory to analyze the main issues regarding the right to health within its social, political, and economic context. It looks at aspects such as food, medicine, education, work, transportation, infrastructure, and public order as systemically linked, going beyond direct cause and effect. Finally, the report benefited from a consultative session in Baghdad with academics, civil society workers, Iraqi health sector workers, and several reviews by the ANND team.

## HISTORICAL OVERVIEW

This section reviews Iraq's historical, political, social, and economic context, analyzing its relationship and impact on the right to health, including health services, in three historical stages. It begins with the establishment of the modern Iraqi state during the British occupation, the monarchy, and the establishment of the republic. Then it moves to the Baath Party era and its great wars. The last stage discusses the post-war period from 2003 to the present day.

### TRANSITIONING INTO THE MODERN WORLD (1920-1968)

Iraq has undergone significant transformations since the first Iraqi government establishment in 1920 under British occupation. The state's shape and systems witnessed many transformations from the parliamentary monarchy to the dictatorial republic, then to the democratic republic. However, the structures of modern state institutions were laid down under British occupation and during the monarchy after four centuries of being part of the Ottoman Empire. For example, the Iraqi army was first established in 1921. Modern schools were introduced, facing popular resistance and the scorn of religious institutions at the beginning. The health system was put in place simultaneously after establishing the first Ministry of Health in Iraq's history and its first government. However, due to the financial crisis during the Iraqi state establishment, it was incorporated into the Ministry of Interior until 1939. That year, it became part of the Ministry of Social Affairs as the General Directorate of Health, consisting of two departments: the Directorate of Public Health and the Department of Brigades Health. The Ministry of Health was re-established in 1952 under Law No. 28 (2014 حسين; 2021 حميد).

When the Ottomans left Iraq, it was not yet a state but a group of scattered tribes and cities torn apart by large waves of plague and cholera in the seventeenth century. Also, poverty and the lack of a culture of hygiene and health were widespread (الوردی 1992). The British mainly introduced health concepts and institutions as a colonial product (Al-Dewachi 2017). The Royal Medical College was established in 1927 in Baghdad to educate and prepare Iraqi physicians in English, mainly by professors from England. Today it is



called the College of Medicine at the University of Baghdad. It is called the mother college, and from which came the University of Baghdad, the mother university. Some foreign professors continued to teach until the first Gulf War in 1980 at the University of Baghdad. Then, the departure of foreign professors indicated that the Iraqi health and education systems had become unsuitable. Waves of immigration of Iraqi doctors and professors soon followed, resulting in the deterioration of health and educational services (Al-Dewachi 2017).

The medical profession became associated with social prestige beyond the importance of medicine, including a better economic situation, foreign language advantage, travel, and proximity to positions of power. Despite the changing social and economic dynamics, medicine remains Iraq's most important social profession and specialty. This social attitude undermines the importance of other essential roles in health and other sectors. Thus, the right to health became reduced to health services, a problem that continues today.

The Monarchical era from 1920 to 1958 began Iraq's transition toward modernity. State institutions began to emerge, and transport, irrigation, sanitation, and other systems were developed, especially in major cities. Meanwhile, the countryside, which formed most of Iraq at that time, remained under the control of an exploitative feudal system. As a result, the peasantry suffered under dire economic and social conditions and low quality of life. Unequal development and the rise of various political and ideological aspirations contributed to the coup of July 15, 1958.

The new state shifted to a welfare state model that abolished the feudal system through the Agrarian Reform Law No. 30 of 1958. The law set an upper limit for owning agricultural land. The state took control of the rest, redistributed it to the peasants, and compensated the owners. However, the peasants, especially indentured workers, could not manage their lands. They lacked the necessary management skills that went beyond agriculture.

On the other hand, the economic situation of middle-class farmers improved. They started moving to the cities (Marr 2012), where the rural and clan culture they brought began to spread. This culture included low health awareness and unhealthy practices in hygiene, treatment, and lifestyle. It also added pressure on the already weak health infrastructure. Furthermore, the migration was disorganized, as most

immigrants were scattered around. Women who used to work in agriculture within their families, while it did not grant them economic independence, became unemployed after migrating to the cities and were confined to their homes.

## ■ THE GREAT WARS (1963-2003)

The nationalist movement rose to power by the February 1963 coup to enforce the concept of the state as custodian of all citizens. The state became more involved in providing education and health services. Banks and some companies were nationalized in 1964, and the state took responsibility for importing and distributing basic needs (Marr 2012). Simultaneously, oil companies were nationalized in 1972, which increased the state's ability to spend directly on services and militarization. The 1970s witnessed a boom in development, health, and education indicators. For example, the maternal mortality rate was 87 per 100,000 live births in 1979 compared to 294 in 1999 and 73 in 2022. "During the 1970s and 1980s, the Iraqi health care system was lauded as one of the best in the Arab region, providing free health care in hospitals and primary health care clinics" (Abdurahim & Bousmah 2019).

Despite the positive impact of the state's immediate ability to spend on development, its long-term effects were negative (Al-Jebory 2017). The abundance of oil resources, dictatorial rule, and militarization after the July 17, 1968 coup, in addition to a patriarchal culture, led to the outbreak of the first Gulf War in 1980. In eight years of war, around 125,000 Iraqis were killed, 255,000 were wounded, and 50 to 80 thousand soldiers were captives. Furthermore, the Anfal operations in the Kurdistan Region of Iraq led to an estimated 50 to 100 thousand fatalities.

The direct war victims amounted to about 2.7% of the total population of Iraq at the time. The populations of entire cities along the war lines were displaced to central Iraq. They produced demographic changes that persist until today and added pressure on the health infrastructure already suffering from the war. The situation led to a significant shake-up in the social and economic system from which Iraq has not recovered. After its exit from the war, Iraq's debts amounted to about 50 billion United States Dollars (USD). Most of the industry had been transformed to serve the military. Iraq had lost about 45% of the workforce by then. Inflation was close to 28% (Marr 2012).

On the other hand, gender roles witnessed a transformation.

Women took over most public sector jobs due to the men's involvement in the war and its resulting reduced wages. Women-led families appeared, and became a phenomenon. However, as migration continued from the countryside to the city, clan values with patriarchal standards became more dominant. It exposed women, in particular, to social discrimination that encouraged violence against them directly and indirectly. More girls were deprived of education and sent to early marriage due to the coupling of the patriarchal culture and poor economic situation.

The ground was set for the Second Gulf War in 1990 as a cover-up for the state's failures and economic deterioration. The First Gulf War brought growing debt, continuous spending on weapons of mass destruction, and militarization in general. Then, the Second Gulf War led to an economic and social setback, with the loss of 10 to 30 thousand Iraqis and the capture of 86 to 90 thousand soldiers. However, after the failure of the popular uprising against the regime in 1991, government repression became harsher and more organized, especially in central and southern Iraq. It instilled a general culture of fear of power and silence in the face of its transgressions, no matter how severe they were. It also produced a culture of lack of transparency and administrative corruption that is still firmly present today. Thus, the health system's efficiency and ability to improve the system's situation were compromised.

Following the cease-fire imposed by Security Council Resolution 687, international sanctions reduced oil exports by 85% for six years (1991-1997). Hence, the Iraqi Dinar (IQD) collapsed from 3.20 USD per 1 IQD before the war to 2,600 IQDs per 1 USD in 1996 (Marr 2012). The infant and maternal mortality rates increased during that period, health indicators dropped dramatically, and "hospitals became places of death and disease rather than treatment" (Al-Dewachi 2017). The government took advantage of the people's suffering to call for the world's sympathy. Pictures of children suffering from deformities filled the television from the end of the 1990s until 2003.

In addition to the collapsed health system and economy, the sanctions were disastrous for the social system in Iraq. Bribery became a socially acceptable practice by most state employees to compensate for their measly salaries (around 0.8 USD a month). In schools, for example, it was common to hand over foodstuffs as a bribe to teachers as one of the conditions for the success of students with medium and weak performance.

The same situation applied to hospitals and other services. Nevertheless, the economic situation saw a slight improvement right before 2003.

In 1995, Saddam Hussein's regime launched a faith campaign to Islamize the state and daily life and encourage radical Islamic ideologies, coinciding with the government's rapprochement with the clans. It ended the liberal character of the state that prevailed until the end of the 1980s. With this change, religious extremism increased, and with it, patriarchal extremism. It led to an increase in girls' early marriage rates to relieve their economic burden. Domestic violence and violence against women increased. Death during childbirth became prevalent due to poor health services and decaying infrastructure.

## **DEMOCRACY AND SOCIAL UNREST (2003-2022)**

After the US occupation of Iraq in 2003, the economy opened up after a long economic blockade. Goods and food entered without regulation or quality control. Salaries jumped from about 0.80 USD per month to around 250 USD. Although consumption rates increased, the tired and poor local industry collapsed, and agriculture was severely harmed. The switch from a completely closed economy to a completely open market (neoliberalism) and a lack of standards transformed Iraq into a consumerist society dependent on imports.

On the social level, the status of the public sector employees rose quickly. People competed for important government jobs, and many were absorbed into the security sector, especially those without university degrees. The white paper of the Crisis Cell for Financial and Fiscal Reform (2020) indicated that the salary expenditures of employees and retirees increased by 400% from 2004 to 2020. Although the number of employees tripled, productivity increased by a mere 12% between 2006 and 2018. On the other hand, most revenues (about 95%) came from oil exports.

As the state's income improved, large sums went to the ministries to reconstruct the infrastructure and clear the way for investments. However, they also opened the door wide for administrative corruption at the higher levels. While bribery in daily transactions generally decreased, fake projects and theft of public money increased significantly, placing Iraq at the bottom of corruption and transparency indicators.

The situation contributed to the failure to improve the health sector in proportion to the population increase. The hospital beds rate decreased from 1.7 per thousand people in 1980 to 1.2 per thousand in 2019. Meanwhile, hospitals dropped from around 305 in 1989 to 295 in 2020 (The World Bank 2022a). Most hospitals were old establishments from the 1970s and 1980s. Some had exceeded their designated lifespan. On the other hand, several new hospitals were temporary, especially those established in response to the COVID-19 crisis. This decrease in the number of hospitals and beds rate was accompanied by a decrease in quality in general, except for a few newly established public hospitals and some private ones.

An indicator of Iraqis' lack of confidence in their health system and its ability to meet their health needs is the spread of medical tourism, especially to Iran, Lebanon, Turkey, India, Syria, and Jordan. For example, Iraq signed two agreements with Lebanon in 2019 and 2021 to provide treatment services to Iraqis and medical expertise to Iraqi health institutions in return for supplying Lebanon with oil. The health services Iraqis travel for vary between hard-to-cure diseases such as cancer and services unavailable in Iraq, such as some complex surgical interventions, all the way to cosmetic services. Moreover, many of these patients "chose to sell their possessions, borrow money, or rely on the help of charitable organizations to seek critical medical and surgical procedures abroad" (Al-Dewachi 2013).

However, the economic situation and health indicators improved between 2003 and 2013. Most of the improvement happened after ending the displacement crisis due to the sectarian war in 2008. The defeat of al-Qaeda in 2008 and the US forces' withdrawal in 2010 were also significant milestones. The so-called "explosive" 2012 budget crossed the barrier of 120 billion USD, allocating a large proportion to investments in services and security, including building new hospitals. However, many of these hospitals have not yet seen the light of day due to administrative corruption.

The emergence of the Islamic State in Iraq and the Levant (ISIS) in 2013 posed an existential threat to the Iraqi state in its current form. By 2014, it had captured Nineveh, Anbar, Salah al-Din, and parts of Kirkuk, Diyala, Baghdad, and Babel. Consequently, The Iraqi Popular Mobilization Forces (PMF) and the Global Coalition to Defeat ISIS emerged, and the war lasted until the end of 2017. Iraq was left with an insurmountable debt and budget deficit. The economic crisis reached its peak in 2016 when oil prices fell. Health and environmental services

were no longer a priority for the government. The war also displaced more than five million persons internally. Between 186 and 209 thousand Iraqis are estimated to have died through direct violence from 2003 until today. They include about 38 thousand persons during the war against ISIL (Iraq Body Count 2022). However, there are no reliable statistics on injuries or disabilities during this period.

During this time, internal displacement significantly impacted the health system, as displaced populations lost their livelihoods and access to essential services. Poor living conditions in camps and other places of displacement, especially those that are not organized, threatened internally displaced persons' (IDPs) physical and psychological health. The long-term effects of displacement include the deteriorating socioeconomic situation, loss of education and other essential services, and increased post-traumatic stress disorder (PTSD) and similar conditions.

The high volume of internal displacement also puts tremendous pressure on public services in host communities already suffering from poor infrastructure. Host communities began rejecting IDPs because of competition for services and job opportunities. Moreover, patriarchal gender norms played an essential role in this rejection. Most IDP men were subjected to security restrictions and prevented from entering cities, especially in the period following ISIS's takeover of Nineveh, Anbar, Salah al-Din, and other regions in 2014. The prohibition of IDPs from entering the cities prevented them from working or accessing health services. As a result, access to essential needs became dependent on humanitarian aid.

The same period saw fluctuating interventions by the Iraqi state. Politicians presented themselves to their constituents through care programs such as compensation for the families of martyrs and those affected by military operations or by providing free services. Government jobs were distributed in a manner closer to social security than actual employment. At the same time, the state tried to keep up with international priorities in developing the private sector, such as the conditions imposed by the International Monetary Fund (IMF) in its 2015 loans, encouraged by international development agencies and donor countries.

The private sector avoided the health sector and was primarily interested in housing and other non-productive sectors (كاظم 2021, p. 165). However, the private sector's health investments increased during and after the COVID-19 crisis, mainly to

provide for required tests and documentation. Private hospitals, laboratories, and medical schools started to open, while medical clinics remained mostly individual and unorganized. Much of the private sector's health-related activities are affiliated with political parties and armed groups. The neoliberal policies, pushed by international parties in Iraq, have been distorted and led to strengthening political parties and their armed wings more than stimulating actual private sector activity.

The post-2003 period also saw the emergence of previously-forbidden CSOs. International and local non-governmental organizations (NGOs), volunteer groups, and religious and charitable institutions contributed to the rapid response to the displacement crisis during and after the war against ISIS. The UN Iraq Humanitarian Fund and other UN agencies, the European Union (EU), the Department of Population, Refugees and Migration in the United States Department of State, and the US Agency for Development (USAID) were among the most prominent international actors in financing the humanitarian response and providing legal and health support services. Locally, the host communities were the first and foremost responders, followed by volunteer teams and local organizations. The government's response was the slowest and least effective. On the other hand, the response of religious institutions was flawed by sectarian and religious bias and discrimination. However, the contribution of civil society to health beyond the displacement crisis is minimal due to the absence of right to health from the donors' priorities.

## ■ IRAQ TODAY

Based on estimates by the Central Statistical Organization in the Ministry of Planning (2022), Iraq's population is more than 42 million people, 28.8% of whom live in rural areas and 61.2% in urban areas. However, there has been no official census since 1997. The annual growth rate is estimated at 2%, and a healthy life expectancy at birth is 62 years. Socially, the illiteracy rate is 6% of the population (WHO 2022). The poverty rate reached 31.7% after the COVID-19 pandemic, according to the statement of the Minister of Planning (زيد 2022). Iraq also faces structural challenges to the right to health, mainly due to climate change. The consequent rise in heat, pollution, water scarcity, and desertification rates adversely impact food security. The impact of financial and administrative corruption in import operations and quality control on inequality in access to health services are discussed later in the report.

## ASSESSING HEALTH DETERMINANTS IN IRAQ

This section provides an overview of Iraq's primary right to health indicators based on assessing health characteristics in 194 countries (Backman et al. 2008). Because these indicators are too many to be covered by this report, priority has been given to 33 indicators. The chosen indicators relate to recognizing health as a right, planning and community participation, access to information, non-discrimination, spending, budgets and debt, health and pharmaceutical services, and health workers.

### LEGAL FRAMEWORK AND HEALTH POLICIES

The legal framework for the right to health in Iraq is inscribed in the Iraqi constitution, which guarantees social security and health services in the chapter on rights.

According to **Article 30** of the Constitution:

#### First

The State shall guarantee to the individual and the family - especially children and women – social and health security, the basic requirements for living a free and decent life, and shall secure for them suitable income and appropriate housing.

#### Second

The State shall guarantee social and health security to Iraqis in cases of old age, sickness, employment disability, homelessness, orphanhood, or unemployment.

**Article 31** continues:

#### First

Every citizen has the right to health care. The state shall maintain public health and provide the means of prevention and treatment by building different types of hospitals and health institutions.

**Article 33** guarantees every individual the right to live in safe environmental conditions.



Although these articles suggest that the constitution sees health as a right, they limit health to insurance and services (by reflecting on the wording used by the Arabic version of the constitution). Furthermore, there is a big difference between the provisions set forth by these articles and the actual situation.

In addition to the constitution, several laws govern health affairs, including the amended Public Health Law No. 89 of 1981, the Ministry of Health Law No. 10 of 1983, the Law of Apprenticeship of Medical and Health Professions No. 6 of 2000, and the Health Insurance Law No. 22 of 2020. However, while the first three laws are in force, the health insurance law is still suspended due to the failure to approve the federal budget since 2021, as confirmed by the Minister of Health in April 2022 (أولاد 2022). In some areas, the Iraqi Ministry of Health recently launched the health insurance registration form as a trial phase.

As for the health-specialized bodies, the Parliamentary Health and Environment Committee is a permanent committee in the Iraqi parliament. It is concerned with reviewing health policies, caring for medical and health staff, and protecting the environment. Nevertheless, it is not usually considered an essential committee in the parliamentary quota system, like the Finance Committee, the Integrity Committee, and the Legal Committee.

The Supreme Committee for Health and National Safety in the General Secretariat of the Council of Ministers was established in response to the COVID-19 pandemic. Its work was limited to organizing public life during the pandemic and providing vaccines. It lacked a clear plan to improve the infrastructure necessary to deal with the pandemic (الألوسي 2021).

In addition to the above, Iraq approved a national health policy for 2014 to 2023 at the beginning of 2014. It was mainly developed by the Iraqi Ministry of Health, the Parliamentary Health and Environment Committee, the WHO, government agencies, and some trade unions. There is also a reference to USAID's participation. However, neither Iraqi civil society nor local communities were involved in its formulation.

The national health policy referred to the link with sustainable development goals (SDGs) in its introduction. Nevertheless, while the first principle guiding the policy indicates that "health is a guaranteed right for every human being," the phrase immediately defines this right as obtaining health care only. It also defines the "human being" exclusively as an Iraqi individual: "Access to healthcare is one of the rights of Iraqi

## THE NATIONAL HEALTH POLICY



individuals” (وزارة الصحة 2014) and does not include non-Iraqis. On the other hand, it failed to mention IDPs completely, perhaps because it was prepared and launched when the displacement crisis was not yet apparent. There are no signs of work to prepare a new policy, noting that the current policy’s implementation period ends this year.

The policy also emphasized the equal provision of health services. However, although it mentioned a few forms of discrimination, such as socioeconomic status, origin, sex, and geographical location, it did not include discrimination based on gender, sexual orientation, religion, disability, age, or skin color. The policy was built on the assumption that the public health sector would remain the primary healthcare provider and be developed on that basis. This is translated on the ground that the state subsidizes public health services at a fraction of the cost in the private sector. However, the current neoliberal policies transfer health services from the public to the private sector contradict the health policy. The Iraqi state also opened private departments in most public hospitals and specialized centers that operate at prices similar to the private sector, but their revenues go to the state.

Although the policy covers reproductive health, it links it to children and mothers only. Moreover, it neglects the term sexual health, possibly due to social considerations. Policy-makers also linked mental health with combating addiction, confusing the matter and causing more social stigma towards people with psychological problems. In all cases, neither mental health patients nor addicts can access basic rehabilitation services in Iraq.

The national health policy also clearly includes comprehensive care and the three stages of primary, secondary, and tertiary health care: prevention, diagnosis, treatment, and rehabilitation. The author’s practical experience in Iraqi health institutions shows that there are programs specialized in prevention, such as vaccination and awareness campaigns, and periodic examinations for children and pregnant women, for example, with follow-up and documentation records. However, these programs are applied inefficiently, and their documentation is inaccurate. In addition, health teams often fake the data that requires time and routine work. For example, the students’ lists get falsely filled without conducting examinations or after examining only a few primary school students. Thus, many children are deprived of treatment and preventive health services, negatively affecting their future health.

## SPENDING, FINANCE, AND BUDGETS

Iraq's annual budgets are often delayed due to the sectarian and partisan quota policy in the parliament. It has become a political norm that the budget is not approved when there is a disagreement between the political parties that control the parliament. Therefore, the last approved budget was in 2021. The 2020 and 2022 budgets have not been approved as of the writing of this report. The government resigned at the end of 2019 after the October demonstrations in the same year. A new government was formed, and early elections were set. However, political tension followed the COVID-19 pandemic in 2020 and the failure to form a new government after the October 2021 elections.

Political forces tried to compensate for the absence of a budget. They approved Law No. 2 of 2022 for Emergency Support for Food Security and Development after the start of the Russian-Ukrainian war, especially with the rise in global oil prices and the increase in the Iraqi Central Bank's dollar reserves (البنك المركزي العراقي 2022). However, since the Ministry of Health and Environment is not accorded a "sovereign" status<sup>1</sup>, it is not considered a priority when forming the government using the partisan quota method, unlike the Ministries of Interior, Defense, Finance, Oil, and Electricity that have high budgets.

According to the World Bank, the share of the Ministry of Health and Environment was 2.47% of the total 2019 budget. Government spending on health in the same year represented 4.7% of total government spending and 4.5% of the GDP, which amounted to \$222.4 billion (The World Bank 2022b). The Ministry's share in 2021 was 2.11%. However, it is unclear whether this spending responds to the population's health needs, as it mostly goes to operating expenses such as the salaries of about 116,000 employees.

Despite the pressure on health services and infrastructure due to the COVID-19 crisis, the Ministry of Health and Environment's allocations decreased between 2019 and 2021. The decline is equivalent to roughly 880 million USD, considering the increase in the exchange rate between the USD and IQD, despite an additional 16 thousand new employees. Thus, the 2021 health budget could be considered operational only. According to the 2020 report, 98.2% of the Ministry of Health and Environment's spending was operational, i.e., salaries and supplies. Investment expenses amounted to a mere 1.8%, indicating the lack of strategic direction for the state to improve health services and

<sup>1</sup> Sovereignty Ministries is a term widely used by the government officials, political parties and media to refer to the 'important' ministries such as The Ministries of Interior, Defense, Finance, Oil, Electricity that take up most of the budget.

infrastructure. According to a report by the Minister of Health (العلوان 2019), improving the health infrastructure depends on investment expenditures.

**Table 1. Government expenditure on health**

Budget Year	No. Employees	Health Ministry Budget (1000 IQD)	Total Government Budget	Health Share of Total Budget	1000 IQD per US Dollar	Health Ministry Budget (USD)
2019	99,630	3,291,900,658	133,107,616,412	2.74%	1.200	2,743,250,548.33
2021	116,460	2,748,783,082	129,993,009,291	2.11%	1.475	1,863,581,750.51
Difference	16,830	- 543,117,576	- 3,114,607,121	- 0.36%	0.275	- 879,668,797.82

On the other hand, the security and military budget represents 18.14% of the 2019 budget, which points to the Iraqi government's neoliberal orientation in its spending, in line with the conditions of IMF and World Bank loans from 2015 when oil prices collapsed. In 2020, Iraq requested an additional IMF loan to mitigate the economic crisis and the collapse of oil prices during the COVID-19 pandemic. However, its request was rejected because it failed to implement its promises to reform the economic system, except for a small loan (\$98 million) to provide COVID-19 vaccines (The World Bank 2022c).

The austerity budget in 2021 tried to bridge the financial deficit by borrowing from multiple parties. However, the decrease in the Ministry of Health and Environment's budget between 2019 and 2021 is about 543 billion IQD (about 368 million USD). The actual decrease is much more significant, considering the decline in the IQD's value against the USD dollar. It is closer to 880 million USD if both budgets are compared using the applicable USD/IQD exchange rates. This drop came despite having to respond to the COVID-19 crisis.

The high military spending during the war against ISIL from 2014 to 2018 coincided with the fall in global oil prices and its ramifications on Iraq's largest source of income. Almost 94% of Iraq's Gross Domestic Product (GDP) comes from oil.

It also coincided with the internal displacement of more than five million people (Warda and Shihab 2021). Consequently, the Abadi government adopted austerity measures, including reduced spending on the health sector and increased reliance on foreign NGOs, the UN, and other international agencies. For example, the Iraq Humanitarian Fund covers health, other essential services, and legal and financial assistance.

In 2019, spending on health was around 151 USD per person, of which 78.5% was out-of-pocket (WHO 2020, p. 14) due to the country's lack of health insurance systems. Programs offered by some hospitals and private companies are merely a form of pre-payment for health services before they are needed. Thus, the most significant burden in obtaining health services falls on individual citizens, meaning their ability to access these services depends on their economic status. Meanwhile, low-income people are left without adequate healthcare and rely on government health facilities alone.

## HEALTH SERVICES AND ACCESS TO INFORMATION

Iraq's health policy and the Ministry of Health and Environment's directives aim to provide comprehensive health coverage. Iraq has 295 governmental and 155 private hospitals, at a rate of 1.2 beds per thousand people, providing secondary and tertiary health services. As for primary health care, 2,805 centers (وزارة الصحة والبيئة 2021) that provide regular care for children and pregnant women, including free vaccination, exist (وزارة الصحة والبيئة 2022). Moreover, in 2019, a special budget was allocated for purchasing medicines, independent of the Health Ministry's budget.

On the other hand, the public health insurance clinics that used to provide medications are generally inactive. They are remnants of the popular clinic system established during the economic blockade after the first Gulf War. After being incorporated into primary health care centers at a later stage, they became dispensaries for high blood pressure and diabetes medications.

Regarding access to health information, a unified electronic registration system for births, deaths, and civil status was established by National Card Law No.3 of 2016. Meanwhile, family primary health centers use a paper-based registration system for obtaining health services. Data on health services and communication between primary health centers and sector administrations in health departments are still mostly

paper-based and follow a system set by USAID. However, the information is also shared electronically between sectors, health departments, and the Ministry, which usually issues detailed annual statistics on the health services provided and the available infrastructure.

Nevertheless, data collection and codification contain many errors, either due to beneficiaries submitting inaccurate information or because the staff fills the fields in by default. Moreover, health centers and hospitals in several governorate health departments still depend on paper due to the staff's inability to use the electronic system. Therefore, the two systems are used in parallel. Although the periodic reports distribute data by region and gender, they do not include information related to economic, social, or educational status, for example.

## HEALTH WORKERS

Health and medical professionals must work in the public sector for at least three years of medical apprenticeship, based on the fourth amendment to the instructions of the Health and Medical Professions Law No. 1 of 2020. They may not work in the private sector except outside working hours exclusively and only after completing the apprenticeship. However, although the syndicates regulate practice licenses, the work of those completing their apprenticeship in the private sector is widespread and unregulated (WHO 2020). Health service providers rarely adhere to this law.

Moreover, the law instructions include sending professionals to villages and remote and rural areas lacking specialized health services. However, many use their connections to transfer to city centers, leaving those areas without adequate health services.

Most employees of the Ministry are nursing and health personnel, while doctors, dentists, and pharmacists represent about 13%. Moreover, the total number of employees mentioned in the Ministry's 2021 statistical report is 259,269 (except for the Kurdistan region), while the budget states 116,451 employees. The difference could be related to contractual employees not being included in the budget. However, the statistical report does not explain the issue.

# THE RIGHT TO HEALTH IN IRAQ: MAIN CHALLENGES

This section discusses three selected challenges and their impact on the right to health in Iraq today. It begins with environmental challenges related to climate change, such as water scarcity, heat waves, and dust storms. Then it moves to analyze the risks facing food security in Iraq. The third challenge concerns the impediments to accessing adequate health services and resulting inequalities.

## THE ENVIRONMENT AND CLIMATE CHANGE

In just two months during spring 2022, more than 11 dust storms hit the country. Most were severe and disrupted daily life activities and air travel, leading local governments to announce holidays for three days. Thousands of people went to the hospitals with respiratory problems, especially those more vulnerable due to factors such as asthma and allergies. The air is usually saturated with dust outside storm days as well, especially in the central and southern governorates. According to the Ministry of Health and Environment, the past 20 years averaged between 243 and 272 dusty days annually. The number is expected to reach 300 days annually in the coming years (Miri 2022). The term "allergies" is popularly used to refer to a broad spectrum of respiratory diseases caused by these pollutants.

Dust storms result from high temperatures and drought, as the last two years have witnessed low rainfall rates. Creeping desertification is another factor. Think Hazard states Iraq ranks first in high heat and water scarcity risks. These environmental factors are beginning to have an impact on Iraqi communities. The International Organization for Migration (IOM Iraq 2022) recorded the displacement of more than 20,000 people from 10 out of 18 Iraqi governorates due to environmental degradation and climate change. Most of them migrated from the countryside to the city.

Moreover, water levels in the Tigris and Euphrates rivers have dropped due to Turkish dams and Iran changing the course of tributaries (Khalaf 2019; Price 2018). In 2018 and 2019, the scarcity of potable water, the wave of poisoning caused by water salinity, and poor health services were the primary factors that triggered the demonstrations in Basra (International Republican Institute 2020). Water pollution

places tremendous economic pressure on families to provide safe drinking water. Selling water treated with reverse osmosis technology has become a natural part of daily life in most governorates and has become a common profession in the informal private sector. Although 85.7% of Iraqis have access to drinking water services, the water is usually unsuitable for drinking (UNICEF 2019, p. 275-293).

Climate change and environmental problems are major causes of disease in Iraq including respiratory problems, sunstroke, food poisoning, and cholera. The latter is endemic to the country and its prevalence in the summer of 2022 was higher than in previous years. The Ministry of Health and Environment took several measures, including banning certain types of food in restaurants to prevent cholera spread.

Such problems reduce the efficiency of services, which already suffer from structural problems. The pressure on health services during dust storms and heat waves reduces their ability to accommodate routine cases. Heat waves also put pressure on the electricity grid due to higher energy loss during transmission and the increased need for cooling. Water scarcity reduces drinking water quality and increases the need for treatment facilities.

Consequently, families are forced to choose economically costly alternatives due to pressure on services. To compensate for the lack of electricity supply hours, Iraqis spend about four billion dollars annually on private generators (خليفة الطواريء للإصلاح الاقتصادي 2020). Such expenditures extend to home reverse osmosis systems and filters, filtered or packaged water, and more efficient cooling devices in high-temperature conditions. As a result, lower-income families living in densely populated areas face unprecedented challenges that expose them to health risks. Moreover, since lower-income workers usually operate in open spaces and exert physical effort, such as in construction and agriculture, they are at a greater risk of direct environmental effects.

On the other hand, awareness of climate change's effects and dangers has grown recently. CSOs started focusing on the issue, encouraged by the change in donor policies. More recently, the government has started to pay more attention to climate change. It ratified the Paris Agreement in 2021 and launched the Ministry of Planning's work on a Green Paper to confront climate change (IOM 2022). However, government efforts in this regard remain very limited, without a clear impact, and rarely link climate change and pollution to health.



Pollution, especially in water and air, is a major environmental factor that negatively impacts health. For example, Iraq ranked ninth out of 117 countries in the IQAir (2022) index for the most air-polluted countries in 2021. In addition to dust, air pollution is also caused by private electricity generators, estimated at 4.5 million generators by the Iraqi Energy Institute, the 7,027,000 cars counted by the Ministry of Planning in 2020, oil wells, refining stations, and factories, most of which operate using archaic systems.

On the other hand, water pollutants include sewage waste dumped in rivers. For example, the sewage disposal site is located in Najaf on the Euphrates River, about a kilometer and a half before the water filtration plant, increasing the risk of drinking polluted water. Regarding factory waste, Shatt al-Arab, for example, recorded high levels of heavy metal pollution between December 2012 and January 2013, during which pollution is usually lower than in summer when the water level is low (Al-Hejuje, Hussain, & Al-Saad 2017).

## ■ FOOD SECURITY

Although Iraq's population increased by 66% from 2000 to 2019, domestic food production increased by only 40%. The urban population doubled in the same period due to migration from the countryside to the city (Fathallah 2020), especially among those searching for government jobs. Agriculture was left behind and has become economically insignificant due to outdated irrigation systems and scarce water. Agricultural land owners close to cities convert their land into residential areas and sell them illegally. Contrariwise, the government neglects the Ministry of Agriculture. It received only 0.32% of the 2021 budget spent on salaries and purchasing local crops without clear development plans.

Iraq is a net importer of essential food items and other food products. Thus, the Russian-Ukrainian war increased local prices, especially of oil and grains (WFP 2022), prompting the Iraqi parliament to pass the emergency support law for food security. However, the law compensated for the absent annual budget rather than supporting food security. The share the parliament allocated to the Ministries of Agriculture and Trade remained low.

The decline in agricultural production and increased food prices impose additional economic pressure on low-income people and vulnerable groups, especially those below the poverty line. They become exposed to the risks of malnutrition or spending

more on food, which prevents them from obtaining other services and meeting other essential needs. Moreover, food products are mainly imported from neighboring countries. The imports go through a corrupt customs process, spreading expired products. One of the priorities of the Al-Kazemi government was to fight customs corruption indicating its significance.

At the local level, public health departments in the governorates' health directorates are responsible for following up on food security. They monitor restaurants, cafes, and markets, issuing health licenses and conducting inspections. Local news often contains reports on destroying large quantities of expired food products.

## ACCESS TO HEALTH SERVICES

The public and private sectors provide health services in Iraq. Services in the public sector are subsidized by the state, especially in primary and secondary care, where the cost does not exceed 3,000 IQD or about 1.6 USD. Emergency services are also covered (وزارة الصحة والبيئة 2022). All health workers are employed by the state, including doctors and nurses. In the private sector, most health workers work part-time in addition to their public sector jobs.

Private health services are considered expensive by Iraqi standards. The sector is divided into three sections: private units within hospitals and public centers, private hospitals and centers, and unorganized private clinics and pharmacies. In both sectors, the distribution of hospitals and health centers does not conform with population density. For example, New Baghdad, home to around one million people, has no hospital.

Access to quality health services depends on income since a high proportion of spending is out-of-pocket due to the lack of a proper health insurance system. Thus, public health services are limited to essential procedures, often of a lower quality than what can be obtained in the private sector. Ironically, private departments in government hospitals are usually cleaner and provide better services than the ones provided by the same hospital, mainly due to the additional financial incentives and fixed government salaries.

Consequently, vulnerable classes, those below the poverty line, those with limited incomes, and even the lower middle-income groups are highly dependent on public services. Simultaneously, higher income groups can obtain higher quality services from

the private sector. They can also travel to other countries such as Lebanon, Iran, India, Turkey, and Jordan for treatment, which is not usually reimbursed by the state.

Health providers have lost the trust of beneficiaries, who are deprived of their rights in the public sector and usually exploited by the private sector. Meanwhile, public health workers believe they are confined by routine, lack of funding, financial corruption, lack of space to grow, and fixed salaries regardless of the quality and quantity of services. The frustrating situation for beneficiaries and workers in the public sector has usually led to tensions and aggression. Health workers are subjected to daily attacks by unsatisfied beneficiaries. In fact, 22% of health workers in Iraq left the country between 2004 and 2007 due to violence and threats (Burnham, Riyadh, & Shannon 2009), which affected 80% of doctors in emergency units (Donaldson et al. 2012).

The absence of transferable medical records between the public and private sectors also hampers access to health. Health service providers often start from scratch with each patient, starting with the medical history and other information that relies entirely on the patient's memory, increasing the chance of inappropriate or repetitive interventions and, thus, failure. The private sector is also highly disorganized and lacks structured communication channels between its providers.

In addition to the above, women and girls are often deprived of access to adequate health services due to prevailing gender and social norms. For example, married rural women and those from religious families often consult gynecologists for all health matters to avoid going to a male doctor. Moreover, despite improving women's access to health services overall, the gap between rural and urban areas has increased dramatically (Abdulrahim & Bousmah 2019), mainly due to patriarchal gender norms. For example, hospitals often deny women of surgical procedures without the consent of a male family member, fearing tribal retribution. Furthermore, some medical specialties, such as surgery and orthopedics, are male-dominated, thus preventing some women from accessing their services.

Domestic violence is also a major challenge in the absence of a law protecting victims of abuse. Husbands sometimes prohibit their wives from leaving the house to receive medical care or refuse to give them the documents needed to obtain a health card. The author of this report encountered such cases repeatedly in primary health care centers in crowded

areas. However, health staff are not sensitized on the issue and cannot rely on legal procedures or referral systems. Many cases of domestic violence have been condoned or mocked in such centers. The term "hysteria" is also still widespread in emergency units. Despite being eliminated from medical textbooks and practices long ago, emergency health workers use it as a preliminary diagnosis until an alternative is proven, leading to fatal medical errors.

Finally, challenges related to access to mental health services are the most severe in the absence of adequate infrastructure and personnel. According to the WHO (2019), there are less than two mental health professionals for every 100,000 Iraqis. The situation is made worse by the social stigma preventing people from seeking services. However, two types of services are provided. The first is psychosocial support, where NGOs provide relatively good services. The other option is psychiatry and medication.

## CONCLUSIONS AND RECOMMENDATIONS

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The availability and quality of health services in Iraq suffered greatly due to the violent conflicts and many wars it witnessed, hindering the ability to achieve the right to health for all. The period after the Second Gulf War and the ensuing international sanctions dealt a harsh blow to the health of Iraqis. The country is still reeling under the wars' impacts, such as the destruction and deterioration of infrastructure, the culture of aggression between beneficiaries and healthcare providers, and the rampant administrative and financial corruption in state institutions and the private sector. As a result, right-to-health indicators recorded low values. The rentier nature of the state's economy also established a harmful dependence on state provisions, which barely cover the operating expenses of inadequate facilities.

Structural problems persist, such as the absence of a unified and digitized medical and health records system, the lack of integration between public and private sector services, the largely unorganized private sector, and the lack of an efficient health insurance system. The impact on vulnerable groups is severe. In parallel, environmental challenges are multiplying. Unless the government prioritizes it, Iraq is expected to be one of the countries most severely impacted by climate change.

Following are some recommendations to address the challenges discussed above:

### **To state institutions:**

- Prioritize the Health Insurance Law No. 22 of 2020 implementation in relevant state entities, especially the Ministry of Health and Environment, to provide fair access to health services in the public and private sectors.
- Establish a unified, electronic medical record system for individuals that can be transferred, updated, and shared. This could increase the integration of health and medical services between the public and private sectors.
- Increase attention to health issues with social stigma, primarily mental and psychological health, and domestic violence in health and education plans and through government spending.

- Develop urgent plans to deal with climate change and pollution threats and intervene immediately due to the enormous impact on human health and security.
- Provide greater flexibility for health workers to move between the private and public sectors to improve health services; and activate and modernize continuing medical education systems.
- Understand and address the barriers that prevent women and girls, especially in rural and slum areas, from accessing health services. This should be combined with analyzing the economic, social, environmental, and cultural factors that threaten their right to health.

**To civil society organizations and unions:**

- Intensify advocacy efforts with the relevant state entities and hold them accountable to provide the right to health for all. This includes the urgent implementation of the health insurance system, focusing on mental and psychological health, addressing the dangers of climate change, and developing laws and procedures to guarantee the right to health for individuals and groups beyond health services and without discrimination.
- Advocate for adopting a Domestic Violence Law and referral systems that may contribute to saving victims, women and children in particular, and protect health service providers who report such cases.
- Advocate with international bodies to pressure the Iraqi government to address the priorities above and provide the necessary funding for issues related to the right to health, in line with the SDGs.
- Contribute to spreading the culture of the right to health, preserving the environment, and dealing with the dangers of climate change at the community level.
- Facilitate mechanisms for joint action between the government, civil society, and local communities on challenges to the right to health, and set indicators to measure progress and produce periodic reports.
- Provide non-traditional methods of mediation between health sector workers and beneficiaries to address the aggressive interactions by promoting peaceful alternatives and such as communication skills.

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  - Law of the Federal General Budget of the Republic of Iraq for the fiscal year 2021, No. 23 of 2021.
  - Law No. 6 of 2000 on the Apprenticeship of Medical and Health Professions.
  - Ministry of Health Law No. 10 of 1983.
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# FACILITATORS AND BARRIERS TO REALIZING THE RIGHT TO HEALTH IN JORDAN

## Hamza Alduraidi, MPH, PhD

Associate Professor of Public/Community Health Nursing, The University of Jordan

Dean of Student Affairs at Aqaba Medical Sciences University, and faculty member in Basic Medical Sciences Department; Associate Professor in Community Health Nursing Department at the School of Nursing at the University of Jordan, and a member of the Accreditation Committee of the Jordanian Nursing Council (JNC). Al Duraidi has published many papers on public/community health topics, particularly on refugee health.

## FOREWORD

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I am honored to be commissioned to write this report on the Right to Health in Jordan due to my previous experiences in public health, the health of vulnerable groups such as the refugees and displaced, and the social determinants of health. Work began in Summer 2022 and was completed in March 2023.

In writing this report, I was keen to involve experts, relevant authorities, and ANND partners in Jordan and not be limited to the practical aspect of health services in Jordan. Instead, the report seeks to provide a comprehensive description and analysis of the political, legal, and social factors related to the right to health in Jordan. The report also considered the diversity of data sources, entailing a comprehensive desk review of publications, reports, and records of organizations involved in the right to health in the country. Finally, an in-depth discussion was held with partners and relevant authorities, and individual interviews were conducted with experts.

The above methodology allowed the report's findings and recommendations to be more objective, diverse, and comprehensive of the health situation in Jordan in its various aspects. In conclusion, I am pleased to present to you this report, hoping that I have been successful in describing and analyzing the Jordanian reality concerning the right to health, identifying the most urgent gaps and challenges, and proposing appropriate and implementable recommendations that would enhance the right of Jordanians to obtain the health they desire, which meets their needs and takes into account their privacy and priorities, within a fair and solid health system.

# INTRODUCTION

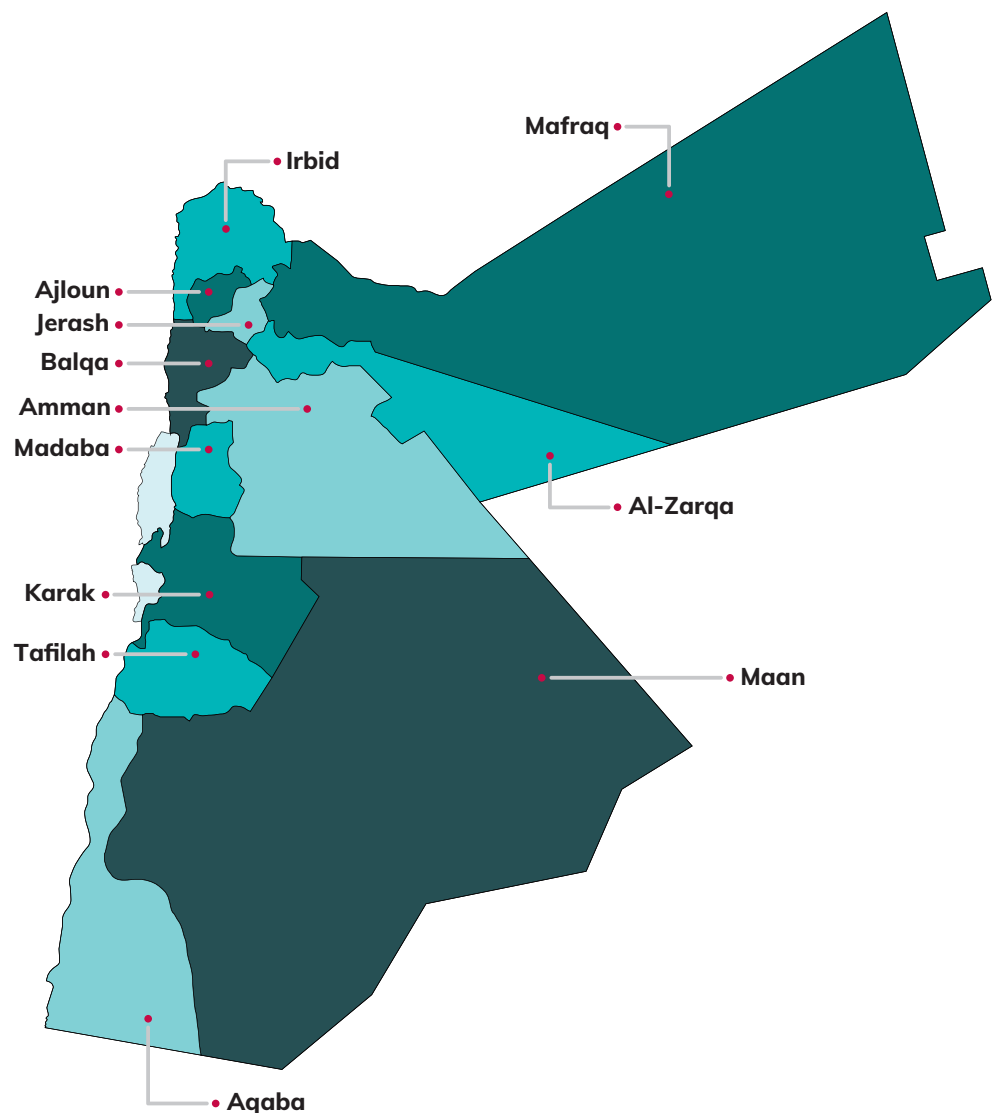
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## I NATIONAL CONTEXT

The Hashemite Kingdom of Jordan, whose capital is Amman, is an Arab country located in the eastern Mediterranean region in West Asia. Jordan covers an area of about 89 thousand square kilometers. It is bordered to the north by the Syrian Arab Republic, to the northeast by the Republic of Iraq, to the east and south by the Kingdom of Saudi Arabia, and the west by the occupied Palestinian territories. Jordan has a population of over 11 million, of whom approximately 38% live in the capital.

Administratively, Jordan is divided into 12 governorates (**Figure 1**), four of which (Irbid, Mafraq, Jerash, and Ajloun) make up the northern region, and four (Amman, Balqa, Zarqa, and Madaba) form the central part. The remaining four (Karak, Tafila, Ma'an, and Aqaba) comprise the Southern Region, with the widest area and the fewest people. Moreover, 750,000 of the country's population are refugees, mostly Syrians concentrated in the Central and Northern regions. Figures also indicate that there are at least a million and a quarter non-Jordanian residents who are not refugees, primarily of Arab nationalities, such as Egyptian, Palestinian, and Iraqi.

Figure 1. Jordan's governorates



The Jordanian state was established in 1921 at the end of World War I under the name "Emirate of Transjordan". It remained under British mandate until its independence in 1946 after World War II. The state's name was changed to "The Hashemite Kingdom of Jordan" under the rule of the founding king, Abdullah I Ibn Al-Hussein. King Abdullah I Ibn Al-Hussein was succeeded by his descendants and in 1999 the throne was inherited by King Abdullah II Ibn Al-Hussein. The system of government in Jordan is a representative, constitutional monarchy, as stipulated in the 1952 Jordanian Constitution, where the King is the head of the state and heads the executive branch. In 1955, Jordan joined the United Nations and was one of the founding countries of the League of Arab States in 1945 (وكالة الأنباء الأردنية (بترا) 2022).

Water and electricity lines reach more than 95% of Jordanian homes, while the sewage network connects only two-thirds of homes. Education in Jordan is compulsory and free up to the tenth grade. Jordan has the highest education rate in the Middle East and a literacy rate of 95%. Notably, Jordanians spend the most on university education out of all Arab counties, as nearly 200,000 students are enrolled in 23 Jordanian public and private universities, in addition to 20,000 others receiving their university education abroad.

Jordan is classified as a low-income country, with a per capita GDP of approximately 1,640 dinars ( $\approx$  2,300 USD). However, according to government figures in 2022, it suffers from high unemployment rates (22.6%) and poverty (24.1%). Moreover, Jordan suffers from a scarcity of fossil energy resources such as oil and natural gas. It is also one of the poorest countries in the world in terms of freshwater resources. The per capita share of water is 156 cubic meters annually, compared to the global water poverty line of 1,000 and the global absolute water scarcity line of 500 cubic meters per year per person (وكالة الأنباء الأردنية (بتر) (2022)).

## **OBJECTIVES**

Jordan has taken appropriate steps to improve the health situation of its population and has achieved remarkable progress in many health indicators, including neonatal mortality, under-five mortality, vaccination rates, health insurance coverage rates, and access to water and electricity services in various regions. In recent decades, however, the country has been negatively affected by several economic and social factors that delayed or obstructed successive governments from continuing to implement measures aimed at securing the right to health for citizens. Thus, a comprehensive review of the issue of the right to health becomes necessary. As a result, this report was prepared to shed light on the right to health in Jordan in an integrated and comprehensive manner, providing several recommendations for its promotion in the country.

The report offers decision-makers involved in the right to health in Jordan a summary of the lived health situation in the country and an objective analysis of its economic, social, political, and legal aspects. It also presents an overview of expert and stakeholder opinions in the form of recommendations that could be implemented in the foreseeable future by health

decision-makers. Undoubtedly, this report comes at a sensitive time, when Jordan is just beginning to recover from the COVID-19 pandemic and the weaknesses it revealed in the Jordanian health system. It also coincides with the Kingdom's second centenary as a country, and a comprehensive vision for development, modernization, consolidation of achievements, overcoming obstacles, and correcting mistakes in all sectors, including the health sector serving more than 11 million residents.

On the other hand, the report could be used to draft appropriate policies to improve the procedures necessary to implement the right to health for Jordanians and other residents of Jordan. Accordingly, the main bodies that may find this report useful are Jordan's legislature, including both parts of the National Assembly, the Senate, and the House of Representatives. Likewise, the executive authority, including government agencies such as the Ministry of Planning and International Cooperation, the Ministry of Health, and the Ministry of Social Development, may find this report helpful in identifying and addressing needs, such as health services, goods, and facilities. In addition, it could be used by international organizations and non-governmental organizations (NGOs) involved in human rights and health issues in Jordan to determine their program priorities. Finally, academic, research, and media institutions interested in the right to health in Jordan may find a comprehensive source of information in this report, including findings and recommendations, which may constitute relevant material to study, analyze, and follow up on in the coming years.

In summary, the report aims to provide an accurate description and analysis of the status of the right to health in Jordan by addressing the health system's economic, social, political, and legal aspects, investigating available health services and facilities, reviewing relevant literature, reports, and data, and surveying the opinions of experts and stakeholders. The report highlights the following issues:

1. The health situation in Jordan in terms of legislation, governance, sustainable development goals, and human, material, and technical health resources.
2. The challenges faced by the health system in Jordan, particularly the gaps in legislation, financing, governance, access, and quality of healthcare.



3. Expert and stakeholder recommendations for realizing the right to health in Jordan.

## HISTORICAL OVERVIEW OF JORDAN'S HEALTH SYSTEM

Since its establishment in 1921, the Jordanian State has sought to provide welfare for its people, including in the health sector. The health sector witnessed continuous development over the past hundred years of the state's history. The first directorate of health was established in the first decade, with a budget of 11,000 Jordanian dinars (JODs). The first law regulating health affairs was issued in 1923. In 1926, the first government hospital was established and opened with a capacity of 20 beds, and the number of doctors reached 28. Development of the health system continued into the second and third decades. Consequently, more hospitals were opened, bringing their number to seven in 1946, while the number of doctors exceeded 124. Furthermore, the Ministry of Health was established in 1950. In the following decades, the Jordanian health sector witnessed significant advances at the legislative, administrative, and financial levels. In 1972, health union laws were enacted. Health directorates and hospitals spread to cover all governorates. The health budget continued to rise until it reached about 6 million JODs for 8,659 beds in the late nineties (وزارة الصحة الأردنية 2022).

The new millennium witnessed more development, reflected in Jordan's health indicators. In 2017, Jordanians' average life expectancy at birth was about 73 years (74.4 years for women and 71.6 years for men), the newborn mortality rate decreased to 11 per 1,000 live births, and the under-five mortality rate decreased to just 19 per 1,000 live births. The number of hospitals in Jordan also increased to 118, with a total capacity of more than 15,000 beds in 2020, distributed as in **Table 1**. However, private-sector hospitals are primarily concentrated in major cities such as Amman, Irbid, and Zarqa (الموقع الرسمي لمئوية الدولة الأردنية 2022).

**Table 1. Number of hospitals in Jordan by sector (2020)**

Health Sector/ Year	2020		
	No. of Hospitals	No. of Beds	%
Ministry of Health	32	5251	35.0
Medical Services	15	3154	21.0
Jordanian University	1	625	4.2
Founder King Abdallah Hospital	1	558	3.7
Private Sector	69	5415	36.1
<b>Total</b>	<b>118</b>	<b>15003</b>	<b>100.0</b>

Source: [www.moh.gov.jo](http://www.moh.gov.jo)

Primary healthcare services are provided in primary care centers available in all governorates and regions. They provide free services to citizens. The development in primary healthcare services is evident in the vaccination rate against infectious diseases, which exceeded 98% in 2022, compared to 90% in 2000. In 2021, there were 121 comprehensive health centers, 366 primary care centers, 187 subsidiary centers, 502 mother and child clinics, and 440 dental clinics, distributed according to population density across the different regions of the Kingdom, urban, rural, and desert. Other developments include launching a disease monitoring system, improving the national vaccination program, amending the Public Health Law of 2008 to meet emerging health needs in Jordanian society, and adopting the Medical Accountability Law of 2018 (2022 الموقّع الرسمي لمئوية الدولة الأردنية). Recently, the National Center for Diabetes, Endocrinology, and Genetics and the Center for Stem Cell Therapy were established. Pioneering and advanced health services and technologies such as cochlear implants for treating deafness and liver, kidney, and heart transplants were also set up.

Hospitals and health facilities' records and transactions were digitized through the "Hakeem" program, a national electronic health (e-health) program. The Ministry of Health implemented its electronic medical records program, and a hotline and

interactive electronic reporting system were launched to monitor communicable and non-communicable diseases and mental illnesses. Indeed, many innovative applications were adopted that provided generous assistance in contact-tracking and organizing home quarantine, patient rooms, and intensive care during COVID-19 (الموقع الرسمي لمئوية الدولة الأردنية 2022).

In terms of human resources for health, physicians are distributed at a rate of 32 per 10,000 people, one of the highest ratios in the world. However, human resources, especially specialists, are not equitably distributed among the various regions. Official figures show a significant concentration of specialized health professionals in major cities in the central and northern areas, while the peripheral regions, especially the southern region, suffer from a shortage in many specializations.

Since 1972, Jordan witnessed the establishment of unions organizing workers' affairs in the health professions, such as doctors, nurses, pharmacists, and dentists. The High Health Council, the Jordanian Medical Council, and the Jordanian Nursing Council partner with the Ministry of Health for optimal strategic planning for the health professions and organize licensing, training, and professional development affairs. The country also benefits from many universities and university colleges offering professional diplomas and bachelor's programs in health professions, higher specialization, and postgraduate health programs. They are assisted by two academic hospitals, namely the Jordan University Hospital in the capital, Amman, and King Abdullah I Hospital, affiliated with the Jordan University of Science and Technology in Irbid governorate in the north (الموقع الرسمي لمئوية الدولة الأردنية 2022).

In 2022, health insurance covered 72% of Jordanians, according to the Health Insurance Directorate at the Ministry of Health. However, the source does not contain data related to people with multiple insurance or insurance rates among resident non-Jordanians. The official figures also do not include demographic details on the 28% of uninsured Jordanians. Likewise, official statistics do not describe the services provided to people covered by insurance with regards to medicines, consultations, surgical and non-surgical procedures, and the like.

Notably, Jordanians over 60 and children under six are covered free of charge by public health insurance. The social safety net covers those whose monthly income is less than 300 JODs, benefiting about 300,000 citizens through public health insurance. According to officials, the government is working to

expand the health insurance to include all citizens. However, several obstacles exist, including lack of funding, overlapping authority, and difficulties obtaining updated and accurate insurance data (دائرة الإحصاءات العامة 2018).

## **SOCIAL, ECONOMIC, AND POLITICAL FACTORS RELATED TO THE RIGHT TO HEALTH**

The right to health in any country is impacted by many social, economic, political, and legal factors, and cannot be viewed in isolation from socioeconomic (such as income and education levels), political (such as efficiency, quality, and governance), and legal (such as laws and regulations related to health) determinants. In its eighteenth annual report in 2021, the Jordanian National Center for Human Rights (المركز الوطني لحقوق الإنسان 2021) stressed that the right to health is a human right guaranteed by international covenants, regulated in Jordan by a set of laws, and based on a set of elements such as access to health; the availability of health facilities, goods, and services; their cultural and moral adequacy; their quality; the participation of users in drawing health policies; and accountability.

The National Center for Human Rights report presents several factors closely related to realizing the above elements. It links the right to health with the socioeconomic status of individuals in Jordan, including poverty and unemployment. It also connects the right to health with state policies – especially concerning spending on healthcare, the impact of the large numbers of refugees, the high cost of securing their needs, and health-related legislation and laws (المركز الوطني لحقوق الإنسان 2021). The factors most closely related to the right to health in Jordan are summarized below.

### **■ POVERTY AND UNEMPLOYMENT**

Poverty and unemployment have persisted, especially in the last two decades, which saw global and regional instability, contributing to a decline in Jordan's economic situation. The Arab Spring, ushering in the second decade of the new millennium, led to significant shifts in the political and social map of Arab countries, including changes in their economic resources. For example, tourism revenues decreased, and the attitudes of international donors and lenders changed. The situation resulted in giant waves of displacement and persons seeking asylum, a significant share of whom came to Jordan

that followed an open-door policy to refugees, mainly from Syria, where the Arab Spring turned into a protracted conflict, forcing millions to flee for their lives to neighboring countries. Before that, Jordan had suffered the repercussions of the “global real estate crisis” in 2008 and 2009, which ravaged financial markets and unbalanced the economies of many countries, negatively affecting the map of money and business.

Likewise, the COVID-19 global pandemic reached Jordan in March 2020. Over two and a half years, it exhausted the country’s economy directly (due to the disruption of production and the cost of mitigating the pandemic) and indirectly (due to the cessation of several economic activities supporting the budget, one of which is tourism). Finally, the Russian-Ukrainian war broke out in 2022, leading to a significant increase in the prices of Jordan’s main imports, such as wheat and other foodstuffs, adding more troubles to the Jordanian economy, which was barely recovering from the consequences of COVID-19 at the time.

These successive economic problems did not help Jordanian governments to solve poverty and unemployment. On the contrary, both poverty and unemployment were exacerbated in light of these difficult circumstances, with poverty and unemployment rates reaching unprecedented records. In 2022, the percentage of Jordanians below the poverty line reached 24.1%, and the unemployment rate reached 22.6%, according to Jordanian government figures. Health insurance for adults is closely related to their access to job opportunities that secure them with adequate coverage. Furthermore, a high percentage of the population—citizens and non-citizens—in the informal sector (known as the daily sector) are often unable to work, and thus do not have the privilege of health insurance, which is usually obtained based on the nature of the job.

Accordingly, the high unemployment rates and number of daily workers are generally associated with low health insurance coverage for them and their dependents. Research also indicates a significant association between low-income levels and the decline in health outcomes for individuals and families. Accordingly, the poverty experienced by increasing segments of Jordan’s population negatively impacts their physical and psychological health (المجلس الوطني لشؤون الأسرة 2018).

### ■ THE RISING COST OF HEALTHCARE AND INCREASED SPENDING

The tremendous progress in medical technology worldwide in the modern era was accompanied by a steady rise in the cost of healthcare and a tangible increase in related spending. Thus, many advanced medical treatments and procedures cannot be provided to those who cannot pay (ميدكس-جوردان 2022). This significant increase in the cost of healthcare has a highly negative economic, social, and moral impact. The high cost of some medical procedures and treatments may explain, to some extent, the low rate of health insurance coverage in Jordan (72%), especially among the poor. On the other hand, the high cost of health services may lead to poverty for many middle-income people who are forced to spend a large proportion of their savings or income to obtain the necessary healthcare for themselves or for their family members who suffer from chronic or complex health problems or who need expensive treatment or surgeries.

In 2021, the number of people affected by poverty globally due to the cost of healthcare was estimated at 150 million (ميدكس-جوردان 2022). Various types of health insurance schemes emerged to counter the considerable increases in the price of health services. Some of them are borne by employers, and some by governments. However, the latter is an additional burden on the economies of low-income countries, such as Jordan, which is passing through critical economic conditions that reduce its ability to provide health as a right for all citizens and residents.

Since the early twentieth century, Jordan has received several waves of refugees due to its relative security and stability, its people's hospitable nature, and the political leadership's open-door policy. The number of refugees in Jordan today is estimated at more than 2 million registered Palestinian refugees, about 700,000 registered Syrian refugees, and tens of thousands of Libyans, Yemenis, Sudanese, and others (UNHCR 2022). There are also hundreds of thousands of unregistered refugees, estimated at nearly twice those officially registered. According to some estimates, the total number of all refugees in Jordan reaches 3.8 million. It is worth noting that only 18-20% of these refugees live in official camps. In contrast, most refugees are scattered in communities in Jordan, often in the poorest areas and the most in need of services (Alduraidi et al. 2018).

Accordingly, the health facilities and services provided to Jordanian citizens must also serve the needs of refugees living in Jordanian cities and towns. Although several health units and centers are operated by UNRWA, UNHCR, and other INGOs, they do not meet all the health needs of refugees (primarily secondary and tertiary care) (Saleh et al. 2022). International and regional aid provided to Jordan to support the country in addressing the needs of refugees has decreased, reaching less than 25% of the required amount in 2020 (UNHCR 2022). Therefore, refugees have burdened the Ministry of Health facilities, which are already crowded with Jordanians.

### ■ COVID-19 PANDEMIC

Like the rest of the world, Jordan was struck by the consequences of the COVID-19 pandemic. The first infections were recorded in the country in the Spring of 2020, and cases continued to increase in successive epidemic waves. The Jordanian health system—especially the government health sector—suffered greatly from the direct consequences of the pandemic. The pandemic revealed a great need for medical and nursing specialties qualified to deal with epidemics, isolation rooms, intensive care beds, and artificial respirators. As a result, the Jordanian government was forced to rent buildings from some private hospitals to cover the massive deficit in its facilities.

Furthermore, the response to the pandemic fell almost entirely on the public sector. The private sector's contribution was poor and limited. At a later stage, the government addressed the matter in cooperation with the armed forces and other parties, establishing several field hospitals in the country's three regions. These hospitals eased the burden on government and private hospitals designated to receive COVID-19 patients. They also bridged the geographical gap in the distribution of qualified centers and secured vaccination for the population in all their coverage areas.

Moreover, the vaccines arrived in Jordan in small batches at first, then grew to cover the vaccination needs of the population, including refugees. In mid-2021, a good proportion of the population had received the two doses, leading to a decline in outbreaks and a gradual return to normalcy. The pandemic drained most of the Jordanian health system's resources and halted development and expansion plans for health facilities and services for nearly two years. The impact of such developments on the right to health in Jordan was severe.

## METHODOLOGY

The report utilizes a mixed descriptive analytical methodology, which combines quantitative and qualitative aspects of data collection for more objective analysis and reliable results. The methodology included three stages: a stakeholder workshop involving representatives of public and private health and human rights establishments in Jordan; a comprehensive desk review of right-to-health-related literature, reports, publications, and statistics; and individual interviews with several individuals with experience and extensive knowledge of the country's health affairs. The three stages are described below.

### STAKEHOLDERS WORKSHOP

The Stakeholders Workshop was held in July 2022, hosted by the Jordanian Women's Union in Amman. It involved representatives of official and unofficial bodies and actors interested in the right to health in Jordan, including the Jordanian Women's Union, the Phenix Center for Economic & Informatics Studies, the Association of the Women's Solidarity Institute, the University of Jordan, and several independent individuals interested in human rights and health issues in the country. Participants were invited to express their opinions and provide recommendations and proposals regarding the reality and future of the right to health in Jordan and to contribute to setting the report's priorities. The participants' priorities in relation to the right to health in Jordan varied, according to their positions. Interventions and discussions during the workshop were documented to be analyzed and summarized later. Discussion outputs served as a starting point for defining the main report themes. Ideas were exchanged in an interactive and organized manner through continuous brainstorming. The discussion revolved around four main issues: assessing the right-to-health situation in Jordan, stakeholder demands, challenges to the right to health, and the report's priorities.

### DESK REVIEW

The desk review included websites, literature, publications, reports, scientific papers, and press articles on the right to health in Jordan from 2018 to 2023, from several sources,



including the Jordanian government, private agencies, international organizations, NGOs, news agencies, newspapers, and scientific and academic articles. **Table 2** lists the sources surveyed during the desk review.

**Table 2. Sources surveyed in the desk review**

Government	Civil Groups	International	Independent
Jordanian constitution	National Center for Human Rights	DHS Program: Jordan Population & Family Health Survey	Med x Jordan
Health laws	Jordanian Women's Union	The United Nations SDGs	Human Rights Library-University of Minnesota
Ministry of Health	Phenix Center for Studies	WHO	7iber Media Corporation
Department of Statistics	Women's Solidarity Institute	The World Bank	Zoubi 2020
Economic and Social Council	Health Coalition for Patient Protection	UNHCR	Saleh et al., 2022
Higher Population Council	Health Professions Unions	UNRWA	Dureidy and Waters, 2018
National Council for Family Affairs	Earth Foundation		
Health Insurance Directorate	Civil Society Knowledge Center		
Jordan News Agency (Petra)			

## EXPERT INTERVIEWS

The third stage of the report's methodology involved expert interviews. Thus, individual interviews were conducted with experts who formerly occupied or are currently occupying positions of responsibility in Jordan's health system. The interviews lasted between 40-60 minutes each and discussed several themes regarding the right to health in Jordan and related strategies. The interviews were recorded and analyzed using appropriate tools. **Table 3** describes the profiles of the interviewed experts and their current or former positions.

**Table 3. List of interviewed experts**

Participant	Expert's Position
1	Current member of Parliament, physician, and member of the Parliamentary Health Committee.
2	Former Senate member, member of the Higher Health Council, academic in the field of nursing.
3	Current Ministry of Health official.
4	Head of a civil rights organization.

## RESULTS

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The next section analyzes the data collected in the three phases above. The section is divided into two main themes: the health situation in Jordan (right to health legislation, governance, SDGs, and the available financial, human, and technical resources) and its challenges (gaps in legislation, financing, governance, and healthcare access and quality).

### HEALTH SITUATION IN JORDAN

#### RIGHT TO HEALTH LEGISLATION

Multiple health-related legislation in the country was identified. Although considered modern and advanced, the 1952 Jordanian constitution and its amendments do not explicitly mention the "right to health," except for the 2011 constitutional amendment, adopted under popular pressure at the beginning of the Arab Spring. Paragraph 5 was added to Article 6 of the Constitution and reads: "The law protects motherhood, childhood, and old age, takes care of young people and people with disabilities, and protects them from abuse and exploitation." Experts believe that the legislative authorities' failure to explicitly stipulate that the state guarantees the "right to health" for its citizens may be linked to its fear of incurring a cost it may be unable to meet. Moreover, although Jordan signed the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1972 and ratified it in 1975, it did not present it to the National Assembly to make it enforceable.

On the other hand, the health system in Jordan operates according to a set of other legal and regulatory texts, including:

- Public Health Law (2008) and its amendments.
- Medical Liability Law (2018).
- Higher Health Council Law (1999).
- Health Professions Syndicates Laws (1972) and their amendments.
- Laws of the Jordanian Medical Council (2005) and the Jordanian Nursing Council (2006).

- The Food and Drug Administration Law (2008).

Along with other legislative texts, the above laws govern the health system's functioning and define the executive responsibilities of governmental and non-governmental agencies. They also regulate health professions, such as medicine, dentistry, pharmacy, nursing, midwifery, and allied medical professions, regarding registration, licensing, continuing education, and professional development. Moreover, they regulate the practice of health professions and specializations, medical studies, studies related to food and medicine, public health, narcotic drugs, smoking, and other health issues. These regulations contribute to the fair organization of the health sector's various components and, thus, indirectly influence the realization of the right to health in Jordan. In parallel, legislative authorities are constantly making the necessary amendments to the laws regulating the health sectors based on scientific, social, legal, and political advances to serve the interest of health service recipients and guarantee their rights.

#### ■ HEALTH SYSTEM GOVERNANCE

Jordan's Ministry of Health plays the most influential role in the health sector's governance. However, the sector extends to several partners contributing to governance and healthcare services. The health sector in Jordan consists of several sectors which provides health services, namely:

- The public sector, which includes the Ministry of Health, the Royal Medical Services, and university hospitals: Jordan University Hospital, King Abdullah I Hospital, and the Diabetes, Endocrinology, and Genetics Center.
- The private sector, which includes hospitals, diagnostic and treatment centers, and hundreds of private clinics and pharmacies.
- The International Organizations Sector provides its services through UNRWA and UNHCR clinics.
- The NGO sector provides its services through some charitable hospitals, such as Al-Hussein Cancer Center, the Islamic Hospital, Noor Al-Hussein Foundation and Caritas, as well as the Jordanian Association for Family Planning, and other charitable clinics.

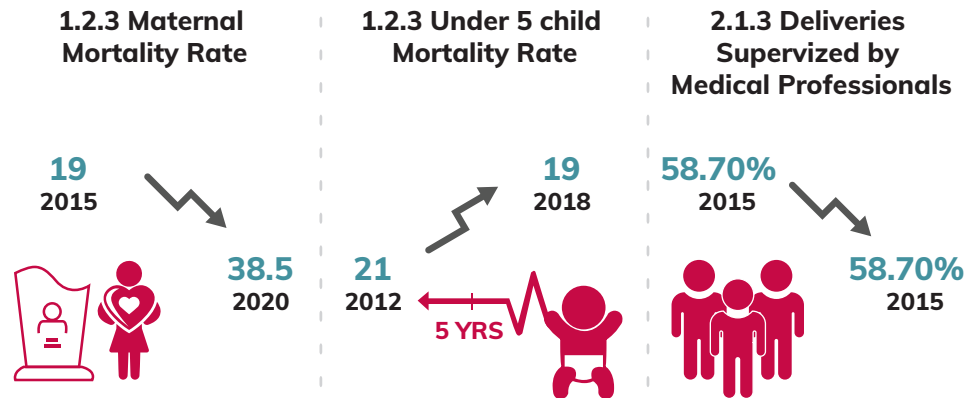
- Other institutions and councils working to develop health policies include:
  - Higher Health Council
  - Higher Population Council
  - and the Jordanian Medical Council
  - Jordanian Nursing Council
  - National Council for Family Affairs
  - The Food and Drug Administration

However, the largest number of providers of secondary and tertiary healthcare services (hospitals) are in the private sector, followed by the Ministry of Health hospitals, military hospitals (affiliated to the Royal Medical Services - Armed Forces), and, finally, the two university hospitals (Jordan University Hospital in Amman, and King Abdullah I Hospital, affiliated to the Jordan University of Science and Technology in Irbid). The Ministry of Health provides most primary healthcare services and other health roles (وزارة الصحة الأردنية 2022).

### ■ HEALTH-RELATED SUSTAINABLE DEVELOPMENT GOALS (SDGS)

In partnership with the United Nations, Jordan seeks to achieve as many of the SDGs as possible through a human rights-based and people-centered approach (وزارة التخطيط والتعاون الدولي 2022). In its second voluntary national review (VNR) in 2022, the Ministry of Planning and International Cooperation presented the Jordanian government's achievements in SDG indicators. The VNR pointed to the accomplishment of several indicators related to Goal 3 related to Good Health and Well-being. As shown in Figure 2, the under-five mortality rate decreased to 19 per 1,000 live births, compared to the global goal of less than 25 deaths/1,000 live births. On the other hand, the maternal mortality rate in 2020, while recording an increase from 2015, is still within the objective of less than 70 maternal deaths per 100,000 live births, registering 38.5/100,000. Likewise, the percentage of births that occur under the supervision of skilled health professionals in Jordan amounted to 83% in 2020 and remained within the global target (وزارة التخطيط والتعاون الدولي 2022). However, the VNR does not include data on SDG health indicators of non-citizens, including refugees.

Figure 2. Achievement rates in selected SDG 3 indicators

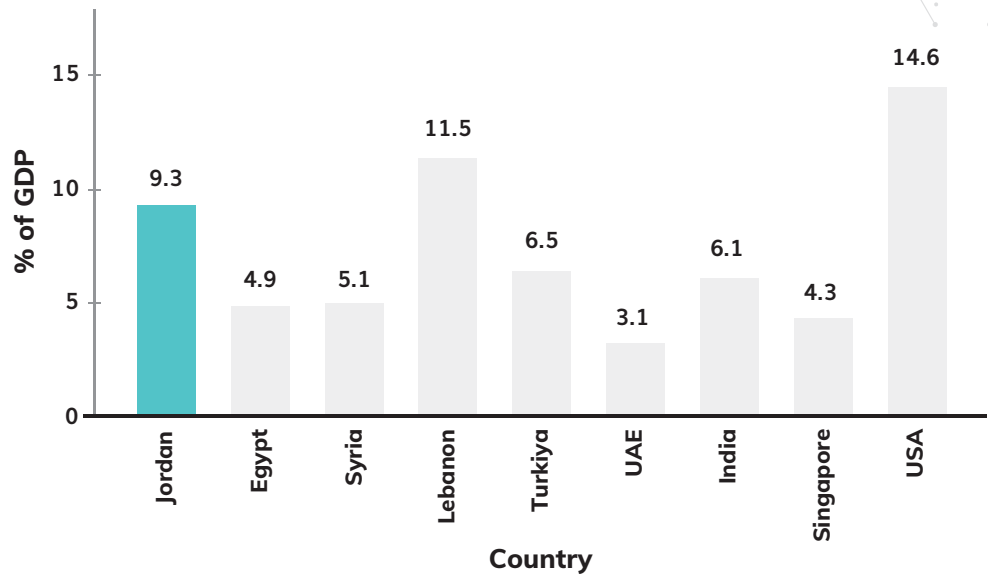


Source: [www.moh.gov.jo](http://www.moh.gov.jo)

There is still much to be done to promote and maintain these health achievements and improve the target SDG indicators in Jordan. In the VNR, the Jordanian government presented a summary of challenges and obstacles impeding the achievement of Goal 3, most significantly the re-emergence of some infectious diseases, the paradigm shift of epidemics and diseases, the increase in demand for healthcare services and facilities, the difficulty of attracting human resources for health with specialized competencies, and the drain in a proportion of qualified professionals. In addition, health-determining factors include high tobacco use, high rates of obesity, and other patterns and practices that increase the risk of non-communicable diseases among Jordanians. The government also admitted in its report that health data is not available in a comprehensive, effective, and detailed manner due to the absence of an effective digital system to monitor and review some diseases and deaths, such as infant and newborn mortality (وزارة التخطيط والتعاون الدولي 2022).

#### ■ FINANCIAL, HUMAN, AND TECHNICAL RESOURCES

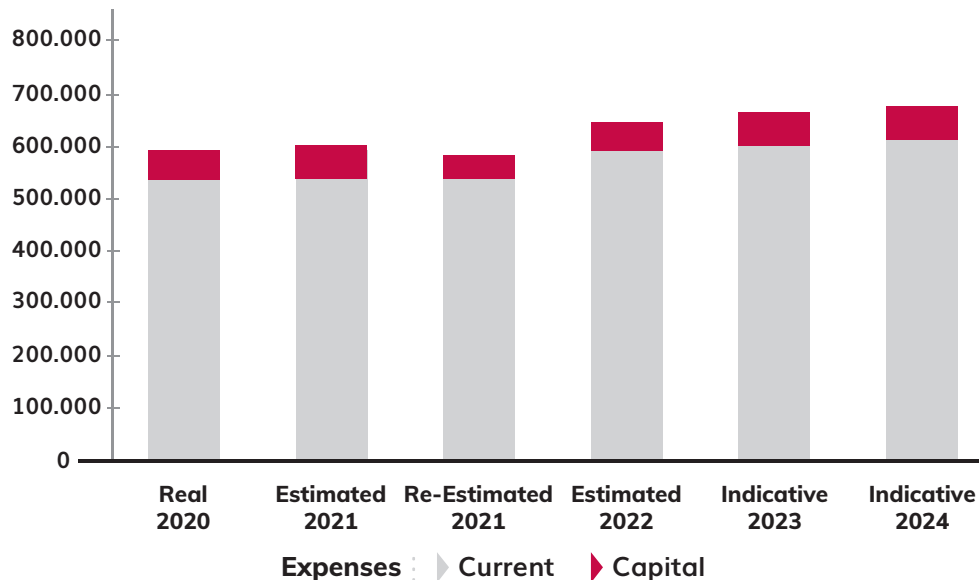
In its 2022 budget, the Jordanian state allocated 9.3% of its GDP to the health sector. However, out-of-pocket spending continues. Furthermore, as shown in **Figure 3**, although health spending as a percentage of GDP is much higher than other countries in the MENA region, middle-income, and high-income countries, out-of-pocket spending on health is rising (ميدكس-جوردان 2022).

**Figure 3. Health spending as a percentage of GDP by country**

Source: [www.medxjordan.com](http://www.medxjordan.com)

The largest share of the government budget for health is spent on current expenditures, primarily salaries, wages, goods (such as medicines and consumables), services (such as energy and maintenance), social benefits, and social security contributions for the Ministry of Health staff. While capital expenditures account for less than 10% of the amount, they are spent on buildings, construction, devices, machinery, and equipment. The allocations are compared in **Figure 4**.

**Figure 4. Current and capital expenses in the Jordanian Ministry of Health's budget**



Source: [www.moh.gov.jo](http://www.moh.gov.jo)

Despite these numbers, experts believe Jordan's health system requires additional funds to meet the growing needs and the massive demand for health goods, services, and facilities. For example, despite achieving several SDG 3 indicators, Jordan lags in others, mainly those related to non-communicable diseases and the number of beds per citizen. Moreover, although the Jordanian government sought to expand the availability of hospitals and other health facilities recently, its endeavors have been hampered due to the lack of funding and changing priorities. Undoubtedly, the delay mentioned above in establishing new health facilities harms efforts to realizing the right to health in Jordan.

According to government figures, 72% of Jordanians are covered by health insurance, which can be seen in the relatively low volume of Jordanian household spending on healthcare. In 2018, a survey on expenditures by the Jordanian Department of Statistics (2017-2018 DHS Program *دائرة الإحصاءات العامة*) and the 2018 Household Status Report published by the National Council for Family Affairs (2018 *دائرة الإحصاءات العامة*) found that the average Jordanian family expenditure on healthcare services and commodities amounted to 497 JODs annually out of the average of 12,236 JODs spent by households overall. The figures confirm that most healthcare services provided to Jordanians are fully or partially covered by one of the health insurance sources. However, they omit non-Jordanians



residing in the country. The reports do not go into the details or patterns of health expenditures, such as place of residence, socioeconomic level, or head of household's gender.

In terms of human resources, the Ministry of Health alone employs 8,030 doctors, 12,500 nurses and midwives, 1,290 pharmacists, and 6,815 technicians from other health professions. The distribution rate of physicians from the entire health system is approximately 32 physicians per 10,000 people, one of the highest ratios in the world. Similarly, the distribution ratio of nurses is 17.8/10,000, and that of pharmacists is 10.4/10,000 (2022 ميدكس-جوردان).

On the other hand, the research indicates that the Jordanian health system cannot attract qualified and trained health human resources. The country also suffers from a drain of skilled and trained human resources for health, evident in the high turnover rates and resignations in search of opportunities with higher incomes and better conditions outside the Jordanian health sector, in the GCC countries, the United States, or European Union. Jordanian health professionals enjoy a good reputation globally and are sought after, which also facilitates their emigration.

For example, according to a 2020 paper by the Jordanian Strategy Forum (منتدى الاستراتيجيات الأردني 2020), at least 427 Jordanian doctors immigrated to the United Kingdom alone between 2017 and 2022. Accordingly, the Jordanian health sector is constantly forced to recruit, qualify, and train newly graduated professionals at an additional cost to the health budget. Moreover, advanced medical specializations, such as cardiovascular, brain, and neurosurgery specialists, are rare in the public health sector in the country, particularly in peripheral regions, villages, and rural areas. In 2019, only two cardiovascular specialists were available in Ministry of Health hospitals, three brain and neurosurgery specialists and one in vascular surgery. Thus, access to specialized healthcare in peripheral areas is limited, leading to a further impediment to realizing the right to health.

Regarding technical resources, the last decade saw remarkable development in digitizing health records, transactions, and services. The Ministry of Health's "Hakeem" program is the primary example. It is used to enter, preserve, and manage patients' medical data in all Ministry of Health hospitals and centers. However, according to experts, the system has not been developed enough to become a national electronic

health record system (EHR). It is still classified as an electronic medical record system (EMR) (مركز الدراسات الاستراتيجية 2019 الأردنّي). Accordingly, it needs urgent development to expand its scope of use and train all health personnel on its proper use to achieve the main national goals for which it was established (مركز الدراسات الاستراتيجية الأردنّي 2019).

## ■ CHALLENGES

Based on the data gathered according to the methodology above, the challenges facing Jordan's health system can be summarized along three main themes, discussed below.

### ■ GAPS IN LEGISLATION, FINANCING, AND GOVERNANCE

The main gap impacting the realization of the right to health in Jordan is the absence of the mention of health as a *right* in the Jordanian constitution and its amendments. Measures to realize the right to health in any country will remain incomplete unless the constitution explicitly mentions health as a right for all citizens. Its adoption contributes to a fair and solid healthcare system that ensures the right to health for every member of society without discrimination based on gender, social level, or place of residence. Experts have pointed out that the failure to stipulate the right to health in the constitution has generated a state of discrimination, as state employees enjoy health insurance, while those not employed in the state's civil and military institutions do not necessarily receive this benefit. Adopting health as a right in the constitution would end this type of discrimination and perpetuate a human rights-based approach to health, as recommended by the ICESCR in 1966 (الأمم المتحدة 1966). On the other hand, the Jordanian Medical Liability Law of 2018 still needs proper implementation to ensure that all health system employees comply with its provisions.

According to the current study, the funding gap is a significant challenge facing the right to health in Jordan. Although the country spends more than 9% of its GNP on health, the sector is still in dire and clear need of more funding to help it absorb the increasing burden, and keep pace with the enormous increases in the cost of healthcare globally, especially the prices of medicines and cost of advanced medical procedures and devices (محمد الزعبي 2020). However, in the last two decades, Jordan pursued a neoliberal financial policy that depended on loans from international financial institutions (IFIs), such as the International Monetary Fund, as a significant source of income.

These loans entail radical policy changes, including abandoning government support programs for essential goods and services such as food, health, and energy. They often negatively impact the most vulnerable and fragile segments of society, including those with limited and median incomes. Therefore, the health sector in Jordan must be immunized against such changes, and adequate means must be found to finance the health sector in a way that does not negatively affect realizing the right to health for Jordanians.

According to experts, another significant gap posing a challenge to realizing the right to health in Jordan is the health sector's fragmentation. Many entities, bodies, councils, and institutions are involved in the health governance process but with different priorities. Significant gaps persist in obtaining and sharing data, aligning the priorities and strategies of the various parties involved in health sector governance, and defining a straightforward strategic approach that pushes the health sector toward a better future (محمد الزعبي 2020). Experts expressed the urgent need to modernize the public sector's transactions and information systems, modernize and computerize the Diwan system, and promote the adoption of a comprehensive national electronic health record (EHR) that includes all health facilities in the country. They also stressed the need to find modern and effective ways to monitor and review health indicators such as mortality, morbidity, and other health data in a comprehensive national bank for health information.

Finally, the experts recommended adopting a transparent and competency-based approach in selecting first- and second-line decision-makers in the health system in the country. They explained that the mechanism by which decision-makers were selected for senior positions in the health system sometimes lacked transparency, especially in the public sector. Experts also mentioned the public health sector's inability to attract qualified and trained health personnel added to the drain of these competencies due to the difficult conditions in the sector. These conditions include the high number of auditors, long working hours, poor financial returns, and lack of incentives and opportunities for professional development.

#### ■ GAPS IN ACCESS TO HEALTHCARE

While most Jordanians enjoy a wide range of health services, coverage and accessibility are still limited and uneven,

especially among the most marginalized and lowest-income groups. Experts indicated that access could be improved and coverage could be expanded more fairly. The results showed a disparity in access to health services, goods, and facilities between urban and rural areas. Moreover, the conditions of health facilities in rural areas, particularly in the southern region, need to be improved and developed due to the uneven distribution of financial and human resources between cities and rural areas and between regions, the center, and remote areas. The situation is due to the lack of financial resources, as residents of these areas are forced to travel long distances to obtain services in the closest city. On the other hand, advanced medical specializations are concentrated in major cities, and some are entirely absent in peripheral areas and small governorates, which also face frequent shortages of medicines and medical supplies.

Health insurance coverage in Jordan is provided through public programs that include: military health insurance (for individuals, serving and retired military officers and their families), the insurance system for civil servants (for workers in the government sector and their families), and the National Aid Fund (which issues cards for the poorest people and beneficiaries of aid boxes). Coverage is also provided through special programs that include private insurance companies (used by some businesses in the private sector to cover their employees and their families, but are subject to company approval for costly medical procedures), professional organization funds (such as insurance for doctors, engineers, and lawyers participating in unions), and international agencies (such as the UNRWA, which covers the needs of registered Palestinian refugees for primary healthcare services), in addition to charities (which cover limited health needs for some needy people, such as the Jordan Red Crescent). Individuals who do not receive any of the above types of coverage can purchase health insurance services from the private sector if they have the means, except for persons under six and over sixty years of age, who are covered by the government regardless of whether their families have any coverage.

Jordanians who need to obtain health services to treat certain types of chronic diseases or tumors or who need expensive procedures such as dialysis and who do not have any of the types of coverage mentioned above may request "medical exemptions" from the Royal Court or the Prime Ministry. The exemption requires they present a recent medical report from

an accredited hospital, which is not possible in some cases. Furthermore, neither body is specialized in health. This situation raises several questions about their ability to distribute exemptions in an appropriate manner that takes into account the real needs of applicants and contributes in an organized, efficient, and scientific way to the realization of the right to health in Jordan.

The following categories of persons have the lowest access rates to healthcare services in the country:

- Refugees not registered with the official authorities, especially those who live outside the official refugee camps.
- Refugees and migrant workers with expired residence permits.
- The unemployed and their families.
- Informal sector workers or day laborers (including non-citizens, often not covered by social security or the state health insurance fund).
- People over six and under sixty years of age who suffer from chronic diseases.

#### ■ GAPS IN THE QUALITY OF HEALTH SERVICES

Although most Jordanians enjoy access to a wide range of healthcare services, the quality of these services is generally described as low, especially in the public health sector. Experts attribute the noticeable decline in the quality of healthcare services in Jordan in recent times to several reasons, including the following:

- There is increasing pressure on health facilities due to population increase, waves of refugees, and the public sector's inability to match this increase by establishing or expanding health facilities, especially in peripheral areas, leading to overcrowding, long waiting times, and far-removed appointments (2017-2018 DHS Program دائرة الإحصاءات العامة).
- The medical and nursing cadres in the governmental and military health sectors are forced to serve many visitors and patients daily, and the public health sector cannot appoint different numbers of qualified staff to meet these growing needs.

- The absence of follow-up mechanisms for medical referrals does not allow healthcare providers to know the entire history of their cases.
- There is a frequent shortage of some types of medicines and medical supplies in the facilities of the governmental and military health sectors, especially in the peripheries.
- The drain of trained and qualified health personnel outside the government and military health sectors and the insufficient ability to attract qualified and skilled professionals.
- Increased pressure on facilities due to the emergence of new epidemics or the re-emergence of old ones after disappearing for a long time.
- Weak spending on preventive health services increases the population's need to come to hospitals and health centers suffering from preventable health problems.
- Inadequate use of telehealth technologies in governmental and military health facilities to help reduce the need for visits for some health services.
- The severe shortage of advanced medical specialties in peripheral governorates' hospitals, increasing the pressure of referrals to major hospitals in the cities, where specialists are present, the consequent discrepancy in access to specialized health services, and discrimination regarding the right to health based on place of residence.
- The urgent need to maintain or replace many old diagnostic medical devices (such as radiographic imaging devices) and therapeutic devices in public health sector facilities and to provide additional devices to meet increasing demand.

## RECOMMENDATIONS

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Based on the analysis of the results and on the outcomes of the stakeholder workshop, this report suggests several recommendations that respond to the challenges and improve the health system in Jordan to realize the right to health:

- Call to amend the Jordanian constitution, adding an explicit text stipulating that the state guarantees the right to health for all its citizens fairly and without discrimination, and apply the amendment on the ground as a guaranteed constitutional right to access health.
- Redirect the health system's funding sources and provide additional sources, if possible, to expand health insurance coverage, enhance equality in spending between cities and the countryside and between the center and regions, and improve the quality of services provided by the public health sector.
- Unify all health insurance programs in a comprehensive national record that addresses imbalances and duplication in coverage and enhances the opportunity for the uninsured to obtain appropriate and adequate coverage within actuarial plans based on accurate data.
- Activate the fifth item of the Social Security Law, providing health insurance for social security subscribers who do not have another insurance, based on an accurate actuarial study that determines the appropriate approach and does not negatively impact the Social Security Corporation's remaining services.
- Enhance the role of regulatory authorities to ensure the appropriate implementation of laws related to the health system, particularly Public Health Law and Medical Liability Law.
- Initiate an inclusive national dialogue that includes all entities, councils, bodies, and organizations concerned with the health sector to formulate a rational governance approach, free of fragmentation and diversity of health references, and ensure the health sector's effective functioning and use of resources.

- Establish integrated programs to prepare health leaders, follow a constructive approach to efficiency and experience in selecting health decision-makers at various strategic and operational levels, and continuously regulate their performance.
- Enhance the health system's Crisis Preparedness through strategic plans, training, and building capacities to improve its response to future disasters, crises, or epidemics.
- Establish a national health information bank that guarantees smooth access to information for those who need it and involves all subsectors and official institutions to facilitate exchange.
- Promote the financing of preliminary healthcare services and improve its infrastructure to manage the right to health.
- Establish preventive health programs and health awareness campaigns, and involve beneficiaries in planning and implementation according to their needs and priorities.
- Pay adequate attention to mental health as an essential component of the right to health, allocating sufficient material and human and technical resources to implement the right to obtain all sorts of mental health services for all.
- Coordinate between higher education institutions teaching health professionals and employers to bridge the gap between higher education outputs and the competencies and skills the labor market needs.
- Improve the software and applications of the "Hakeem" program, expanding its use and encouraging its adoption by all health sectors to establish a comprehensive national health record.
- Reconsider the mechanism for exemptions granted by the Royal Court and the Prime Minister, and replace them with a comprehensive and thoughtful approach that gives coverage to the broadest possible segment of the population according to need and necessity within a complete and updated database and contributes to providing health for all as a right, not as a privilege or grant.
- Pay attention to qualified health staff, improve their working conditions, reconsider their salary system and incentives, and ensure professional development opportunities, to



prevent drain and facilitate their recruitment in the public health sector throughout the country.

- Expand the use of e-health and telehealth techniques to reduce crowding in health facilities, providing the required regulatory legislation, training, electronic infrastructure, and technical support.
- Enact laws that realize the right to health for the most vulnerable and marginalized groups, such as non-registered refugees, the unemployed, PwDs, and older people who suffer from chronic diseases.
- Galvanize political and logistical support and genuine partnership between the health sector and other sectors (such as service and environmental institutions, municipalities, local councils, industry and trade rooms, civil society organizations, and national community leaders) to overcome difficulties, and advocate in favor of implementing the right to health in Jordan as a strategic national goal.
- Conduct controlled scientific studies to measure beneficiary satisfaction with the health system's healthcare services and legal aspects, and draft development and improvement plans in the various sectors concerned with implementing the right to health based on the results and recommendations of those studies.

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# IN THE HOTTEST COUNTRY OF THE WORLD: WHO IS MOST VULNERABLE TO CLIMATE CHANGE?

Climate, migration &  
health in Kuwait

Case study

## Barrak Alahmad

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Harvard T.H. Chan School of Public Health,  
Harvard University, Boston, USA

College of Public Health, Kuwait University,  
Kuwait City, Kuwait

Barrak is a physician from Kuwait who works on air quality, climate change & health in the Middle East, specifically the adverse impacts of dust storms and extreme temperatures on migrant workers. His work was highlighted by professional health organizations such as the World Health Organization (WHO) and the American Heart Association (AHA) as well as many media outlets.

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## INTRODUCTION

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While climate change, as a global crisis, affects all aspects of life, including our health, these impacts have far-reaching consequences for vulnerable populations such as migrant workers. Migrant workers are a significant part of the workforce in Kuwait. Workers face many challenges in host countries, including discrimination, poor living and working conditions, and limited access to health services. The health of migrant workers will be further threatened by the impacts of climate change, which exacerbates the challenges they face and exacerbates health inequities and disparities. Migrants' health is often neglected in host countries, and their right to health is frequently violated.

This case study aims to examine the impacts of climate change on the health of migrant workers in Kuwait and to explore the ways in which the right to health of these workers is being violated. The case study will shed light on the complex intersections between climate, migration and health in Kuwait, and provide overarching recommendations tailored specifically for migrant workers who are at the frontline of extreme climate conditions.

# GLOBAL CLIMATE CHANGE IS A HEALTH CRISIS

In a series of assessments done by the Intergovernmental Panel on Climate Change (IPCC), the links between climate change and population health were clearly established (Intergovernmental Panel Climate Change 2021). Climate change is no longer only an issue for environmental alarmists and conservationists; it is a health emergency. The evidence now shows that the changing climate has led to unprecedented damages to the balance of ecosystems and sustainable living.

**Figure 1. How does heat affect health?** *Examples of climate-sensitive health outcomes that will be amplified due to increasing heat duration, intensity and frequency of heat exposure.*

Example of Climate-Sensitive  
Environmental Exposure



Extreme Heat



Example of Climate-Sensitive  
Health Outcomes



Respiratory  
Diseases



Heart  
Diseases



Kidney  
Diseases



Mental &  
Psychosocial  
Effects



Strains on  
Healthcare  
Facilities



Work-related  
Injuries

The pathways in which climate and health interact are complex, bi-directional and interdependent (Khraishah et al. 2022; Rocque et al. 2021). One of the simplest pathways is the direct effect of extreme heat on health. Over the last decade, heatwaves and extreme heat are becoming more frequent, longer in duration and higher in intensity. In an analysis of all global deaths around the world, it was estimated that non-optimal temperatures may be responsible for about five million deaths each year (Zhao et al. 2021). Another global analysis showed for every 100 heart-related deaths, at least

one death is attributed to extreme temperatures alone (Alahmad et al. 2023). Prolonged exposure to heat can have a range of dangerous and even life-threatening effects on the human body (**Figure 1**). When the body is exposed to heat, it sweats to cool down and blood diverts away from many organs towards the skin. Sweating increases the risk of dehydration if fluids are not replenished. Strains on the heart, lungs and kidneys can exacerbate existing conditions in vulnerable individuals (Ebi et al. 2021). Additionally, more research is now showing adverse effects on mental health (Berry et al. 2010), increased healthcare demand (Bone et al. 2018), occupational injuries (Fatima et al. 2021) and others.

## UNIQUE DEMOGRAPHY

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Unlike anywhere else in the world, the Gulf countries have a distinct demographic profile: the majority of the population are non-citizen migrant workers. In Kuwait, the total population is 4.2 million. Nearly 70% are non-Kuwaitis, of which approximately 65% are males (PACI 2020). The majority of migrant workers in the country come from South and Southeast Asia (mainly India, Bangladesh, and the Philippines), whereas the non-Kuwaiti Arab working population comprises largely of Egyptians. Migrant workers are predominantly employed in the hospitality and service industry as well as manual and construction work (Alahmad et al. 2020).

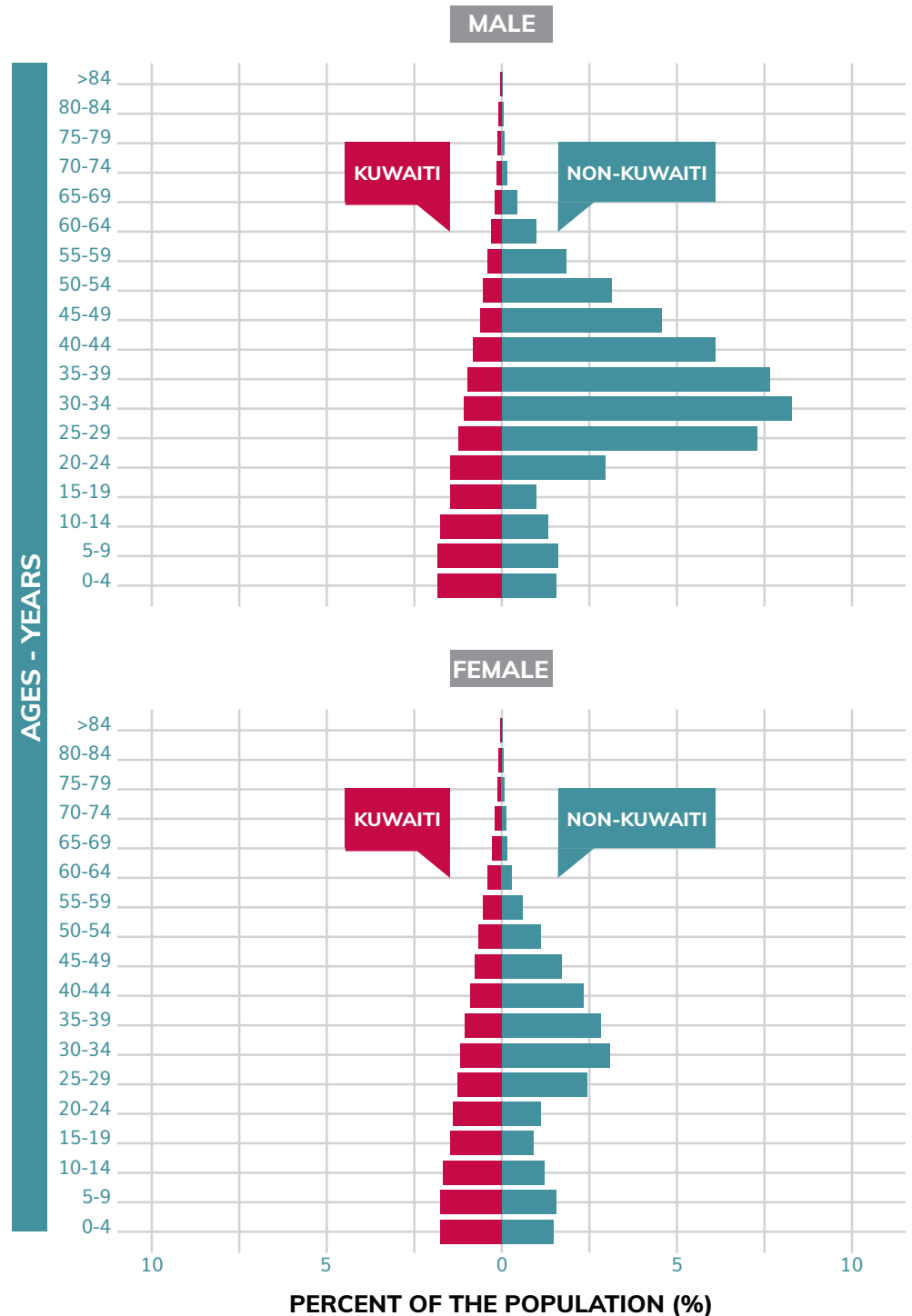
In their home countries, workers are usually trapped between unemployment, poverty and despair. They look for jobs abroad every year. They pay significant amounts of money to agents that promise them job security in the Gulf countries. They borrow money and get in serious debt to pay these agents.

Once in the host countries, family visas in the Gulf are very strict which forces workers to come unaccompanied by their families. The Kafala system, also known as sponsorship system, governs labor migration rules in Kuwait. Kafala ties the legal status of a migrant worker to their sponsor or employer. By design, the system prohibits workers from leaving their job or to change employers without the permission of their sponsor. Effectively, Kafala creates an immediate power differential between migrants and employers. This results in a situation where workers are often subjected to exploitation and abuse, including poor working conditions, long hours, low wages, and inadequate housing. On top of that, Gulf governments usually assign certain residential neighborhoods to be for 'bachelors-only.' These neighborhoods turn into deprived areas of crowded and male-dominated clusters of migrant workers as compared to the traditional Kuwaiti 'families-only' affluent neighborhoods.

In stark contrast with the Kuwaiti population, the majority of non-Kuwaitis are young males in working age (between 30 and 49 years), with only 20% of non-Kuwaitis having an educational attainment beyond high-school (PACI 2020). The skewed population pyramid is thought to have different strains on the public health system (**Figure 4**).



**Figure 2. What can be learned from a skewed population pyramid in Kuwait?**



#### FOR THE KUWAITI POPULATION

- **Symmetry:** close enough ratios of males to females
- **Narrow apex:** low proportion of people living longer, a typical finding for developing countries
- **Wide base:** high fertility rate and a young population

#### FOR THE NON-KUWAITI POPULATION

- **Distorted pattern:** influx of migrants in working age
- **Sex structure:** Very high male to female ratios
- **Narrow base:** low birth rate or small number of children

## FUTURE CLIMATE IN KUWAIT

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The warming of our planet is not evenly distributed. In countries that are inherently hot and have a harsh climate, temperatures are rising at a faster pace and setting record-high levels. Recent evidence is now suggesting that the Arabian Peninsula could be facing significant risks to maintain human survivability due to climate change (Safieddine et al. 2022). One projection for the region estimated an eight to 20 times increase in mortality rates in the future (Ahmadalipour, Moradkhani, & Kumar 2019). As temperatures get hotter and hotter, we risk pushing the limits of human adaptability (Pal & Eltahir 2016).

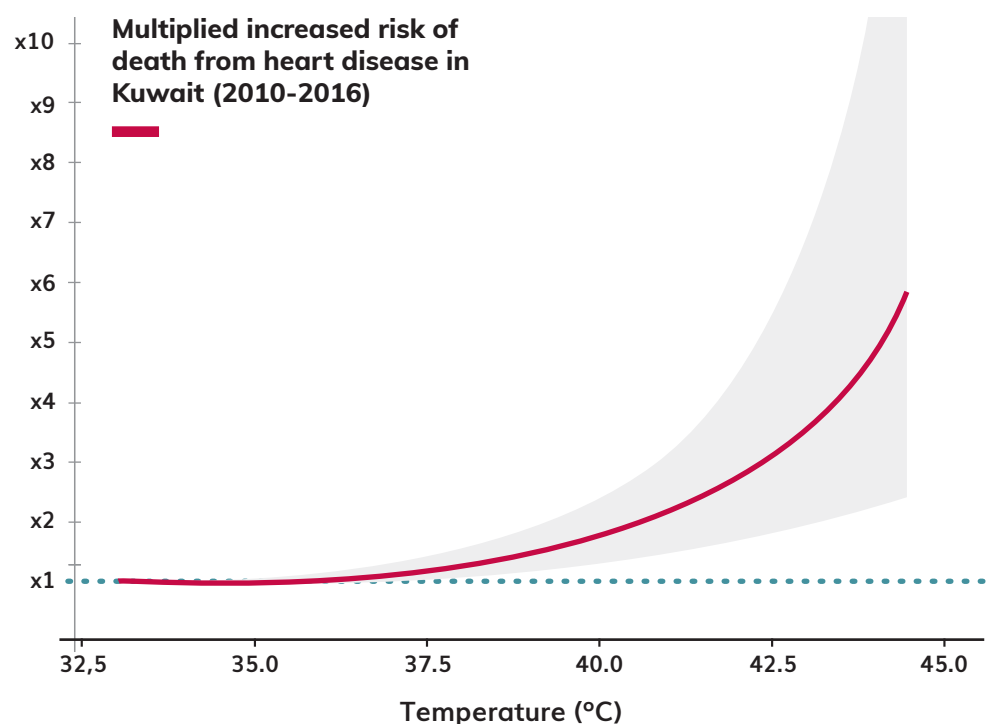
Kuwait, commonly dubbed as the hottest country in the world, registered one of the highest temperatures on record; a 54.0°C in the summer of 2016 (Merlone et al. 2019). In recent years, far too many days in Kuwait's summer are exceeding 40°C and 50°C. In the last couple of years, at least a dozen of news stories came out covering different aspects of today's extreme heat in Kuwait and the Middle East, viewing it essentially as the "canary in a coal mine" for the rest of the world (e.g., NYT 2022). That is, Kuwait's summer today is a good indicative for what future summers could look like in Southern Europe, warm states in the United States and other regions.

In an analysis of historical temperatures in Kuwait from 2010 to 2016, the risk of death from heart disease doubles and triples at 41°C and 42°C, respectively, compared to the optimum temperature of 34°C (**Figure 2**)(Alahmad et al. 2020). This alarming evidence from Kuwait clearly shows the potential devastation that extremely hot temperatures can have on populations. Put another way, we do not have to look at the future to see the health impacts of climate change in Kuwait; extreme heat is already increasing mortality substantially in the country (Alahmad et al. 2019).

The IPCC, in its 2021 sixth assessment report, said that scientists were 'virtually certain' that the intensity and recurrence of heat events have increased globally since the last century (Intergovernmental Panel Climate Change 2021). It is rare for scientists to use language that does not express any uncertainty. Globally, by the end of the century, the average temperatures are expected to increase by 2.4°C ('moderate' climate change scenario: SSP2-4.5) and 4.4°C ('extreme' climate

change scenario: SSP5-8.5), compared to pre-industrial times (from 1850 to 1900)(Intergovernmental Panel Climate Change 2021). This increase in average temperature will result in possibly globally unprecedented heat in already hot Kuwait.

**Figure 3. How does heat affect risk of death from heart disease in Kuwait?** *The dose-response relationship between daily average temperatures in Kuwait (x-axis) and the relative risk of death from heart disease compared to the optimum temperature of 34°C (y-axis)*

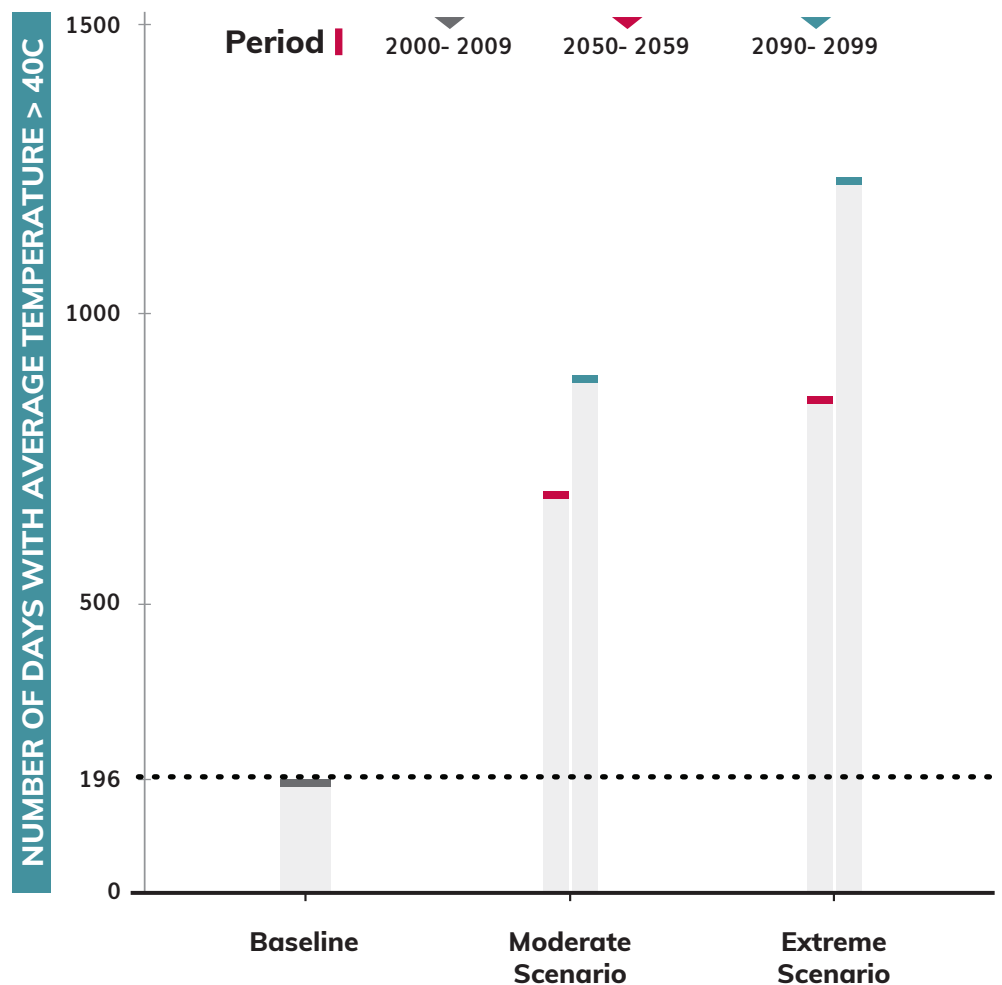


In an analysis of future temperatures from 2060 to 2099 vs. temperature baseline from 2000 to 2009, Kuwait could see an increase of 1.8°C to 2.7°C in a moderate scenario, and 2.6°C and 5.5°C in an extreme scenario, respectively (**Table 1**) (Alahmad et al. 2022). The country is expected to continue heating at a fast rate; an increase in average temperatures seems inevitable even under moderate scenarios. By mid-century, even a moderate scenario will result in 692 days per decade (69.2 days per year) where average 24-hour temperature exceeds 40°C. In an extreme scenario and by the end of the century in Kuwait, there will be 1,232 days per decade (123.2 days per year) in which the temperature exceeds 40°C. To put this into context, there were only 196 days of temperature > 40°C in the 2000 to 2009 decade (19.6 per year) (**Figure 3**).

Future projections of mortality in Kuwait due to climate change were not a case for optimism. Climate change would increase heat deaths by an additional 5.1% (moderate scenario) and 11.7% (extreme scenario). Researchers estimated that these percentages will translate into heat driven by climate change to be responsible for 14 of every 100 deaths in Kuwait by 2099 (Alahmad et al. 2022). Remarkably, migrant workers were identified as extremely vulnerable to heat and are set to bear a larger impact from climate change.

**Figure 4. How many days of extreme heat are in Kuwait?**

*Number of days when the average 24-hour temperature exceeds 40°C in the 2000 to 2009 baseline compared to the future scenarios by 2059 and 2099. Moderate climate change scenario = SSP2-4.5; Extreme climate change scenario = SSP5-8.5.*



| Source: Alahmad et al. 2022

**Table 1. What are the expected warming levels in Kuwait?**

*Decadal increase in average temperature compared to the baseline decade of 2000 to 2009. Moderate climate change scenario = SSP2-4.5; Extreme climate change scenario = SSP5-8.5*

Decade ▼	Increase in Mean Temperature (°C) ▼	
	Moderate Scenario	Extreme Scenario
2000-2009	0.00 (Baseline for comparison)	
2010-2019	0.30	
2020-2029	0.71	0.79
2030-2039	1.06	1.32
2040-2049	1.45	1.92
2050-2059	1.79	2.57
2060-2069	2.07	3.21
2070-2079	2.29	3.96
2080-2089	2.69	4.66
2090-2099	2.69	5.54

| Source: Alahmad et al. 2022

## MIGRANTS' HEALTH DISADVANTAGE



Migrant workers' health is often overlooked as they tend to be counted in the groups of those who are 'young and healthy'. However, migrants face an extraordinary number of stressors in host countries that shape their physical and mental health, and their overall right to health.

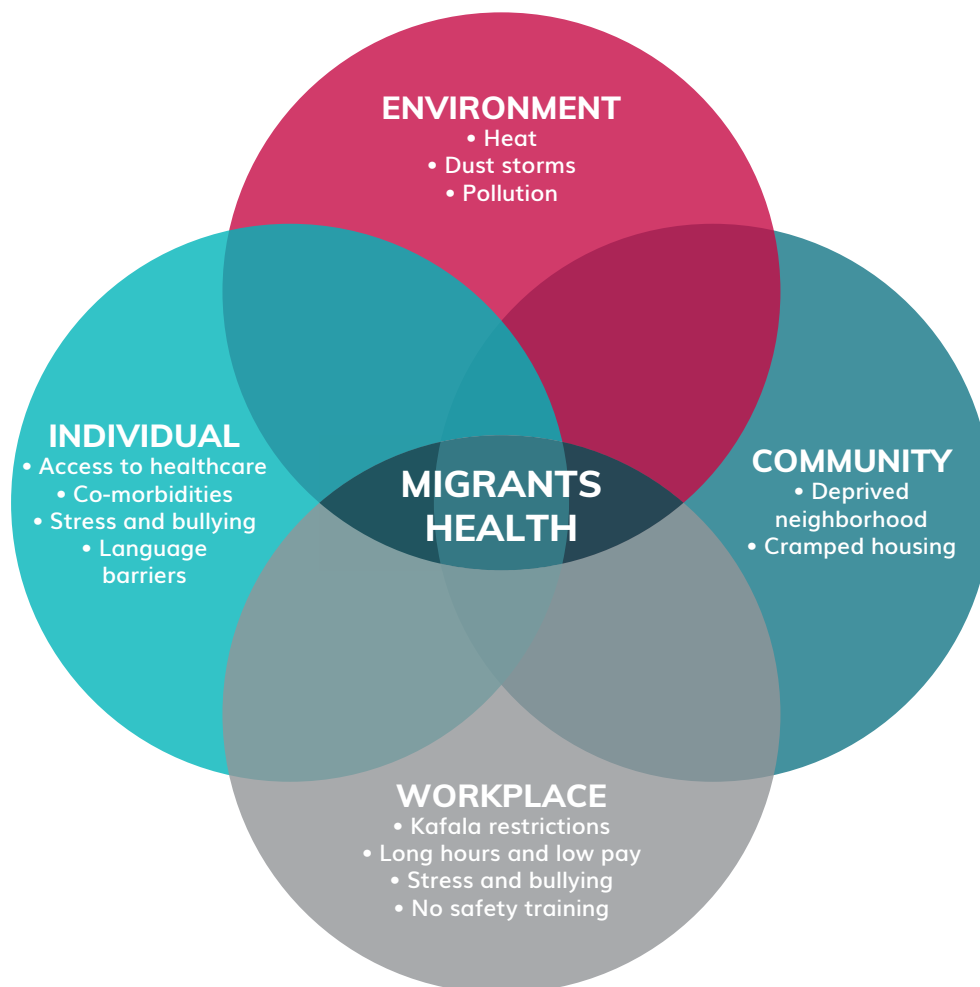
They often come from devastated communities that are affected by extreme poverty, conflict, violence and environmental disasters. Sometimes, their long and exhaustive journey alone could jeopardize their health. But as soon as they arrive in host countries, they face social, political and economic exclusion.

There are four domains at which stressors cumulatively wear down the health of migrant workers (**Figure 5**).

At the individual level, it is difficult for migrant workers to access and utilize healthcare in Kuwait (Hamadah et al. 2020). The public healthcare system in Kuwait is funded by the government and provides free or low-cost medical services to citizens and certain categories of migrants, such as government employees. For the rest of migrant workers, they pay out-of-pocket for services for a range of medical services, including primary care, specialist care, and hospitalization. A recent survey found that at least one in three non-Kuwaitis could rarely or never afford healthcare (Vital Signs 2022). Even if they can afford it, the healthcare system in many ways is segregated in Kuwait based on nationality. For example, there are morning outpatient clinics that run for Kuwaitis only. Jaber Hospital, the recently opened largest state-of-the-art architectural beauty, is restricted for Kuwaiti patients only. At the time of writing this case study, there are no mandatory interpretation services at public hospitals for non-Arabic speaking patients.

### Figure 5. What creates the migrants' health disadvantage?

Four key domains in which stressors can cumulatively result in poor health outcomes for migrant workers: the environment, community, workplace, and individual



Source: Alahmad, Kurdi, et al. 2020

At the workplace, migrant workers in Kuwait are also often subject to exploitative and abusive working conditions, with lax occupational health and safety regulations resulting in preventable injuries. Unregulated long hours, heavy physical workloads, and low pay are drivers of psychosocial stress that can negatively impact migrant workers' physical and mental health. The Kafala visa system further exacerbates the issue, as workers may be reluctant to assert their rights or seek medical care for fear of losing their job or being deported. The system denies any right to unionize in the country.

Migrants' health is also impacted at the community level. There are striking differences between the neighborhoods for Kuwaitis and non-Kuwaitis. Migrant workers often live in

poorly maintained, cramped houses that can have an effect on their ability to adapt to health stressors. For example, during the COVID-19 pandemic, housing and community conditions facilitated the spread of infectious diseases (Khadadah et al. 2021). They also lack access to healthy food options and recreational facilities, such as gyms and parks.

Finally, we get to the environmental stressors. An emerging body of epidemiological literature in Kuwait shows that the harsh environment is differentially affecting non-Kuwaiti migrant workers as compared to the Kuwaiti population (Table 2). From a public health standpoint, seeing an increased effect on 'young and healthy' migrants compared to the general public is extremely concerning. A changing climate is not being felt equally by everyone. The poor and the most vulnerable, such as migrant workers are the worst hit. The hazardous hot conditions where non-Kuwaiti migrant workers perform physically demanding jobs for extended periods outdoors is disproportionately increasing their susceptibility. This health inequity is expected to worsen as climate change and hazardous heat intensifies, making the need for addressing the right to health of migrant workers in Kuwait and the region all the more pressing.

**Table 2. What are the environmental health disparities in Kuwait?** *The health disadvantage of migrant workers in Kuwait extends to environmental exposures and climate change (statistical significance is determined based on a p-value > 0.05)*

	Risk among Kuwaitis	Risk among non-Kuwaitis
<b>Current impact</b>		
Dust storms days vs. non-dust storm days	No significant increase	4% increase in deaths (range: <1% to 6%)
Extreme heat days vs. optimal temperature days	No significant increase	96% increase in deaths (range: 10 to 352%)
<b>Future simulations</b>		
<b>Moderate</b> climate change projections of heat deaths in 2059 vs. today	No significant increase	4.6% increase in deaths (range: 0.9 to 7.5%)
<b>Moderate</b> climate change projections of heat deaths in 2099 vs. today	No significant increase	6.8% increase in deaths (range: 1.5 to 11.7%)
<b>Extreme</b> climate change projections of heat deaths in 2059 vs. today	No significant increase	6.8% increase in deaths (range: 1.5 to 10.5%)
<b>Extreme</b> climate change projections of heat deaths in 2099 vs. today	No significant increase	15.1% increase in deaths (range: 4.6 to 22.8%)

| Sources: Achilleos et al. 2019; Alahmad et al. 2020; Alahmad et al. 2022



## MOVING FORWARD

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No magic stick can solve all the problems for migrant workers in Kuwait. There must be a set of interventions to address essential domains at the individual-, community- and workplace-level(s). In the meantime, environmental exposures and right to health are arguably inseparable for migrant workers.

Unfortunately, many days are becoming too hot to work. Climate change is only going to make it worse. Migrant workers work in dirty, dangerous & demeaning jobs in hazardous hot conditions. Despite a warming climate, heat policies to protect workers are lacking at international and national levels. The International Labor Organization (ILO), the World Health Organization (WHO) and even the U.S. Occupational Safety and Health Administration (OSHA) do not have heat standards to protect workers (especially migrant workers) from dangerous heat exposure.

Gulf countries have adopted a ban on work during midday hours during summer months. However, this simple solution has many drawbacks. Firstly, it assumes that the heat risk is limited to only the summer months. Extreme heat events can happen outside these months and may become more frequent due to climate change. Additionally, the policy does not take into account many environmental (e.g., temperature, humidity, wind speed and sunlight), workplace (e.g., rest, shade, hydration, etc.), or personal factors (e.g., acclimatization, comorbidity, etc.) that affect occupational heat stress. As a result, heat-related injuries are unlikely to be prevented despite the ban on midday work.

Moving forward, the mission of policy-making and implementation of heat protection measures must consider the following key elements:

- **Saving lives:** Extreme temperatures can kill. And even when there are no fatalities, these hot temperatures can lead to injuries and lifelong disabilities. Science-driven heat standards are needed to promote lifesaving interventions for millions of migrant workers in Kuwait and around the world.
- **Communicating risk:** Better communication channels

need to be established between policymakers and those who are concerned about climate risks. This can be done through meaningful involvement of embassies, civil society organizations, media, international organizations, and government bodies in Kuwait. It is essential to recognize the diversity among migrants and identify the most vulnerable subgroups (e.g., most at-risk job categories).

- **Closing the gap on climate inequity:** In the Gulf, many migrant workers died in the prime of their lives to build fancy buildings and structures. Their deaths provide a vivid and upsetting wake-up call to better address currently avoidable risks for migrant workers. In the absence of more effective policies and interventions, health inequities will grow, and result in less-advantaged migrant workers bearing greater harms from excess heat exposure. General education should be made more equitable by incorporating awareness of vulnerable communities, community engagement studies, and disparities in school curriculums, especially for medical schools and residency programs.
- **Coordinating and collaborating internationally:** In disseminating findings, elements of an effective risk-based standard must be communicated to the ILO and WHO and other key stakeholders to inform more effective policies within countries and regional jurisdictions. An international or local cost-benefit analysis can determine the economic burden of heat on the country's workforce, especially migrant labor. Measures such as productivity loss in hours or dollars when taken into account may provide more incentives to enforce safe and productive heat standards.
- **Accountability:** The lack of accountability for the heat-related deaths of migrant workers is a complex issue that stems from several factors. These include inadequate legal protections, socio-economic exclusion, lack of representation and unionization, as well as a lack of political will and inaction on the part of host and home governments. This results in a situation where the health and well-being of migrant workers is not properly addressed. It is important to recognize that ensuring the health of migrant workers is a collective responsibility that should be shared by various stakeholders, including the governments of host and home countries, the employers who hire them, and international organizations. Without concerted efforts from all these parties, it will remain difficult for migrant workers to access justice and protection.

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# NATIONAL REPORT ON THE RIGHT TO HEALTH IN MAURITANIA

## Towards achieving access to the right to health

### Mohamed Ahmed el Mahboubi

Development expert, consultant and independent social expert

Independent consultant. Holder of the Scientific Grade Master I and II in Development, in Sociology-Philosophy. Mahboubi has an extensive experience in studies, development research, consulting, and policy evaluation. He is involved in civil society activities and has participated in seminars and research with a number of national and international partners.

### Sidina Ould Khatri Elatigh

Consultant in economics

Elatigh is a trainer at the Institute for Vocational Education and Training, Nouakchott, Mauritania. Civil society activist, head of the Mauritanian Network for Social Action. He conducted various researches in the social field and on the civil society organizations' role in development. He participated in several national and regional economic and social forums.

## INTRODUCTION

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This paper presents an overview on Mauritanian citizens' access to the right to health, health insurance, and healthcare, especially the vulnerable groups, in a country suffering from poverty, marginalization, poor health infrastructure, and inequitable access to hospitalization between citizens living in the city center and the outskirts, and citizens in rural and urban areas. This context pushed us to draw the attention of stakeholders including public authorities, civil society, the media and partners, and to promote advocacy that leads to improving the level of services, especially with regard to social and economic rights (health, education, welfare and social protection).

The report is primarily based on the methodological axes included in the background paper of the sixth Arab Watch Report, with a focus on the Islamic Republic of Mauritania in terms of information availability, the right to health and its enforcement.

**Objective:** Presenting a comprehensive and critical analysis of the situation of the right to health in Mauritania, with some insights on the post-COVID-19 period.

**Methodology:** The reporting methodology is based on two axes: the first focuses on desk research, meetings, and interviews with relevant specialists, human rights activists, actors in the health sector, and civil society activists working for the developmental health field, this is an active participatory approach. The second focuses on objective research, questioning history, and analysing reality, based on answers to the report's key questions on the reality of access to the right to health in Mauritania, the level of human rights awareness concerning this specific right, and inequality in health services availability.

# GENERAL CHARACTERISTICS OF THE MAURITANIAN CONTEXT

This section addresses the most important characteristics of the Mauritanian context, with a focus on some aspects related to the right to health. It provides an overview of the institutional, historical, economic, social, political, and legal aspects of the context, and highlights the positive and negative distinguishing points.

## POLITICAL, GEOGRAPHICAL AND HISTORICAL DATA AND CHARACTERISTICS

Since Mauritania's independence in 1960, various government policies included the right to health, but it wasn't until the 1980s that a new approach in health policies was adopted to respond to the needs of the largest possible number of citizens with regards to health and basic treatments program. From the Fourth Health Plan 1981-1985 to the Basic Plan 1998-2002, priority was given to primary health treatments and the improvement of health coverage. In 1998, new concepts and terminology were introduced on the type and quality of performance and effectiveness of the health system.

## ECONOMIC AND SOCIAL DATA

The general demographic situation in Mauritania is changing, as 52.8% of the population were living in urban areas in 2013, while 48.3% were living in rural areas. 28.2% of the population<sup>1</sup> are below the poverty line, and 50.7% of the total population are women. The population is mostly young, as 44.2% of people are under 15 while the elderly constitute 5.3% of the population. Social services are still poorly distributed among regions, and access to these services varies between regions and districts, and even at the economic and social levels.<sup>2</sup> Furthermore, displacement from the countryside to the cities has contributed to demographic fluctuations and increased pressure on the already poor services' infrastructure, greatly limiting access to health, education, water, electricity, food and employment services, as the capital alone attracted a third of the country's population.

<sup>1</sup> المسح الدائم حول الظروف المعيشية للسكان 2082  
<sup>2</sup> المرسوم رقم 361 المُحدّد لصلاحيات وزير الصحة المادة 2



### **Access to the Right to Health and How it is Linked to the Mauritanian Political System**

The process to accessing the right to health in a country like Mauritania was not easy. Despite its intentions and the expressed and implied will for reform, the Mauritanian state has faced and is still facing many challenges that, to say the least, are multifaceted challenges, where the territory is large, the resources are lacking, and the outdated manners hinder development in every sense.

A major factor also limiting access to the right to health is related to the political orientation and nature of the respective regimes and their varying national and international approaches and agendas. In fact, the right to health was an official approach in various government policies and plans, and the achievements, even if few, were effective and marked with a kind of responsibility at the birth of the state. However, with the link to the global health approach and health internationalization, we are facing an "imported" health starting from medicines, to devices, and to the laws regulating health. Local health has become a cross-border health, whereas it should be based on climatic and geostrategic findings. Health economy has become one of the most important economies in the world; opening health to the private sector and depriving it of any humanitarian and rights-based essence.

The political orientation remains the first determinant of access to the right to health. Only the political will allows the citizens to access their right or deprives them of it; it determines, prioritizes and prohibits the financial resources. The political will is the factor that classifies citizens as first or second class and grants them insurance and access to health for free or in exchange for an amount of money. This political dimension in Mauritania revealed the ability to adapt and try to take care of the sick. It also revealed the significant dysfunction and failure behind various government achievements, which are mainly intended for media consumption.

We would like to point out a very important issue, which is that access to the right to health is granted to some with favors. For example, the state provides healthcare for persons who are national symbols, such as heads of parties, former presidents, opposition figures, or poets, which are granted as extra benefits, or what has been called presidential, royal, and princely gratuities, but these are limited in time and space, and the beneficiaries are very few. As for all others who have the right to health, they are often not granted this access, not even to its financial and human infrastructure, and this is mainly due to a political choice.

## DETERMINANTS OF THE RIGHT TO HEALTH IN MAURITANIA<sup>3</sup>

### INSTITUTIONAL AND LEGAL FRAMEWORKS FOR THE RIGHT TO HEALTH IN MAURITANIA

The right to health is considered a national priority and one of the state's strategic objectives. It is a subject of attention for legislators, policymakers and strategists. It is a right that has been addressed in various national health and non-health instruments and strategies. The Constitution of 1961 and the Constitution of 1991 address the right to health several times. The Mauritanian Constitution guarantees equality between men and women and all citizens or residents without discrimination based on color, race, religion, sex or social status, which is equality in rights and before the law, and health is one of the pillars and components of these rights.<sup>4</sup>

The current Mauritanian Constitution does not differ from previous constitutions, as it addresses citizens' social and economic rights, indicating in many of its articles that all citizens are entitled to enjoy all rights within the conditions established by the law. The Constitution stipulates in Article 16 that "the State and the society protect the family," in Article 31 that the State protects the family, motherhood and childhood, and in Article 33, that the State protects public health and works to encourage free medical assistance to the needy. Article 35 provides that the State guarantees freedom of education, and that it is free in government schools in its early stages. Article 37 of the Constitution stipulates that the state shall ensure social security and aid and shall guarantee the right to a pension for its employees, as well as the right to assistance in cases of accidents, illness, or inability to work, according to the law.<sup>5</sup>

We list in this paper some of the Mauritanian legal instruments related to access to the right to health, as we have come across more than 36 decrees, laws, and decisions, that all deal with health, insurance, security, access to the right to health and treatment in a purely legal way. The instruments cover the various health aspects and concerns and the structuring of insurance and social security systems during the past fifty years, revealing that the topic was analyzed from the

<sup>3</sup> السياسة الوطنية للصحة في أفق 2030 المصدر 2017 ص 8

<sup>4</sup> المخطط الوطني لترقية قطاع الصحة 2020 - 2030 ص 34

<sup>5</sup> التقرير الوطني للجمهورية الإسلامية الموريتانية في موضوع (منظومة الحماية الاجتماعية للمرأة في مجال الصحة في المنطقة العربية) (إعداد الخيرة الزينة محمد الأمين. يمكن الوصول إلى التقرير على هذا الرابط

institutional and legislative point of view and was not targeting a specific group but rather included the entire population, including citizens, expatriates, refugees, vulnerable groups, disabled people and the elderly. Without marginalizing any group, the instruments focus in some of texts on specific groups and prioritizes them in treatment, service, and health insurance.

Mauritania is also party to most or all the international charters, covenants and agreements related to economic, social and cultural rights, especially those related to the right to health and social care, issued by the United Nations General Assembly since its establishment, and by other regional, continental and inter-regional assemblies.

## **THE DETERMINANT RELATED TO RIGHT TO HEALTH AND GENDER**

Improvements in health at the national level hide some of the existing social and economic disparities between groups. In fact, health indicators have been and are still alarming, especially in rural areas, among the poorest groups, and for those that do not have a high educational level. Analysing health indicators according to social and economic groups reveals several differences at various levels, especially in terms of access to the right to health. Health indicators related to malnutrition, fertility, and death rate explain these disparities and may even provide economic explanations for them due to low income, poverty, illiteracy, and the severe lack of access to services, especially care for children, monitoring their growth, giving birth without receiving proper medical care, and others.

Practically, we note the permanent inequality, discrimination, and perhaps even disparity based on gender in the health field. These relate mainly to social, economic and cultural barriers and obstacles that limit women's access to their right to health and treatment like family planning, gender-based violence in all its forms, traditional societal practices harmful to women such as female circumcision,<sup>6</sup> early marriage or force-feeding (leblouh), etc. Moreover, it should be noted that there is what we call "health violence" and that the quality of the provided health services is affected by the gender. This is clearly evident when dealing with maternal mortality, gender discrimination, stigmatization and contempt, or refusal to provide services, for example, to people with sexual diseases, sex workers, or those who are not in a legitimate relationship. According to the Ministry of Health's 2018 statistics, 58% of the ministry's workers are women, but they are still marginalized at the level of decision-making.

<sup>6</sup> excision or female circumcision

## THE ECONOMIC DETERMINANT OF ACCESS TO THE RIGHT TO HEALTH

Mauritania is among the poorest countries around the world, thus, investment in health requires significant financial resources that are crucial to provide health infrastructure, or even to acquire equipment, medicines, or build clinics that guarantee citizens' insurance and care for patients. Despite efforts to increase budget allocations for the sector, these are still at a modest level compared to neighboring countries in the south and north: i.e., about 5.3% of the state budget compared to 10% in Senegal and more than 18% in the Kingdom of Morocco. Furthermore, resources distribution is not optimal in terms of geographical justice, fair and equal access, and respect for the National Health Policy's priorities.

## DETERMINANTS RELATED TO WATER, SANITATION AND ENERGY

68.1% of the population have access to potable water, 34.2% have access to proper nutrition, while 40.4% have access to adequate sanitation. All of the latter factors have a significant impact on health <sup>7</sup> and can contribute to the spread of infectious, parasitic and nutritional diseases.

The availability of energy services of all kinds at affordable prices and the increase in investments in energy infrastructure also facilitate access to the right to health. In Mauritania, energy is only available to 48% of the total population. As for the energy infrastructure, Mauritania has a national network that is among the weakest in the Arab region, in terms of production, distribution, or transportation. Access to the right to health requires the existence of a strong and comprehensive energy network with multiple options that guarantee fair access to electricity at the national level. Health and electricity are interlinked, as without electricity and energy, diagnostic equipment breaks down, food spoils, access to water becomes challenging, and other social services may be affected. <sup>8</sup>

## NATIONAL HEALTH INFRASTRUCTURES

Access to the right to health depends on providing the service within the closest possible distance to the citizen and without excluding any part of the country. Most of the policies related to health infrastructure have focused on providing comprehensive health coverage including for adjacent areas, and ensuring accessibility within a distance not exceeding 5 to 10 kilometers

<sup>7</sup> ملخص الاستراتيجية النمو المتسارع والرفاه المشترك <sup>7</sup>

<sup>8</sup> استراتيجية النمو المتسارع والرفاه المشترك 2022 - 2026 ص 40 <sup>8</sup>

for all. However, despite all the achievements, there is still a considerable shortage, and there is a need to build more health posts, as the currently existing 808 posts do not meet most of the population's needs and do not meet the recommended international standards. Many health posts and centers were built due to the interventions of the Ministry of Health and the Taazour Delegation. Civil society activists and businessmen involved in the health field tried to contribute to posts according to their capabilities.

## TRANSPORTATION

In recent years, Mauritania has tried to pay attention to road infrastructure and means of transportation due to its importance and its role in economic growth and health and the enjoyment of rights. The national road network guarantees access to 70% of the population withing a distance of less than two kilometers in 2020, compared to only 40% in 2016. Access to the right to health requires the provision of modern road infrastructure, airports and ports that guarantee the transport of goods and medicines, the provision of equipment and the supply of food to the market. However, transportation infrastructure in Mauritania suffers from several obstacles related to the lack of proximity to medical and health services to citizens, especially for those who live in remote areas.

## EPIDEMIOLOGICAL TRANSITION

The spread of communicable and non-communicable diseases with high costs places an increasing burden on the health system, that is already insufficiently prepared to provide the protection, prevention, diagnosis and treatment of these diseases. Mauritania has quickly adopted the One Health approach that takes into consideration the health of humans, animals, and the environment at all levels. The country is witnessing waves of epidemics that are not familiar to the national health system, represented by the difficulty of managing the emergency cases of malaria, dengue fever, COVID-19 and viral foot-and-mouth disease, in addition to issues related to climate change, rainfall, drought, and malnutrition. As for the pharmaceutical sector and the provision of medicines and medical supplies, the general situation in Mauritania is characterized by weak capacities at all levels, raising questions about availability, quality and access.

# ANALYSIS OF THE CURRENT SITUATION OF THE RIGHT TO HEALTH IN MAURITANIA

Public authorities have made great efforts and taken many measures to guarantee citizens' access to health as a human, religious and legal right. These measures and efforts have been portrayed in the adoption of many plans and strategies since independence to date, but access to quality health services remains a challenge. We present here a general idea of the level of access and related obstacles.

## THE NATIONAL PLAN FOR UPGRADING THE HEALTH SECTOR 2020-2030

Mauritania has established a plan to upgrade its health work. This plan was previously consistent with the strategic framework for combating poverty and is now in line with the current strategy of accelerated growth and common prosperity, which represents the reference framework for government policies that are aligned in some of their provisions with the Sustainable Development Goals and various national and international commitments.

## SECTOR GOVERNANCE AND MANAGEMENT

A multisectoral approach was adopted aiming at coordinating the implementation of health strategies, which facilitated the work of those involved in the health and social sectors. A formal mechanism for cooperation was created between the Ministry and the various actors involved in the sector. In fact, this cooperation improved the performance of the Ministry of Health and the Ministry of Social Work. However, several issues persist, especially when it comes to the governance of human resources and the management of the scattered health infrastructures, which are often built based on political desire and not on a needs assessment.

## HEALTH COVERAGE

Comprehensive health coverage remains an out-of-reach goal. Access to the minimum level of health services at the national level requires huge investments and more human resources,<sup>9</sup> as more than half of the population (55.3%) live more than 30 minutes away from the nearest health center, and only a

اليونيسف 2009 : مذكرة تشخيصية حول السياسات الاجتماعية وصحة الأم والطفل - فؤاد الحماية الاجتماعية في غرب ووسط إفريقيا.<sup>9</sup>

third of them (32.7%) live within 5 km of the nearest health institution. This coverage varies in the different regions, going from 52% in the semi-urban countryside to 98% in the capital. As for the countryside, health services are not available in the first place, and if they are available, most people do not trust them. Inequality is portrayed in the fragility of a large proportion of the population, such as women, the elderly, immigrants, prisoners and the poor, who are affected more than others. For example, 13% of women do not benefit from prenatal health coverage, and 33% of them give birth without any medical assistance. Child immunization, a basic indicator of health protection, witnessed an alarming decline, from 80% in 2014 to less than 70% in 2018.

The Mauritanian health system consists of several levels through which health services are provided:

- Level of districts, municipalities and villages where the health posts and centers are located.
- Regional level, where there are a number of medical bodies such as regional hospitals, and their number exceeds twenty hospitals in all regions' capitals, including those that have been converted into administrative public institutions.
- The national level, which includes the national reference institutions in the hospital field, the four regional health schools, the Faculty of Medicine and the National Institute of Medical Specialties.

As for private health centers, they are spread mainly in large cities such as Nouakchott and Nouadhibou, and they play a pivotal role in improving the performance of the public sector, complementing it, facilitating citizen access to services, and assisting in expanding and simplifying health coverage and facilitating access to health. However, benefiting from the private health sector services often requires significant and even high costs that are not available to everyone. Therefore, the most important beneficiaries of these services are the rich, those who have a sponsor, and people who have health insurance.

## **FINANCIAL ACCESS TO THE RIGHT TO HEALTH**

Various national reports analyzing the situation of the sector show the urgent need for financial reconsideration of the health sector, especially at the regional level. Public funding does not cover the expenses necessary for the citizens to access their right to health, and the annual allocations from the state's general budget do not meet the needs of the



sector and are not in line with the Abuja recommendations, which acclaim providing 15% of the state's general budget for the health sector. Health expenditures show that hospitals benefited from 46% of the Ministry's budget, at the expense of facilities that provide direct services to the most marginalized population, and primary care that only benefited from 20% of the expenditures.

In this context, the distribution of the Ministry's expenditures shows that the urban community benefited from an increase of 43% compared to 12% for the rural community,<sup>10</sup> while funds were unevenly distributed among the regions. However, the Ministry adopted multiple approaches and systems to bridge these gaps and respond to the problem of financial access to treatments and services, and to ensure their access and preservation. One such approach, the reimbursement of costs system that supports the provision of essential medicines, responds to obstacles related to inefficiency, poor representation in the steering committees, lack of supervision, and the problem of frequent interruption of the medicines' supply and interruption of warehouses' supply. Nevertheless, paying the costs for medicines remains very difficult for the poor, marginalized and other disadvantaged groups such as women, women immigrants, immigrants, persons with chronic diseases, and others.

## COMPREHENSIVE HEALTH COVERAGE

Theoretically, Mauritania, like other countries, has committed at the highest levels to achieving comprehensive health coverage that leads to almost total access for citizens and residents to quality health services, and social protection and care, if available. Usually, health coverage is funded through the government's general budget, the international funding and contributions from private and charitable persons of goodwill and civil society. Recently, the government has adopted important policies that have so far resulted in the establishment of a health map and a health investment plan, opening a number of insurance funds, such as the Health Insurance Fund and the Health Solidarity Fund. The Taazour Agency has introduced an initiative to access health treatments and expand access to treatment services, the expanded Health Department's "Taahoudati" (تعهداتي) program, the "Muyassar" (مُيَسَّر) program and the regional Health Solidarity Fund. An approach was also adopted, and was approved by the Ministry of Finance, the Ministry of Health and partners related to budget management, based on programs and results.

However, the population benefiting from health coverage in the form of support, assistance, or health insurance remains modest, and the largest family expenses are health expenses. This confirms what was previously mentioned, that the individual benefits annually from only \$57, compared to the necessary amount set by the United Nations at \$112 needed to achieve SDG 3.<sup>11</sup> Concerning the government budget, we find that the government allocated approximately 7% of the budget for health in 2020, which is less than half of what is stipulated in the recommendations of the Abuja Declaration, which recommends spending and allocating no less than 15% of the state budget for health.

The government's various efforts remain limited and collapse before the fragility and quick expansion of the country and before unhelpful citizens' mentalities and behaviors, the decline in funds and the deterioration and even the lack of service infrastructure that facilitates access to the right to health, such as electricity, water, roads, and transportation infrastructure, etc. "The values of equality and justice and the fairness, cooperation and social cohesion principles constitute a guide that indicates the strategic choices of health and social policy; they also represent the guarantee for the sustainable improvement of the population's health."<sup>12</sup>

In Horizon 2015, the Mauritanian National Health Policy sought to develop, establish and provide a contemporary, well-functioning, interactive health system that was suitable and available to all the country's residents, regardless of their place of residence, educational level, age, gender, origin, economic status, etc. The report affirms that "this health system will contribute significantly and clearly to raising life quality, life expectancy, and other health rights in coordination and integration with other sectors involved in combating poverty and destitution and eliminating disease associated with poverty and ignorance."<sup>13</sup>

## KEY PLAYERS IN THE HEALTH AND SOCIAL CARE SECTOR

- Ministry of Health: (National Fund for Disease Insurance, National Fund for Health Insurance, National Solidarity Insurance Fund (إنصاف), National Executive Secretariat for AIDS Control, Ministry of Social Affairs, Children and Family)
- Ministry of Public Service (National Office of Occupational Medicine)

<sup>11</sup> تمويل النظم الصحية التحويلية نحو تحقيق أهداف التنمية المستدامة للصحة، نموذج للاحتياجات المتوقعة من الموارد في 67 من البلدان المنخفضة الدخل والمتوسطة الدخل. [الرابط](#)

<sup>12</sup> السياسة الوطنية للصحة 2015 - 2025 الصحة 22

<sup>13</sup> السياسة الوطنية للصحة 2015 - 2025 ص 9

- Ministry of Islamic Affairs and Original Education: newly established Zakat Fund
- The comprehensive organization of the health sector includes other ministerial sectors: Ministry of Water and Sanitation, Ministry of Environment and Sustainable Development, Ministry of Trade, Ministry of Equipment, Ministry of Education, Ministry of Communication, etc.
- Development partners, the private sector, and civil society organizations.

## THERAPEUTIC HEALTH SERVICES ACCORDING TO THEMATIC PRIORITY

### ■ MATERNAL AND CHILD HEALTH OR REPRODUCTIVE HEALTH

Mauritanian laws relating to reproductive health and its regulation are based on principles established by the international community in this field. The public authorities have enacted a currently applicable reproductive health law (the Reproductive Health Act No. 2017-025), facilitating access to health services and raising awareness in the areas of sex, health, as well as obstetric and reproductive services.

Data from 2019 indicate that the maternal mortality ratio (MMR) reached 454/100,000. This is a relatively high number, despite attempts by the competent authorities to provide the necessary reproductive health related services. According to the 2019 data of the National Health Information System, the percentage of married women who use contraceptive methods amounted to 13.3%, while 2018 data indicates that only 25% of health authorities provided family planning services. Meanwhile, only 33% of trained health agents in the field of family planning were available in 2018 compared to 54% in 2016, due to socio-cultural obstacles and constraints, access to health facilities providing health services related to family planning and reproductive health, and the lack of supply mechanisms and access to nearby health services. This fundamentally hinders full access to these health services and prevents attaining the approved related indicators.

There was a sharp decrease in coverage between 2018 and 2016, where 32% of health facilities did not have the necessary treatments in 2018, compared to 49% in 2016. Additionally, these health facilities and structures lacked 58% of needed personnel trained to provide care and primary

prenatal treatments in 2016. Meanwhile, coverage of prenatal consultations totaled 69%, as a result of weak capacities and lack of capacities outside the capital and large cities. Health facilities have only 28% trained staff to manage antenatal care, compared to 58% in 2016. The coverage of prenatal consultations at the national level is 69.1 out of 100 births according to 2019 data. On average, the rate is 70.37%, still far from the 80% target (PNDS).<sup>14</sup> With regard to cesarean delivery (C-section), the target has not yet been met, as it reached 8.1% in 2019. According to the national health information system (SNIS),<sup>15</sup> the lack of blood units in health facilities is a contributing factor to maternal and neonatal mortality.

### Health and Gender

Regarding women and their access to the right to health in a qualitative and equal manner as men, the Ministry of Health has adopted several positive programs in favor of women (including reproductive health, combating obstetric and cervical fistulas, specialized health programs, women's health insurance, taking care of divorced women, social support programs for vulnerable groups, the feminist movement, etc.). However, the various programs have yet to succeed in bridging the gender-based gap and disparities. Indeed, health services are still patriarchal despite all the investments and incentives that were made. Furthermore, inequality still persists, especially in access to health services at the regional and rural levels, where women suffer from several problems related to customs, traditions, and access to health, most of which are stereotyped, such as early marriage, violence against women, and health violence.

### ■ NUTRITION

Mauritania is one of the most food-fragile countries and is located in a geographical area subject to successive droughts. As such, it requires food assistance and is dependent on imports for nearly two-thirds of its food needs. Mauritania also faces challenges related to food security due to low food sufficiency rate, as its grain production covers only 20% to 50% of its population needs, as well as widespread poverty, especially in rural areas, and due to the dependence of

<sup>14</sup>PNDS : Perioperative Nursing Data Set

<sup>15</sup>SNIS : Système National d'Information Sanitaire

agricultural production on rainfall and climate changes and their impacts on living conditions. As a result, food insecurity affects 30% of families during droughts and 20% during the harvest period, while the rate of malnutrition among children is 10%, and the number of food insecure people has reached record levels of 800,000 people.

The results of the Permanent Living Conditions Survey for 2019-2020 indicate an increase in food insecurity rates estimated based on the World Food Programme's Food Insecurity Experience Scale (FIES) indicator related to food insecurity, as 9.43% of households suffer from severe malnutrition. The nutritional reality of infants and children is also alarming due to harmful practices with regards to nutrition (as per a demographic and health survey). Less than half of infants aged less than six months are breastfed (41%), while only one-fifth of children aged between 6 to 23 months benefit from appropriate complementary feeding. Underweight newborns represent a significant percentage, and 3% of the population consumes iodized salt. As for anemia, it affects 77% of children under 5 years of age and 56% of women of childbearing age (as per the summary report of the second action plan of the Strategy for Accelerated Growth and Shared Prosperity (SCAPP 2022, p. 55-56).

### ■ TAKING CARE OF THE TREATMENT OF THE ELDERLY AND PEOPLE WITH DISABILITIES

Taking care of the elderly and people with disabilities is considered a fundamental problem, as there is no consensus regarding the term old age and its definition. Taking care of the elderly and people with disabilities is the mandate of the Ministry of Social Work, Childhood and Family through the Department of Social Work and National Solidarity, in addition to the Taazour delegation, several projects, the National Human Rights Committee and the concerned NGOs, including the Mauritanian Network for Social Work<sup>16</sup> and some approaches developed by the Ministry of Health and the Ministry of Islamic Affairs through the Department of Endowments and Zakat, as well as others. However, the implementation of said approaches lacks seriousness and speed. It was noted that the system of community health associations<sup>17</sup> is almost nonexistent in Mauritania, as there are fragmented, discouraged, and scattered experiences. A relevant example would be the initiative of the International Labor Organization, which funded a pilot health insurance project for

<sup>16</sup> الشبكة الموريتانية للعمل الاجتماعي، مقابلة بتاريخ أيلول/سبتمبر 2022

<sup>17</sup> وهي جمعيات /Associations or Amicales/

the informal sector through the establishment of mutual fund under the STEP initiative.<sup>18</sup>

### **Status of Access to Mental Health**

Psychological or mental health and its relevant issues (drugs, addiction, and alcohol) are one of the main public health concerns in terms of their different effects on the schooling of children (or young adults), the high crime rates in quantity and quality, and with regards to taking care of addicts and prisoners. Undoubtedly, drug abuse is closely connected to the public health system, as a result of the fragile health system and the limited resources, even at the level of human resources, whether in terms of care, rehabilitation, or treatment. The issue is still considered a taboo, and all those suffering from psychological problems hide it by using other names related to colon diseases, or by blaming the evil eye or envy. However, the bitter truth is that we are witnessing an unprecedented spread of mental illness, addiction and drug abuse at different educational levels, at the level of upper social classes, and it is spreading among people from poor social classes. Data related to this subject is unavailable, as it is classified as confidential at the level of the health and security sector. As for the treatment, it is rarely possible to make an appointment with a specialized psychiatrist due to fully-booked schedules, since psychiatrists are few while the number of patients is large. The Ministry of Health adopted a mental health strategy that is yet to be implemented. In fact, the department charged with handling the strategic and planning aspects was abolished in the Ministry's last restructuring process. With regard to drugs and stimulants, Mauritania adopted in 2018 a multisectoral strategy to combat drugs, accompanied by a practical action plan. However, it did not receive sufficient funding for implementation.

## **COMBATING NON-COMMUNICABLE DISEASES**

Mauritania was marked by an alarming spread of urinary tract diseases, cancers, strokes, arterial diseases, obesity, diabetes, heart and chest diseases, mental disorders, as well as oral and dental diseases. Changing food culture and

<sup>18</sup> The International Labor Organization's (ILO) global Strategies and Tools against Social Exclusion and Poverty Program (STEP) supports the design and deployment of innovative systems aimed at extending social protection to excluded populations, contributes to strengthening linkages between these systems and other social protection mechanisms, and supports the establishment of social protection systems.

habits have contributed to this spread. Early detection of non-communicable diseases is so far absent as an approach in Mauritania. There is no national communication strategy or even a vision for combating non-communicable diseases. Furthermore, there is severe shortage of well-trained staff and lack of equipment and infrastructure to deal with these types of diseases. Non-communicable diseases are also associated with high costs of care and there is a complete lack of involvement of other health sectors. A national strategic action plan was introduced in 2016 aiming to prevent non-communicable diseases, as well as a national plan to combat addiction, however, neither plan has been implemented due to a shortage of financial resources. Available resources are mainly directed to support national centers for combating these diseases, such as the National Center for Heart and Arteries, the National Center for Cancer Treatment, and others.

Nevertheless, heart and arteries related diseases are no longer neglected, rather they are almost completely covered through the center for heart diseases, whether in terms of human or financial resources or medical staff and equipment. This has enabled many citizens, especially the vulnerable, to access therapeutic services at this level. Finally, we highlight a reduction in the cost of health services related to the heart and arteries diseases such as catheters and surgeries by half during the first week of March 2023 which has enabled access to these services for various vulnerable groups.

The transition from a traditional diet to a modern, multi-calorie diet, rich in carbohydrates and sugars, without fruits and vegetables, is one of the main causes of these types of non-communicable diseases, in addition to the lack of health education, protection and prevention, the spread of smoking, obesity, refraining from exercising, and the lack of health education, especially among women and the elderly. Cancer diseases, heart diseases, diabetes and AIDS are the main health challenges facing our country. Both the health community and the civil society have made significant efforts in the mobilization and sensitization to combat diseases in general, with a special focus on prevalent diseases.

## **HIV/AIDS**

The spread of HIV in Mauritania is considered confined, as it spreads at a rate of less than 1% among the population and more than 5% among some high-risk groups such as prisoners. National estimates indicate that 3,944<sup>19</sup> persons

(1,904 women, 1,614 men and 120 children) live with the virus and require treatment, although the total number of infected people exceeds 9,968. Nevertheless, the country's coverage of HIV treatment does not exceed 39%. This results in incomplete health coverage for the population, especially the most vulnerable, through interventions affecting the spread of the epidemic.<sup>20</sup> Patients still lack healthcare, access to health insurance, and treatments for opportunistic diseases, as the national program only provides medication. Indeed, examination, diagnosis, nutrition, and others, are unavailable since 2018. There is also a pressing need for collective assistance and socioeconomic support for children, orphans, widows, and families living with the virus. This has become challenging as the activities are limited and centralized in the capital, Nouakchott, while the actors in the field require greater efforts, especially with regard to training and supervision. The authorities adopted Law No. 42-2007 related to preventing HIV/AIDS and taking care of affected people, which improved public health. Among the involved partners, we mention the United Nations Fund to Fight AIDS in Mauritania, as it followed up with the patients and provided them with support during the COVID-19 pandemic and continues to do so today.<sup>21</sup>

## RIGHTS OF PERSONS WITH DISABILITIES

Legal Order No. 2006-043 on the Protection and Promotion of the Rights of Persons with Disabilities includes provisions on their access to vocational training and work. To enhance their protection, Decree No. 2015-062 was adopted, stipulating the implementation of Article 46 of aforementioned Legal Order No. 2006-043. Moreover, the state guarantees for persons with disabilities the different medical treatments necessary for their mental and physical safety and health, according to Article 204. Persons with disabilities can access these services for free, provided they hold a disability card from one of the government medical institutions or municipalities. These services are also available for children with physical disabilities preventing them from engaging in an income-generating activity. This insurance provides its beneficiaries with coverage from the risks of disease and the costs of health treatments related to maternity accidents, illness, physical or functional rehabilitation and compulsory insurance against disease. It also grants the right to compensation and direct responsibility for the costs of preventive treatment, medication and appropriate medical rehabilitation, specifically: primary treatments, hospital treatments, medication, and taking care in cases of treatments abroad, pursuant to the adopted regulations.

<sup>20</sup> الشيخ ولد سيدي رئيس الشبكة الموريتانية لمنظمات الأشخاص المصابين بالسيدا، مقابلة بتاريخ 11 تشرين الأول/أكتوبر 2022

<sup>21</sup> الدكتور المصطفى خطري، مكلف بمهمة لدى صندوق الأمم المتحدة لمحاربة السيدا نواكشوط. مقابلة بتاريخ 10 تشرين الأول/أكتوبر 2022



As for the procedures for taking caring of and protecting children: preserving the child, raising the child, developing the child's capabilities, and protecting the child's family has been a concern for the Mauritanian authorities and partners. CSOs played an active role in the field of mobilization and sensitization aimed at raising awareness about this issue.

## **HUMAN RESOURCES FOR HEALTH**

Mauritania records a significant deficit in health activities, if population density is taken into consideration. In fact, for every 1,000 citizens there are 0.39 specialized doctors, and for every 1,000 citizens there are 0.41 general practitioners. Thus, we are far from international standards in the health field, which allocate a general practitioner for every thousand citizens. Also, 60% of doctors mix general and specialized practice. Further, financial resources allocated to human resources are neglected, as is training.

Sufficient human resources require significant investments; a matter that authorities were late to realize. Once the structural reform process that precluded the state from investing in sectors such as health and education ended, the health sector was liberalized and a policy for capacity building and up-scaling was adopted. Many institutes, schools, medical colleges, and several nursing schools and a higher school of health sciences were opened in Nouakchott.

We conclude that the sector suffers from a severe shortage of human resources, medical staff, workers, and health personnel who are qualified, trained, and motivated. This shortage was exacerbated by the opening of a large number of clinics, hospitals, and health centers across the country due to the lack of human resources, in addition to widespread clientelism, lack of respect for legal and administrative procedures, and the refusal by several employees to work in remote areas or outside the capital, Nouakchott.

## **TRADITIONAL MEDICINE AND THE RIGHT TO HEALTH**

Traditional medicine is part of Mauritania's cultural heritage and is rooted in the Mauritanian mentality and subconscious. Even those who practice modern medicine sometimes integrate ancient and traditional medical treatment in addition to ruqyah in their practice, which is a widespread practice that is tolerated and allowed as long as it does not lead to a

major health problem (death or total or partial disability of the patient). To date, Mauritania does not have a legislation regulating this practice, nor a licensing process to perform the latter or even methods of adopting traditional therapeutic prescriptions. Rather, those who provide these treatments are not included in primary treatment programs.

## THE RIGHT TO HEALTH AND HEALTHCARE FOR IMMIGRANTS AND NON-CITIZENS

Given that guaranteeing freedom, equality, and human dignity is only possible in light of a society that enshrines the rule of law, and out of their keenness to create favorable conditions that aid in harmonious social growth that respects the provisions of Islam—the sole source of law—and which aligns with the requirements of the modern world, the Mauritanian people, in particular, stress the following rights and principles: “the right to equality, basic human rights and freedoms, etc.”<sup>22</sup> In this sense, Mauritania provides all primary health, educational and treatment services to immigrants, political and economic asylum seekers, displaced persons and others, where possible, with the support of a range of UN agencies, organizations and bodies, and parties involved in the humanitarian field. These services are extended to residents of the Mbera camp in the far eastern basin on the Mauritanian-Malian border, which hosts more than 119,000<sup>23</sup> displaced Malian migrants, in addition to migrants from sub-Saharan countries, Syria, Libya, Sudan, Liberia, Sierra Leone, Guinea and Guinea-Bissau, estimated at 142,975, as per the last immigrant census in 2023.<sup>24</sup>

<sup>22</sup> ديباجة الدستور الموريتاني

<sup>23</sup> حسب مصادر وزارة الداخلية الموريتانية

<sup>24</sup> تقرير الوزير الأول أمام البرلمان 2023، إلخ

## THE RIGHT TO HEALTH AND SOCIAL SECURITY FROM SOCIAL PROTECTION PERSPECTIVE

Article 9 of the Mauritanian Covenant recognizes “every person’s right to social security, including social insurance.” This requires the introduction of some form of social insurance system protecting people from the risks of illness, disability, maternity accidents, work injuries, unemployment and old age, in order to provide it to survivors, orphans and those who cannot afford healthcare costs, and to ensure that families are adequately supported and that the benefits from this scheme are sufficient and available to all without any discrimination. Social protection is a pivotal pillar for all the different national strategies. It is not available under a unified institutional framework, it is rather unevenly distributed among several government sectors, including: The Ministry of Social Work, Children and Family, the Ministry of Health, and the General Delegation for Combating Exclusion.

However, social protection remains part of a whole and varies depending on the geographical location and service access of citizens to health, treatment, preventive and awareness facilities. In order to contribute to overcoming these obstacles, facilitating equal access to different services, and ensuring social protection, the state is currently working on developing a multi-partner national strategy aimed at protecting the elderly, in addition to ensuring and providing social protection to vulnerable and disadvantaged groups. Therefore, the following objectives were set:

- Preparing an integrated national plan to ensure social health coverage at the level of the most vulnerable population;
- Expanding and integrating the different programs and social protection mechanisms to include and cover all potential beneficiaries (Taazour) and insure 100,000 people, and to provide symbolic salaries to several families (about 215,000 beneficiaries). Additionally, reviewing the microfinance policy and facilitating access to financing services;
- Encouraging access to basic services by bringing these closer to citizens and focusing on isolated, vulnerable areas.

On the other hand, determining social protection targets is done in multiple ways and on several levels, through:

- The Ministry of Health, by setting and developing plans to facilitate and ensure universal access geographically, financially and technically through: expanding health coverage, reforming and revitalizing the system of costs covering, mainstreaming the lump sum for childbirth, and expanding the trial to include the elderly, the disabled, and children in dire circumstances.
- Financial and monetary access targeting disadvantaged groups, the unemployed and the elderly with no support and those who are most affected by social and financial disparities.
- The Ministry of Social Work, Childhood and Family, the Ministry of Islamic Affairs, the Taazour Delegation, loan institutions and the private sector, by improving taking care of the elderly and developing mechanisms for risk sharing (loans and savings to finance income-generating activities, health cooperatives, collective funds, solidarity funds, etc...).
- Expanding social protection coverage and introducing new mechanisms suitable and compatible with the Mauritanian milieu and culture.

## FINANCING SOCIAL PROTECTION

In 2012, investment in social protection amounted to 5.8% of total public spending and 0.3% of GDP. Meanwhile in 2021, the rates reached 8% and 0.43% of GDP.<sup>25</sup> Government spending amounted to more than 1.1 billion Mauritanian ouguiyas on social protection alone and 1.52 billion on health (health: 1,362,301,510 new ouguiyas, about 3,884,170.76 USD and social protection: 908,501,023 new ouguiyas, about 2,582,243 USD), according to a review of public spending prior to the pandemic. As for the 2023 draft budget, it included significant expenditures for social protection. Expenditures on anti-poverty activities amount to 668,304,453 new ouguiyas, and the allocations for loans and microfinance total 17,000,000, while an amount of 15,000,000,000 new ouguiyas has been allocated for social services, and an amount of 1,500,000,000 new ouguiyas for old age services.<sup>26</sup>

<sup>25</sup> ارتفع الناتج الداخلي الخام الى 355,032 مليار أوقية جديدة خلال النصف الأول من سنة 2021 MRU

<sup>26</sup> قانون المالية 2023 مشروع

**There are several positive points resulting from increasing social protection:**

- The existence of a political will committed to social protection.
- The establishment of Taazour agency in 2019 in charge of Social Solidarity and Combating Exclusion.
- The Program for Improving Purchasing Power, Job Creation and Access to Basic Services.
- Extending and increasing the value of cash transfers to vulnerable groups.
- The provision of free health services to the poor.
- The establishment of a new health insurance system consisting of a set of institutions.
- The establishment of the School Feeding Program.
- The ratification of the Zakat Fund.
- The economic integration of persons with disabilities.

# HEALTH INSURANCE

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In Mauritania, there are many mechanisms for social protection, insurance, and healthcare, varying between modern and traditional. The ILO Convention No. 102 of 1952 serves as the reference in terms of social protection issues. Health insurance in the country is relatively new. Various researches and studies confirm that social care in Mauritania is still fragile, especially for the poor and the unemployed, although it is a union demand and a constitutional right dictated by need but hindered by resource availability. The lack of free health services, the lack of patient care and linking it to employment, and the weak health system in its different structures and formations indicate the shortcomings of various policies, despite the attempts of successive governments to formulate decrees, laws, and health strategies related to care, social protection, insurance, and establishing many institutions for patient care and social care.

Among the main actors with regard to social protection and health insurance systems in Mauritania, we can mention some institutions and governmental bodies legally in charge of the issue, for instance:

## ■ THE NATIONAL SOCIAL SECURITY FUND

The law establishing the latter and the Social Security System in 1967, amended on July 18, 1972/1987, stipulates that a Social Security System shall be established throughout the territories of the Islamic Republic of Mauritania, in charge of the following services: Family benefits (family benefits branch), compensation services in the event of accidents at work and professional diseases (professional risks branch), old-age, disability and death pensions (pensions branch), and any other social security benefits that may be established at a later stage for wage workers.<sup>27</sup>

The Fund's law stipulates that the employer shall provide social security and insurance for workers and their families, especially health treatments, and shall commit to paying daily allowances in case of illness. However, one of the shortcomings of this scheme is that it does not cover unemployment risks. Also, maternity benefits are compensated in a delayed manner and within the framework of family services, and the compensatory percentages are very low, ranging between 2% for old age,

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<sup>27</sup>The National Social Security Fund is a public institution of an industrial and commercial nature that was established by virtue of Decree No. 87-099 issued on July 1, 1987. It is mandated to run the social security system established by Law No. 67-039 of February 3, 1967 and the accompanying texts: Decision No. 464 of 4 September 1967 Regulating Social Security Services. For laws and decisions related to the National Social Security Fund in Mauritania, see [link](#).

disability and death, 2.5% for accidents at work and 8% for maternity. The typical wage (minimum wage) is 39,000 ouguiyas, equivalent to 92 USD per month). On the National Independence Day in 2022, the President of the Republic issued a decree increasing the minimum wage to 59,000 thousand ouguiyas, equivalent to 140 USD.

#### ■ THE NATIONAL HEALTH INSURANCE FUND (CNAM)

The state was late to introduce health insurance. The first serious attempt was in 2005 when it approved the establishment of the CNAM, which was established as a fund dedicated to employees and state agents. The CNAM continued to expand and its mandatory statute states that it shall be applied to several groups of insured persons: parliamentarians, civil servants, state agents, members of the armed forces in service, civilian or military pensioners from the two previous groups, and workers in public institutions and state companies. Its duties were extended to cover the largest number possible of citizens.

Overall, the Fund currently insures 30% of the country's total population, and it has brought different services closer to citizens, expanding co-payment systems to cover different public and private health agencies, while reducing the review period, especially for compensation cases related to chronic diseases, dialysis, and procedures for transferring patients abroad.

The proceeds of the CNAM for 2018 amounted to approximately 1.05 billion new ouguiyas, or five million USD covering 462,279 numbered and registered insurers in March 2019, i.e., about 11.6% of total population, without taking into consideration the hundred thousand people consisting of poor and vulnerable families, who were added in 2021. However, the total number of insured persons reached 1,200,000 people by the end of 2022, according to the Mauritanian Minister of Health. As for health cooperatives and private insurances, they are special mechanisms designed to assist in social health protection. These initiatives are still primitive.

#### ■ ESTABLISHMENT OF THE NATIONAL SOLIDARITY INSURANCE FUND IN 2022

This fund targets self-employed persons and the informal sector. It shall carry out the tasks of social protection for the most vulnerable groups, in addition to a set of traditional actors, each in their respective fields, such as the Ministry of Social Work, Children and Family, the Ministry of Health, the

General Delegation for Combating Exclusion, Taazour (social protection net system), the Ministry of Islamic Affairs and Indigenous Education, and the Zakat Agency, which will be introduced in 2022, Small and Medium Enterprises Support Program, the multi-sectoral national plan to address the COVID-19 pandemic, the women's empowerment project and the demographic dividend, the private sector, and CSOs working in the health field or active in the human rights field in general and health in particular. These CSOs are one of the major components of the Mauritanian civil society and, among many functions, they take care of patients, provide medication, build health centers, provide aid and charitable equipment in the health field, prepare and organize health and medical staff, health advocacy, mobilization, awareness-raising and sensitization, as well as financing and operating some health centers.

Examples of the role of civil society in providing patient care in some neighborhoods: Al-Nour Hospital in Toujnine, Al-Radwan Eye Hospital in Riyadh, Dar Al-Naim and Bouamatou Ophthalmological Hospital, Ard Al-Rijal Hospital and the health center of the Mauritanian Society for Health Education in Dar Al-Naim, Casablanca Hospital, etc., in addition to the health centers in a number of villages and rural municipalities, which are funded and built by civil society, in addition to other organizations active in the field of family, mother and child rights. We recall that Mauritania has a large legal arsenal, all related to social protection.

#### ■ TRADITIONAL SOCIAL INSURANCE

This is related to community cohesion in Mauritania, as traditional ties and clan and tribal kinships still take care of a large part of social insurance in all its aspects, whether relating to illness, security, education, financing for digging a well, owning a car, or other general matters. Indeed, tribes provide security for their members and assist them to overcome difficulties. Community insurance against disease is provided through materially and financially taking care of the expenses and costs of surgeries and medication, which is mutually shared between the members of the group in the form of a division among the different members of the clan. We notice a kind of socioeconomic cohesion based on religious and social dimensions. Since the state is unable to provide insurance and health protection for all citizens, tribes continue to play a pivotal role, even if the latter diminished along with the resources. The traditional and rural society still socially takes care of its members through a range of mechanisms.



## PRACTICAL STEPS TOWARDS THE REALIZATION OF THE RIGHT TO HEALTH TAKEN BY AUTHORITIES

Following are a few of the most important steps taken by the Mauritanian authorities to contribute to the realization of the right to health:

- Formulating an appropriate legal and legislative framework that is adapted to the global foundations of access to health.
- Building an infrastructure that contributes, as much as possible, to bringing treatment and health services closer to citizens (see **Table 1**).

**Table 1. Distribution of health services**

	Public Sector (Hospitals)	Private Sector (Private Clinics)	Total
Grade A Health Facility	21	37	58
Grade B Health Facility	115	49	164
Grade C Health Facility	794	62	856
<b>Total</b>	<b>930</b>	<b>148</b>	<b>1078</b>

- Establishing a solidarity insurance system to ensure that 100,000 low-income families are secured.
- Semi-functional and comprehensive care of critical cases.
- Designing programs for vulnerable groups.
- Building specialized hospitals such as the Cardiology Center, the National Oncology Center, Dialysis Centers, the National Center for Infectious Diseases and the National Liver Institute.
- Trying to expand health coverage and mainstreaming social protection.

- Funding for reproductive health to focus on maternal and child health.
- Creating a legal framework that regulates the issue of patient care, especially for poor patients, and taking care of them.
- As for human resources: 402 medical specialists, 532 general practitioners, 117 dentists, 76 pharmacists, 526 high-level technicians, 1,027 midwives, 1,556 state nurses and 2,208 social nurses were subscribed. Furthermore, there are between 473 and 702 general practitioners, 142 dentists, 4,500 medical staff members with 204 ambulances, in addition to 955 health institutions that have kidney filtering devices and 905 that have tomography devices.
- Medication prices were unified across the country and the salary of all health sector employees was doubled.
- As for free health services, some are now 100% free of charge, including those related to medication, intensive care, medical transport between hospitals and the transport of traffic accident victims while covering 60% of the treatment of pregnant women through a lump-sum cost approach.
- The development of a national solidarity insurance fund "Insaf", which is mainly directed towards the informal sector and will insure about 500,000 people by 2024. The services provided include hospital services and primary treatments across the entire country. According to the Mauritanian Minister of Health, this fund will, for the first time, include parental insurance.
- An easy system that ensures the provision of quality medication at reduced prices of 50% of the general pharmaceutical price at all health establishments across the country, and it will also contribute to the provision of free treatments for the poor. Central medication purchasing is available from a safe pharmaceutical inventory that enables the provision of medicines for a period of 6 months for an amount exceeding 8 billion ouguiyas, in addition to the availability of 15 cars equipped to ensure the transport of the medication.

## CONTRIBUTION AND ROLE OF CIVIL SOCIETY

A healthy or active civil society in the field of human rights in general and health in particular constitutes the most important component of Mauritanian civil society. Numerically, it is the most important component in the national associative fabric, where 37% of non-governmental organizations working to ensure the right to health carry out various tasks such as patient care, provision of medication, construction of health points, provision of health-related charitable aid, organization of health and medical convoys, health advocacy, mobilization, awareness and sensitization, as well as funding and operating some health points.

There are several model NGOs working on health, the right to live in a healthy, balanced environment and fighting for patient care in line with their field of expertise. However, prioritization is difficult because of the complexity of the context, varying interests, urgency and vast needs. In general, Mauritanian civil society organizations working on health, social protection and protecting rights played and still play pivotal roles that have and will yield benefits. They are also credited with health transitions, changing health behaviors, the adoption of several legislative texts, laws, and decrees related to strengthening the healthcare system, maternal and girl health, taking care of the disabled and people with chronic diseases, and constantly maintaining attention to human rights issues, including related to the right to health, environmental rights, women, girls and migrants' rights and economic and social rights, particularly in vulnerable and marginalized rural settings and poor neighborhoods in large cities such as Nouakchott and Nouadhibou. Finally, it should be noted that in February 2023, civil society organizations working in the field of non-communicable diseases formed a network of organizations interested in partnerships, especially ones with the World Health Organization.

# MAURITANIAN HEALTH SYSTEM AND COVID-19 PANDEMIC

When the first case of COVID-19 appeared on March 13, 2020, the government took several precautionary measures and prepared an action plan for the health response to the pandemic in addition to several social measures on top of the restrictive measures that were already in place. The COVID-19 pandemic revealed that the right to social protection is a fundamental human right that enables people to live in dignity and to face shocks and pandemics with strength, determination and preparedness. The repercussions and consequences of the pandemic have exceeded the already weak capacities of the state, with all its resources (human, financial, material, media and societal) that remain insignificant and vulnerable. The effects of the pandemic specifically on women were noted based on the comprehensive epidemiological trajectory survey<sup>28</sup> as well as the human, economic and health losses sustained, the severe suffering of the sick and healthy due to the difficult economic effects on an already weak economy such as ours, the high cost of health systems, the economic downturn, and the loss of employment. The impact on women and the elderly was more serious, as they represent the vulnerable groups most affected by the pandemic, where women were exposed to hunger and domestic, family and marital violence during lockdowns. Women lost access to the right to health, especially reproductive health, where pregnant women were subjected to a lot of arbitrariness due to the closure of hospitals and clinics and due to health and home confinement. Many women lost their jobs and were not able to attend school. They were exposed to sexual harassment,<sup>29</sup> rape and lost access to their civil status rights due to poor health, lack of insurance and social security.

In response to the pandemic, the government adopted a comprehensive plan that focused on the health and preventive aspect. It did not neglect resilience and the ability to adapt to pandemic conditions, and relied on the health aspect while planning using a coordination approach that followed the progression of the pandemic and development of the national economy. The government also adopted a number of measures to mitigate the pandemic's socio-economic side effects, all of which was accompanied by the launch of a presidential program that contributed to facing the pandemic. Examples of government interventions during 2020 include:

<sup>28</sup> Comprehensive epidemiological trajectory survey

<sup>29</sup> A personal analysis of the situation during and after the pandemic

- The development of an epidemiological surveillance system that enabled the permanent reprocessing of information.
- The provision of necessary supplies to national laboratories in addition to supplies, equipment and human resources that enable the availability and access to a highly capable technical platform for the National Institute of Research on Public Health allowing us to perform 1,000 tests per day instead of 100.
- Increasing Nouakchott's patient care capacity to 219 beds, including 59 recovery beds.
- The provision of supplies, tools and testing tools to as many health agencies as possible based on number of patients.
- Carrying out mobilization and awareness-raising campaigns on cleaning, sterilization, etc. at various public places designated for confinement.
- Equipping all regional and central administrations and hospitals with remote telecommunication techniques and equipment.

In order to achieve faster success and better effectiveness, the operational branch of the health sector and other sectors concerned had to coordinate their activities. The COVID-19 pandemic displayed the need for coordination and activation of the role of all sectors in order to move towards the concept and activation of the "One Health" approach and the need for coordination of various interventions and policies. The pandemic demonstrated the importance of the multilateral and solidarity dimensions of the interveners for a more effective performance, and that health work and the healthcare system must be strong, coordinated and prepared for all possibilities and to face shocks of all kinds. It also showed that urgent preventive measures should be taken to confront the crisis and to prepare to take immediate practical steps related to the establishment of a better social protection system than the existing one with the aim of providing assistance that ensures the continuity of life and helps to recover quickly in the short and medium term. In this context, the authorities waived water and electricity fees for a period of two months, exempted fishermen and workers in the informal sector from some taxes, and offered compensated leave for some of the working classes, provided free testing, screening and medication, provided cash subsidies to the poor and families in need, and partially covered the costs and expenses of vulnerable groups such as women, the disabled and others for a period exceeding one year.

Pre-pandemic data indicate that approximately 6.6% of the Mauritanian population had social coverage of any kind and 41% had access to universal health services, which is equivalent to 3.6% of GDP in 2015. As for the data from the pandemic period, there were 61,870 confirmed cases and 987 deaths related to the pandemic during October 2022. Several approaches were adopted to face the pandemic, including social distancing, vaccination, diagnosis, quarantine, closing schools and mosques, closing roads, confinement, closing land, air and sea borders, banning movement between cities, suspending various activities based on the development of the virus, its propagation and containment, and spreading awareness. Among these measures were interventions by the military, civil society, and the private sector.

The virus cycled between spreading and being contained during 2021, as a result, public authorities lifted and imposed the ban based on health variables. The government worked continuously to cope and develop strategies and plans for immunization, vaccination and protection from the virus. In addition to other proactive measures to address the various socio-economic impacts of the crisis the following was done:

- The launch of the national prevention and response campaign for the food and nutrition crises.
- Sustainable investments in social protection.
- The establishment of a special fund for social solidarity and the fight against COVID-19 with a government contribution of 2.5 billion ouguiyas, reaching 4.3 billion ouguiyas at the end of June 2020.
- The development of a multisectoral response plan in May 2020.
- The establishment of a special fund for solidarity and the fight against COVID-19 (FSS), with its revenues reaching 6.2 billion ouguiya (164 million USD) in January 2021.

Despite the authorities' efforts to monitor the situation regularly and raising pensions to protect everyone, unemployment among vulnerable groups increased during the pandemic. Accordingly, it was necessary to strike a balance between contributory and non-contributory pension systems. Women, modest workers, informal sector workers, other unemployed people and disabled persons face multiple types of discrimination. Their situation does not allow them to contribute to the social protection system in any way, despite the fact that the law guarantees their access to economic and social rights.

## HEALTH ECONOMICS: THE IMPACT OF NEOLIBERAL POLICIES ON HEALTH INVESTMENT AND ACCESS TO THE RIGHT TO HEALTH

After gaining its independence on 28 November 1960, the Mauritanian republic undertook all economic activities in order to meet the urgent needs of a newly established country. In addition to the traditional state functions (security, defense), Mauritania has worked to carry out most of the other functions of establishing economic and social infrastructure and managing economic activity in general. However, over time, the country faced unfavorable internal and external conditions and experienced a period of political instability from 1979 to 1991, when the debt ratio (the World Bank, the African Development Bank, the Islamic Development Bank, the International Monetary Fund, Arab and European funds, etc.) with respect to GDP worsened, and debt service exceeded all expectations.<sup>30</sup>

The political and economic conditions of the country increased its burdens along with the public budget deficit which required the search for ready-made solutions to reduce this deficit or generate savings. However, the country found it necessary to implement International Monetary Fund reforms which are usually known for not taking into consideration the social impact. Consequently, the country cooperated with the World Bank and the International Monetary Fund in a series of structural reform programs<sup>31</sup> whereby the state abandons a large part of its social obligations, and opened the door wide for the private sector to participate in economic, production and service activities thus resulting in privatization or restructuring.

The health sector was not spared from the direct effects of the restructuring as the state allowed the private sector to provide many basic health services at double the prices. In addition, a charge was introduced for health services and consultations. Despite the charge being nominal in some health centers and at reduced prices in government hospitals, this still does not match the capabilities of most citizens as there is no health insurance that covers the variety of health services. It also became clear that government hospitals were ill equipped as there was a lack of specialized staff, stress level, time allocated for examinations, and availability of equipment and medication.

<sup>30</sup> عيوني ولد عالي استاذ بجامعة نواكشوط، مدخل إلى الاقتصاد الموريتاني: المسيرة، الملامح، المؤشرات، ص 23، إصدارات المركز الموريتاني للدراسات والبحوث الاستراتيجية

<sup>31</sup> Economic evaluation program covering the period from 1985 to 1988, followed by a program for financial support and payment (PREF), the two framework documents for economic policy that were adopted in 1992 to 1995, as well as the development strategy covering the period from 1998 to 2001.

In this context, the Mauritanian authorities paid close attention to the role of the private sector in development, especially in the health field, and to the role of the beneficial partnership between the public and private sectors (public-private partnership), and despite the delay in doing so, they took the initiative to legitimize and codify the role of the private sector. In accordance with the national orientation in the health sector and the need to have access to health, the position of the private health sector in the national health system should have been strengthened to enable it to integrate effectively and meaningfully into the national health system as a lever and as an essential and even pivotal element in the implementation and development of health and social policy. On that account, the institutional and legal framework for the private health sector had to be improved to ensure respect for legal procedures and the adoption of the ministry's approach.

Access to the private sector's health services is much easier than it is for the public sector despite the latter's near-free access. The private sector is very prosperous in Mauritania and covers various specialties, but it remains exclusively accessible to the well-off financially or to those who have health insurance from the state or the private sector. It is noteworthy that 83% of private sector agencies do not provide vaccination services. The average availability rate reached 60% in hospitals, 39% in health centers and 12% in health establishments. It is necessary to organize the private sector in order to improve its performance with regards to basic treatment services and to search for ways to integrate between the public and private sectors where needed, and this is an important issue given the existence of about 37 private clinics compared to 21 public clinics.

The private health sector is mainly located in major urban centers such as the capital Nouakchott and Nouadhibou, and has witnessed significant growth during the last twenty years, and has contributed to the improvement of the health sector. Based on the survey held in 2018, there are 1,078 health institutions, of which 148 belong to the private sector and 930 to the public sector.<sup>32</sup>

Despite that, and despite the advantages of the private sector, we must refer to some observations related to commercial health sector and its relationship to neoliberal capital and the resulting capitalist opportunism that is already familiar in various sectors. The health philosophy remains originally based on the principle of free or almost free access to the right to health, medication, diagnosis, care and insurance, especially for the poor and vulnerable groups. However, this is a missing issue



in the private approach as it is based on profit. Mauritania by virtue of its poverty and geographical and developmental situation, which was imposed on it at one point in its history, followed the Bretton Woods institutions methodology (i.e., the International Monetary Fund and the World Bank, which held a conference in 1944 in the Bretton forests in the United States of America), and were coerced to submit to their harsh conditions based on profitability.

This is the philosophy of ruthless neoliberal rentier economics. However, the private sector has pros as well as cons. Though its services are based on profitability, means and quality rather than on the social and human dimension, in some cases, these services are more equipped and more easily accessible than the services provided by the state, especially in the service field. The private health services provided to citizens are built on the basis of profit and not on the basis of rights. The road to obtaining rights is long and mined, and the other path is fraught with financial challenges before anything else. The most important negative effects of the neoliberal economy on access to the right to health can be summarized as follows:

- The decline of central state services and the abandonment of some of their responsibilities.
- The right of access to health services becomes a commodity and not a right.
- Lack of access by vulnerable groups.
- Discrimination based on resource and financial capacity.
- Availability and quality of service.
- High cost of access to health.
- Trafficking in rights.
- Reliance on financial capacity and marginalization of the social and human dimension versus focus on profit.
- Temporal and spatial availability of the right to health components.
- Relative availability of the right for those who can afford to pay the price.
- Inability to access services by the poor due to lack of means.
- The increase in the number of uninsured citizens with the absence or decline of social welfare.

## PRACTICAL CONCLUSIONS

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We draw out of this work some conclusions related to our assessment of the access to the right to health in Mauritania. These include:

- That the Mauritanian network for social work and its partners, in cooperation with the relevant sectors, especially the Ministries of Health, the Ministry of Social Work, the National Human Rights Commission and other civil society organizations, should start advocating for human rights issues related to health, education and social protection.
- The network should follow the work that has begun and be a living example of an enlightened civil society that realistically and objectively defends the social and economic rights of all citizens while highlighting shortcomings.
- Adopting a human rights approach and advocacy that serves inclusive growth.
- The success of any initiative to implement the right to health is conditional on our ability to ensure the establishment and development of an integrated policy.
- Adopt a comprehensive human rights approach.
- Provide political stability and ensure security.
- Provide a political, economic and social ecosystem.
- The stated and clear commitment of the various actors such as the government, civil society and parliamentarians.
- Comprehensively mobilize all those involved in the realization and implementation of the right to health while mobilizing them to advocate for the relevant causes.
- Engage health professionals at all levels to provide community health as a right, not as a service.
- Mobilize the necessary funds on a permanent basis, especially for remote areas.
- Change the mindsets of beneficiaries and decision-makers about the need to understand the right to health.

- Include the right to health in various government policies and action plans as a development lever involving various actors and not related to health as a sector or ministry that is part of it.
- Full coordination with government sectors concerned with the enforcement of rights, as well as civil society, the private sector, parliament and the press to make everyone understand the need to change perceptions and adopt a rights-based approach that makes the right to health and social protection a citizen's right.

## OVERVIEW OF CHALLENGES TO ACCESSING THE RIGHT TO HEALTH

- Access to health insurance for rural women.
- Rural women are in areas not covered by the primary health service.
- Women in the city suffer from the absence of alimony and the spread of diseases.
- Poor health infrastructure and associated infrastructure such as roads, electricity, water and others.
- Weak civil society resources and partnerships.
- The limited financial and human resources of the country.
- The chaotic report, which fragments state resources.
- Healthcare and social security services are focused at the urban centers' level.

## GENERAL RECOMMENDATIONS TO ENSURE ACCESS TO THE RIGHT TO HEALTH

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- Adopting a rights-based approach to enable citizens to access the right to health.
- Adopting an integrated approach focused on changing mindsets in the health field.
- In the area of health, prioritizing the health of mothers and girls, and care for the disabled and vulnerable groups.
- Adopting a doubled budget for the health sector to enable it to acquire and procure financial and human resources.
- Expanding health and social coverage.
- Addressing human rights issues, whether health, environmental, women's, girls', migrants', or economic and social rights, in particular in vulnerable settings of former slaves and vulnerable groups in rural areas and poor neighborhoods in large cities such as Nouakchott and Nouadhibou.
- Activating the role of the media and health education.
- Consider a 'One Health' approach that addresses the veterinary, environmental and human dimension.
- Fighting pollution and prioritizing the environmental dimension.
- Controlling food products and ensuring their validity and sources.

## CONCLUSION

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The health situation in Mauritania is not much different from its counterparts in most Arab countries and the poor countries of the Sahel region, although it has witnessed a remarkable and clear improvement in recent periods. However, access to and enjoyment of the right to health as a human rights goal remains elusive, as society and citizens' understanding of the access to the right and the level of adherence of actors and decision-makers to the issue at the strategic level remains unexpected and below the required level. Achieving the fulfillment of commitments in this area requires a strict policy, adequate and appropriate funding and an effective approach that involves civil society and the private sector as essential and indispensable actors, and the development and implementation of programs and policies based on human rights rather than a therapeutic approach through the mobilization of human and financial resources and infrastructure that are not yet available. This health policy changes and fluctuates with the fluctuations of international conventions and agreements, United Nations policies and programs, and based on the situation. On the ground, the diagnosis and in-depth analysis (of the current Mauritanian health situation in a given period) in its various economic, cultural, environmental, educational, climatic and commercial manifestations is necessary, while taking into consideration the cultural, societal and environmental framework of the country and global health trends, and the fight against poverty as a determinant of health.

Through all strategies, policies and plans, Mauritania is committed to the implementation and development of a health policy within the framework of universal access for its citizens to health services in an equitable manner and that is easily accessible to all. Progressive governments have tried and continue to try to create the necessary conditions for the success of such a strategy by ensuring successful leadership and mobilizing the necessary resources to achieve this goal.

The administrative and technical health services at various levels are tasked with implementing these policies, each according to its capacity, competency, and authority. The government will also work on involving all actors, especially local groups, beneficiaries, development partners and civil

society, who must play an important and critical role in health and social work and access to the right to health, services and social welfare.

This paper constitutes the Mauritanian report on the right to health, and covers the public sector, the private sector and the role of civil society. We hope that it will be activated and its outputs implemented by taking into consideration the recommendations offered to the various actors, through a human rights' approach that adopts health as an economic, social, constitutional, national and international right, not as a political service that may or may not exist based on political desires.

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# THE RIGHT TO HEALTH IN MOROCCO

Key issues and  
challenges

## Saad Zbiri, PhD

Doctor of Economics and Public Health  
Health Systems and Policy Analyst  
Professor Researcher  
Mohammed VI University of Sciences and  
Health

Saad Zbiri holds a PhD in economics and public health from the University of Paris. He is an economist and health systems analyst. He is a professor at the International School of Public Health of the Mohammed VI University of Sciences and Health in Casablanca, Morocco.

# NOTE



This report is based on a literature review of national documents related to the right to health in Morocco. It incorporates discussions and comments from civil society actors. Through a critical economic and public health analysis of the health situation in Morocco, it highlights key issues and challenges of the right to health in the country. Finally, given the various health elements analyzed, it proposes recommendations to improve the right to health for the entire population in Morocco.

# HISTORICAL BACKGROUND OF MOROCCO AND KEY SOCIOPOLITICAL FACTORS RELEVANT TO THE RIGHT TO HEALTH

Morocco, a low-middle-income country, has experienced significant democratic, economic, and social changes in recent years.

## COUNTRY OVERVIEW

The Kingdom of Morocco is located in North Africa, in the Maghreb region, on the Atlantic Ocean and the Mediterranean Sea. The neighboring countries are Algeria and Mauritania.

Morocco is a constitutional, democratic, parliamentary, and social monarchy led by King Mohammed VI since July 1999. It is considered one of the world's oldest monarchies, in which the King, with executive powers, is the Head of State, the Supreme Chief of the Armed Forces, and the Commander of the Faithful. The King appoints the Head of Government, the equivalent of the Prime Minister, who is responsible for i) advising on the formation of the government, ii) chairing the Government Council, and iii) enacting legislation.

The 1997 reform decentralized the Moroccan administration (Official Bulletin of Morocco, 1997). The country now has 12 regions (comprised of a total of 75 provinces), each headed by a Wali (or governor) and a Regional Council composed of the vital forces of the region. These regional councils elect assemblies responsible for the democratic management of their affairs under the conditions laid down by law.

This decentralization aimed to respond to the country's socioeconomic needs on the one hand and, on the other, to ensure that the region's territorial framework was better adapted and more coherent to its new status as a local authority. The need to revise the division is also explained by the persistence of inter-regional imbalances linked, in large part, beyond natural factors, to spatial differentiations inherited from the colonial period. It reflects the evolution towards regionalization as indicated in the constitutive texts, but also given the improvement of the region's status and the adoption of the law relating to its organization. The regions created thus constitute a significant improvement on the former economic

regions, which merely reproduced the French experience of the 1930s.

## ■ NEW CONSTITUTION

Since July 2011, Morocco has had a new constitution which, for the first time, enshrines the right of access to healthcare and medical coverage as fundamental rights, in the same way as access to education and employment (General Secretariat of the Government of Morocco 2011). This new constitution also has the particularity of strengthening governance through establishing several governance bodies or through the link between responsibility and accountability.

**Article 31** of the new constitution reads as follows:

“The State, public institutions, and local authorities shall work to mobilize all available means to facilitate equal access for citizens to the conditions enabling them to enjoy the rights: to healthcare, social protection, medical coverage, and mutual solidarity or organized by the state, to modern, accessible, and quality education, to education on the attachment to the Moroccan identity and the immutable national constants, vocational training, and physical and artistic education, decent housing, work and support from the public authorities in finding employment or self-employment, access to public functions according to merit, access to water and a healthy environment, and sustainable development...”

Indeed, the 2011 constitution allows the promotion of rights as one of the major contributions of this new constitution. It is the first constitution to explicitly include the right to health (Article 31). The word right(s) is cited 88 times, [Constitution(s): 158 times and Law(s): 152 times].

## ■ NATIONAL LEGISLATION AND REGULATIONS

Morocco has a bicameral legislature:

1. the House of Representatives, *Majlis Al-Nuwab*, composed of 395 members elected directly by universal suffrage for a five-year term, and
2. the House of Councilors, *Majlis Al-Mustacharin*, composed of 120 members elected indirectly by local authorities, professional organizations, and trade unions.

Two-thirds of its members are elected for a six-year term, the others for a three-year term. Parliament has the authority to examine budgetary matters, approve draft legislation, hold ministers to account, and set up ad hoc committees of inquiry to examine government action.

## ■ DEMOGRAPHICS FEATURES

The current total population of Morocco is approximately 37 million (The World Bank 2021). The annual population growth rate is estimated at 1.1%, and the median age is around 29 years. Almost 26% of the population is under 15 (The World Bank 2021). Life expectancy at birth is about 74 years (higher for women than men). The gender distribution of the population is balanced, with women accounting for about 50% of the population. Just over half of the population (about 60%) lives in urban areas (The World Bank 2021).

## ■ ECONOMIC SITUATION

According to the latest statistics, Morocco's Gross Domestic Product (GDP) in 2021 is around 143 billion current United States dollars (USD). The country went through a period of economic stagnation. However, since the 1990s, it has experienced a more prosperous period and has gradually recovered an average growth rate of 5% in recent years. The Moroccan economy remains dependent on the agricultural sector. The poverty rate (4% of the population, poverty headcount ratio at national poverty lines) and the unemployment rate (11% of the population) remain controlled (The World Bank 2021).

## ■ SOCIOCULTURAL CHARACTERISTICS

Morocco is ranked 121st in the 2019 Human Development Report, with a Human Development Index of 0.686 (UNDP 2019). The government has invested heavily in education since the 1990s when the literacy rate was low (50% of the total population and only 30% of women). Since then, the adult literacy rate has increased significantly, and it now exceeds 90% (but is still higher for men than women) (The World Bank 2021).

Arabs and Berbers, also known as Amazighs, make up 99% of the population. The country's official languages are Arabic and Berber, although French is also widely used in government institutions.

## KEY ISSUES AND CHALLENGES MOST RELEVANT TO DISCUSS THROUGH A CRITICAL ANALYSIS OF A RIGHT-TO-HEALTH FRAMEWORK

Some national reports point out that the impact of the qualitative and quantitative developments recorded in the legislative system and institutional structures may remain limited in terms of guarantees of the effective protection of rights and freedoms (Economic, Social and Environmental Council 2018; National Council for Human Rights of Morocco 2022).

Strengthening the effectiveness of the right to health is central to implementing the national strategy. The basis for understanding the right to health is generally the definition of the World Health Organization (WHO), which defines health as "a state of complete physical, mental, and social well-being and not only the absence of disease or infirmity." Achieving this goal requires the development of multidimensional public policies that work in harmony with each other to achieve the "maximum" level of physical and mental health.

Implementing the right to health in Morocco and effective access to the right to health face several structural obstacles. We focus in this report on the development of five main issues facing the right to health in Morocco today. These are regional inequalities, financial difficulties in terms of universal health coverage, the shortage of health professionals, the lack of integration of the private sector, the absence of coordinated care pathways, and the weakness of the approach to prevention. These are discussed further below.

### GEOGRAPHICAL AND SOCIOECONOMIC DISPARITIES

Morocco has significant disparities between the 12 regions that make up its territory. These disparities concern demographic growth, social sectors, and economic dynamics. Indeed, there is a demographic and economic concentration along the Atlantic coastline and divisions between the central and peripheral regions on the one hand and between the highly urbanized and the agricultural regions on the other. This situation creates disparities in healthcare supply with a concentration of hospital structures and health professionals in large cities and on the

coast, particularly in the Rabat-Casablanca axis.

## **HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE**

Although health financing is considered a key factor for effective access to the right to health, the budget of the Ministry of Health in Morocco is still between 6% and 7% of the general State budget. It, therefore, remains below international standards (15% of the general State budget according to the Abuja Declaration and 12% according to the WHO) or in comparison with other countries with a comparable economy.

Also, out-of-pocket (OOP) expenditure represents about 50% of health expenditure, and more than 60% of this includes contributions to medical coverage, which constitute a real obstacle to access to care. This also contributes to the fact that a significant proportion of the population finds itself in a situation of fragility and precariousness due to health problems.

These financial barriers compromise the generalization of universal health coverage in Morocco. Universal health coverage for the entire population should require adequate financing mechanisms that guarantee individuals partial coverage of health expenses. This will allow people living in precarious conditions, including those with long-term chronic diseases, to access primary healthcare services. Today, health coverage systems in Morocco suffer from three significant imbalances: the challenge of financial balance, the challenge of efficiency, and the lack of a third-party payment system.

## **DEMOGRAPHY OF HEALTH PROFESSIONALS**

There is an insufficient number of health professionals in Morocco. The overall number of doctors working in the country is estimated at 2,300, of which almost half are concentrated in the regions of Rabat and Casablanca (Ministry of Health of Morocco, 2022). Also, Morocco needs 32,000 doctors and 65,000 nurses to meet the population's needs according to WHO standards. In addition, we also observe a weakness and underutilization of human resources due to management difficulties.

There is also a "flight" of doctors and health executives. The number of doctors trained in Morocco and working abroad is between 10,000 and 14,000 (Ministry of Health of Morocco 2022).

## PRIVATE SECTOR AND PUBLIC-PRIVATE PARTNERSHIP

The private sector has been developing steadily in recent years. It is thus becoming an important part of the national health system, which has a large capacity for care supply and takes care of a significant part of the population. However, the private sector is not sufficiently regulated and controlled. Also, it is not well integrated into the national health system. Public-private partnerships are thus very limited. This situation considerably limits the accessibility to the right to health and remains a fundamental issue for overhauling the national health system.

## COORDINATED CARE PATHWAY AND PREVENTION

There is an absence of a coordinated care pathway and inadequate management of human resources. The absence of this care pathway is one of the main reasons for inadequate human resources management (doctors and other health professionals). Similarly, the opacity of the care process may lead to problems in diagnosing and treating sick populations, thus putting the prognosis of patients at risk.

The preventive approach is not effectively implemented and does not address all the axes of targeting socioeconomic and environmental determinants of the right to health. Also, it does not always adopt the primary healthcare strategy, often does not establish coordinated care pathways, and does not significantly promote sexual and reproductive health.



# RECOGNITION OF THE RIGHT TO HEALTH IN MOROCCO

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The organization of health as a public service in Morocco originates from the reforms introduced by French colonial rule. The first regulatory text organizing the services of the Ministry of Health after independence was issued in August 1956. In the same year, Morocco joined the WHO on 14 May 1956. After that, there were several key stages in developing the national health system.

## THE FIRST NATIONAL HEALTH CONFERENCE IN APRIL 1959

The guiding principles of health policy in Morocco were laid down at the meeting of the first national conference on health following the country's independence in 1956. These principles are: "The health of the nation is the responsibility of the State"; and "The Ministry of Public Health is responsible for its design and implementation" (Ministry of Health of Morocco, 2013). These major principles, which form the basis of the national health system, were operationalized in the various economic and social development plans adopted from independence until 1980.

## THE DEVELOPMENT OF PRIMARY HEALTHCARE FROM 1981 TO 1994

The starting point of this second phase was Morocco's subscription to the Alma-Ata declaration on primary healthcare in 1978. The primary healthcare policy became a national priority. It was implemented with the adoption of the 1981-1985 development plan, which promoted the establishment and development of primary healthcare structures throughout the country.

## THE THIRD PHASE BEGAN IN 1994

This third phase is characterized by the restructuring of the Ministry of Health and the beginning of hospital reform. New central directorates were created for hospitals, drugs, and regulation. In addition, the reform process initiated during this period led to the start of the basic medical coverage project.

This phase was initiated by the National Colloquium on Health in Morocco: "Health development in Morocco, realities and prospects," Ouarzazate 13-16 July 1992. During this colloquium, which was attended by almost 1,200 people, 16 commissions dealt with various themes (High Commission for Planning of Morocco 1992).

## **BASIC HEALTH COVERAGE IN 2002 AS A MEANS OF IMPLEMENTING THE RIGHT TO HEALTH**

In principle, basic medical coverage aims to ensure universal access to healthcare and thus constitutes a means of implementing the right to health. Technically, it is a response to the problem of financing healthcare services, which was the subject of specific reflection in the context of the 1992 national symposium on health in Morocco (High Commission for Planning of Morocco 1992). The reform of basic medical coverage led to the promulgation of Law No. 65-00 of 3 October 2002. The generalization of the Basic Medical Assistance Scheme (RAMED) was officially launched in March 2012. It aims to guarantee the right to healthcare to economically disadvantaged people who do not benefit from compulsory health insurance.

## **THE FRAMEWORK LAW NO. 34-09 OF 2011 ON THE HEALTH SYSTEM AND HEALTHCARE SUPPLY**

In the history of health legislation in Morocco, the framework Law No. 34-09 is the first of its kind (Official Bulletin of Morocco 2011). It lays down the fundamental principles and objectives of the state's action in the health field and the health system's organization. Article 1 states that the right to health protection is the responsibility of the state and society. The law also defines the health system as a set of interdependent and complementary elements, largely in line with the WHO concept.

## **THE RIGHT TO HEALTH IN THE NEW CONSTITUTION OF 2011**

The constitution of July 2011 expressly enshrines for the first time the right to "healthcare" and "medical coverage." Indeed, Article 31 considers the right to healthcare as a comprehensive right, linking it to the determinants of health (General Secretariat of the Government of Morocco 2011). Thus, the same article also places the responsibility on public authorities

to facilitate the enjoyment of other rights, such as the right to education, decent housing, work, access to water, and a healthy environment.

## **HEALTH SECTOR STRATEGY OF THE 2012-2016 PERIOD**

The 2012-2016 health sector strategy comes from the governmental program prepared by the government appointed in the framework of the 2011 constitution (General Secretariat of the Government of Morocco 2011). In its preface, the document "Health Sector Strategy 2012-2016" announces that it is part of the political and social transformations that Morocco has experienced, which requires the adoption of a new approach based on human rights and health democracy, and thus gives a sectoral echo to the provisions of the new constitution, and in particular those relating to the rights of access to care and medical coverage (Ministry of Health of Morocco 2012).

## **TOWARDS A NATIONAL HEALTH CHARTER IN 2013**

Fifty-four years after the first national health conference in 1959, a second conference was organized by the Ministry of Health in July 2013. The overall stated objective of the conference is to reform to address current shortcomings and emerging needs in health.

The objective of this conference was to set the major priorities for action in the field of health for the next thirty years, to seek a national consensus on the major challenges and the main priorities for action in health, to initiate a collective approach to integrate the concern for health into all public policies, and to develop visibility in the field of health financing with a view to the generalization of medical coverage.

This second Conference of Health in Morocco brought together more than 500 people composed of health actors and partners of the sector to discuss the priority axes of the reform of the health system, which emerge from the expectations of the citizens, the ambitions of the health professionals, and the perspectives of development of the national health system. The event was attended by representatives of government sectors, civil society organizations, social partners, elected bodies, international organizations, and national and international experts.

## HEALTH PLAN FOR THE 2018-2025 PERIOD

The Health Plan 2025 aims to adapt to the new challenges of the 21st century, including demographics, aging, and new technologies, and to meet the needs of citizens better (Ministry of Health of Morocco 2018). It prioritizes primary healthcare and health promotion and advocates the development of hospital centers of excellence and strengthening skills and innovation. This plan proposes an innovative mode of governance and financing, a mobilization and valorization of human resources, with the involvement of citizens and the commitment of local authorities.

## THE GENERALIZATION OF SOCIAL PROTECTION IN 2021

The year 2021 was marked by the launch of the reform of the generalization of compulsory health insurance to achieve universal health coverage, which is one of the main pillars of the project for the generalization of social protection. The aim is to enable 22 million additional beneficiaries to access compulsory health insurance, which covers the costs of care, medicines, and hospitalization.

This major project will mobilize an annual budget of 51 billion dirhams (1 USD corresponds to approximately 10 dirhams) from 2025 distributed between the generalization of compulsory health insurance, the generalization of family allowances, the enlargement of the beneficiaries of the pension scheme, and the generalization of access to compensation for job loss (Ministry of Economy and Finance of Morocco 2022).

## THE NEW FRAMEWORK LAW NO. 06-22 OF 2022 ON THE NATIONAL HEALTH SYSTEM

The recently adopted framework Law No. 06-22 on the national health system repeals and replaces the framework Law NO. 34-09 on the health system and the supply of care (Official Bulletin of Morocco 2022).

It aims to reform the sector using a multidimensional approach and is based on four pillars: good governance, development of human resources, upgrading of the health offer, and digitalization. This text sets out an overall plan for an in-depth reform that should, in particular, enable the completion of the project to generalize social protection.

The aim is to "facilitate citizens' access to health services and

improve their quality, and to ensure an equal and equitable distribution of healthcare throughout the country." This reform also aims at "a territorial implementation of the public health service and the improvement of its governance through the establishment of territorial health groups, and the guarantee of medical sovereignty and the availability of medicines and health products as well as their safety and quality."

## **CREATION OF THE HIGHER AUTHORITY FOR HEALTH IN 2023**

The government is preparing to ratify the law establishing the High Authority for Health and which defines the roles and powers of the institution on which the government relies heavily in the health system reform project. This independent high authority will replace the National Health Insurance Agency, which will be dissolved immediately after the enforcement of this law.

The new institution will assume the task of technical supervision of basic compulsory insurance for illness, as well as evaluate the services of health institutions in the private and public sectors and the conditions of medical care for patients, accreditation of health institutions, and periodic evaluation for medicines, health products, and professional business based on their effectiveness and feasibility.

This institution will also be entrusted with tracking, analyzing, and evaluating epidemiological data, evaluating programs related to disease control, and conducting studies and research, in addition to expressing an opinion on public policies in the field of health, as well as submitting proposals to public authorities regarding the necessary measures to be taken to prevent any threat to the health of the population.

Since its independence, Morocco has implemented various successive reforms to ensure the entire population's right to health. As described above, several legislative texts reflect this national will. In particular, the new constitution of 2011 indicates the right to access care as a fundamental right, the responsibility of which lies with the state. Moreover, the reform to generalize universal health coverage for the benefit of all citizens was recently launched to ensure equitable access to care for all. Also, the overhaul of the health system is underway to ensure better quality and greater efficiency of health services. However, what is the reality regarding the right to health? Through data and evidence, we attempt to make an inventory and analyze the current situation, the difficulties, and the challenges regarding the right to health in Morocco.

# DESCRIPTIVE SUMMARY OF THE HEALTH SYSTEM IN MOROCCO, ITS ACHIEVEMENTS AND SHORTCOMINGS

As described below, Morocco is undergoing a demographic and epidemiological transition with an overall improvement in health indicators leading to new health needs. The health system is of the Bismarckian type, still relatively centralized, and with poorly integrated public and private sectors.

## POPULATION GLOBAL HEALTH SITUATION

Morocco is experiencing a significant change in its epidemiological profile, characterized by an increase in the burden of non-communicable diseases, which currently accounts for 75% of the total population (the three leading causes of death being: cardiovascular diseases (34%), diabetes (12%), and cancers (11%)). Injuries account for 7% of mortality, and the remaining 18% of deaths are due to communicable diseases and maternal, perinatal, and nutritional conditions (Ministry of Health of Morocco 2016).

In recent decades, Morocco has shown an advanced level of epidemiological transition. The transition in the healthcare sector in Morocco is characterized by overall economic growth, the increase in life expectancy (74 years in 2021), the decrease in the fertility rate, the regression of communicable diseases (with the persistence of some specific infectious diseases such as tuberculosis and HIV/AIDS), and the emergence of non-communicable diseases such as cardiovascular diseases, diabetes, and cancers. In addition, despite the significant reduction in maternal and child mortality over the past decade, there is still room for improvement.

## ORGANIZATION OF THE NATIONAL HEALTH SYSTEM

The Moroccan health system comprises a public and private sector (including profit and non-profit sectors). It is mainly the Ministry of Health that manages the national health system. Under the supervision of the Minister, the central administration of the Ministry of Health is organized into eight central directorates (Population, Epidemiology and Disease

Control, Hospitals and Outpatient Care, Human Resources, Equipment and Maintenance, Regulation, Financial Resources and Planning, Pharmacy and Medicines) under the direct supervision of the Secretary-General. The Directorate of Epidemiology and Disease Control is responsible for disease surveillance and public health issues in coordination with the other technical directorates. The Directorate of Population is responsible for health promotion and monitoring the health of populations, including those with special needs.

At the regional level, the Ministry of Health is represented in each of the sixteen regions by a Regional Health Directorate, which is also under the supervision of the Secretary-General. There is a provincial delegation in each province or prefecture. There is a policy of decentralization of the administration of health services from the central level to the regional health directorates. However, it appears that several tasks are still carried out by the Ministry of Health, such as the recruitment of health personnel, budgetary issues, and the development of regional health plans. The public health sector has 2,157 primary healthcare facilities, 155 hospitals (at different levels: local, provincial, regional, and tertiary) with 25,199 beds, and ten psychiatric hospitals with 1,512 beds. The private sector consists of about 11,928 private practices and 384 clinics with 12,534 beds, located mainly in urban areas and on the North Atlantic coast (Ministry of Health of Morocco 2022).

These numbers differ slightly from those reported in 2018 when the public sector included 2,860 primary healthcare facilities, 148 hospitals, including five university hospitals and 21,692 beds, ten psychiatric hospitals with 1,146 beds, 106 hemodialysis centers, and ten regional oncology centers. The private sector includes 356 clinics with 9,719 beds, 9,475 medical practices, 8,914 pharmacies, and 3,121 dental practices (Ministry of Health of Morocco 2021).

The public hospital sector remains the basis of the national health system in Morocco. The private sector also has an important place, even though it is not fully regulated and considered in the national health strategy, leading to a poor public-private partnership. There is still an inequitable geographical distribution of public and private hospitals between regions and rural and urban areas.

# THE HEALTH SECTOR IN MOROCCO AND THE MAIN CHALLENGES OF THE RIGHT TO HEALTH

We present in this section an in-depth analysis of the different elements of the Moroccan healthcare system concerning the fundamentals of the right to health.

## DETAILED HEALTH SITUATION OF THE POPULATION

The health status of the Moroccan population has significantly changed in recent years. Progress in living conditions and access to care has contributed to the improvement of many demographic and epidemiological indicators: control of population growth, increase in life expectancy, and decrease in the burden of communicable diseases, with however an increase in the burden of chronic diseases and trauma. Indeed, the overall health situation of the entire population has improved in recent years. However, health inequalities remain across social and geographic groups. Also, the preventive approach is still limited.

### ■ MATERNAL AND CHILD HEALTH

Since the 1990s, maternal and child health has been a top priority for the health sector. The maternal mortality rate has been reduced to 73 deaths per 100,000 live births. Preventable causes remain predominant: postpartum hemorrhage, hypertensive disorders including pre-eclampsia/eclampsia, infection, and abortion complications. Moreover, this progress was more observed in urban than rural areas: the annual reduction in maternal mortality is 8% in urban areas compared to 5% in rural areas, and the supervised delivery rate is 97% in urban areas compared to 74% in rural areas. Postpartum care is still provided to less than 30% of women (Ministry of Health of Morocco 2018).

The neonatal mortality rate fell 38% between 2011 and 2018, from 21 to 14 deaths per 1,000 live births. The main causes identified are respiratory distress, infections, and prematurity (Ministry of Health of Morocco 2018). On the other hand, infant and child mortality due to neonatal tetanus (elimination certified by the WHO in 2002) and measles and whooping cough in children aged 1 to 12 months have decreased sharply.



No cases of poliomyelitis and diphtheria have been reported since 1987 and 1998, respectively. Since the introduction of the specific vaccine in 2007, an 85% reduction in cases of Hemophilus Influenza type b meningitis has been noted. For measles, Morocco is considered by the WHO to be in the pre-elimination phase (Ministry of Health of Morocco 2018).

Family planning among married women aged 15-49 has shown good progress, reaching 71% in 2018. Modern method use is 58%, and unmet need is 11% in 2018 compared to 20% in 1992 (Ministry of Health of Morocco 2018). Priorities for the future include changing the contraceptive structure (48% in 2018 compared to 4% in 2011 for the intrauterine device), addressing unmet needs, and improving the quality of services. In addition, infertility and pre-marital and pre-conceptional health are new areas of concern (Ministry of Health of Morocco 2018).

Breast and cervical cancers are the most common cancers among women in Morocco, with a standardized incidence of 45 and 14 new cases per 100,000 women, respectively. Since 2012, early detection of breast cancer has been generalized at the national level, and early detection of cervical cancer is effective in some territories. While early detection of breast cancer has been very successful, early detection of cervical cancer is being expanded (Ministry of Health of Morocco 2018).

To combat violence against women and children, the Ministry of Health has instituted a national program to care for women and children who are victims of violence. However, several challenges need to be met, particularly the strengthening of inter-sectoral coordination and the development of the necessary resources, particularly human resources, including forensic doctors, psychiatrists, psychologists, and social workers (Ministry of Health of Morocco 2018).

#### ■ **NON-COMMUNICABLE DISEASES**

In Morocco, the epidemiological and demographic transition is reflected in an increase in the morbidity and mortality burden of non-communicable diseases such as cancers, diabetes, cardiovascular diseases, and chronic renal failure. Adults over 18 years show a prevalence of diabetes of 11%, a prevalence of hypertension of 30%, a prevalence of obesity of 20%, and hypercholesterolemia of 11% (Ministry of Health of Morocco 2016). The prevalence of tobacco use is around 13% (men 30% and women 1%) compared to 18% (men 31% and women 3%) in 2006.

The incidence of cancer is estimated at 40,000 new cases per

year (Ministry of Health of Morocco 2012). Kidney failure shows a prevalence of chronic kidney disease of around 3% or about 1 million people affected (Ministry of Health of Morocco 2011). Chronic respiratory diseases, notably asthma (about 4%) and chronic obstructive pulmonary disease (also about 4%), are real public health problems in Morocco (Ministry of Health of Morocco 2016).

### ■ COMMUNICABLE DISEASES

The burden of communicable diseases in Morocco has been reduced since the 1980s, and they are currently responsible for only 18% of deaths. Some diseases have been eliminated. We now distinguish three groups of communicable diseases: diseases that have been eliminated or are in the process of being eliminated: malaria, blinding trachoma, schistosomiasis, leprosy, and poliomyelitis; diseases that are still public health problems: tuberculosis, HIV infection, viral hepatitis, meningitis and certain diseases, including rabies, leishmaniasis, and anthrax; and emerging diseases and/or those that constitute threats of public health emergencies: hemorrhagic fevers, respiratory infections with new infectious agents, vector-borne diseases, etc. Leishmaniasis, collective food poisoning, the scourge of envenomation by ophidian bite, and scorpion sting are still major public health problems (Ministry of Health of Morocco 2016).

Morocco has strengthened some of its capacities (surveillance and response plans) to consolidate national health security, including for some global health crises such as the AH1N1 influenza pandemic and the Ebola virus disease epidemic. Nevertheless, this system needs to be strengthened and modernized by establishing public health emergency operational centers and using new communication techniques (Ministry of Health of Morocco 2016).

### ■ MENTAL HEALTH

Mental disorders represent a significant burden of morbidity in Morocco. Almost one individual in two declares at least one mental disorder, ranging from simple insomnia or a nervous tic to more serious disorders such as depressive, anxiety/psychotic disorders, or those disorders linked to the consumption and/or abuse of alcohol or drugs (Ministry of Health of Morocco 2016).

Regarding health infrastructure, we only observe 34 psychiatric and addictology care structures spread across the different networks of health facilities (hospital care, primary care, and sociomedical care). The total bed capacity is 2,209 beds,

i.e., a density of 0.65 beds per 10,000 inhabitants (below the EMRO region average of one bed per 10,000 inhabitants). There is also an inequity in the territorial distribution of these facilities. Indeed, two regions do not yet have any psychiatric or addictology facilities (Ministry of Health of Morocco 2016).

## ■ NON-DISCRIMINATION

In recent years, the population with special needs has received much attention from public authorities and health policies (Ministry of Health of Morocco 2020). This population is made up of four groups:

- People with disabilities represent nearly 7% of the population of Morocco, of whom 34% are aged 60 and over. The prevalence of disability, which is increasing worldwide, is a real challenge for Morocco today, given the aging of the population and the diseases associated with this group (Ministry of Health of Morocco 2018).
- The elderly, the majority of whom have at least one chronic disease. The prevalence of diabetes and high blood pressure are respectively 20% in 2018 (23% in urban areas and 15% in rural areas) against 15% in 2011 and 34% in 2018 (36% in urban areas and 30% in rural areas) against 28% in 2011 (Ministry of Health of Morocco 2018).
- The carceral population, estimated at 83,203 in 2018, is predominantly male and under 40 years old (Ministry of Health of Morocco 2018). This population is more vulnerable due to the accumulation of many risk factors, including socioeconomic and health precariousness, poor access to care, etc., and sometimes inadequate detention conditions (overcrowding and promiscuity).
- The immigrant population benefits from Morocco's new strategy (2014), responding to one of the major problems facing Africa and the Euro-Mediterranean area. The measures taken in its favor are based on the values of solidarity and integration. Immigrants legally have the same access rights to care in the public health sector as nationals.

The right to health is theoretically ensured for vulnerable populations, as it is for the entire population in Morocco. However, in practice, these special populations may have difficulty accessing healthcare.

## HEALTH FINANCING

According to the latest estimates, total health expenditure in Morocco reached approximately 61 billion dirhams in 2018 against 52 billion dirhams in 2013, an overall increase of approximately 17% and an average annual increase of approximately 3% (Ministry of Health of Morocco 2013; 2018). Moreover, current health expenditure represents 97% of total health expenditure; the rest is devoted to investment-related expenditure. Between 2013 and 2018, total health expenditure evolved at a slower pace than the evolution of GDP. Indeed, in 2018, total health expenditure represented 5.5% of GDP against 5.8% in 2013, i.e., a drop of 0.3 points during 2013-2018 (Ministry of Health of Morocco 2013; 2018).

Health expenditure per capita amounts to 1,730 dirhams (approximately 180 USD), with a relative evolution of approximately 10% in 5 years. Households are still the first health funder in Morocco, with a share of 46%, higher than the internationally recommended standards (less than 25%). The second funder is health insurance. In 2018, it covered approximately 41% of the Moroccan population and financed 30% of total health expenditure, with an increase of 7 points compared to 2013 (Ministry of Health of Morocco 2013; 2018). The share of the state in health financing via national and local tax resources remained almost constant between 2013 and 2018, recording a proportion of around 24% in 2018. The contribution of international cooperation to health financing represented only 0.2% in 2018 (Ministry of Health of Morocco 2018). Indeed, the support of partners is more qualitative than quantitative and is concerned with mobilizing the necessary expertise and capacity building (Ministry of Health of Morocco 2020).

Of the total current health expenditure, pharmacies and suppliers of medical goods are the primary beneficiaries, with a share of 23%. They are followed by public health establishments, which mainly include hospitals under the Ministry of Health and primary healthcare establishments, with a proportion of 22%. Private clinics and mutualist clinics represent approximately 19% of current health expenditure. Private outpatient providers, including but not limited to medical practices, dental practices, dialysis centers, and other centers offering outpatient services, receive only 15%. The remaining share of current health expenditure goes to laboratories and radiology centers, including national public institutes and laboratories, with a share of 12%, and to other

care providers (for example, NGOs, traditional care providers, etc.), with a proportion of 8% (Ministry of Health of Morocco 2018).

The resources mobilized by the national health system during 2018 are devoted first and foremost to expenditure on hospital care, comprising almost 30% of current health expenditure. This item includes all expenditures related to full and day hospitalization (including drugs and medical goods, analyses, radiology, etc., consumed during the hospital stay). Also, expenditure on ambulatory care (curative and preventive) and the purchase of drugs and medical goods represented respectively 29% (of which 5% for preventive care) and 23% of current health expenditure, whereas biological analyses and radiology only received 12% of this expenditure (Ministry of Health of Morocco, 2018).

The pricing of medical procedures in Morocco is still based to a large extent on negotiations between representatives of the Ministry of Health and associations of doctors and other health professionals. Also, the method of financing hospitals and liberal health professionals does not yet integrate the notion of financing based on performance or incentive financing for the quality of care. Informal payment, directly at the patient's expense, is still practiced in the public sector and is heavily used in the private sector.

Despite an increase in recent years, the budget allocated to health in Morocco remains limited. Also, OOP expenditure continues to be the main source of financing at the expense of social insurance mechanisms. The pricing system for healthcare professionals does not fully integrate the logic of cost analysis and financing based on performance and quality of care. Finally, informal payment is still an existing practice.

## **HEALTH SERVICES AND MEDICINES**

Undeniable progress has been recorded in Morocco since independence regarding healthcare supply. This progress concerns, in particular, the extension of the network of primary healthcare facilities, medical practices, pharmacies and dental practices, hospitals, and private clinics, and the development of university hospitals.

In terms of population coverage, the overall public service provision has gone from one primary healthcare facility per 14,600 inhabitants in 1990 to one primary healthcare facility per 12,238 inhabitants in 2018 (Ministry of Health of Morocco

2021). Despite this favorable evolution, several constraints and dysfunctions are to be reported, notably, the inequitable distribution of the various health facilities between urban and rural areas and between regions; the service which remains insufficient to meet the needs of the population; the delays in the implementation of the health map; the obsolescence and lack of maintenance of the real estate and medical and technical equipment; and the poor complementarity between the public service and the private sector.

Concerning the drug sector, since the 1960s, Morocco has implemented a national pharmaceutical policy to improve access to medicines and health products and to regulate the pharmaceutical sector. This strategy has enabled the gradual establishment of a strong national pharmaceutical industry and a structured, codified, and demanding distribution and dispensing circuit, allowing the accessibility and availability of medicines at the level of health structures and pharmacies. It has also promoted the rational use of medicines by regulating the professional methods of prescription and delivery.

In addition, the sector has developed according to the socioeconomic evolution of Morocco and the technological and therapeutic progress. Thus, the new Pharmacy Code was published in 2005, followed by a legal arsenal comprising different legislative and regulatory texts specific to medicines and pharmacy (Ministry of Health of Morocco 2018). Despite all these efforts, several constraints still characterize the drug sector and have an impact on the right to health, including the prices of medicines which remain high in relation to the purchasing power of Moroccans and compared to similar countries; the therapeutic protocols that are not generalized; the system of supply and management of medicines in the public sector which is deficient; and the low penetration of generics.

## ■ ACCESS TO DATA AND HEALTH INFORMATION

The constitutionalizing of the right of access to information occurred with the promulgation of the 2011 constitution (General Secretariat of the Government of Morocco 2011). Article 27 of the constitution establishes the principle and refers to the law for the terms and conditions of implementation. The organization of access to the information within the national health system takes three forms which are made available to decision-makers and managers at all levels of the health system. This is useful for planning and budgeting, improving

quality, and responding effectively to consumer needs.

#### ■ INFORMATION FOR HEALTH ACTORS

The task of information, education, and communication in relation to the various health programs was not clearly defined until 1994 by the Ministry of Health. Subsequently, the Internal Regulations of Hospitals of 2010 (Ministry of Health of Morocco 2011) entrust the hospital director with developing a hospital's internal and external communication strategy and supporting the various departments in drawing up their specific communication plans. Finally, the Framework Law of 2011 (Official Bulletin of Morocco 2011) attributes to the state the mission to "develop information, education and communication actions" one of the tools of prevention in health matters (article 4).

The publication of information by the Ministry of Health uses the Ministry's website and the sub-sites to which it links. The Ministry's website also links to general government websites that compile cross-sectoral information. Other tools, such as information, communication, and awareness campaigns, are also used.

#### ■ INFORMATION FOR PATIENTS AND USERS

Moroccan law does not define in a detailed manner the patient's right to be informed, prior to any medical act or intervention, about his or her state of health, treatments or preventive actions, their usefulness, their possible urgency, their consequences, the frequent or serious risks that are normally predictable, the possible alternatives, and the possible consequences if the patient refuses the treatment.

In the current state of the law, this question is implicitly addressed through the provisions relating to the patient's prior consent to care, which is the subject of two main texts: the 1953 Code of Ethics for Doctors and the 2010 Internal Regulations for Hospitals (Ministry of Health of Morocco 2011). However, prior consent to care is better organized by the Internal Regulations of Hospitals of 2010 (Ministry of Health of Morocco 2011), which concerns the public sector. Nevertheless, these internal regulations devote only a single article to patient information.

The right to access health information is legally guaranteed in Morocco but may be difficult. A national health information system exists; however, researchers and policymakers may have limited access to some health data.

## HEALTH WORKERS

Human capital is the most important asset and the primary resource that the health system must develop to create the conditions necessary to improve population health continuously. Despite the efforts made, the human resources situation in Morocco still shows a quantitative and qualitative deficit, which is increasingly significant, even worrying.

The WHO places Morocco among the countries with an acute shortage of healthcare personnel. The current number of medical and nursing staff remains below the minimum requirements to guarantee the entire population quality healthcare access. The public sector data indicate that the national health workforce represents a ratio of about seven doctors per 10,000 inhabitants and about nine nurses per 10,000 inhabitants (Ministry of Health of Morocco 2018).

The regional distribution of health professionals largely favors metropolitan regions and urban areas. About 60% of health professionals in both public and private sectors are concentrated in the Casablanca and Rabat regions, where only 34% of the population lives. The distribution between general practitioners and specialists in the public sector is abnormally reversed. The age pyramid of human resources in the public sector shows a higher number of staff in the 40-60 age group, with a greater risk of retirement in the years to come (Ministry of Health of Morocco 2016).

### ■ RECRUITMENT CAPACITY BELOW MINIMUM REQUIREMENTS

The recruitment rate, particularly in the public sector in recent years, has not been able to improve coverage or compensate for accumulated retirements. The same applies to the private sector, which increasingly requires qualified health professionals for its development.

Indeed, compared to the needs expressed by the Ministry of Health, i.e., more than 51,000 budgetary posts between 2008 and 2018, only 23,600 budgetary posts have been created, and during the same period, 10,450 retirements have not been compensated (Ministry of Health of Morocco 2018).

These departures will increase over the next fifteen years to reach an annual average of over 1,400. Moreover, staff instability and endemic absenteeism sometimes aggravate the shortage of human resources (Ministry of Health of Morocco 2016).



## ■ AN EVOLVING SYSTEM FOR TRAINING HEALTH PROFESSIONALS

Over the last few decades, the public authorities have invested heavily and continue to do so in medical and paramedical training to provide the population with a sufficient number of qualified health personnel.

Concerning medical training, and despite all the efforts through the national initiative for the training of 3,300 doctors per year by 2020, Morocco still suffers from an acute shortage of medical personnel, both in terms of quantity and quality (Ministry of Health of Morocco, 2018).

Currently, Morocco has seven public medical faculties whose geographical location aims to improve accessibility to medical studies and university hospital infrastructures in all the regions. Three private universities in the health sciences have been added to the national capacity to train doctors, two of which are non-profit.

Regarding continuing education, there is no clear strategic plan for skills development. In a context characterized by rapid developments in the health sciences and new biomedical and therapeutic technologies, it is now necessary to develop a concerted policy of compulsory continuing education and put a continuous system for evaluating knowledge and skills in place. This policy could be facilitated by the new distance learning tools.

The health workforce suffers from a significant deficit in Morocco. This quantitative and qualitative shortage in human resources is structural and is aggravated by an unbalanced regional distribution.

## ■ GLOBAL FACTORS AND COVID-19

The year 2020 was marked by the COVID-19 pandemic, a major health crisis, calling on all governments to prioritize measures likely to limit its spread and mitigate its consequences.

This health crisis resulted in significant changes responsible for social, economic, and political crises, requiring large-scale, collective, and united responses. Morocco prioritized the health security of the population by working to prevent the spread of the COVID-19 pandemic (containment) and by taking proactive initiatives and measures to reduce its impact (prevention, information, vaccination, etc.).

Indeed, from the start of this health crisis, Morocco was able to

secure the acquisition of biomedical and laboratory equipment and the tests and reagents necessary for COVID-19 detection, vaccination, and treatment and ensure their delivery to the population. These efforts at the national level also focused on mobilizing partners towards support for crisis management and sharing expertise for developing innovative solutions and new technologies for the resilience of the national health system.

In addition, several budgetary supports (grants, loans, etc.) from different multilateral partners were mobilized to support the financing of health activities in the context of the COVID-19 crisis, helping to make the health sector more resilient to public health emergencies.

Indeed, the health crisis linked to COVID-19 has been relatively well managed in Morocco. It is necessary to transform the threats imposed by the pandemic into opportunities to strengthen the health system's resilience in the face of possible future crises. Strategies must then be put in place to ensure self-sufficiency in health.

# ROAD MAP AND RECOMMENDATIONS FOR ACHIEVING THE RIGHT TO HEALTH IN MOROCCO

Several recommendations can be proposed for strengthening effective access to the right to health in Morocco. Indeed, it is important to continue and strengthen the structural reform of the health sector in Morocco, to address structural healthcare issues, and to seize the historic opportunities offered by the COVID-19 health crisis to bring about qualitative changes in the understanding of health as a public service placed at the center of the protection of national security and sovereignty.

The mission of the state to ensure the enjoyment of rights does not only rest on its sovereign functions of governing and protecting society but also on its legal responsibility, based on its international and national obligations, to promote and protect the rights of its citizens and to prevent violations of those rights. The right to health must be seen as one of the main responses to the challenges of development in general and the right to development in particular. This is because of the close relationship between the determinants of health on the one hand and the conditions for sustainable development and human security on the other.

Based on the barriers and dysfunctions identified above and considering the position of the national reference administrations (Economic, Social and Environmental Council, 2018; National Council for Human Rights of Morocco, 2022), efforts to improve access to the right to health for all the population may incorporate the following fundamental actions.

## STRENGTHENING THE COORDINATED CARE PATHWAY AND THE PREVENTION APPROACH

- Strengthen prevention, early diagnosis, and primary care programs based on right to health principles of equity.
- Create, operationalize, and develop surveillance and epidemiological observation mechanisms and early warning centers.
- Adapt health facilities to be safe and adequate in normal and crisis situations.
- Consider the human rights-based approach and the need for

a progressive improvement of the enjoyment of the right to health for all and/or groups of people in developing health policies and strategies, not only the efficiency aspect.

- Consider all the social determinants of health, such as providing safe drinking water, nutrition, adequate housing, the environment, and other determinants that impact the enjoyment of the right to health.
- Overhaul the national health system by placing primary healthcare at the heart of the system as the best qualified and most effective means of achieving universal health coverage in general and the social protection agenda in particular.
- Rely on an adapted care pathway that allows each citizen the right to choose his or her doctor, who will follow, receive, orientate, and accompany him or her and coordinate his or her pathway through the health system in order to save time in diagnosis and treatment, and to rationalize the use of the efforts of health professionals, health expenditure, the use of basic infrastructures and the improvement of the quality of care.
- Adapt doctors' training to the population's basic needs, and accommodate the particularities of community medicine.
- Consider mental health in its broadest sense as "the ability of each person to feel, think and act in a way that enables him or her to enjoy life and meet its challenges." This will be done within the framework of the principles of equity and dignity of persons in all its dimensions.
- Promote mental and psychological health by restructuring hospitals at national and regional levels to follow the changes and dynamics induced by societal, demographic, and epidemiological transformations.
- Develop the community approach and give associations and civil society an important place in promoting health education, urban health, and youth health.

## **PROMOTING GOOD GOVERNANCE AND REDUCING GEOGRAPHICAL SOCIAL DISPARITIES**

- Develop and implement advanced regionalization in the health sector to meet citizens' expectations and involve them in the reflection, management, and implementation of

health policies adapted to their territorial, cultural, health, and economic specificities.

- Adapt and harmonize the legal system relating to the health sector with the requirements of the human rights-based approach. This starts with recognizing access to healthcare as a human right by removing legal obstacles that could prevent citizens or certain groups of citizens from benefiting from this right.
- Take into consideration the multisectoral approach in drafting draft laws and proposals relating to the health sector to overcome certain difficulties that are not directly related to the health sector and hinder access to the right to health. This will help to address some of the complex management difficulties that do not necessarily fall within the government authority responsible for the health sector.
- Reorganize institutional health structures with a rights-based rather than a needs-based logic, and adapt them to the coordinated care pathway in the national health system.
- Find the legal means and institutional mechanisms to integrate the determinants of the right to health (economic, social, cultural, environmental, and cultural dimensions) in designing, implementing, and evaluating public health policies.
- Anticipate health crises to ensure better territorial management of health risks by developing proactive and appropriate health strategies and programs to deal with health hazards.

## **INCREASING HEALTH FINANCIAL RESOURCES TOWARD UNIVERSAL HEALTH COVERAGE**

- Increase the budget allocated to the Ministry of Health in relation to the general state budget to meet the standards of the WHO, which recommends a percentage of 12%, to progressively reach universal health coverage.
- Increase per capita spending on health to 419 US dollars in 2030 while reducing household spending by more than half: from 50% currently to less than 30% as the primary target, to fall below the 25% threshold eventually.
- Free health financing from the constraints of macroeconomic balances and treat the health sector

as an investment sector that would strengthen national sovereignty.

## **REGULATING THE PRIVATE SECTOR AND ENCOURAGING THE PUBLIC-PRIVATE PARTNERSHIP**

- Establish public health policy as a strategic sector that transcends political divides and legislatures.
- Improve the attractiveness of public hospitals through increasing financial investments and enhancing quality of care to create competition for the patient's benefit.
- Better regulate the private sector by controlling its activity and the pricing within private facilities by limiting informal payments and improving the quality of care it provides to patients.
- Clearly define the notions of health services and health establishments, regardless of their legal status. In this regard, it is important to treat the public and private sectors equally in terms of their responsibilities as service providers, whether in terms of prevention, diagnosis, treatment, or rehabilitation.
- Develop the private, not-for-profit sector, a health sector that can collaborate closely with the public sector to promote access to care for all while limiting the costs of care for patients by following national reference pricing.
- Develop the public-private partnership to mobilize the financial, technical, and human resources available to the private sector and place its expertise at the service of the state's public health policy.
- Accelerate the implementation of the national public-private coordination commission, to make it a decision-making and not a consultative body. The ultimate objective of such an initiative is to enable the two sectors to be involved in defining the strategic orientations of the national health system.

## CONCLUSION

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Morocco has an important legal arsenal allowing the enjoyment of rights and has recently launched several projects to overhaul the national health system, the fruits of which will be reaped in the years to come.

Nevertheless, given the current situation and based on the data available, the fact remains that the right to health still suffers from various barriers, notably geographical and socioeconomic disparities, low health financing and incomplete universal health coverage, shortage and geographic inequality of health professionals, non-integrated private sector and poor public-private partnership, and weak coordinated care pathway and prevention approach

Health sector reform should be seen as an integral part of reducing social and territorial disparities. With the consolidation of decentralization as a method of managing public affairs, health policy becomes one of the components of the strategy for promoting spatial justice. Thus, advanced regionalization can be a lever for promoting spatial justice in the area of access to the right to health and the reduction of territorial disparities. Expanded health coverage should guarantee an adequate financing mechanism, allowing individuals to benefit from sufficient coverage of their healthcare costs. The national health system should fully regulate the private sector and facilitate cooperation with the public sector to establish a coordinated care pathway. The national health system must also be able to attract more health professionals and better distribute them across the country. The preventive approach must be able to target the socioeconomic and environmental determinants of the right to health, the adoption of the primary healthcare strategy, and the promotion of sexual and reproductive health.

Finally, it would be beneficial to assess how the current health sector reforms will improve health rights in Morocco once implemented. For this, high-quality studies are strongly recommended to analyze the effects of these reforms and derive the best benefits for the entire population.

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# THE RIGHT TO HEALTH IN PALESTINE



## Ali Nashaat Al-Shaar

Dr. Ali Nashaat al-Shaar is an academic and a medical doctor from Palestine with local and international expertise in social health and health systems. He has extensive experience in health promotion, reproductive health, early childhood, and relief interventions.

## INTRODUCTION

Historical Palestine is an Arab country on the eastern side of the Mediterranean Sea. It borders Jordan, Egypt, Lebanon, and Syria, with an area of 27,000 square kilometers. Since the 1948 Palestinian Nakba, Palestine has been under a military occupation that has displaced the vast majority of Palestinian citizens to neighboring Arab countries and refugee camps in the West Bank and Gaza Strip.

The 1967 Nakba was another stage in immigration, displacement, and occupation. It is the year when Israel occupied the West Bank, the Gaza Strip, the Egyptian Sinai desert, and the Syrian Golan Heights, displacing hundreds of thousands of Palestinians to neighboring Arab countries.

The 1993 peace agreement with Israel included the withdrawal of the occupying state from the West Bank, Gaza Strip, and East Jerusalem. However, the withdrawal never took place. The manner in which Israel implemented the agreement resulted in unilateral practices of land confiscation and settlement expansion. It established its own road network and more than 600 checkpoints that isolate and fragment Palestinian land and impede the possibility of establishing a Palestinian state in a geographically contiguous area.

According to 2022 statistics, Palestinians around the world numbered 14.3 million (**Table 1**).

**Table 1. Palestinians' place of residence**

Place of Residence	Number (in millions)
West Bank and East Jerusalem	3.19
Gaza Strip	2.17
Areas Occupied in 1948	1.7
Arab Countries*	6.4
Other Countries	0.8
<b>Total</b>	<b>14.3</b>

\*Palestinian refugees and residents of Palestinian origin in these countries.

| Source: Palestinian Central Bureau of Statistics 2022.

Based on the peace agreements with the occupying state, the Palestinian territories were defined as areas occupied on June 5, 1967. According to UNSC Resolutions 242 and 338, the following constitute the lands on which the Palestinian state shall be established: the West Bank, East Jerusalem, and the Gaza Strip. These are the areas defined in the current report.

5.4 million Palestinians live in the West Bank, Gaza Strip, and East Jerusalem. Palestinian society's demographic composition is characterized by high fertility rates and, consequently, a high percentage of young people. Around 38% of the population is under 14. Those over sixty-five make up 3% of the population. 2.17 million people live in Gaza, which is a 360 square kilometers strip, making it one of the most densely populated regions in the world, with 6,027 people per square kilometer.

Unemployment and poverty are the most prominent features of Palestinian lives in the territories due to the deteriorating political and security reality resulting from the military occupation's policies, apartheid, and closures. Those living under the poverty line comprise 26.4% of the population (15% in the West Bank and 47% in the Gaza Strip).

The human rights situation of Palestinians in the West Bank, Gaza Strip, and East Jerusalem is an important entry point for the report. Legal violations include the continuous military occupation and its exclusionary, racist practices (See the box below for the advisory opinion presented to the International Court of Justice).

### **Advisory opinion presented to the International Court of Justice**

The Committee recognizes that the continued Israeli occupation, settlement expansion, and blockade of the Gaza Strip, which are illegal under international law, pose severe challenges and impede the full implementation of its obligations under the Convention and lead to grave violations of the rights of Palestinians, such as arbitrary detention, torture, ill-treatment, and excessive use of force and ill-treatment by Israeli security forces, acts of violence by Israeli settlers, restrictions on freedom of movement, forced displacement and evictions, appropriation of private land, home demolitions, construction of illegal settlements, and

restrictions on access to healthcare services, and preventing access to humanitarian aid.

The Committee recalls the obligations of Israel as the occupying power under international humanitarian law and international human rights law. It also recognizes that the challenges above limit the State party's effective control over its jurisdiction over its territory and its ability to prevent and combat torture and ill-treatment effectively, but reminds the State party that the Convention applies throughout its territory and that the State party should take all possible measures to implement it throughout its territory.

In this regard, the Committee regrets that, although Fatah and Hamas signed an agreement to end the Palestinian division on October 12, 2017, the State party has made only limited progress in resolving internal political issues that negatively prevent Palestinians in the West Bank, including in East Jerusalem and the Gaza Strip from enjoying their rights under the Convention and contribute to the political and geographical fragmentation of the territory of the state party. It notes that, due to this fragmentation, Palestinians are still subject to multiple legal regimes that impede the full realization of their rights under the Convention.

## PREAMBLE

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Although the right to health is considered a fundamental human right, its implementation under occupation poses a significant challenge to the Palestinian health institution and society. Palestine suffers from multiple influences on the right to health and the determinants of this right in terms of comprehensiveness, the direct impact on health, and the association of these determinants with political, social, economic, and environmental factors. This report aims to study and demonstrate the extent to which rights bearers obtain their rights and the extent to which duty bearers are committed to developing legislation, enforcing laws, and establishing a service system that respects the right to health and delivers it to its bearers in a fair manner.

This report on the right to health in Palestine does not constitute an evaluative study of health system and facilities performance, nor does it aspire to blame any party. Instead, it tries to shed light on the successes and challenges faced by the system and its users and inform the extent to which the right to health is realized. In addition, the report aims to provide transparent observations to inform multisectoral national efforts to reach a better level of care.

The realization of the right to health in Palestine is affected by a complex set of public and private determinants. The COVID-19 pandemic and the pattern of global and local interventions carried challenges related to the unequal distribution of prevention and treatment resources. The confusion of health systems, the lack of coping even in developed countries, and the decline of an essential group of health services in favor of confronting the pandemic are factors that apply to many countries, including Palestine. Moreover, combating COVID-19 in Palestine faced several challenges and sometimes failure. Notably:

1. The health system focused on preventing the pandemic and dealing with infections. This has led to shifting priorities away from other health and medical sectors, such as maternity care, kidney patients, people with mental illnesses, disabled and cancer patients. All of the latter faced difficulties in accessing services and medicines. For example, the maternal mortality rate sharply increased during and after the pandemic, indicating a decline in essential

maternal safety services.

2. There were many sources and varying types of messages to citizens during and after the first lockdown (March-June 2020), specifically regarding safety measures, the second lockdown, and the conflict between economic and health priorities. Unfortunately, this pluralism and lack of unification of the health message led to a decline in citizens' confidence in information and, consequently, to a significant decline in compliance with prevention instructions and uptake of vaccines, which led to successive waves of infections and deaths.
3. To overcome the unavailability of vaccines in the Palestinian territories, the Ministry of Health agreed to obtain a certain quantity from the Israeli side close to the expiration date. This led to severe confusion and a problem with public opinion at the time. Receiving Pfizer vaccines from Israel posed a serious challenge to promoting compliance with the vaccination campaign.

Furthermore, health and social systems in developing countries are influenced by neoliberal policies that deepen the class divide, redistribute resources in favor of the wealthiest groups, and restrict programs to address root causes of poverty and improve the lives of the poorest and most vulnerable societies or social groups. This report will not delve too much into the impact of neoliberalism on the right to health in Palestine due to urgent priorities. However, its impact on the local reality could be summarized in the following:

1. Development programs are influenced by the policies of international institutions and donors: Over the years of building the Palestinian state and its institutions, the number and size of aid, relief, and development institutions grew. However, developmental results and gains do not align with the extent of spending due to the fragmentation of donor mechanisms and policies and the political nature and conditions of a large segment of financing. As a result, programs targeting the health sector for relief and development are impacted. The report does not provide an in-depth look into the role of international institutions, including the United Nations (UN), but its observations point to the need for its review.
2. The occupation's pervasiveness in the economic reality and horizon through unfair agreements: The Paris Economic Agreement is one of the most critical examples of the lack



of justice for Palestinians in achieving balanced economic development. The occupation generates 41 billion USD annually in profits from the exploitation of natural resources that are supposed to be under the ownership and control of the Palestinian Authority. In addition, the Palestinian National Authority loses 3-4 billion USD annually due to confiscated funds, unfair taxes, and economic restrictions.

3. The impact of international pharmaceutical and medical equipment companies on the local market:

#### **Medicines:**

The list of drugs in Palestine is long and changes frequently due to rapid changes in medical and pharmaceutical sciences, the absence of strict treatment protocols for many emerging cases, and pressures on drug manufacturing and importing companies. Successive developments in medical products, strategies for promoting newly discovered and expensive products under trial, and pressure on patients and caregivers are significant contributors to the high cost of the drug bill for patients and the health system.

The above point and the lack of clear and binding medical protocols for many diseases contribute to a similar pressure on patients and the health system to use expensive therapeutic alternatives outside the basic basket of medicines. In addition, the private procurement mechanism delays patients' access to medicines and forces them to make costly transfers or lose valuable time waiting.

#### **Legislations exempting from accountability:**

**Article 4** of Decree-Law No. 11 of 2021 regarding the regulation of medical products to combat the COVID-19 virus states that "except for the death or severe injury caused by intentional misconduct or violation of the terms of the agreement signed with the Ministry, the responsibility does not rest on the producing company or supplier as a result of damage resulting from acts or activities related to the regulation of the medicinal product or from the results of such acts or activities."

This article aligned with international policies and instructions that granted legal cover, exempting vaccine production companies from accountability in case of harm from the newly produced vaccine used without going through the clinical trial processes. At the same time, this exemption gave companies a large margin to promote the vaccine's impact with the intent of

making profits.

## ■ FOCUS OF THE NATIONAL REPORT

The current report attempts to shed light on the right to health in Palestine in line with the effort to examine this right in the Arab region. Considering the complex and multiple nature of the determinants associated with the right to health, the Palestine report will focus on three most prominent reasons for deprivation in Palestinian society and various community groups:

1. The dominating military occupation is the primary determinant and greatest challenge to realizing the right to health in Palestine. The direct impact of its measures on the fundamental right to life and health is evident in the number of martyrs, wounded, and disabled as a direct result of military operations by the occupation army, its special forces, and settler mobs. According to al-Quds Center for Human Rights, in 2022, for example, the West Bank witnessed 154 Palestinian deaths and 10,000 injuries at the hands of the occupation forces and settlers (مركز القدس 2023 لحقوق الإنسان). As of writing this report (March 2023, and numbers increase by the day), the number of prisoners in occupation prisons reached 4,700, including 150 children and 460 women. Added to the above figures is the indirect impact on the right to health, evident in the exposure to constant harassment and restrictions on freedom of movement, work, and access to resources and services. Consequently, the percentage of Palestinians suffering from mental disorders significantly increased with 51% and 70% of West Bank and Gaza people report at least one symptom of depression respectively (World Bank report on mental health in West Bank and Gaza, March 2023).
2. Added to the above factor, the division of authority in the regions and the blockade of the Gaza Strip are essential determinants in the deterioration of healthcare capabilities, the decline in access to specialized services, the flow of essential resources necessary for the operation of health services, thus leading to extremely high levels of deprivation.
3. Over 30 years, the process of establishing a Palestinian healthcare system as a component of the future state faced several challenges related to governance, efficiency, and quality of services in parallel to impediments resulting from occupation practices. These difficulties impede what Palestinian citizens aspire to in terms of universal and fair

access to high-quality services. It is important to stress that despite the multiplicity of health sectors, the responsibility for realizing the right to health for Palestinian citizens rests with the governmental body that bears the duty. It means drawing up national strategies, activating participation and complementarity in covering health services and controlling their quality.

The three determinants mentioned above are the lens through which the right to health and its implementation in Palestine shall be assessed, and will be the main focus of this report without neglecting other direct and indirect determinants.

# METHODOLOGY

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The report utilized an investigative research methodology of three elements:

1. Reviewing literature and local and international reports on the right to health: They included reports of the Palestinian Ministry of Health, the Central Bureau of Statistics, and the publications of legislative and executive bodies. The reviews also included reports from international organizations, particularly the World Health Organization (WHO), UN-OCHA, and UNDP. References also included reports of Palestinian human rights organizations such as the Independent Commission for Human Rights, the Jerusalem Legal Aid and Human Right Center, and the Palestinian Institute for Economic Studies (MAS).
2. Individual and group meetings with representatives of governmental and private bodies working in the health sector.
3. Meetings with the Palestinian NGO Network.

A preliminary meeting with the Palestinian NGO Network (PNGO) set the ground for a shared conceptualization of the Palestine report and the themes that should be covered. Accordingly, the literature was reviewed, consultations were held with representatives of a group of institutions, and an initial draft was developed. Comments by AWR's regional coordinator led to a second draft. Finally, the third and penultimate draft was developed based on ANND's comprehensive review.

## ■ LIMITATIONS

- International organizations were not involved in the research due to a lack of response to the request sent to the health cluster for a meeting.
- Many relief and development institutions and UN organizations are operating in Palestine. Unfortunately, the report could not cover their contributions to realizing the right to health. However, this aspect could warrant an in-depth study.

## DEMOGRAPHIC AND HEALTH OVERVIEW

Palestinian society is young due to a persisting high fertility rate, reaching 4.1 according to the latest population census. Those under 15 comprise 56% of the population, and youth between 15 and 29 comprise 30%. Around 3% of the population is over 65 (الجهاز المركزي للإحصاء الفلسطيني 2022). The average life expectancy at birth is 74 years (76 for females and 72 for males) (الجهاز المركزي للإحصاء الفلسطيني 2022).

From an epidemiological point of view, the high calorie intake and sedentary lifestyle, the spread of health services, and the decent economic situation have led to a significant transition in the morbidity pattern as follows:

1. Several infectious diseases that contribute to high child mortality rates have been eradicated due to 100% coverage of polio, mumps, and rubella vaccination (الجهاز المركزي للإحصاء الفلسطيني 2021), leading to a drop in child mortality rates and an increase in the life expectancy index at birth.
2. Environmental changes, a technology-dependent lifestyle, and decreased physical activity among Palestinians are pushing a wave of chronic diseases. Consequently, cardiovascular diseases, diabetes, and cancer are now the top three causes of adult death (الجهاز المركزي للإحصاء الفلسطيني 2021).

### MAIN HEALTH INDICATORS

**Table 2** presents the leading health indicators based on the latest surveys.

**Table 2. Main health indicators**

Indicator	2019/2020
Neonatal mortality rate per thousand live births <sup>1</sup>	9.4/1000
Infant mortality rate per thousand live births <sup>1</sup>	12.1/ 1000
Under-five mortality rate per 1000 <sup>1</sup>	14.2/ 1000

<b>Vaccine coverage<sup>ii</sup></b>	99.8%
<b>Maternal mortality rate per 100,000<sup>iii</sup></b>	47/100000
<b>Proportion of hospital births</b>	99.6%
<b>Healthcare during pregnancy (at least four visits)<sup>iv</sup></b>	94.8%
<b>Total fertility rate<sup>ii</sup></b>	4.1
<b>Average life expectancy at birth (years)<sup>v</sup></b>	74
<b>Number of hospital beds per 1000 inhabitants<sup>ii</sup></b>	1.3
<b>Average number of citizens per health center</b>	5000
<b>Number of doctors per thousand citizens</b>	2.3
<b>Number of nursing staff per thousand citizens</b>	2.7

<sup>iv</sup> الجهاز المركزي للإحصاء الفلسطيني 2021 b

<sup>v</sup> الجهاز المركزي للإحصاء الفلسطيني 2020

<sup>i</sup> الجهاز المركزي للإحصاء الفلسطيني 2021 a

<sup>ii</sup> وزارة الصحة الفلسطينية 2019 a

<sup>iii</sup> وزارة الصحة الفلسطينية 2022

Based on the above table, health indicators in Palestine point to a relatively good situation due to the systematic and extensive effort of governmental, NGO, and private health teams. Following the Oslo Accords, the national health system was considered a crucial pillar in building the Palestinian state and national authority through national sectoral institutions.

When the Palestinian National Authority (PNA) was established, the Ministry of Health assumed responsibility for the health system. However, by that time, Palestinian CSOs already had in place a system of health services reaching particularly to the marginalized communities and contributed to primary care service provision reaching 28% of primary healthcare needs (البرغوثي 1991).

Following the PNA's establishment, social and economic developments contributed to improving nutrition, services, and information among citizens. The Ministry of Health exerted significant efforts in health education in close cooperation with health CSOs, promoting healthy behavior related to mother and child care, adherence to vaccinations, and access to preventive and curative healthcare. The cumulative improvement in the above matters led to a significant decrease in infant mortality and an increase in the average life expectancy at birth and health indicators such as coverage and

access to services.

In the past few years, investment in training and education, such as expanding the faculties of Medicine, Nursing, and Health Sciences, provided more qualified health personnel. The growth in numbers significantly improved the quantity and quality of health services in Palestine.

Healthcare in Palestine is provided through a complex network of primary, secondary, and tertiary facilities covering the West Bank, Gaza Strip, and East Jerusalem. The government sector is the largest provider of primary and secondary healthcare. UNRWA provides primary healthcare services to refugees, who comprise 40% of the population. In addition, NGOs contribute 8% of such services. The private sector provides primary healthcare in private clinics. However, its work focuses on the secondary and tertiary levels and is organically linked to the government system through the referral program or service purchase.

**Table 3. Child mortality rates (comparison between 2014 and 2020)**

Year	Premature Infant Mortality (after birth) Death per 1000 live birth		Premature infant mortality (first 28 days) death per 1000 live births		
	2014	2020	2014	2020	
Area	All Palestine	7.1	2.7	11.2	9.4
	West Bank	6.2	1.9	10.9	9.8
	Gaza Strip	8.1	3.9	11.5	8.8
Location	Urban Population	7.0	2.2	12.0	9.3
	Rural Population	9.7	3.4	8.0	9.5
	Camp Population	2.7	7.0	9.4	10.5
Education	Primary	19.9	3.6	11.8	9.6
	Secondary	7.3	2.3	14.7	10.8
	Higher	2.7	2.7	10.4	8.1

Economic Situation	Poorest	10.3	5.6	7.2	9.2
	Average	6.2	1.8	15.9	14.3
	Wealthiest	5.6	0.8	6.0	7.8

Source: Palestinian Central Bureau of Statistics (2021)

Several factors contributed to Palestine's significant progress in reducing infant mortality (**Table 3**). They include an improvement in the rate of births under medical supervision in hospitals, progress in medicine and premature infant resuscitation skills, and an almost 100% vaccination rate. For example, the mortality rate for children under one is 12 deaths per thousand live births (2021 وزارة الصحة الفلسطينية). However, the table above indicates that many infant deaths occur in the first days after birth. According to public health principles, these deaths are attributed to health conditions during pregnancy and quality of medical care during this critical period.

The apparent disparity in infant mortality rates in Palestine is linked to education, place of residence, and economic status. It is a clear indicator that vulnerability is related to access to resources, access to services, and sufficient awareness to provide optimal care for children. The low level of infant mortality among camp residents clearly indicates the quality of the primary healthcare programs used by service providers in the camps, namely UNRWA.

**Table 4. Women's health: Access to essential reproductive health services**

Year		Access to 4 visits during pregnancy (%)		Giving birth under professional supervision (%)		Cesarean birth (%)	
		2014	2020	2014	2020	2014	2020
Area	All Palestine	95.5	94.8	100	100	20.3	25.8
	West Bank	95.7	94.3	100	100	22.7	28.2
	Gaza Strip	95.3	95.4	100	100	17.4	22.4
Location	Urban Population	95.6	94.7	100	100	19.4	24.8
	Rural Population	94.7	95.2	100	100	24.1	30.5
	Camp Population	94.3	94.6	100	100	22.4	24.9



Education	Primary	93.8	91.3	100	100	22.3	25.8
	Secondary	95.9	94.6	100	100	18.9	22.5
	Higher	96.3	96.1	100	100	20.2	25.2
Economic Situation	Poorest	95.4	94.3	100	100	17.7	20.0
	Average	96.1	92.2	100	100	20.3	29.0
	Wealthiest	96.3	97.0	100	100	26.5	34.0

| Source: Palestinian Central Bureau of Statistics (2021)

**Table 5. Women's health: Access to family planning**

		Unfulfilled need (%)		Use of modern method (%)		Use of any method (%)	
Year		2014	2020	2014	2020	2014	2020
Area	All Palestine	10.9	12.9	44.1	42.8	57.2	57.3
	West Bank	11.0	13.6	46.3	42.8	59.8	55.9
	Gaza Strip	10.7	11.9	40.8	42.8	53.4	59.4
Location	Urban Population	10.5	12.6	43.4	42.3	56.6	57
	Rural Population	10.8	14.8	45.2	43.5	59.9	56.9
	Camp Population	11.7	11.9	48.1	47.1	57.6	61.1
Education	Primary	14.3	10.9	48.7	48.6	61.1	62.0
	Secondary	10.9	12.6	43.7	42.5	56.7	56.5
	Higher	10.5	14.4	39.4	39.4	53.4	54.8
Economic Situation	Poorest	95.4	94.3	100	100	49.0	56.3
	Average	96.1	92.2	100	100	55.9	54.5
	Wealthiest	96.3	97.0	100	100	66.3	58.5

| Source: Palestinian Central Bureau of Statistics (2021)

Although women's sexual and reproductive health services have wide coverage (**Table 4**), the maternal mortality rate recorded 47 deaths per 100,000 live births in 2021. This 3-fold increase from the rate in 2017 is worrisome. The 2021 maternal

mortality rates report shows that 80% of those deaths could have been prevented, which points to healthcare quality. Nevertheless, maternal mortality witnessed a significant increase between 2017 and 2022, increasing four times in the Gaza Strip. As a crucial indicator measuring the health system's performance, the reason behind the increase in maternal mortality warrants investigation. However, the report's scope does not cover the multiple causes associated with maternal mortality.

**Table 5** indicates a deterioration in another indicator related to women's reproductive health. The unmet need for family planning rose from 10.9% to 12.9% between 2014 and 2021. The matter warrants study since the indicator is related to a human rights issue for women. It also relates to social issues such as decision-making in family planning, access to services, contraception methods, and the quality of services if available. Moreover, the unmet need for family planning increased significantly among rural and urban residents compared to camp residents, indicating the stability of these services through UNRWA and their decline through the Ministry of Health, the leading service provider in cities and villages.

# RIGHT TO HEALTH IN PALESTINE: MAIN DETERMINANTS

## DIRECT REPERCUSSIONS OF THE OCCUPATION

According to the Central Bureau of Statistics, the number of martyrs of the al-Aqsa Intifada between 2000 and 2008 reached 10,577, in addition to 35,099 wounded. In addition, occupation prisons hold around 5,000 detainees at any given time. Although the above statistics are not updated, daily life in Palestine gives a clear idea of the occupation's continued violation of the right to life and health. The following factors influence the situation in this context:

- Martyrdoms, injuries, and detentions do not occur during military clashes between two equal forces. Instead, they are due to the encroachment of occupying forces and armed settlers onto unarmed and civilian areas, considered under military occupation according to international law.
- The impact of killings, disabilities, and arrests does not stop at the victim's physical health. However, it extends to their future and those around them.
- The high number of injuries, especially from major invasions, weakens the health service system, which already suffers from challenged human and financial resources.
- The Palestinian territories are subjected to many military incursions, which are detrimental to the health system's infrastructure. For example, statistics from Gaza indicate that the military operation against the Gaza Strip in 2014 put 50% of medical equipment out of service. The attack destroyed six hospitals and 50 primary healthcare centers. Another 30 centers were closed as a result of extensive damage to the infrastructure (UNFPA, WHO, MOH, 2014).

### MARTYRS

In terms of quantity, the question of martyrs describes the magnitude of the negative impact of the occupation on the most basic human right, the right to life. The social and psychological impact of martyrdom is escalating dramatically within Palestinian society. Along with disappearances, it has become the focus of social movements that aim to mitigate the

impact on martyrs' families, find sources of psychological and material support, and broaden the scope beyond numerical simplification. One of the practices involves the occupation refusing to hand over martyr's bodies, which is equal to the killings and executions, even exceeding them in brutality.

The bodies of 375 martyrs are currently being held by the occupation, which is a compound violation of International Humanitarian Law. It is an attack on the right to life. UN reports indicate that 62% of assassinations since the beginning of 2022 were not armed and did not fall during armed confrontations, including the assassination of a high percentage of children (مركز القدس للمساعدة القانونية والإرشاد 2022).

The occupation army has stopped conducting investigations, even formally. In December 2021, it changed its shooting instructions to allow armed response to stone-throwing, leading to a significant increase in murders targeting young people as a general rule. The year 2022 was the deadliest year in the last two decades, while in the first half of 2023 154 Palestinians were killed, including 28 children. The occupation authorities also refuse to issue death certificates for martyrs whose bodies are withheld, and their cases remain pending. The majority meet the definition of enforced disappearance in light of the uncertainty of their martyrdom.

In many cases, the occupation authorities handed over the bodies in ice blocks, stipulating that they be buried within two hours, before the ice melts. In other cases, they set conditions for burial, including preventing a forensic autopsy and obtaining guarantees from families not to violate the instructions under the penalty of a fine.

## ■ PRISONERS

The occupation authorities do not adhere to international standards and laws for the treatment of prisoners, especially concerning health.

"Based on observing the health status of prisoners, it is clear that healthcare was inferior. Reports of local and international human rights and prisoner affairs institutions confirm that the treatment of prisoners has become a subject of bargaining, extortion, and pressure on detainees by Israeli prison administrations. This is a flagrant violation of the articles of the Third and Fourth Geneva Conventions (Articles 29, 30, and 31 of

the Third Geneva Convention and Articles 91 and 92 of the Fourth Geneva Convention), which stipulate the right to medical treatment and care, the provision of appropriate medicines for sick prisoners, and the conduct of periodic medical examinations.”

(Report of the Palestinian National Information Center 2022)

Around 5,000 Palestinians are detained in occupation prisons, including 150 children and 1,083 administrative detainees (detained for precautionary reasons without being charged or announcing the reasons for their arrest). Administrative detention is carried out as a practice of British law imposed on Palestine during the mandate days and continues today under Israeli occupation. Since 1967, the number of martyrs among prisoners due to diseases contracted during their imprisonment reached 233. In addition, 500 prisoners are in poor health. They suffer from incurable diseases such as cancer, nervous system diseases, kidney problems, and cardiovascular ailments.

Deprivation from healthcare and preventing minimum medical services is a clear policy practiced by the occupying prison authorities against Palestinian prisoners (See box below). The Palestinian National Information Center Report indicates that the occupation authorities tend to neglect the health status of prisoners, preventing access to timely diagnosis, treatment, and palliative care in most cases.

### **Case examples of the situation of prisoners in occupation prisons**

#### **Ahmad Manasra**

Ahmad Manasra was born on January 22, 2002, in Beit Hanina, occupied Jerusalem. He was arrested on October 12, 2015, at the age of 13, on stabbing charges. On November 7, 2016, the Central Court sentenced Manasra to 12 years in prison for allegedly stabbing settlers and imposed two fines of one hundred and eighty thousand shekels (50,000 USD). The judge stated that “the child’s young age does not give him immunity from punishment.” Ahmed has been held in solitary confinement since the beginning of November 2021. On April 17, 2022, the Israeli Prison Service requested a renewal of solitary confinement for another six months.

In October 2022, an independent Israeli psychiatrist working with Physicians for Human Rights in Israel diagnosed Ahmed Manasra with severe psychological problems and stated that these problems had arisen since his imprisonment. In February 2022, Ahmed was diagnosed with schizophrenia. He has psychosis and severe depression accompanied by suicidal thoughts (Al-Jazeera 2016).

#### Nasser Abu Hamid

Prisoner Nasser Abu Hamid was killed in a hospital after the occupation authorities neglected his treatment for 12 consecutive years after his lung cancer diagnosis. Although his condition kept deteriorating in the past years to the point of near death, the military authorities refused to release him or grant him facilities to visit his relatives until hours before his death. The occupation authorities also refused to release the prisoner's body and insisted on imprisoning the body in the refrigerator until the end of his sentence.

Moreover, the Palestinian National Information Center Report indicates that the transfer of patients to specialized facilities or hospitals occurs only when there is a direct threat to life. However, these transfers occur under humiliating conditions and do not comply with international human rights conventions. For example, sick prisoners are transported using heavily sealed but standard transport vehicles. They remain in handcuffs in hospitals.

Palestinian female prisoners in Israeli prisons suffer from a humiliating health and humanitarian situation. They are deprived of special medical services, even during pregnancy or childbirth, and are treated by general physicians. Furthermore, female prisoners' medical and humanitarian needs during pregnancy or childbirth are not respected. They are forced to give birth while their hands are still tied.

#### ■ OBSTRUCTION OF ACCESS TO SERVICES

The occupation's closures, movement restrictions, and the blockade of the Gaza Strip are serious impediments to realizing the right to health and access to health services in Palestine. Palestinian areas are divided into three completely isolated geographical sections. Movement between them is subject

to permits closely linked to the occupying state's security agencies.

The Gaza Strip has been under a complete blockade since 2007, making it the largest open prison in the world. The blockade has restricted any potential for economic, service, or humanitarian growth. In 2017, a UNDP report concluded that if the blockade and the living conditions in Gaza continue at the same pace, the Strip would not be suitable for living by 2020.

Following the outbreak of the second Intifada in September 2000, the Gaza Strip suffered from repeated Israeli attacks, a blockade, and isolation from the outside world. The consequences of such actions were felt by the health sector and the Ministry of Health, which could no longer cover its operational expenses and had to halt all development projects. Moreover, the bombing of health facilities has been a staple of the war on Gaza. For example, in 2014, such attacks destroyed six hospitals and fifty primary care centers, and severely damaged 30 centers, leading to their closure (UNFPA, 2014).

In terms of healthcare, the Ministry of Health facilities suffer from a 41% shortage of medicines and a 17% shortage of medical supplies. The interruption of supplies and spare parts has led to the failure of many medical devices.

Gaza's residents, especially those needing healthcare outside the Strip, suffer from a double blockade. Patients and accompanying persons must obtain special permits subject to a security check that may extend to family members (**Table 6**). Permits are denied in the event of a security reason. As a result, many people, including children, have lost their lives while waiting for a permit or because of its rejection by the occupation authorities. The occupation's permit policy impedes Palestinians' access to healthcare due to the security checks. Data from 2021 indicate that 40% of medical permits were delayed.

As reported by Amjad al-Shawwa (Gaza, September 21, 2023 (Petra)), "A human rights organization said that a patient from the Gaza Strip died after he was denied from traveling for treatment in Al-Matlaa Hospital in occupied Jerusalem. This brings the number of patients who died due to denial of travel for treatment outside to six, including three children, since the beginning of the year." (وكالة الانباء الأردنية 2023).

**Table 6. Rate of acceptance of referral permits for patients in the Gaza Strip in August 2022**

August 2022 2022 ▼ Age Group	Number of Applications		Rate of Approval	
	Male	Female	Male	Female
0-3	92	59	60%	59%
4-17	276	218	51%	52%
18-40	271	273	44%	56%
41-60	218	270	56%	66%
Over 60	209	181	68%	77%
Total	1066	1001	54%	62%
Grand Total	2067		58%	

| Source: WHO 2022

Similarly, the West Bank is divided into separate cantons patrolled by the occupation authorities, and includes 362 roadblocks and checkpoints between areas. The isolation and closures restrict the movement of citizens, including patients. According to the Central Bureau of Statistics, while the percentage of births in hospitals in Palestine has reached 99.6%, between 2000 and 2007, 1.4% of births occurred at checkpoints or on the way to the hospital (الجهاز المركزي للإحصاء الفلسطيني 2007), which is equivalent to 1400 births annually. These closures are impeding access to essential health services, leading to many deaths and disabilities, in clear violation of the right to health and the occupation authorities' duty towards civilians.

A permit system controls the movement of citizens through checkpoints to and from the PNA territories. In addition to Jerusalem's residents, around 140,000 Palestinian workers pass through the checkpoints to work in Israel. Patients from the West Bank and Gaza referred to hospitals in Jerusalem or the Palestinian interior must follow the same route. With some exceptions, patients are forced to enter through very crowded crossings, leading some to refrain from going for treatment even if the entry permit is approved.

The impact of the occupation on the residents of the West Bank and Gaza is far-reaching. According to the World Bank, more



than 50% of the West Bank's and 71% of Gaza's population suffer from symptoms related to depression. A third of the residents have post-traumatic stress disorder (PTSD) due to the impact of the political and social situation on mental health in the Strip and recurrent exposure to violence (البنك الدولي والجهاز المركزي للإحصاء الفلسطيني 2023).

#### ■ DEPRIVATION OF NATURAL RESOURCES - WATER

Water in Palestine is a significant challenge due to climate change and, to a greater extent, the Israeli occupation's almost total control over water resources. On average, Israeli settlers consume 13 times the amount of water used by Palestinian citizens. The following list summarizes the impediments facing the right of access to water:

- **Discrimination in distribution:** The UN Committee on Economic, Social, and Cultural Rights has expressed concern about the "inequity" of Palestinian access to water sources. The committee noted that the wall "would limit or prevent access to land and water resources." The United Nations Committee on the Elimination of Racial Discrimination called on Israel to "ensure equal access to water resources for all without any discrimination."
- **Denial of access to water:** The quantities of water available to Palestinian communities in some areas are far below internationally accepted levels.
- **Unsafe water:** There are unacceptable levels of chlorine and nitrates in the drinking water resources in the Gaza Strip, which endangers public health, especially the health of children. Unlicensed water sellers in PNA areas often sell water of questionable quality at inflated prices.
- **Destruction of infrastructure:** The UN Fact-Finding Mission on the Gaza Conflict documented the Israeli army's widespread destruction of water and sanitation infrastructure during Operation Cast Lead. Amnesty International has documented the destruction of water cisterns and other infrastructure in West Bank communities by the Israeli army and settlers.
- **Blockade of Gaza:** The United Nations Humanitarian Coordinator for the Occupied Palestinian Territories called for an immediate end to the blockade, as "the deterioration and collapse of water and sanitation facilities in Gaza compound the continued denial of human dignity in the Strip."

- High cost: On average, Palestinian citizens spend 11% of their income on water, more than any other citizen in the Arab region, where the average is 2% of the income.

## **DIVISION OF AUTHORITY**

In early 2006, disagreements between Fatah and Hamas following the results of the Legislative Council elections led to armed clashes. In mid-June 2007, Hamas took control over Gaza, creating a new reality that strengthened the geographical division between the West Bank and the Gaza Strip. As a result, the government in the West Bank has no authority in the Gaza Strip and has little supervision authority over the facilities of the Ministry of Health located in Gaza.

The division of the Palestinian authorities after 2007 created a distorted reality and multiple political and service references. This situation helped the occupation authorities tighten the embargo on Gaza, adding to their brutality through a series of wars on the Strip, resulting in many martyrs, injuries, and disabled people and the destruction of the basic healthcare infrastructure. In terms of the right to health, the tightening of the blockade led to a deterioration in the health system's ability to respond to health service needs in the Strip and its citizens' right to access health services on an equal basis with the West Bank.

Due to the division, the health sector in Gaza witnessed several setbacks, affecting its performance and threatening its existence:

- Most Ministry of Health employees in the Gaza Strip stopped working after the division, leading to the loss of expertise and competencies in the field.
- Challenged financial management of Gaza human resources in health: The PNA in Ramallah refused to pay the salaries of a significant number of Ministry of Health employees in Gaza. During the years of division extending from 2007, no employee of the Ministry of Health in Gaza was employed on the Ramallah government's salaries, while hundreds of its employees left their jobs due to retirement or death.
- The conflict over the management of the health sector between the governments of Gaza and Ramallah meant the absence of a unified plan, and health became an issue of political dispute.
- The number of referrals for outpatient treatment dropped,

and the quality of external services deteriorated. Under the objective of nationalization (توطين) "treatment abroad," Gaza Strip patients were sent to private health sector facilities in the West Bank, proliferating at the expense of the public health sector, especially in the Gaza Strip.

- Health employees in Gaza and Ramallah are treated differently. The Ramallah government pays the salaries of many Ministry of Health employees registered on the Ministry's records in both Gaza and Ramallah. Employees in Gaza are deprived of the allowance for the nature of the profession, resulting in the relative insignificance of their salaries compared to their peers in the West Bank, which impacts their motivation.
- The Ministry of Health in Ramallah spends on specialized treatment abroad for patients in the Gaza Strip and on the needs of its facilities in terms of medicines and medical supplies. However, despite the recent improvement in this situation, the Ministry's shipments of medicines and medical consumables to its facilities in the Gaza Strip has long been scarce and seasonal.

The impact of the division on the right to health can be summarized as follows:

- The multiple political and procedural authorities in the Ministry of Health lead to disarray in performance and resource management protocols.
- Work procedures related to development priorities, maintenance of facilities, provision of medicines and supplies, training, and referrals are complicated.
- Material and human resources are unstable and not always available.
- Practical capacities declined due to the lack of training and development.
- A new service sector has emerged to bridge the gap and provide as many services as possible that are unavailable within the government system (public service, private sector). However, this sector has placed a huge financial burden on citizens despite its importance, and access to care has been limited to those who can pay.

# HEALTH SYSTEM GOVERNANCE

## LEGISLATION

Although occupation is the root cause of the non-fulfillment of the right to health for Palestinians, this section of the report reviews the extent to which Palestinian legislation is committed to clarifying the right and enacting laws and policies that lead to its realization.

Palestinian Basic Law does not address the right to health directly. However, it stipulates in Article 10 the commitment to human rights and fundamental freedoms and that they are binding and must be respected. Furthermore, it obligates the national authority to join, without delay, regional and international declarations and covenants that protect human rights, including charters that affirm the right to enjoy the highest standard of health. The Basic Law also addresses several issues related to the right to health, such as medical, scientific experiments, maternal and child care, and occupational health.

Similarly, the Palestinian Public Health Law No. 20 of 2004 does not directly address the concept of the right to health. However, the concept can be deduced from several health topics covered by the law and the tasks entrusted to the Ministry of Health. These include maternity and childhood care, combating communicable diseases and epidemics, quarantine, health adversities, environmental health, occupational health, health culture, medical drugs, paramedical professions, food safety, hospitals, clinics, and health centers. Nevertheless, the various economic factors imposed by the Israeli occupation weaken the PNA's capacity to define the right to health. The thousands of martyrs and wounded and the separation wall are some factors.

Article 60 of the Public Health Law of 2004 describes patients' rights in health facilities regarding receiving care, being informed about treatment, enjoying privacy, and submitting complaints. However, PNA laws and legislation do not refer to them as rights, although the law describes the duty of public health authorities to provide essential services within their facilities, specifically those directed to children and women.

The right to access services was addressed through legal

decrees aimed at facilitating access to healthcare and benefiting from coverage through the various government health insurance schemes. The Palestinian President took the most prominent legal decision in this regard. He exempted the people of Gaza from health insurance fees while granting them comprehensive coverage.

Other enforced legal decisions contribute to clarifying the concept of the right to health in the Palestinian legal system. However, many issues mentioned in the health law remain absent due to the lack of implementing regulations. On the other hand, the law does not mention other critical issues, such as health insurance, mental health, geriatric health, and persons with disabilities (PwD). Furthermore, while it pays attention to women's reproductive roles, it does not extend attention to other stages of their lives.

A review of the health laws mentioned above indicates the extent to which the health system fulfills the right to health as guaranteed by international conventions. Following the enactment of the Basic Law of 2002 and the Public Health Law of 2004, advanced steps were taken in legislative regulations on several health issues to achieve the highest possible standards. However, they do not cover the entirety of the conventions, and the Health Law does not utilize a Human-Rights Based Approach (HRBA). Instead, it considers health a mere service to citizens that required regulation.

However, determining consistency with international human rights standards is not limited to harmonization. It requires a review of regulations, decisions, and policies implemented by the authorities. While some laws and decisions are adequate, they are poorly executed, leading to a deteriorating health situation despite the presence of legal text. The same applies to the health budget. The more efficient the financial administration is in managing the budget allocated to the health sector, the closer this budget is to realizing the right to health.

Based on interviews with experts, most rights-holders do not see health as a right. The legal understanding stops at the right to obtain services, the availability of facilities and medicines, and guaranteed coverage of all health ailments on the individual, family, and community levels. This type of understanding leads to seasonal practices, random enrollment in the government's health insurance, and multiple and duplicate use of health facilities.

There is still no clear description of the right to health and HRBA. Moreover, while accountability for failure to achieve the right is addressed by national human rights organizations, there is no committee specialized in monitoring and tracking the right to health in a holistic sense outside the scope of health or medical services.

When it first assumed management of daily life in PNA territories, the PLO established the Higher Council for Health, which developed a guide on patient rights emphasizing that access to healthcare must be safe and dignified. Despite the guide's pertinence, it remains the only document addressing the health rights of citizens.

## COMMUNITY PLANNING AND PARTICIPATION

Since its establishment, the PNA has developed several strategic health plans <sup>1</sup>. They focused on building the health system and ensuring services to all Palestinians fairly and comprehensively. In 2019, the Council of Ministers mandated a National Health Committee to develop a health plan between 2019 and 2030. The plan addressed the right to health, the significance of social determinants of health, and the services that guarantee access to this right<sup>2</sup>. The strategic plan and health reports cover a broad range of issues, such as maternal and child health, sexual and reproductive health, mental health, and chronic and infectious diseases.

Sexual and reproductive health, equivalent to 40% of services, are addressed in detail in a national strategy covering the period between 2018 and 2022 (وزارة الصحة الفلسطينية 2018). Moreover, work is underway on a national strategic plan for children's mental health, and a national strategic plan has recently been issued to reduce suicide and self-harm attempts. The Strategic Health Plan in Palestine is developed through a participatory process that combines various health sectors covering primary, secondary, and tertiary services. These include:

- The government sector, including the Palestinian Ministry of Health, its facilities, and military medical services covering military and security institutions
- NGO sector
- UNRWA
- Private sector

<sup>1</sup> Strategic Health Plan (1994-1999, 1999-2004, 2004-2007, 2007-2010, 2018-2022)

<sup>2</sup> National Health Plan

All the above sectors participate in preparing the strategic plan. However, despite duplication and a high level of lack of coordination in service provision, there are various forms of integration between the public, NGO, and private sectors:

- Healthcare NGOs and CSOs coordinate with the Ministry of Health through joint facilities where the programs are harmonious and integrated. This mechanism was successful in several Palestinian areas and provided adequate services, particularly in marginalized areas.
- NGOs also work jointly with the Ministry of Health to provide healthcare services within a network of mobile clinics for remote communities. This network helps facilitate access to essential health services in areas threatened with removal and forced displacement, strengthening their steadfastness.
- The Ministry collaborates with the NGO and private sectors in secondary and tertiary healthcare by purchasing services, including through the referral system. This system allows access to health services unavailable in the Ministry's facilities. It acts as a service channel to fulfill the common interests between the two sectors and their users.

Nevertheless, beneficiaries and vulnerable groups are still absent in the planning process and in influencing policies and practices related to fulfilling the right to health. Although the various concerned groups are organized into representative and advocacy groups, their role is limited to the service provision stage, if any.

People with incurable and chronic diseases lack access to services, medicines, and special equipment. Despite several active CSOs advocating and defending their rights, reaching sufficiency remains a significant challenge for patients, institutions, and the health system alike. The coverage of persons with disabilities is a clear example of deprivation. Their representatives are still striving for the recognition of the right of persons with disabilities to obtain fair and comprehensive health insurance.

#### ■ HEALTH SERVICES TO PERSONS WITH DISABILITIES

The Rights of Persons with Disabilities Law No. 4 of 1999 regulates the lives of persons with disabilities. The law filled a vacuum after years of neglect and the absence of local laws emphasizing their rights. Although the law mentions the right to education, work, and accommodation for persons with disabilities, it remains general and does not go into

detail. It also lacks precise mechanisms and unified standards between service providers and committees entrusted with determining the type and scope of coverage. However, coverage is contingent on a 40% disability rate, determined randomly and without uniformity between regions, leading to deprivation in access to services and privileges. The absence of punitive conditions in the law also lead to flexibility in its implementation, making the rights of persons with disabilities subject to the discretion of ministries, regional bodies, and individuals.

The deprivation faced by persons with disabilities with regard to the right to health is summarized as follows:

- **The right to obtain necessary medication:** Many types of medications needed by persons with disabilities are unavailable in the Ministry of Health's departments. Patients are forced to buy them from outside the Ministry's pharmacies, increasing their burdens and those of their families.
- **The right to obtain equipment:** The government occasionally provides some equipment as gifts or in response to individual appeals. However, community organizations supporting persons with disabilities bear the greatest burden in securing this equipment, including artificial limbs, electric chairs, wheelchairs, and walking devices for polio.
- **Diagnosing and determining disability levels by medical committees:** In determining disability levels, the committees rely on a book dating back to 1965, during the Israeli civil administration. Unfortunately, the book has not been amended to adopt the modified 1997 WHO classification as a basis for determining the type and percentage of disability, despite the significant shift in the concepts of disability and the inclusion of several disabilities that were not known before, such as autism, in addition to the long journey to obtain this classification in terms of costs and physical exhaustion.
- **Obtaining medical consumables:** The health insurance coverage basket does not include medical consumables for people with disabilities, although they are an essential element in rehabilitation, treatment, and engagement in everyday life.



## UNIVERSAL HEALTH COVERAGE

Since 2012, Palestine has been committed to universal health coverage, whose methodology and mechanism are centered on the family medicine model. The Palestinian Ministry of Health and its partners use universal health coverage as a compass for planning health programs. As for the family medicine model, significant experience has been accumulated in the UNRWA system at the regional level and certainly in PNA areas. However, implementing the concept on the ground faces the following obstacles:

- Despite political and policy commitment to this principle, there is no precise programmatic analysis regarding its alignment with Palestinian society's demographic and epidemiological reality.
- Monitoring is absent, and there is no clear definition of the basket of services, the distribution of appropriate health facilities, and the mechanism for entitlement to services for the category under coverage.
- Efforts to develop a universal and unified health insurance system faltered.
- Harmony and integration in the provision of health services between the different sectors are absent.
- The scarcity of funding and the inefficient management of resources in the health sector leads to financial obstacles.

**Table 7. Health insurance subscription**

		Any Insurance (%)	Government Insurance (%)
Area	All Palestine	79.3	75.6
	West Bank	68.9	68.4
	Gaza Strip	94.8	83.4

Location	Urban Population	79.6	75.2
	Rural Population	68.3	84.0
	Camp Population	95.1	68.9
Education	Primary	78.5	76.3
	Secondary	78.7	76.0
	Higher	80.1	75.0
Economic Situation	Poorest	93.4	82.3
	Average	74.5	72.0
	Wealthiest	72.0	65.6

\*Health insurance subscription (all forms: government, UNRWA, private)

| Source: Palestinian Central Bureau of Statistics (2021)

The health insurance system in Palestine includes several insurance schemes and segments, which vary according to the provider, the service financier, the basket of services, and the insurer's contribution. According to the Independent Commission for Human Rights, the following health schemes are available in Palestine:

- Governmental health insurance, administered by the Palestinian Ministry of Health
- UNRWA insurance, managed by the agency and benefits registered refugees
- Health insurance affiliated with the military medical services, covering workers in the Palestinian security and military establishment and their families and intersecting with government health insurance
- Private health insurance (2% of the coverage), managed by private insurance companies and adopts a coverage ceiling and a limited basket of services

These schemes cover 79% of Palestinians (Table 6). However, they can barely respond to service needs, suffer from financial inefficiency, and deprive some segments of the population of services. Governmental health insurance covers 64% of citizens, 68% in the West Bank, and 83% in the Gaza Strip. However, out-of-pocket expenditure on health is high at 39%, which is catastrophic and leads to impoverishment, according to WHO definitions. It also points to the need for a clear definition and

fair access to the appropriate basket of services included in government health insurance.

The Palestinian health system, government health insurance in particular, suffers from a low collection level in exchange for a high level of spending on health, amounting to 11% of the GDP. According to Ministry of Health reports, its revenues are a mere 10% of expenditure (وزارة الصحة الفلسطينية 2019). Since the government health coverage basket is open, it includes many high-cost interventions. In addition, the basic list of medicines includes open items that allow the use and purchase of medicines outside the basket based on the recommendations of service providers, leading to inflated spending and increased lack of justice and equality in access to health services. The low health insurance revenue is an obstacle to improving services and coverage. However, Palestinian citizens contribute to the national budget through taxes and fees, and they need to see that reflected in health services.

## SPENDING ON HEALTH

The Ministry of Health's budget makes up 13% of the PNA's total budget. Per capita spending from this budget is 320 USD per person per year, the highest among countries with similar social and economic levels. However, health spending suffers from challenges related to output, efficacy, and quality of care, the most important of which will be addressed in this part of the report.

### FINANCIAL EFFICIENCY (OUT-OF-POCKET SPENDING ON SERVICES)

A set of interrelated indicators provide a description of the right to access services in Palestine: the percentage of citizens enrolled in health insurance (79%), the gap between the revenues of the Ministry of Health (68 million USD) (وزارة الصحة الفلسطينية 2019) and its expenses (714 million USD), and out-of-pocket spending on healthcare (39.5%). The above numbers point to a significant challenge in covering expenditures through revenues. There is a high reliance on donors, and the health budget suffers from a chronic deficit. However, healthcare financing must also be through the various taxes and fees citizens pay.

The financial feasibility of the Palestinian health system requires a detailed study within the framework of its commitment to universal health coverage. This requires working systematically to determine needs based on the demographic reality and epidemiological characteristics. Furthermore, it must define the roles and contributions of the different sectors in providing services according to specialization and capacity. Finally, the use of financial resources must be rationed effectively and sustainably.

Spending on referrals is high, as is the number of referrals outside the Ministry of Health facilities. In 2019, the cost of health services from outside the Ministry of Health facilities was estimated at 264 million USD (وزارة الصحة الفلسطينية 2019), equivalent to 35% of the Ministry's total budget. Although the Ministry succeeded in localizing health services to a large extent, spending on referrals has gone mainly to Palestinian health institutions outside the Ministry's facilities. Due to the high level of spending, this aspect requires consideration of

its sustainability, fairness, and adherence to the best care protocols. As in the above paragraph, spending on purchasing services from outside the Ministry's facilities must be in accordance with rights, eligibility, and financial efficiency. With regards to access to referrals for those in Gaza, although 40% of the population lives in Gaza, they only benefited from 13% of medical referrals in 2021.<sup>3</sup>

**Table 8. Number of referrals to purchase services outside the Ministry of Health facilities between 2011 and 2021**

Year	Number of Referrals
2011	56468
2012	56076
2013	61635
2014	74683
2015	87620
2016	91927
2017	94939
2018	109818
2019	104881
2020	80020
2021	99064

<sup>3</sup>International Cooperation & Projects General Directorate, Gaza, December 2022

## QUALITY OF HEALTH SERVICES

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The Palestinian health system achieved a qualitative leap under the PNA due to the sincere work of the national health staff in the harshest conditions. Several indicators are close to the levels in developed countries. However, the quality of services in Palestine remains an obstacle to achieving the right to health and well-being according to citizens' potential, expertise, and expectations. Deficiencies in the quality of healthcare can be summarized as follows:

- The rates of mortality and complications associated with healthcare are unreasonably high. In 2021, the Maternal Mortality Committee reported that the maternal mortality rate in Palestine was 47 deaths per 100,000 live births, a significant increase from 15 deaths in 2017. The latest report indicates that 80% of maternal deaths were preventable (وزارة الصحة الفلسطينية 2022). However, despite the tendency to attribute the rise to COVID-19, the steady increase began in 2017, three years before the pandemic. Thus, the actual reason for the rise could be associated with the deterioration of maternal mortality surveillance and response systems at the national level.
- Medical errors are prevalent due to the lack of standardized operations procedures and best practice protocols adoption and the lack of learning processes to advance the quality of healthcare. Instead, medical errors and adverse incidents are largely addressed through a penal legal framework that does not foster the question of quality improvement and system strengthening. The Ministry of Health, the Physician's Syndicate, and the private hospital network adopted a Decree-Law No. 31 of 2018 under the auspices of the Council of Ministers. The law addressed medical and health protection and safety from the medico-legal point of view, but was not implemented due to the absence of an insurance system for health worker practice.
- Multiple utilization of health services (or described as shopping for healthcare) is prevalent due to lack of harmony and coordination among health service providers and the country's health insurance schemes, without an added value to the quality of outputs. For example, the average number of pregnancy visits per pregnant woman per pregnancy

is 7.7, compared to the scientific recommendation of four visits. In addition, 60% of emergency visits could have been handled within healthcare facilities, indicating a clear gap for both facilities and users.

- Early detection, confirmation of diagnosis, treatment and post-treatment support for the most dangerous and burdensome diseases, such as cancer, are incomplete. For example, reports indicate that 70% of breast cancer cases are detected in the third or fourth stages of the disease leaving little space for cure or effective treatment.

The above points indicate the need to focus on healthcare quality as one of the pillars of realizing the right to health. However, its negative impact on people's confidence in the healthcare system causes a financial burden that affects the system and impedes its development.

## MAIN CONCLUSIONS

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The Israeli military occupation is the primary determinant impacting Palestinians' right to health. The occupation's policies and practices represent a threat to the right to life, first and foremost, and impact other determinants related to access to services, their quality, and adequacy. Therefore, ending the occupation is the priority for realizing Palestinians' right to health.

Several attempts were made to cover the social and economic determinants associated with the right to health in Palestine. However, the right to health at the legislative, institutional, and societal levels is defined as the right to access health services. Palestinian legislative documents and the Palestinian Basic Law lack clear articles and clauses regarding the right to health. Within the frame of service provision, there is a gap and an opportunity for wider definition of this right to include social, environmental and economic determinants. Within the frame of universal health coverage, there is an opportunity to both improve the definition and better articulate the right to health within the wider scope at the policy and practice levels.

Achieving the right to health in Palestine is a highly complicated endeavor. The elements of neoliberalism, political reality, and the multi-faceted emergency significantly obstruct access to this right. Although it was impossible to look into the role of international institutions, the decline in a set of health indicators related to some of their missions, mandates and programs indicates the need to review this role and put it in its proper framework and direction.

The division between the Gaza Strip and the West Bank poses a serious challenge to Palestine's political and institutional situation. However, despite its negative impact on the national health system's performance, it cannot be seen in isolation from the embargo imposed on Gaza.

The Palestinian health system is multisectoral and serves a relatively small population of 5 million people. However, the fragmentation of services and the multiplicity of policies and interests impede the realization of the right to health and thus lead to the loss of meaningful opportunities for justice and development.



Significant differences exist in the distribution of services between geographic regions and societal groups. Persons with disabilities suffer from an apparent deprivation in obtaining the right to health and the privileges that take into account their health and dignity.

Out-of-pocket spending on health, which amounts to around 40%, is a clear indicator of the state of inadequacy and deprivation with regard to coverage, justice, and universal access to health services. Although this indicator reaches higher levels in some Arab countries, the nature of Palestinian society, the multiplicity of healthcare sectors, and the distribution of utilities require out-of-pocket spending that is caused by system deficiencies or collateral expenses on transportation and medications outside the essential list. Here, the health sector's economic (actuarial) management efficiency requires a more in-depth study.

The maternal mortality rate is a comprehensive indicator that reflects the performance of health systems in different countries. The doubling of the maternal mortality rate in Palestine during the last five years is evidence of a systematic challenge. All relevant local and international players must be taken into consideration. While the current report did not look into the performance of international institutions, an in-depth study is necessary.

Governance of the health system requires a comprehensive and detailed discussion. Health services must be localized, maximizing integration and complementarity among care sectors, increasing the efficiency of health spending and coverage within a comprehensive and fair national health insurance system, and improving the quality of each health service. Within the current report, systemic governance is a prerequisite for realizing the right to health. However, efforts in this regard are still in the planning stage.

## RECOMMENDATIONS

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The Israeli occupation is responsible for the deterioration of health status and services in Palestine. As long as the occupation remains, the occupying power must respect international covenants and international humanitarian law in this context.

Bearing in mind the confines of the Israeli occupation, the Palestinian government, in general, and the Ministry of Health, in particular, are the duty-bearers concerning the right to health. Accordingly, the government and the Ministry must assume legal and moral responsibility for the lives of Palestinian citizens and ensure access to high-quality healthcare that guarantees their lives and dignified access to services.

In particular, the following recommendations would serve to realize the right to health in Palestine:

1. End the occupation and pressure the occupation government to stop its practices against Palestinian citizens and the Palestinian health system. In addition, the embargo on Gaza must be lifted to ensure access to health services.
2. Work on the adequate and faithful application of the national health system, which requires that executive authorities put in place decisions, bylaws, systems, instructions, and all other executive procedures for these texts.
3. Develop the public health legal system in line with global and national developments in this regard, particularly in relation to the 17 sustainable development goals (SDGs) and the State of Palestine's accession to the International Covenant on Economic, Social and Cultural Rights in 2014 and its obligations to reconcile the conditions of its health legislation according to the covenant.
4. Amend the Public Health Law to guarantee the right to access health services through a national plan based on localizing healthcare and strengthening partnerships between providers.
5. Implement a universal health insurance system based on citizens' rights to a basket of services that covers their needs and prevents the financial burden of out-of-pocket spending.

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# RIGHT TO HEALTH IN SUDAN

## Current situation and determinants

### Maisa Mustafa Elfadul

Public Health Specialist

Dr. Maisa Elfadul is a Public Health Specialist and Assistant Professor in Public Health Programs at the University of Medical Sciences and Technology, Sudan. Al-Fadul's experience extends to eleven years, focused on health system research, humanitarian development, and epidemiological surveys for issues related to governance, primary healthcare, gender-based violence, maternal health, migrant health, HIV, and recently COVID-19 in Sudan and the Arab region.

### Samia Youssef Idris Habbani

Public Health and Community Medicine Consultant

Dr. Samia Youssef Idris Habbani is a Public Health and Community Medicine consultant, focusing on health management and health research system. She has blended experience in academic and professional work, and has worked in the Ministry of Health, WHO, as Minister of Social Affairs, parliament member and head of Health, Environment and Population Committee. Habbani worked as part time in British Council, Sudan Medical Specialization Board. She is a board member of several national and international organizations. Habbani has published and presented several papers.

### Mona Fath El-Rahman Omer

Public Health Specialist

Dr. Mona Fath El-Rahman Omer (MBBS, MPH, and Research Methodology and Ethics Diploma) is a Public Health Specialist with over 20 years of experience in health system research. She is head of the Research Department at the Ministry of Health, Khartoum-Sudan. El-Rahman Omer is a lecturer in Health Research Methodology and Ethics in many national universities and an active member in several Research committees and Health professional institutions.

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## INTRODUCTION

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The Republic of Sudan is an Arab African country with a predominantly Muslim population. It is located in northeast Africa and bordered by seven countries: Egypt, Libya, Chad, Central Africa, South Sudan, Ethiopia, and Eritrea. It covers an area of 1.866 million km<sup>2</sup>. Before South Sudan's secession in 2013, the Republic of Sudan was the largest country in the Arab World and Africa. Today, it is the third largest.

In 2022, Sudan's population was estimated at 46.87 million, growing at a rate of 2.6% (World Bank 2023). According to the 2014 Sudan multiple indicator cluster survey (MICS), nearly 70% of the population of Sudan lives in the countryside. Almost half of the population is comprised of children, and the number of men is equal to that of women. Around 68% of the population has access to safe drinking water. Although 41% enjoy improved sanitary facilities, the rate fluctuates between 28.2% in rural areas and 69.3% in urban areas. The fertility rate for the three years preceding the MICS was 6.2 per woman. It was higher in rural areas, reaching 225/1000, compared to 167/1000 in urban areas (Republic of Sudan, Council of Ministers & UNICEF 2014).

The survey indicates that six out of 10 young women in Sudan can read and write. However, literacy rates varied by geography, reaching 79.8% in urban and 50% in rural areas. The percentage of women who know how to read and write also varied according to the household's economic status. For example, in the 15-24 age group for women from the wealthiest families, literacy was around 92.2%, compared to 31.1% of women in the poorest households (Republic of Sudan, Council of Ministers & UNICEF 2014).

Furthermore, Sudan hosts many refugees from neighboring countries: Ethiopia, Eritrea, Chad, the Central African Republic, and South Sudan. In recent years, it has also received numerous Syrian refugees and several thousand Yemenis. At the beginning of 2022, Sudan hosted nearly two million refugees. Sudan is a multi-ethnic and multicultural country. It is a federal state with three levels of government, distributed over 18 states and more than 189 districts. According to the Juba Peace Agreement of 2020, a regional level was established below the federal level. The country was divided into eight regions following the Governance and Administration Conference in

2021 (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية).

As a Least Developing Country (LDC), Sudan faces multiple socioeconomic development challenges. According to the Sudan National Health Sector Recovery and Reform Policy 2021-2024, the country's GDP fell to less than US\$40.85 billion, and the annual economic growth was merely 2.3%. Thus, about 36.1% of the population lives below the poverty line (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية). Millions of children and households suffer from financial hardship and its health, social, and economic effects, exacerbated by the spread of COVID-19.

Moreover, the country suffers constant risks related to floods, droughts, conflicts, and displacement (Republic of Sudan, Council of Ministers & UNICEF 2014). It is vulnerable to natural and human-made disasters, and an estimated 8.7 million people require emergency assistance due to reduced living standards. In 2020, the worst floods in decades affected nearly 900,000 people, damaging homes, causing deaths, and leading to the loss of livelihoods and agricultural production (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية). High poverty, unemployment, conflict, and insecurity lead many Sudanese citizens to emigrate.

Due to the country's multiple socioeconomic challenges and the long-term state of war, many health indicators are deteriorating. Health services do not cover several geographical areas. Furthermore, health services that exist are inadequate, as human and material resources are not fairly distributed between the various regions (2022-2021 جمهورية السودان، وزارة الصحة الاتحادية).

## OBJECTIVES

The report aims to address the following issues and themes:

1. Do all social segments in Sudan enjoy the right to health?
  - a. Legal provisions;
  - b. Adopting scientific health policies to achieve the right to health;
  - c. Planning to attain the right to health for all; and
  - d. Fairly providing human and financial resources.
2. The political impact of the right to health.
3. The social impact of citizen awareness and participation in health planning.

## METHODOLOGY

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The study follows a qualitative analytical approach based on a review of published and online information from relevant parties' official websites and communication platforms. Interviews with key health and social rights figures supplement the data extracted from these documents. The documents include health laws, regulations, plans, and reports.

Interviews were conducted with decision-makers in the Federal Ministry of Health and some employees of the Ministries of Justice and Social Development (formerly Welfare and Social Security). Moreover, focus group discussions were held for representatives of the Khartoum Resistance Committees, a representative of the Central Physician's Committee, and representatives of research centers and organizations working on gender, women's rights, and people with disabilities and special needs.

The collected data focuses on economic, social, and health indicators. The study delves into the recognition and knowledge of the right to health and the availability of health services for all groups, including conflict areas, refugees, displaced persons, and other vulnerable groups. Furthermore, the study findings provide insight into health insurance coverage, distribution of human resources, and availability of essential medicines. They also address political instability, peaceful protests, demonstration casualties, and economic decline.

The report addresses health through its social determinants, including clean water, food, housing, education, and the political and social situation. On the other hand, it analyses the six health system structures through governance and leadership, human resources, health services, government spending on health, information and research systems, and drug supplies. The report also addresses international support for health in the transitional period. Finally, it focuses on health challenges, such as the most common diseases and epidemics, including COVID-19, and their direct and indirect impact on securing the right to health in Sudan.

The Federal Ministry of Health Undersecretary approved data collection from the Federal Ministry of Health staff and other institutions.



The study faced several obstacles, particularly difficulties in coordinating with relevant authorities, especially the Ministry of Health, to conduct interviews. Moreover, political instability has negatively affected institutional structures and memory, including data available in the various ministries. Finally, demonstrations and protests made it difficult to move around the capital to collect data.

# THE SOCIAL, ECONOMIC, AND ENVIRONMENTAL DETERMINANTS OF HEALTH

The country's environmental determinants of health are linked to growing concerns about the impact of climate change and biodiversity loss on the changing patterns of communicable and non-communicable diseases, disabilities, and injuries. Decisive action is needed to address current and emerging challenges. The 2030 Agenda for Sustainable Development highlights the critical and inextricable links between development, the environment, human health, well-being, and the economy, as central to realizing a wide range of human rights. It includes the right to life, enjoying the highest attainable standard of physical and mental health, an adequate standard of living, safe food, drinking water, sanitation, safety, and clean soil, water, and air, essential for promoting justice and peace. Sound environmental and health policies contribute to an overall increase in life expectancy and well-being, and health gains are among the most desirable social and economic benefits of adequate environmental protection.

Environmental degradation, pollution, climate change, exposure to harmful chemicals, and destabilization of ecosystems threaten the right to health. Moreover, they disproportionately affect disadvantaged and socially vulnerable populations, exacerbating inequalities. However, according to Federal Ministry of Health officials, the Ministry seeks to cooperate with all related actors through its strategic plan to improve justice. Thus, it intends to adopt health issues in all policies and ensure its systematic consideration in all other sectors.

The Federal Ministry of Health of Sudan recognizes the 2030 Agenda for Sustainable Development. Thus, it is committed to coherent multi-sectoral strategies emphasizing system-wide preventive policies and justice to improve environmental health conditions and mitigate their consequences on social health determinants (2021-2024 جمهورية السودان، وزارة الصحة (الإتحادية)). Education is a significant indicator of the right to health. However, low educational attainment, especially among women, remains a critical obstacle to spreading knowledge of fundamental human rights.

## THE CURRENT POLITICAL SITUATION AND THE RIGHT TO HEALTH

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The political situation is crucial to achieving the right to health in Sudan. After a government that lasted thirty years, the Sudanese Revolution erupted in late 2018. It brought about political change leading to a transitional government in April 2019 comprised of civil forces and the military. According to the Constitutional Document, the government was entrusted with ensuring stability and paving the way for national elections after three years. The government appointed according to the Constitutional Document stayed in power until October 25, 2021. On that date, the President of the Transitional Sovereign Council issued what is known as the October 25 Decisions and dubbed the October 25 Coup by some politicians and respondents. The date was a turning point, but the Decisions faced growing international, regional, and local opposition.

Accordingly, the modern history of Sudan can be divided into four stages: before the fall of the Inqaz regime, between the fall of the regime and the decisions/coup of October 25, 2021, after the October decisions, and currently, a new era that began in December 2022 with the adoption of a framework agreement between the military authority and some political forces.

The stage between the regime's fall and the decisions/coup of October 25 was characterized by openness in all fields, including health. A strategic plan was developed that was consistent with the requirements of the transitional period. The health sector witnessed the influx of many international organizations and the resumption of vital projects to strengthen the health system through developing the work environment, training cadres, and supporting the information system. During this period, the transitional government adopted critical issues such as providing medicine and increasing insurance coverage by introducing an additional million families to expand health insurance coverage. This period was accompanied by basic measures to remove empowerment from government institutions and all state agencies. This led to a vacuum in senior administrative positions at the center and state levels. Despite filling all posts and the renewal of faces with new patriotic blood, a defect in the administrative system remained, due to the weak follow-up of the handover processes and the absence of documentation, which weakened institutional memory and

led to problems in the follow-up and implementation of health interventions and projects.

The impact of the political situation after the October 25 decisions/coup on the right to health can be summarized in three axes related to donors, support and staff retention, demonstration injuries, and the rise in displaced persons due to increased violence in conflict and border areas. This report will highlight the impact of the political situation on the right to health by focusing on the most critical basic structures of the health system affected by the political situation. In-depth analysis and approaches to the status of the right to health in urban areas were conducted for peaceful demonstrators, displaced persons, and refugees from remote rural areas.

The current problematic political situation is related to the consequences of the decision/coup of October 2021, which were followed by many statements rejecting the decisions, followed by a series of measures to stop cooperation with the existing government. Support for health sector projects funded by the European Union, United Nations organizations, and the Global Fund also stopped. Thus, several health projects and services were suspended, especially in areas dependent on donors. The freezing of support was documented in a report on the effectiveness of development partnerships issued by the General Department of International Health at the Federal Ministry of Health, which dealt with funding challenges in light of the current political situation, especially after the October decisions/coup.

The frozen amounts for health projects are estimated at US\$316,700,749, of which US\$159 million were from the World Bank and US\$40 million from the EU.<sup>1</sup> The report showed that health services and medical supplies bore the brunt of removing subsidies. The influence of the October decisions/coup on the health system in Sudan is documented in an analytical article by Osman and colleagues titled "Saving the Fundamentals: The Impact of the Military Coup on the Sudan Health System" (Osman et al. 2021). The paper addressed the consequences of the October 25 decisions/coup on the health sector, which can be summarized in the administrative vacuum of senior positions, the cessation of health services, the antagonization of health personnel by the security and regular forces, and the impact of stopping donor support on medical services and drug supplies.

The October decisions/coup also led to a change in donor funding and support policies. They began adopting an

<sup>1</sup> Directorate General of Global Health, Federal Ministry of Health, *Effective Development Partnership*.

approach of direct implementation, leading to delays in implementing some projects, especially vaccination campaigns, due to the complex bureaucratic procedures of organizations that require direct financing of activities. The previous measures also weakened the Ministry of Health's governance as the implementing body for health interventions, according to the Director of Evaluation and Follow-up at the General Department of International Health at the Federal Ministry. The decisions created an administrative vacuum for senior positions in the Ministry of Health, disrupting administrative procedures and the workflow on the federal and state levels, negatively affecting health services and interventions.

Furthermore, due to the prominent role played by health cadres in the Sudanese Revolution, which was recognized in international and local forums, medical cadres became known as the White Army. They played a prominent role in opposing the October 25 coup, organizing an open strike with an 80% observance rate, which paralyzed health services, especially in peripheral regions. On the other hand, many violations and repeated attacks on hospitals and medical personnel were registered, increasing the loss of medical personnel and negatively impacting retention policies in government facilities (Osman et al. 2021).

In January 2020, the WHO issued a statement condemning the repeated attacks by regular forces on health facilities, amounting to 15 episodes, 12 confirmed in Khartoum and other cities. The attacks ranged from intimidation to verbal and physical violence. In addition, there were reports of attacks on patients and medical staff and arrests of the wounded. Consequently, some hospitals were forced to suspend emergency services, and patients sometimes had to escape before the treatment was complete. In addition, frequent incidents of interception of ambulances and forced searches of medical staff were recorded (WHO-EMRO 2022).

Representatives of the Ministry of Health, voluntary organizations, and the Central Physicians Committee agreed that attacks by the security services and the police impede access to health services during protests, impacting regular citizens and protesters. The attacks were a prominent reason for stopping service in some hospitals providing emergency services to the injured from the demonstrations, such as Al-Arbaeen Hospital in Omdurman and Royal Care and Fadil Hospitals in Khartoum.

## RIGHT OF PROTESTORS TO HEALTH

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The impact of the political situation on wounded demonstrators was evident. The numbers rose, and serious injuries increased after the October 2021 decisions/coup. More than 8,000 people were injured during the peaceful demonstrations, according to a statement by the representative of the Central Physicians Committee, with 78 cases requiring intensive care, 116 deaths, and 50 cases of rape, three of which were documented in the courts (*Hadhreen* 2022).

The number of serious injuries reached 1074 (mostly direct injuries to the chest, head, and neck), resulting in permanent disability or death. The Council of Ministers formed a committee to follow up on the issue regarding those injured in the protests and to cover the cost of treatment. Technical committees were also created from the relevant ministries, such as the Ministries of Health and Foreign Affairs. Injury cases and supporting agencies were monitored to legalize their work and improve coordination between the various agencies. However, most organizations refused to deal with state agencies and limited their work to monitoring and covering treatment costs. On the other hand, civil society organizations (CSOs) adopted the issue, most prominently the "*Hadhreen*" organization, which documented those injured in the Revolution and peaceful protests in coordination with the Central Physicians Committee.

*Hadhreen* organization monitored and followed up the treatment of 5,600 cases, collected donations to cover the treatment of the injured and contributed to treating 855 injuries, of which 19 were enough to be treated outside Sudan. The total cost of treatment by the "You are not alone" coalition is estimated at 517,846,269 Sudanese pounds or 97,308,500 US dollars (*Hadhreen* 2022).

Notably, the National Supply Fund for Health Insurance contributed to treating the injured to fulfill the social responsibility clause. The Central Physicians Committee established standard protocols and procedures for facilitating access to emergency services. The medical staff in health facilities across Sudan and Khartoum, in particular, contributed to maintaining the continuity of emergency services to those injured in the demonstrations, despite the difficulties, political

pressures, and attacks on some health facilities. Health institutions and facilities, both public and private, supported the provision of treatment services, as 80% of the injured were treated inside Sudan, and this confirms the commitment of doctors to the right of demonstrators to health and also documents the state's commitment to its responsibility towards the demonstrators, according to the statements of the representative of *Hadhreen* organization.

In August 2022, *Hadhreen* announced that it would stop covering treatment expenses due to the growing costs, the accumulation of debts, and the budget deficit. The decision is expected to lead to negative consequences on obtaining health services and the deterioration of the health condition of the 400 patients under treatment.

## RIGHT TO HEALTH IN LAWS AND LEGISLATION

Sudan has ratified several international agreements and charters, aligning its laws accordingly. Thus, the State of Sudan is legally bound before the international community to ensure and protect its citizens' right to health. National legislation and laws stipulate that all citizens have good health and fair access to health services. In 2019, the Constitutional Document stipulated the following in Article 4.1 of Chapter One as follows (جمهورية السودان، وزارة العدل، 2019):

“ The Republic of Sudan is an independent, sovereign, democratic, parliamentary, pluralistic, and decentralized state in which rights and duties are based on citizenship without discrimination on the grounds of race, religion, culture, sex, color, gender, social or economic status, political opinion, disability, or affiliation. ”

The document also adopts the rights and duties included in ratified international and regional human rights conventions, covenants, and charters ratified. Moreover, it stipulates that the state undertakes to protect and promote the rights included in the document and guarantee them to all without discrimination based on race, color, gender, language or religion, political opinion, social status, or other reasons. Furthermore, the document stipulates that “the state is committed to respecting human dignity and diversity and is based on justice, equality, and the guarantee of human rights and basic freedoms.” It adds that every human has an inherent right to a decent life and personal safety, that citizenship is the basis of equal rights, and that men and women enjoy civil rights equally.

In terms of health, the 2019 constitutional document stipulates that the state provides healthcare for motherhood, childhood, and pregnant women and guarantees the elderly respect of their dignity and their benefit from medical care and services. Furthermore, Article 65 stipulates that the state undertakes to provide the minimum level of healthcare, primary healthcare, and emergency services, free of charge for all citizens, to develop public health, and to establish, develop, and rehabilitate primary treatment and diagnostic institutions. Sudan's 2005 transitional constitution stipulated these same rights (جمهورية السودان، وزارة العدل، 2005).



The National Public Health Law of 2008 guarantees all citizens the right to obtain healthcare free of charge in state facilities for primary healthcare services and emergencies involving accidents. Free primary healthcare was also guaranteed for children up to the age of 5 and for pregnant women, including standard delivery and C-section (2008 جمهورية السودان، وزارة العدل). The 2008 National Health Insurance Fund Law provides compulsory health insurance for all resident Sudanese, foreigners, and refugees (2016 جمهورية السودان، وزارة العدل).

In terms of mechanisms, the National Mechanism for Human Rights and International Law was formed in 1994 and tasked with following up the implementation of international covenants and agreements, monitoring human rights, and harmonizing national legislation with international covenants. The National Mechanism is affiliated with the General Department of Human Rights and International and Humanitarian Law at the Ministry of Justice. It comprises 21 members representing relevant ministries, including the Ministry of Health, commissions (humanitarian aid and refugee affairs), universities, civil society organizations, and a UN observer.

The Mechanism submits periodic reports on indicators related to international recommendations and monitors their implementation by the Ministries. Sudan's third report was submitted and approved before the UN UPR mechanism in its third session (2022 Sudan News Agency/وكالة السودان للأنباء (سونا)). Recently, in a notable development, Sudan legislated the criminalization of Female Genital Mutilation (FGM) after 40 years of demands. Accordingly, the crime was added to Article 141 of the Criminal Code.

However, although Sudanese laws and legislation guarantee the right to health, the reality on the ground is different. Interviews with decision-makers indicated a unanimous agreement on the discrepancy between legislation and implementation. For example, a decision-maker at the National Health Insurance Fund (NHIF) confirmed the following:

“ The state believes that citizens have the right to health, reflected through laws, plans, and programs that set high aspirations, such as broadening health insurance and allocating budgets. However, in reality, health does not represent a top priority for the state. Spending the allocated budget depends on the availability of money. When budgets are short, health budgets are dropped, and the existing funds are spent on other priorities that the state values, such as security, salaries, and peace agreements entitlements.



## RIGHT TO HEALTH IN POLICIES AND PLANS

The General Department of Health Policies and Planning at the Federal Ministry of Health is tasked with developing health policies, strategies, and annual plans and following up on their implementation. The Federal Ministry of Health is keen to cooperate with government partners to ensure the effective development and realization of policies and plans in partnership with health-related sectors and through community participation. In particular, these partners include the NHIF, development agencies, including the UN, donors, development banks, national and international NGOs, and local community organizations. It also cooperates with other health service providers, including the private health sector, the army, the police, and voluntary organizations that provide health services (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية 2007 جمهورية السودان، وزارة الصحة الاتحادية). Moreover, officials from health-related entities, such as the water, environmental, and educational sectors, are also involved. The Ministry of Finance plays a pivotal role in the process, the WHO usually provides technical and financial support, and UNICEF and UNDP also participate in policy development and planning.

During his presentation of the Strategic Plan for Health Sector Recovery and Reform, 2022-2024, the Minister of Health stated that he looks forward to working with various health sector stakeholders to achieve the desired results of the strategic plan, especially in its implementation. He considered strengthening the health system at the state and local levels a prerequisite for implementing the strategic plan and achieving its goal of reaching universal health coverage for the population. He also pointed out the importance of community participation and that of all government agencies related to health, especially the NHIF, and partners in the humanitarian and development fields, including UN organizations, donors, development banks, local and international volunteer organizations, and CSOs (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية 2007 جمهورية السودان، وزارة الصحة الاتحادية).

The National Quarter-Century Strategy 2002-2027 was developed to follow a ten-year strategic plan. The health document was approved in all policies in 2018. Several other policies were prepared, such as the Sudanese child health

policy, the policy towards voluntary organizations, the health research policy, and the nutrition policy. In their entirety, these policies refer to the right of all residents to obtain adequate health services. Several policies and plans were drafted after the April-December 2019 Revolution. They include the Sudanese National Health Sector Recovery and Reform Policy 2021-2024, the National Health Sector Recovery and Reform Policy 2022-2024 and the National Health Sector Recovery and Reform Strategic Plan 2022-2024.

The quarter-century strategic plan envisions a health system capable of improving health and fulfilling citizen aspirations based on justice, efficiency, modernity, and the harmonization of technologies and the environment. Moreover, it must focus on quality, innovation, and health promotion and actively involve the community. The 25-year strategic plan also envisions that the system helps improve citizens' health and quality of life so that they can enjoy the highest attainable level of health, enabling them to lead an economically productive social life. Most significantly, the strategy is committed to providing health for all as a fundamental right of citizens. It also adopts primary healthcare in its broad sense to achieve health for all, which includes fairly covering the entire population with healthcare according to need and paying attention to poor and vulnerable groups. In addition, it calls for justice in the provision and financial contribution through social solidarity, where the poor groups contribute much less than wealthier segments through direct or indirect payment methods. The strategy's priority programs involve expanding health coverage, ensuring fair distribution, removing geographical and physical barriers that impede access to services, and building and strengthening the health system's capacities (جمهورية السودان، وزارة الصحة الاتحادية 2007).

The National Policy for the Recovery and Reform of the Sudanese Health Sector 2021-2024 and the National Strategic Plan for the Recovery and Reform of the Sudanese Health System 2022-2024 adopted the same approach to ensure that "all people in Sudan enjoy high-quality and equitable access to basic health services and are protected from emergencies towards a healthier, fairer, and safer future." In addition, they adopted a mission to "organize and strengthen the health system to provide quality, equitable, and affordable health services, aiming to achieve universal health coverage and the relevant, sustainable development goals and objectives, overcome health challenges, and cooperate with all actors by

incorporating health in all policies to ensure an optimal status for all and contribute to comprehensive social, environmental, and economic development and peacekeeping" (2021-2024 جمهورية السودان، وزارة الصحة، 2007; جمهورية السودان، وزارة الصحة الاتحادية). The guiding principles of the above policy included the right to health, equality, quality, accountability, transparency, and community participation. The above policy's guiding principles encompassed the right to health, equality, quality, accountability, transparency, and community participation.

The 25-year Pharmaceutical Strategy 2005-2029 focused on access to medication and providing essential medicines to the population reasonably and affordably (وزارة الصحة، الإدارة العامة للصيدلة 2005).

The above health policies and plans are appropriate and fully cover the right to health for all. However, persistent problems still face their implementation in a manner that allows the right's full realization. The challenges were stressed by most respondents, who pointed to several examples:

1. Officials and health workers are not familiar with legislation, policies, and plans, particularly on the level of implementation in states and localities. The Director of the General Department of Planning and Policies stated that the Ministry informs health officials at the state level of plans and policies. Still, the implementers of these plans are usually not informed. Knowledge of the plans is also lost due to the continuous replacement of trained health officials.
2. The scarcity of financial resources is a critical obstacle preventing implementation.
3. Weak infrastructure.
4. Weak governance, mismanagement of available financial resources, and unfair distribution of resources between hospitals and primary healthcare facilities that provide services to more than 75% of citizens and are managed and financed by localities suffering from considerable scarcity of financial resources.
5. The instability of policies and their impact on political change.
6. Weak information systems and lack of national surveys.

## PERCEPTIONS OF THE RIGHT TO HEALTH

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Respondents almost unanimously agreed that citizens' knowledge of the right to health varies according to several economic, social, and geographical determinants, primarily educational levels, geographical location in terms of rural and urban areas, and age. The Director General of the NHIF stated that educated people consider health and health insurance their right because it guarantees them treatment without financial barriers. On the other hand, he believed ordinary citizens, especially in rural areas, appreciate health insurance cards as a state service. Moreover, health partners and experts see health as a right for citizens, which the state must provide adequately through the six essential components identified by the WHO: service provision, human resources, health information systems, access to essential medicines, financing, leadership, and governance. They discuss the importance of health system reforms. For example, the former Minister of Social Development believes that health is a right, should be accessed without discrimination, and must be provided through government facilities, even to foreigners. The approach distinguishes Sudan from most countries, even rich ones, which only provide services to foreigners who pay the fees. Sudan's system does not deprive anyone of its services. On the other hand, the Director of Health Policy and Planning stated that there are attempts to inform citizens of their right to health. Work is underway to develop strategic plans for community engagement and risk communication.

# RIGHT TO HEALTH SITUATION IN SUDAN

## HEALTH SERVICES

Sudan's primary healthcare program was established in 1976, even before the Alma Ata Declaration (OCHA – Sudan 2020). Thus, the country provides health services on three levels: primary, secondary, and tertiary healthcare. The state offers Primary healthcare through local governments (the third level in the country's governance hierarchy) in collaboration with some private entities and voluntary organizations. Primary health service facilities are classified into three categories: family health units that provide the basic primary healthcare package. Family healthcare centers offer a larger package and a higher level of primary health services to which medical doctors are assigned, and rural hospitals.

Between 2011 and 2018, the proportion of health facilities offering a minimum complete primary healthcare package increased from 24% to 95%. The improvement is attributed to the Primary Healthcare Expansion Project, which began in 2012. However, although the plan aimed to distribute one healthcare facility per 5000 people, the rate remains at 1/6816. Moreover, only 83% of facilities were in operation in 2019 due to a shortage of health personnel, poor infrastructure, and security issues.

On the other hand, a remarkable disparity in the number and quality of primary healthcare facilities appears between and within states (جمهورية السودان، وزارة الصحة الاتحادية 2021-2024). Around a quarter of the population cannot access health facilities due to distance, poverty, or conflict. Access to facilities varies between regions. In addition, financial, social, and economic barriers limit access to health services. Patients from high-income segments use healthcare services almost ten times more than those from lower-income segments (2022-2021 جمهورية السودان، وزارة الصحة الاتحادية). Conversely, target villages covered by midwives rose from 36% in 2011 to 85% in 2019, and the training of midwives, paramedics, and community health workers expanded.

In parallel to the primary healthcare level, the second level encompasses general hospitals, and the third level covers

specialized hospitals and centers. There is a significant disparity in the geographical distribution of hospitals. For example, the rate in the Northern State is 3.2, compared to 1.1 in Central Darfur. Similarly, the Northern State has 178.1 beds per 100,000 inhabitants, compared to 58.9 in Central Darfur (2022-2021). (جمهورية السودان، وزارة الصحة الاتحادية 2021). Nevertheless, despite adopting relevant national guidelines, the referral system between the different levels is inoperative.

Public Health Insurance is consequential in ensuring the right to health. It allows access to health services to all categories and covers 81.7% of the population (Elfadul & Elfadul 2022), with broader coverage for poorer segments. By actively providing health services in areas where they do not exist, it ensures access for all citizens, even those who can afford them.

The private sector is also a leading contributor to access to health services. The strategic health plan acknowledges the issue. In addition, the Director of Health Policies and Planning at the Federal Ministry of Health believes the private sector has a significant role, especially in dealing with COVID-19. However, coordination could be improved, as he explained.

Furthermore, voluntary organizations participate in providing health services. For example, the Director of the Voluntary Organizations Department said there is coordination with the Federal Ministry of Health, represented by the Department of Emergency and Epidemic Control. Thus, the organizations work according to the health strategy and in line with the Federal Ministry of Health policies and protocols. Similarly, the Director of the General Department of Therapeutic Medicine at the Federal Ministry of Health indicated that there is a health map according to which curative, preventive, and promotional health services are fairly distributed. However, lacking human resources in some areas diminishes the ability to provide services fairly.

The Ministry of Social Development is another ministry closely influencing the right to health through its several arms. They include the Zakat Bureau, which, according to the Minister, helps the poor access the right to health and protects the middle class from falling into poverty due to disease. She also mentioned that the Zakat Bureau pays the health insurance contributions of a set number of poor and pensioners, contributes to treating children under five, and tackles malnutrition, tuberculosis, and other diseases that lead to poverty, such as kidney failure and cardiovascular diseases. Health treatment is one of the Bureau's main expenditures.

According to its Unified Treatment Department, it also supports treatment abroad for those who need it. In addition, its Humanitarian Aid Commission intervenes during health emergencies, epidemics, military clashes, and natural disasters and focuses on the displaced. The Ministry also reports to the Public Authority for Prosthetics, which provides them for people with disabilities.

The health system in Sudan suffers from multiple problems caused by scarcity of resources, high workforce turnover, poor infrastructure, and poor service delivery, all of which lead to unsatisfactory health outcomes (جمهورية السودان، وزارة الصحة 2022 الإتحادية).

The COVID-19 pandemic affected the health system. It disrupted health service provision directly, especially at the onset, due to the preventive measures (complete and partial closures) that limited access to health services. In early 2020, a study by the Occupational Safety and Health Administration (OSHA) estimated that only 38% of primary healthcare institutions were operational (Elfadul & Elfadul 2021). Another study on the impact of lockdowns on health services recorded that 80% of Khartoum patients faced access difficulties due to the lack of health personnel and targeted health services, including emergency and pharmaceutical. Furthermore, another study confirmed the impact of the pandemic on maternal and child services. It showed that access to prenatal services was as low as 40%. Postpartum services recorded the lowest access rate at 15%. The study also documented the indirect impact of COVID-19 (WHO 2022), particularly fear of infection and transportation difficulties (Mohamed et al. 2021).

Sudan faced many challenges related to COVID-19 due to the health system's fragility and structural deficiencies, including in medical personnel, health information systems, and financing essential medicines. Challenges related to governance also weakened oversight and accountability. In addition, it led to shortcomings in preserving the right to health and health services.

Based on the above and the statements by the Director of Health Policy and Planning, there is another problem in the unfair distribution of services. For example, specialists are only available in major cities, and some states lack mental health doctors and neurologists. Indicators also show that infant mortality differs between rural and urban areas and various states.



## HEALTH INDICATORS

**Table 1** shows the significant disparities in child mortality rates between rural and urban areas. The rate is significantly higher in urban areas, especially for children under five. Among states, the ratio in four states is greater than 90 per 1,000 live births, compared to 29.9 per 1000 live births in the Northern State. The four states that top the child mortality list are the regions suffering from instability and witnessing frequent internal and tribal conflicts.

**Table 1. Geographical and Urban Distribution of Child Mortality Rates**

Indicator	Under- five mortality rate	Infant mortality rate	Newborn mortality rate
<b>Geographical area</b>			
Urban	56.5	45.1	30.3
Rural	72.8	54.5	33.4
<b>State</b>			
Northern	29.9	30.0	23.0
Nile River	35.1	28.1	25.8
Red Sea	61.3	44.2	18.6
Kassala	80.5	62.1	47.2
Al-Qadriif	76.7	53.4	32.6
Khartoum	49.8	45.1	30.5
Gezira	53.5	41.4	26.2
White Nile	65.8	46.8	30.3
Sennar	51.6	34.1	18.0
Blue Nile	83.9	46.8	26.0
North Kordofan	41.9	35.6	23.0
South Kordofan	95.4	70.2	32.5
West Kordofan	82.1	68.2	43.4
North Darfur	90.3	68.5	43.9
West Darfur	91.4	71.2	39.2
South Darfur	71.9	52.6	35.2
Central Darfur	77.4	44.5	24.7
East Darfur	111.7	88.5	51.8
Sudan	68.4	52.0	32.6

Source: Data from the 2014 MICS, Republic of Sudan, Council of Ministers & UNICEF

## HEALTH ISSUES

The country suffers from the double burden of communicable and non-communicable diseases, malaria being the country's number one challenge in all states. In 2021, the frequency of malaria patients reached 17% of the total number of visitors to health institutions; it was the primary cause of hospital deaths in 2021 at 8.4%. However, the rates vary by state and are highest in the Blue Nile, Sennar, and Gezira (جمهورية السودان، وزارة الصحة الاتحادية). Other endemic diseases include schistosomiasis, tuberculosis, and leishmaniasis. However, there was a decrease in TB incidence and prevalence, and the death rate associated with the disease is estimated at 25 per 100,000 people (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية). Furthermore, malaria, diarrhea, and pneumonia are the leading diseases affecting children. As for non-communicable diseases, 21.1% of the population suffers from diabetes, and cancer cases are increasing dramatically (2022-2021، جمهورية السودان، وزارة الصحة الاتحادية).

According to a WHO report on March 12, 2022, the COVID-19 pandemic led to an estimated 631,275 cases, including 419,61 deaths (WHO 2022). Khartoum State ranked first in the number of cases, followed by Gezira State. The first case was announced in March 2020. Accordingly, many health precautions were issued to limit the spread of the disease in communities and neighboring countries following international health requirements published by the World Health Organization. Regarding vaccines, Sudan was one of the first African countries to complete arrangements to introduce the vaccine through the joint COVAX mechanism. Twenty percent of the population was set as a target for vaccination coverage. As a result, the total coverage rate for Sudan reached 82% of the target. The states of Darfur (Central and West Darfur), South Kordofan, and Blue Nile state topped the list in achieving the coverage target, while the Red Sea state recorded the lowest coverage at 40% (Federal Ministry of Health 2022).

Moreover, several modern models and methods deliver services in remote regions. However, difficulties were observed in obtaining vaccine services in some states of Darfur. In 2002, a study by al-Anoud and others found many obstacles in the fragile health system in some Darfur States that limit access to the required COVID vaccine coverage. Shortcomings were reported regarding quality and cold-chain storage. In addition, the unstable electricity supply impeded vaccine preservation

and added to difficulties in transportation and delivery to remote areas and the precarious security situation in areas of tribal conflicts (Mohamed et al. 2021). Furthermore, respondents from the Federal Ministry of Health also reported that the worsening security situation in West Darfur in the Jebel Moon region poses a threat to vaccine interventions and primary healthcare services and that they are an obstacle to access to health services, especially among vulnerable groups such as children under five and pregnant women.

Although the vaccination rates in some states surpassed 100%, some researchers and representatives of international organizations had severe reservations about the target. Based on WHO guidelines, they believed it was very far from the minimum level to reach herd immunity (80% of the population).

## **MATERNAL, CHILD, AND ADOLESCENT HEALTH**

Maternal and child health is one of the main priorities in development plans and government grants due to its crucial impact on improving the entire community's health, economic, and living conditions. These commitments are reflected in many supporting projects and strategies, such as the free medication policy for children under five, the free C-section policy, the introduction of new vaccines, and national commitment and international support for the Integrated Management of Childhood Illnesses (Emergency Obstetric and Neonatal) strategy and Newborn Care, for example.

Despite some improvement, health officials confirm that maternal and child mortality rates are still high compared to other countries of similar social standing. In addition, a significant difference is evident between rural and urban areas and the different states, as shown in **Table 1**.

In 2021, a UNICEF report uncovered impediments to children's access to health services. For example, the rate of access to health centers for children sick with diarrhea was around 25% (Mohamed et al. 2021) The report also indicated an apparent decline in health indicators among children from the vulnerable segments who live in crisis and conflict areas. For example, one in seven children does not have enough food to prevent malnutrition and stunting, and survival rates for children under five are declining (one in eighteen children will die before their fifth birthday) (UNICEF 2021).

Most adolescent deaths could be avoided through access to quality health services, education, and social support, which are currently unable to cover needs. Furthermore, the National Adolescent Health Strategy is still in preparation, albeit providing a package of services expected to meet the health needs of Sudanese youth. Youth and adolescent drug abuse issues have recently come to the surface. In January 2023, the head of the Sovereignty Council inaugurated a campaign aimed at combating this phenomenon (UNICEF 2021).

## **VACCINATION**

The Director of the immunization program at the Ministry of Health said his program provides vaccines in fixed centers that serve the population within 5 square kilometers and is called the holding area. Areas between 5-10 square kilometers are served in sub-centers. Those of more than 10 square kilometers around the region are served through mobile teams. He said it was because health is a right for citizens and must be provided wherever they are, regardless of their geographical location or numbers. He added that vaccine services are fairly distributed. The program is based on the location of the targeted population, covered through fixed and mobile teams. He also spoke about community participation in planning and implementation. The coverage rate for children under one was around 82% or about 1,313,458 who took the third dose of the DTP3 vaccine. In addition, 11,281,745 children (82%) received the first dose of the measles vaccine, compared to 64% for the second dose (UNICEF 2021).

## **MENTAL HEALTH**

The Sudanese mental health policy was prepared in 2008 and indicated the importance of integrating mental health within primary healthcare services, increasing human resources, involving patients and their families, strengthening advocacy, protecting patients' human rights, fairness, facilitating access to mental health services for all groups, improving quality, financing, follow-up, and evaluation. Furthermore, although the mental health law was passed in 2009 (2021-2024 جمهورية السودان، وزارة الصحة الاتحادية), mental and neurological health services are not provided through primary healthcare facilities. Only 12 states out of 18 have government hospitals fully equipped and staffed to provide mental health services. As a result, the rate of mental health personnel is around 1.6 per 100,000 people, compared to the global target of 6 per 100,000 to reach universal coverage (Osman et al. 2020).

The concentration of services in large cities has limited access in remote regions, according to the Director of Health Policy and Planning and the Director of Human Resources Development at the Ministry of Health. He reiterated the results of the health statistical report, which shows 23 specialists in Khartoum State, while 11 states lack specialists (جمهورية السودان 2021، وزارة الصحة الاتحادية). Thus, neuropsychiatric services are unequally distributed, and the vast majority of citizens do not access them unless the disease worsens and the patient's family is forced to seek services in these hospitals or go to municipal therapists, elders, or, in a few cases, general physicians. Nevertheless, around 6.5% of the population suffers from neuropsychiatric disorders, reaching 12% in Khartoum State. Studies in the country registered the highest rate of disorders among IDPs, which reached 35% (Osman et al. 2020).

## HUMAN RESOURCES FOR HEALTH

Sudan faces challenges in health human resources regarding their numbers, expertise, and distribution, in addition to their poor salaries and lack of work incentives. The situation was exacerbated by the country's general political and economic crises and the challenges posed by COVID-19. In addition, the country suffers from a constant drain of health personnel due to their migration outside the country (حاتم 2021).

Therefore, according to the 2017 Annual Health Report, the ratio of the total health workforce per 1,000 population is 1.9 compared to the global average of 2.35 (جمهورية السودان 2021-2024، وزارة الصحة الاتحادية). In addition, the distribution of health workers is not commensurate with population needs. For example, 38% work in Khartoum (34.2 doctors per 100,000 people), and 70% are in urban areas. Moreover, although 70% of the population resides in rural areas, more than half of the doctors' work in Khartoum, while six states only have 1% of doctors each, compared to a national average of 21.3/100,000. Khartoum also has around 1000 specialists, compared to four states with one to ten specialists (جمهورية السودان 2021، وزارة الصحة الاتحادية). Furthermore, two-thirds of the doctors are in the secondary and tertiary systems rather than the primary healthcare level (جمهورية السودان 2021-2024، وزارة الصحة الاتحادية).

The contradiction in health capacities and resources between and within states and localities has created a significant discrepancy in the health workforce's absorption, provision, and distribution. Consequently, their ability to provide primary

health services was reduced, weakening the possibility of securing the right to health.

The discrepancy in human resources distribution could be attributed to limited employment opportunities, weak budgets, shortages, unfavorable working conditions, unattractive living conditions (mainly in rural and remote areas), security concerns in conflict-affected areas, and lack of career development opportunities. All of these reasons contributed, directly and indirectly, to the unfair distribution and the migration of health workers to other countries for better employment opportunities and a promising future.

## ■ MEDICAL SUPPLIES

Although the pharmaceutical sector in Sudan aims to ensure sufficient quantities of safe, affordable, and high-quality essential medicines, the country is facing a drug availability crisis. In January 2020, drug availability was less than 50% of the target. As a result, imports of human medicines decreased significantly from US\$256 million in 2015 to US\$159 million and US\$161 million in 2018 and 2019, respectively. In 2015, the local pharmaceutical industry accounted for 36% of the total value of medicines in the country, estimated at US\$227 million. However, the share decreased to US\$80 million in 2017 (جمهورية السودان، وزارة الصحة الاتحادية 2021). Furthermore, the cost of medicines is increasing dramatically due to economic inflation.

The free treatment program, approved in 2008, provides medicines for cancer and kidney diseases, heart and eye surgery, children under five, and transfusion and hemophilia services. In 2020, its total budget was US\$29,100 million. However, the project faces significant challenges due to the unavailability of medicines, distribution issues, transportation, weak supervision, poor reporting, and a high staff turnover rate.

Each state has been assigned a specialized pharmacist and a program committee to improve performance (جمهورية السودان 2021). Vertical programs provide medicines for tuberculosis, AIDS, and malaria free of charge. However, out-of-pocket spending on drugs remains high despite the interventions.

Sudan's National Health Sector Recovery and Reform Policy aims to improve access to essential medicines, health products, and health technologies in a safe and effective manner, of good quality, and at reasonable prices (جمهورية السودان، وزارة الصحة 2022). According to the latest data on personal spending on

medicines in 2008, the proportion of out-of-pocket expenditure was 26% (جمهورية السودان، وزارة الصحة الاتحادية 2021-2024).

Consequently, the supply of medicines in Sudan is a cause of concern due to increased out-of-pocket spending, rising prices, and the general deterioration of the health sector's performance.

## HEALTH FINANCING

The federal, state, and local governments finance the health sector. The federal government supports governmental health facilities using 69.3% of its budget (الصندوق القومي 2015). The budget director at the Ministry of Finance confirmed that spending on health is carried out according to the approved plan and from the three levels of government (federal, state, and local). In 2018, total health spending amounted to US\$2.554 billion, or 4.9% of GDP. The Federal government spends 3.45% of its budget on health. As a result, federal expenditure on health amounted to 23.3% of total spending, compared to 6.7% from external financing (جمهورية السودان، وزارة الصحة الاتحادية 2021).

According to the Budget Director at the Ministry of Finance, most national spending on health goes to salaries, operations, maintenance, and projects. Additionally, the NHIF provides 27.6% of expenditures (جمهورية السودان، وزارة الصحة الاتحادية 2021). The budget Director added that 2021 public spending on health amounted to about 6% of general government spending. It did not include spending from states, localities, or foreign grants. However, according to the Director General of Health Insurance, the targeted goal for health spending had been set at 15% by the 2015 Abuja Agreement.

Financing the health system is primarily through out-of-pocket expenditures (69.2%) (جمهورية السودان، وزارة الصحة الاتحادية 2021). The high rate explains why citizens face financial obstacles in accessing health services. Consequently, the risk of increased impoverishment and catastrophic health spending is rising. For some groups, financial costs are a barrier to access to health services (no less than 60% of citizens). Illnesses may even lead to the impoverishment of those who could pay for the services, often through selling property, especially for incurable and chronic diseases. However, Health insurance guarantees them access to these services without financial obstacles, as stated by the Director General of the NHIF.

According to the Director of Voluntary Organizations, national voluntary organizations also contribute to health spending through various interventions, especially in peripheral areas and areas of conflict. For example, they assist in providing health services, medicines, tents, and saturated mosquito nets. However, it is difficult to obtain information about the amount such organizations spend due to a lack of data.

Although critical steps were taken to strengthen the health financing system in recent years, significant challenges remain. Funding shortages, weak governance, and inefficiency are among the main challenges facing health financing in the country. In addition, the severe economic crisis in the country has led to high rates of inflation, depreciation of the local currency, and scarcity of cash. It resulted from South Sudan's secession in 2011, leading to a significant drop in oil revenues and the ongoing conflicts and wars in South Sudan, then in Darfur, South Kordofan, and other regions. An additional factor is the US sanctions that began in 1997 by freezing Sudanese financial assets and banning economic activities in all their forms. The scope of sanctions was later expanded in 2006 and 2007.

Consequently, investments amounting to US\$745,300,000 million were suspended, and the value of seized assets amounted to US\$48,200,000 million. In addition, the US imposed fines amounting to US\$1,530,000 million on countries violating the American Economic Emergency Act. Thus, Sudan lost the international cover for investment by losing any opportunities for international financing from global or regional financial institutions after the commitment of most countries to the US decision, especially EU countries (نون بوست/Noon Post 2014).

One of Sudan's National Health Sector Recovery and Reform Policy's main elements involved financing public health to improve health system efficiency and provide strong protection from financial risks (جمهورية السودان، وزارة الصحة الاتحادية 2022).

The Budget Director stated that preserving the right to health requires developing the country's resources, improving national income, committing the Federal Ministry of Health to set an accurate and precise national budget, activating the institutional follow-up and evaluation mechanisms, and ensuring the clarity and accuracy of the Federal Ministry of Health Budget by specifying expenditure channels.



## NEOLIBERAL POLICIES

Neoliberal policies were adopted in Sudan in the 1970s, as the country went through severe economic crises that led it to submit to IMF policies to obtain World Bank and IMF loans. As a result, the government adhered to the recommendations of what is known as the “Sudanese Economy Structural Reform Program,” according to which the regime was able to obtain some loans and technical assistance in return for adhering to the IMF prescriptions, which included devaluing the currency, withdrawing subsidies on essential commodities, increasing taxes, and liberalizing foreign trade, among other conditions (2019 عبد الحميد).

Accordingly, health policies guaranteeing citizens’ enjoyment of free health services were halted. Indeed, the country did not benefit much from these loans but rather fell into more debt. The negative social impact of IMF policies on poor classes continued, and health, social, and educational services deteriorated, leading to less social justice. Following the lifting of US sanctions in December 2017, the IMF initiated a recommendation paper for Sudan. It instructed the regime to pursue structural reforms to “exploit the opportunity of the US lifting its sanctions in the best possible way.” The IMF recommendations included floating the Sudanese pound, a “vital factor for Sudan’s economic stability,” and unifying currency exchange rates in the Sudanese market. The fund also recommended the abolition of government subsidies on wheat and energy resources and expanding the tax base to collect more money for the state treasury (2019 عبد الحميد). All of this exacerbated the problems, especially for the poor, despite the state’s attempts to carry out some remedies, which included direct cash support for the poorest groups, support for bringing the poor under the umbrella of health insurance, and others.

The former Minister of Social Development indicated that the state usually looks at international policies and prepares its national policy based on local knowledge. For example, the World Bank recommended cash support for the poor, while the state’s approach was to integrate development and livelihood projects (humanitarian aid based on development) and limit cash support to those who cannot work. She also referred to the concept of solidarity that characterizes the country and its solid social system, where citizens assist their poor relatives, acquaintances, and neighbors, for example. She added that social solidarity had a significant impact on people’s resilience.

Finally, she referred to her Ministry's policies promoting social solidarity as a moral issue.

On the other hand, the Director of Financial and Administrative Affairs at the Federal Ministry of Health believes that the World Bank's demand to lift subsidies should be accompanied by mitigating policies. For example, although free treatment had been a highly successful policy, the lack of resources caused by the World Bank's demands reduced its impact.

## ■ HEALTH INSURANCE

Health insurance is provided through several institutions, the largest of which is the National Health Insurance Fund (NHIF) (جمهورية السودان، الصندوق القومي للتأمين الصحي 2023). Other insurance schemes include regular forces (army, police, and national security), for example, and other institutions. In addition, some individuals receive health services through local and international private insurance companies.

The NHIF is under the Ministry of Social Development and supervises the health insurance departments in various states. It is a solidarity-based institution providing distinguished medical care services fairly, sustainably, and conveniently for beneficiaries. The NHIF aims to cover all citizens. The former Minister of Social Development believes that health is a citizen's right and that her Ministry continues to fulfill this right by providing health insurance to citizens.

In 2020, the number of subscribers to the NHIF reached more than 33.6 million people, or 81.7% of the population (Elfadul & Elfadul 2022). The NHIF provides medical services to all subscribers without discrimination between different sectors. It is particularly interested in poor families and seeks to cover them through several donors. Coverage of poor families began in 2007, and by 2020, 5,787,122 families were covered, representing 71% of the total insured families (جمهورية السودان، وزارة الصحة الإتحادية 2021-2024). The Federal Ministry of Finance covers the cost of most of these families in active cooperation with the Zakat Bureau. In addition, the Federal Ministry of Finance and some organizations, companies, and individuals participate through the White Hands Initiative. As for refugees who put pressure on health services, an agreement has been reached with the United Nations and the UNHCR to include them under the health insurance umbrella, as stated by the finance minister.

The NHIF offers a wide range of medical services compared to many countries in the Eastern Mediterranean region, according to the Minister's statement, which was certified by the WHO. Services even include dental treatment, which is unavailable in most countries' insurance systems. Beneficiaries contribute to 25% of the price of medicines available in the country. The Zakat Bureau covers the amount for those who cannot pay it, according to the Minister whose Ministry the Zakat Bureau reports to. She also noted several complaints from citizens about the unavailability of medicines through the insurance card. However, she believes the problem is not with availability but the diversity of companies providing medication.

It is worth noting that hospital expenditures comprise 80% of the total budget for medical services, reducing funds for primary healthcare facilities, which provide services to more than 75% of the population (جمهورية السودان، وزارة الصحة 2021-2024). (الإتحادية).

Although the proportion of the insured population is high, the availability of services in rural areas remains a challenge due to the unfair distribution of services and their concentration in urban areas. Consequently, many have to travel long distances to access services.

However, as the Minister said, a lack of understanding of how to benefit from the insurance card is also an obstacle. She also believes that health insurance is the most adequate health intervention. It allows providing services to the poor, contributes to the operation of many health facilities that the Ministry of Health cannot operate, establishes new health facilities in agreement with the Ministry of Health, and offers a wide range of costly medical devices.

Despite the great efforts to increase insurance coverage, there are persistent obstacles to covering the informal sector. The informal sector absorbs poorest and low-income classes amid rising poverty rates, economic crises, and displacement. However, the lack of information and current surveys makes it difficult to accurately project the number of people working informally and targeted by health coverage schemes.

Another data challenge is that coverage indicators are calculated by considering the number of insured issued with a medical insurance card. However, planning experts believe the indicator falls short of expressing the actual coverage rate based on the total number of insured who used the card

to receive health services in a specific sector. Therefore, high coverage rates do not mean the actual use of the card, as reflected in practice. The paradox in health financing appears clearly between high insurance coverage and out-of-pocket spending that exceeds 67%. It shows that most of the population spends on treatment from its own money, despite access to health insurance.

## ■ HEALTH INFORMATION SYSTEM

The Ministry of Health has several health information systems. Data is collected from various health facilities, namely primary healthcare units, primary healthcare centers, and all types of hospitals. Reports from rural departments, centers, and hospitals are sent to the centers of the localities. In contrast, the reports of the specialized hospitals and specialized centers are sent to the ministries of health in the states. The information system is a standard paper and electronic system. The data is collected on paper monthly in particular forms and appears on the locality and Ministry's websites. In addition, the data on the Ministry's website can be accessed on the Internet from anywhere. Following the collection, the Department of Health Information, Follow-up, and Evaluation at the Federal Ministry of Health collects and analyzes overall reports and issues the Annual National Health statistical report.

However, the information system is a negative factor influencing the right to health in Sudan. Its shortcomings in completeness, periodicity, and quality of published data on right-to-health indicators are evident. As mentioned previously, there is no data on the health situation in Sudan during the past two years. Most of the information on health interventions targeting vulnerable segments such as IDPs, immigrants, and women is unavailable on the official websites of the concerned departments. It must be obtained, with difficulty, from voluntary and international organizations specialized in health interventions. Furthermore, the health information system does not link the private and public sectors, an obstacle to monitoring health indicators between the two sectors. Furthermore, there is no obligation to share data except in cases during disasters and epidemics.

According to researchers and experts, the health information system's failures came to the fore in the collection and integrity of information on COVID vaccines. The shortcomings are attributed to conflicting information between government

agencies and on-the-ground observations. The conflict also appears in coverage rates between other vaccines and COVID. States that suffer from eternal problems in vaccination coverage, such as Central Darfur and South Kordofan, recorded high rates. While not enough studies have been published on the Ministry of Health data, recent studies dealt with coverage in the states of the Darfur region.

All of the above has meant the lack of indicators reflecting the reality of health for citizens and vulnerable segments. It has led to weakening strategic planning to preserve the right to health and affected decision-making related to health, in general, and the right to health, in particular.

## ACCOUNTABILITY AND REFORM MECHANISMS

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The mechanisms for accountability and reform in the health system are multiple. They start with the legislative body, which presents annual reports to the Minister of Health and asks him to respond to any questions received from deputies. Next, the Minister directly presents the periodic reports to the Services Committee of the Council of Ministers and the annual report to the Council of Ministers.

The Supreme Council for Health Coordination, chaired by the Head of State, reviews the performance of the health system and health-related ministries and the extent of their coordination with the Ministry of Health. The Medical Council and the Health Professions Council investigate medical errors by medical personnel and issue appropriate penalties that could amount to withdrawing work permits. The General Audit Bureau reviews financial and administrative performance and presents an annual report to the legislature.

According to the 2021 World Bank report on governance indicators, namely the Voice and Accountability Index, Sudan's progress since 1996 was scored -1.47, indicating failings in accountability and citizens' ability to claim rights. The highest reached by Sudan was in 2020 after the December 2019 Revolution, accompanied by an immense interest in reforming state systems and legislation to preserve human rights and implement monitoring and evaluation tools to achieve the Revolution's slogan, "Freedom, Peace, and Justice." Nevertheless, several obstacles to accountability were mentioned by interviewed officials and in discussion groups in the national consultative workshop. They are summarized in the following points:

- A weak culture of accountability and claiming rights at the competent authorities and relevant institutions.
- Lack of awareness among citizens of the fundamental rights guaranteed by the state and the relevant authorities entrusted with preserving and monitoring human rights.
- There is no publication and exchange of information on the recommendations of the last meeting of the International Review Mechanism at the level of senior management

and directors of public departments in the Ministry of Health. However, a representative of the Ministry of Health was present in the national mechanism. In addition, no plan exists to follow up on the implementation of the recommendations approved by the national mechanism regarding health. Nevertheless, the Secretariat of the National Mechanism at the Ministry of Justice provided the health representative with all the information related to health recommendations discussed in the international review mechanism to share with the relevant departments and follow up on their implementation in the next four years.

- CSOs play a limited role in accountability, especially in raising awareness about rights and building the capacities of society and vulnerable segments. For example, the representative of persons with disabilities stated that “the role of civil society organizations is almost minimal, and there are no initiatives to adopt issues of the right to health systematically. Rather, there are individual efforts of organizations or persons to advocate for specific issues, such as sexual violence or ethnic discrimination.

On the other hand, political instability and the consequences of the October 25 decisions slowed the implementation of interventions and plans for institutional reform in the relevant Ministries. Thus, according to the representative of the Secretariat of the National Mechanism at the Federal Ministry of Justice, they cast a shadow over monitoring, follow-up, and the promotion of all rights, including the right to health.

## CONCLUSIONS AND RECOMMENDATIONS

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The following conclusions were formulated based on the above information and a framework consisting of three themes: respect, guarantee, and performance, by which human rights are measured.

In terms of respect, the extent of the state's diligence in concluding covenants, harmonizing national legislation, and passing laws to preserve rights when necessary is evident. It could be said that Sudan has made an appreciable effort in concluding international covenants, working to harmonize national legislation, and establishing mechanisms to follow up on human rights, including the right to health.

Several laws and legislations were adopted to guarantee access to the right to health at all times (peace, war, and epidemic) and for all groups without discrimination or exception. Sudan included health and education among the priorities of the transitional period. National strategies and plans have been developed in line with the SDGs and take a health perspective in all policies as a framework to ensure the complementarity of roles between the relevant authorities and ministries in preserving the right to health.

Moreover, the right to health was guaranteed through interventions to ensure and secure access to health services by providing health insurance and continuing Zakat support. The health system also offers free emergency treatment and treatment for children under five, patients with kidney failure, heart catheterization, and other procedures. At the planning level, Sudan has worked to strengthen the health system in fragile, less developed, and conflict areas through particular interventions, including policies to retain staff and expand the contribution of national and international organizations to health services during conflicts.

In terms of performance, health indicators point to the poor health of Sudanese citizens. The burden of diseases is concentrated among vulnerable segments and in rural and less developed areas. This reality appears in the discrepancies in access to essential health services between Khartoum, the capital, and major cities, on the one hand and other towns



and villages, on the other. In addition, the health system shows weaknesses in its six components, primarily financial and human resources and drug supply. These weaknesses have led to the unavailability of health services for the most common ailments and childhood diseases. The COVID-19 pandemic exhausted health services. However, health subsidies, including health aids and training, increased hospital readiness for emergency services and expanded infection control.

The political situation remains one of the most influential determinants of health performance. Political instability has obstructed the implementation of the transitional period's priorities in the health sector. Political transformations created confusion in public administrations at the central and state levels, blocking operational plans. On the other hand, the transitional period saw many strikes by health workers, adding to the deterioration of health services in the public sector. In addition, citizens became reluctant to use government health facilities due to the unstable receiving. Thus, they started using the private sector and incurred exorbitant expenses.

In war and conflict regions, the importance of political stability is evident in securing peace and ensuring the continuity of sustainable development, closely linked to other fundamental rights related to health, namely the right to life, food, peace, environment, and development. The complex political situation faced by the current Sudanese government, lack of recognition by the international community, and international pressure also profoundly impact Sudan's performance in the right to health. For example, removing health subsidies impeded services, drug and medical supplies, and staff training. Indirectly, it led to freezing plans and activities on other human rights related to health, such as food, peace, development, and the environment.

The following recommendations are based on the interviews and reviewed literature:

- Achieve political stability with national consensus and provide security and stability for conflict areas.
- End the economic decline, develop the country's resources, and raise the national income.
- Spread a culture of knowledge of health laws, legislation, plans, policies, and accountability of implementation agencies.

- Control governance and build the capabilities of states and localities in leadership, management, and resource mobilization.
- Develop an accurate and precise national health budget, define spending channels, activate monitoring and evaluation mechanisms, provide the necessary financial support to implement plans, and commit to implementing government health financing of at least 15% of the national income.
- Increase citizens' awareness of their rights and duties, and promote active community participation in planning and supervision.
- Expand social security mechanisms and networks, such as Zakat and NHIF.
- With regard to the health sector's human resources, coordinate with health-related authorities such as the Ministries of Higher Education, Finance, and Labor to ensure the production, employment, motivation, and retention of health personnel and find incentive packages to retain positions with the highest need and the least developed areas. In addition, put in place the necessary remedies to reduce the migration of health personnel, improve the health system's capacity to absorb staff, and create jobs for midwives, health assistants, and medical assistants, among others.

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# DEVASTATION OF THE RIGHT TO HEALTH DURING THE CONFLICT IN SYRIA

## Syrian Center for Policy Research<sup>1</sup>

The Syrian Center for Policy Research (SCPR) is an independent, non-governmental, and nonprofit research center; which undertakes policy-oriented research to bridge the gap between research and policy making process. SCPR aims to develop a participatory evidence-based policy dialogue to achieve policy alternatives that promote sustainable, inclusive, and human-centered development.

<sup>1</sup> The authors of the report are: Rabie Nasser, Hamed Saffour, and Majd AlGhatrif.

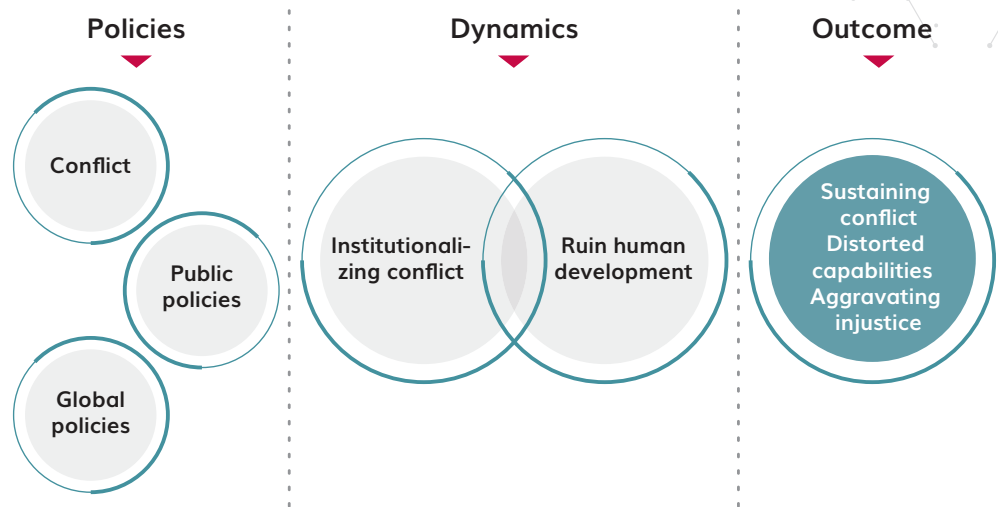
## INTRODUCTION

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The health sector lies at the heart of every political, social, and economic system that governs a country. The sector has two major interlinked components, the health system and the health outcome or population health (WHO 2008). A healthy population and an effective, efficient, just, and accountable health system are vital goals of the sustainable development paradigm that is based on empowering people's capabilities and functions. In addition to external factors such as the geopolitical situation, the health system and its outcome are formed by key determinants (WHO 2008), including: the power structure and political system; the social relations and norms; the economic performance and status of living conditions; environmental conditions and demographic characteristics.

This paper is written as part of the Arab Watch Report on Economic and Social Rights 2023 on the Right to Health. It aims to assess the right to health during the conflict in Syria. The paper uses the political economy approach (Cohn & Hira 2020) to deepen the understanding of power relations in conflicts through analyzing the context of war, mapping the key actors, analyzing the policies and interventions, and assesses the impact of different factors on populations' capabilities (as per the capabilities approach, developed by Sen 1999). It integrates the political, social, and economic spheres in the time of war to diagnose the complex dynamics of the conflict.

This paper summarizes the disastrous health outcomes, identifies the key actors and their policies that affect population health and health system, and diagnoses the social determinants of health in the conflict context. In the context of the conflict, the warring actors' policies create dynamics that institutionalize conflict and weaponize health systems to dominate power and subordinate people and society (**Figure 1**). Finally, it provides recommendations to counter the conflict dynamics and mitigate the negative impacts on public health.

**Figure 1. Policies, dynamics, and outcomes of conflict**

| Source: SCPR, 2022

The report relies on several surveys that have been conducted by the Syrian Center for Policy Research (SCPR) in the whole of Syria, the population status survey 2014, socioeconomic surveys 2020 and 2021,<sup>2</sup> and citizenship surveys 2022. These surveys used participatory approaches with the local community and comprised in-depth interviews with key informants. Also, this paper uses the monthly SCPR Consumer Prices surveys 2020-2022; the SCPR contribution to the Lancet-AUB Commission on Syria;<sup>3</sup> and a background paper on Syrian Conflict and Health Capabilities.<sup>4</sup> The paper also uses relevant secondary data and literature from different sources, cited throughout the report.

The intractable catastrophic conflict in Syria reflects a critical failure of international, national, and local mechanisms to enforce the right to protect, as millions of Syrians have been killed, injured, kidnapped, tortured, displaced, and deprived from basic rights. The conflict has squandered massively people's rights, capabilities, and options. This has been associated with a severe distortion of institutions and socioeconomic and environmental systems. The conflict also has dangerous effects for the region and the whole world such as the aggravation of transnational conflict economies, identity politics and extremism, oppression and unaccountable political powers, normalization of grave human rights violations, and struggles in the Security Council.

The intractable armed conflict has fragmented the geography of Syria between several local, regional, and international

<sup>2</sup> These surveys cover the whole of Syria. They were administered to several purposively selected key informants in each district to assess the socioeconomic status in the respective district. In 2020, 134 interviews were conducted, in 2021, 179 interviews were conducted, and in 2022, 232 interviews were conducted across all of Syria.

<sup>3</sup> Read more about the Lancet-AUB Commission on Syria [here](#).

<sup>4</sup> See the background paper on Syrian Conflict and Health Capabilities [here](#).



actors. This fragmentation resulted in the creation of institutions highly dependent on violence; as the conflict became the source of power, resources, and incentives. These institutions negatively affected the overall health system; including hampering access to services and medications; perpetuating pervasive discrimination; weakening healthcare capacity; causing the destruction of health infrastructure, including the targeting of hospitals and Healthcare Workers (HCWs); and triggering the deterioration of the Syrian pharmaceutical industry (Fouad et al. 2017; SCPR 2020).

COVID-19 is a new factor that damaged public health directly as the confirmed cases and related deaths increased substantially, and the pandemic caused the further deterioration of the socioeconomic situation for Syrians across the country. Moreover, the earthquake in February 2023 added a new level of suffering for Syrians. The catastrophic impacts of this earthquake were not limited to physical and human losses but extended to impact Syria's economic, social, and political structures.

## RIGHT TO HEALTH IN LEGISLATIONS

The right to health is addressed in the Syrian constitutions of 1974 and 2012 in addition to the five years plans and health related legislations. For instance, the 2012 Syrian constitution referred to the right to health in Article 22: "1- The state guarantees every citizen and his family in cases of emergency, sickness, disability, orphanhood, and elderly. 2- The state protects the health of citizens and provides them with means of prevention, treatment and medication." Article 25 of the 2012 constitution states that "Education, health and social services are basic pillars for building society, and the state works to achieve balanced development among all regions of the Syrian Arab Republic."

The 10th Five-Year Plan (10th FYP), covering 2006-2010, was the most promising government plan to develop health policies and outcomes. The Plan highlighted six principles for health development (The 10th FYP 2006<sup>5</sup>):

1. The state's commitment to ensuring healthcare for all citizens without discrimination and working to improve health conditions throughout their lives.
2. The Syrian people are the focus and goal of the comprehensive development process, and ensuring

<sup>5</sup> The original text in Arabic translated by the authors.

a better health condition for all of them is the best investment in the process of sustainable development.

3. Improving the health status of the poor and deprived groups represents the most effective way to improve the health status of society.
4. Preventing disease and promoting healthy lifestyles represents a priority for the health sector.
5. Equitable distribution and availability of basic and emergency health services to all citizens, regardless of their ability to pay.
6. A high-performance and quality health system that citizens trust and participate in at all levels.



The plan also critically analyzed the health system prior to 2006: "...the structural and functional weaknesses of the health system prevented the optimal investment of the limited resources available. The weakness of the health system is evident in the absence of a regulatory reference and a clear health policy that sets priorities and coordinates the roles of stakeholders to prevent overlapping roles, conflicts of interest, bureaucratic inflation, and random growth of the private sector. This has led to poor response of health services to the real needs of the population, poor distribution, low quality, and poor economic efficiency" (The 10th FYP 2006).

The Constitution and the 10th Five Year Plan addressed the right to health and insisted on the importance of establishing an effective health system and inclusive health policies. However, the 10th FYP adopted implicit neoliberal policies such as aiming for cost recovery and targeting the poor. For example, the plan stated that "A fee system will be used in all health institutions to cover the costs of health services not included within the basic health services portfolio for solvent people. It is worth mentioning that the costs of providing the poor with those services will be through the security and protection nets." Also, the plan considered changing the role of the state in health towards regulating function and expanding the role of the private sector in providing services: "The state will focus on providing an enabling environment for the private and civil sectors to increase investments in the health sector and provide economic, financial and legal incentives to encourage these two sectors to respond to the health needs of

citizens according to a national plan; yet the state will continue to play a key role in providing these services in disadvantaged areas and for poor people. (...) while the state will stop capital investment in health facilities (except in cases of extreme necessity)" (The 10th FYP 2006).

## PUBLIC HEALTH PRIOR TO THE CONFLICT

In Syria, prior to the conflict, the health sector witnessed several phases, of which the first – in the nineteen sixties and early nineteen seventies – was marked by a horizontal expansion in infrastructure, services, and human resources, particularly in the public sector. This phase ended in the late nineteen seventies when the country witnessed an escalation of internal and external conflicts with a severe distortion in institutional performance which continued during the nineteen eighties. These conflicts, especially the internal one, and the dominance of military and security-based governance created a reversed socioeconomic transformation in Syria. The political power excessively used violence and withdrew gradually from providing adequate health services for the population while the private sector expanded to fill the gaps in providing health services and participating as a producer in the pharmaceutical industry. The quality of services dropped substantially, and governance of the sector was severely damaged.

In the third phase, which began in the early 1990s, the political regime gradually shifted towards neoliberal market-oriented policies<sup>6</sup> which were associated with severe inequality and created new alliances between the military/security and the private elite. The public resources allocated to the health sector dropped substantially, and the cost accumulated at the expense of the ordinary people. The economic “reform” was associated with the continuation of the authoritarian political regime. The neoliberal policies expanded in the first decade of the new millennium, and the public sector shrunk in the health sector while the cost of health services increased. Several external donors, particularly the European Union (EU), supported the health sector “reform” which aimed at changing the role of the public sector towards regulation, and gradually implemented the principle of cost recovery, in addition to replacing free services with an insurance system.

The marginalization of most Syrians and the absence of political participation prevented any channel to correct the public health policies. Additionally, the corrupted and inefficient institutions led to the deterioration in health system’s performance and hence the public health outcome. The reduction of oil production in the new millennium affected public revenue, the structure of trade, and available rent for

<sup>6</sup> As part of the radical change that was associated with the dissolution of the Soviet Union.

the elite. This led to a drop in public investments and public services, and a reduction of subsidies for basic commodities including oil derivatives and basic food items. These socioeconomic "reform" policies increased the cost of living, created only few job opportunities, expanded the informal labor market, and reduced the labor force participation rate for men and women (SCPR 2016). Therefore, the determinants of health had already deteriorated prior to the conflict.

Syria witnessed a substantial shift in the stages of epidemiological transition during the last quarter of the previous century, as chronic diseases formed about 60% of the overall diseases burden in Syria, while maternal and child diseases formed 25%, and accidents and injuries formed 15%. The following diseases were the main causes of mortality in Syria in 2008 (Higher Commission for Scientific Research 2011):

- Heart and blood vessels diseases: the main cause of mortality in Syria, as the rate of mortalities caused by these diseases was 49.2%.
- Respiratory diseases and infant diseases: the second largest cause of mortality, causing 11.1% of the number of deaths.
- Malignant tumours: is the third most common cause of mortality in Syria (6.7% of the total deaths).
- Accidents: 5.5% of all deaths.

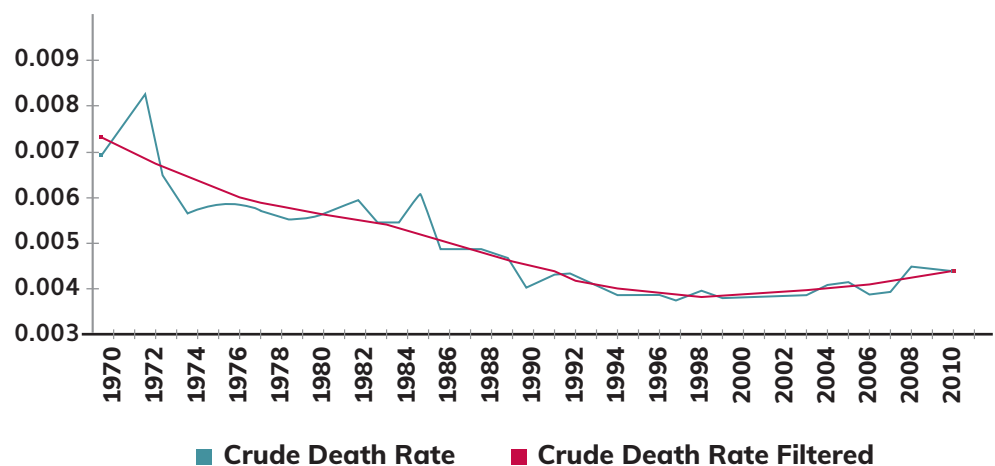
As for the nature of common diseases, the Health Expenditure Survey in 2010 shows that 20.1% of healthcare services were provided for treatment of respiratory disorders, 13.1% for heart problems, 11.2% for muscular system disorders, and 10.9% for dental issues. These were followed by gynecological diseases, intestinal disorders, diabetes, and tumors. The results indicate that respiratory problems among children aged less than fifteen years rose significantly. The survey shows that the health system focuses on treatment of chronic and acute diseases, whereas it spends little effort on precautionary measures. It also indicates that medical care is mainly a private service, as only 18% of medical services are provided through the public sector.

The Forced Dispersion report showed an increase in life expectancy at birth from 64 years in 1978, according to a fertility survey in 1976-1978, to about 71 years in 1995 and 72 in 2000. Life expectancy did not increase between 2000 and

2007 and then declined to 70.8 in 2010<sup>7</sup> (SCPR 2016). These numbers indicate a decline in the level of Syrians' wellbeing and wellness during the last decade.

Other health outcome indicators reflect the inefficiency of the health system such as high rates of chronic diseases, which increased from 7.9% in 2001 to 10.3% in 2009, and the mortality of children under 5 years of age from 20.2 children per thousand to 21.4 per thousand in 2001 and 2009 respectively (Family Health Survey 2001 and 2009). Also, the crude mortality rate increased from 3.8 per thousand in 2000 to 4.4 per thousand in 2010 (**Figure 2**). The increase of the mortality rate indicates the status of inequality and ineffectiveness of the health system and the public health policies in Syria before the war (SCPR 2016).

**Figure 2. Crude death rate in Syria 1970 - 2010**

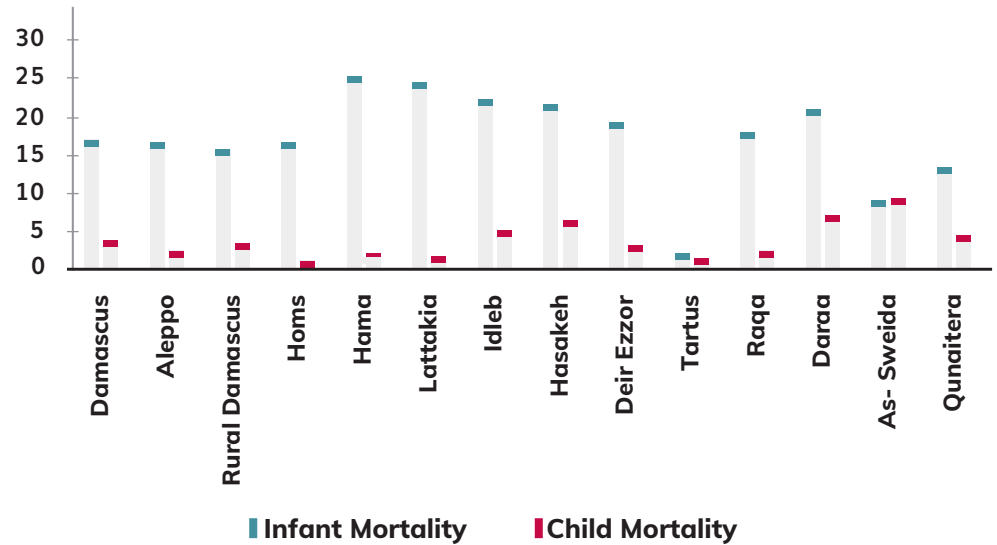


*Source: Vital records and SCPR's calculations.*

The openness, deregulation, and privatization expanded the role of external and internal private elites in designing public policies and increasing inequalities between regions, population groups, and classes. For example, health indicators in 2009 such as the child mortality rate per thousand live births indicated high rates in Hama and Lattakia (25), Idleb and Hasakeh (22), compared to (2) in Tartous (**Figure 3**) (Central Bureau of Statistics 2009). The average population-to-doctor ratio is 1185 in Idleb, 1157 in Hasakeh, compared to 186 in Tartous and 340 in Damascus, while the national average is 661. Indications from public health and healthcare systems also suggest general neglect of rural areas, particularly in the northern and eastern regions (Central Bureau of Statistics 2012).

<sup>7</sup> According to the Human Development report, the life expectancy in Syria reached 74.7 in 2010, which is higher than the average life expectancy of high human development countries (73.9).

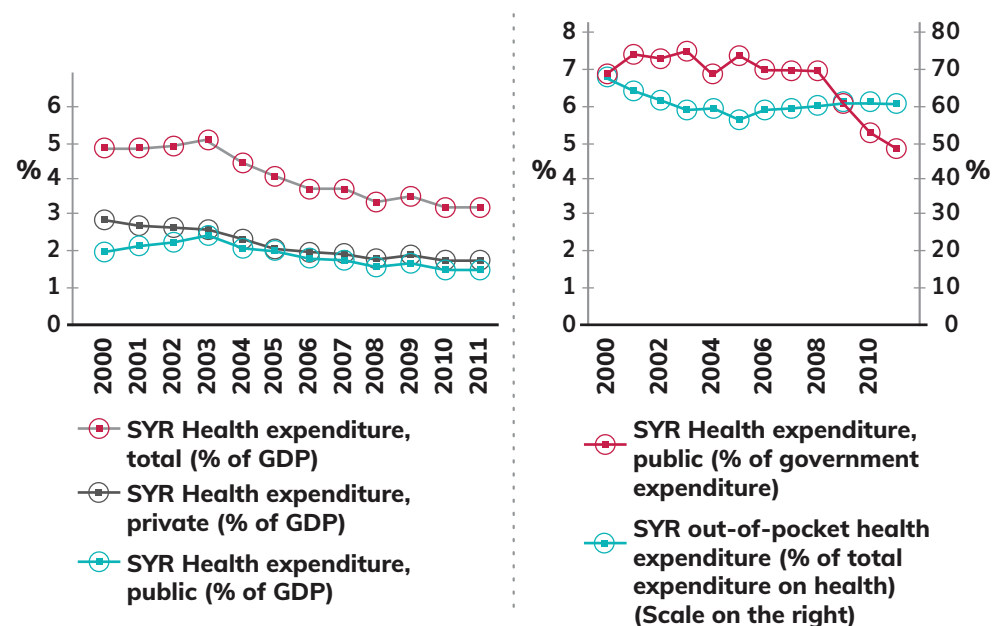
**Figure 3. Infant and Child Mortality Rates in 2009 across governorates**



Source: Central Bureau of Statistics of Syria, 2009, "Health Household Survey - Papfam"

Furthermore, the public expenditure on health dropped from 2% of GDP in 2000 to 1.5% in 2010, while the private expenditure on health dropped dramatically from almost 3% of GDP to 1.7% in 2000 and 2010 respectively (Figure 4). Additionally, instead of the large public health infrastructure, equipment, and subsidies, medical care was mainly a private service, as only 18% of medical services were provided through the public sector (Central Bureau of Statistics 2011).

**Figure 4. Expenditure on health**



Source: World Bank Indicators 2022

# PUBLIC HEALTH DURING THE CONFLICT

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## PREFACE

The conflict in Syria has multidimensional socioeconomic, political, environmental, and geopolitical roots, however, the core root can be labeled as the “institutional suffocation” as the political oppression was the extreme factor that abused the public authorities, prevented power sharing, marginalized most Syrians, and shrunk the public space with the hegemony of the military and economic elite.

The social movement in 2011 called the “Arab Spring” demanded freedom and social justice and represented accumulated political and developmental grievances that the ruling authorities failed to address or mitigate. The authorities decided to suppress the movement using violence, which triggered a vicious cycle of armed conflict dynamics that created new unprecedented levels of injustice, violations, and deprivations.

Several global and regional powers were involved in the conflict which internationalized it and expanded the resources and means allocated to fuel the battle. The brutality and intensity of the conflict have resulted in a failed country where the political power has been fragmented between state and non-state actors. Public institutions and resources are reallocated to destructive policies and activities and the social fabric has been degraded based on identities, political affiliations, and economic interests. The human and economic resources have been destroyed or distorted. At the same time, enormous humanitarian efforts and interventions have been initiated to support Syria, which has become dependent on international aid.

The armed conflict in Syria ruined human capabilities and freedoms, as defined in Sen’s capability approach (Sen 1999), as the orientation of public policies and interventions were shifted towards fueling and sustaining the violence and military battles and/or mitigating the impact of the war on allied institutions and communities. The conflict led to a radical reformation of the roles of the subjugating political actors, each of whom adopted conflict-centered policies that supported their priorities to “win” the war. Nevertheless,



humanitarian and/or pro-peace actors expanded their roles to mitigate the impact of the conflict and facilitate reconciliations or peace building initiatives in addition to their developmental contributions to plant new foundations for sustainable development in the future. However, those pro-peace actors in many cases lacked the power and capacity to stop the war, as the sources of power during the conflict, including military, economic and institutional, were controlled by the subjugating actors. The shrinking space for civil society, humanitarian and development actors forced them to adapt their strategies and subordinate to the rules of the oppressors.

The conflict led to a substantial and direct deterioration of human capabilities including basic rights such as the right to life, dignity, equity, security, protection, work, decent living conditions, health and education among others. Conflict prevents people from being or doing what they value, and more dangerously, it might force them to alienate themselves from their public and private interests which might lead them to the identification with the oppressors or war lords.

## DEVASTATING HEALTH

The violence unleashed in wartime has had profound and immediate impacts on the fabric of life in Syria. The section investigates the enormous health burden caused by the conflict.

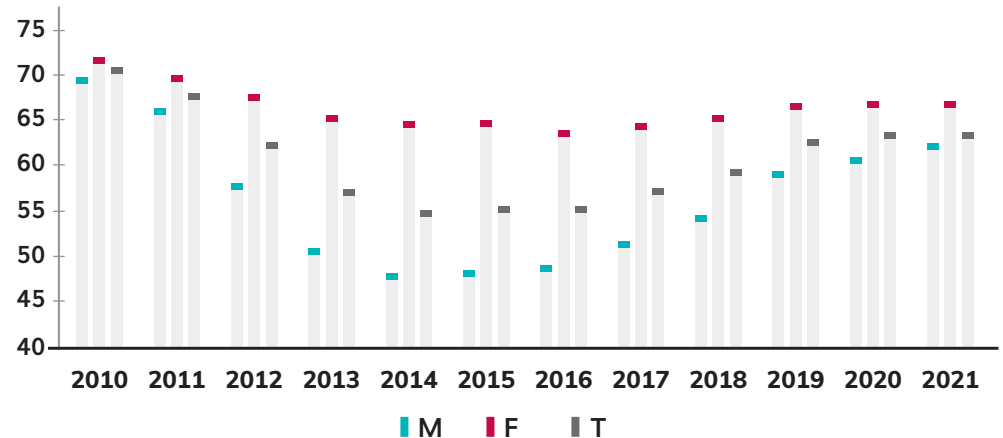
This section provides key health status indicators in Syria during the conflict, that includes communicable and non-communicable diseases, mortality rates and life expectancy, disability, and malnutrition. It shows the severe collapse of the public health sector that was accompanied with grievances, violations, and inequalities.

According to SCPR estimations the conflict in Syria caused the death of more than 700 thousand persons.<sup>8</sup> This represents the brutal violation of people's right to life. Accordingly, the mortality rate surged as the most catastrophic impact of the conflict. The crude death rate rose from 4.4 persons per thousand in 2010 to 10.9 per thousand in 2014, after which it gradually declined to 7.1 per thousand in 2021. The high number of lives lost reflects the brutality and intensity of the Syrian conflict (SCPR 2020). Males of working age were disproportionately affected by this, which widened the gap in life expectancies between men and women to around 17 years in 2014 and reduced again to 5 years in 2021. However, the mortality rates of women, elderly and children exposed the

<sup>8</sup> Human Status in Syria: estimates based on the results of a survey conducted by SCPR in the whole of Syria through 2,100 in depth interviews with key informants.

grave violations carried out by the warring parties (Figure 5).

**Figure 5. Life expectancy by gender (2010-2021)**



Source: Population survey 2014 and SCPR estimations, 2022

The earthquake in February 2023 led to 10,659 deaths among Syrians in the affected areas and for Syrians residing in Turkey,<sup>9</sup> and 11,829 injuries inside Syria. The victims were distributed as follows: 1,935 victims and 3,450 injuries in Government of Syria (GoS) controlled areas, 1,295 victims and 1,499 injuries in areas controlled by the Syrian Interim Government (SIG), and 3,162 victims and 6,880 injuries in areas controlled by the Syrian Salvation Government (SSG). These losses in human lives led to a sharp increase in death rates and a significant decline in life expectancy in the affected communities.<sup>10</sup>

Many communicable diseases outbreaks occurred during the conflict. In 2013, 37 cases of wild poliovirus type 1 (WPV1) were detected in Deir-ez-Zor, one of the most deprived governorates in Syria before the conflict. Combined with low immunization coverage, the weakening of the health system led to 74 cases of circulating mutated poliovirus type-2 (cVDPV2) confirmed in Syria in 2017. The outbreak was officially declared over in November 2018 (Reliefweb 2017). With public health infrastructure still compromised, low immunization rates, and poor living conditions, the threat of future outbreaks and an export of WPV and cVDPV2 to other areas remains high (SCPR 2020). Furthermore, cases of measles have increased since 2011, with 594 reported cases in 2014 and 738 cases in 2017. Recently, the suspected cases in 2022 increased by 29.4% compared to 2021, the cases concentrated in Raqqa, Idlib, and Aleppo (WHO 2022). The reported cases are defined as laboratory confirmed, epidemiologically linked, and clinical

<sup>9</sup> [The statement](#) of the Turkish Interior Minister on March 4, 2023, indicated that the number of Syrian victims in Turkey had reached 4,267 out of a total of 45,000 victims.

<sup>10</sup> Syrian Center for Policy Research, 2023: Field survey on the impacts of the earthquake. It is worth noting that the number of casualties in Syria, according to the official statistics of the GoS and the Assistance Coordination Unit, is about 5,914 victims and 10,849 injuries. This is less than the center's figures for the increased number of deaths in the Jabal Sam'an area, which reached 991 according to the Center's field survey, compared to 444 according to the Syrian Ministry of Health data.

cases as reported to the World Health Organization (WHO).

From 2012 to 2022, the most prevalent communicable diseases were influenza-like illnesses (ILI) followed by acute diarrhea (WHO 2022). Acute Bacterial Diarrhea (ABD) cases increased in 2022 by 7% compared to 2021. Moreover, in September 2022 an outbreak of cholera was declared in Aleppo where 15 cases were confirmed (UN-OCHA 2022a). In the Northeast region, the number of new typhoid cases reported across the three governorates was also high, reaching approximately 3,430 in October and 2,595 in November 2018. This outbreak is thought to be due to the consumption of unsafe water and follows the ABD outbreak in Deir-ez-Zor Governorate (UN-OCHA 2018). Conditions across many internally displaced populations (IDP) sites are already dire and poor weather and heavy rains represent an increased risk of outbreaks of water-borne diseases including typhoid and ABD.

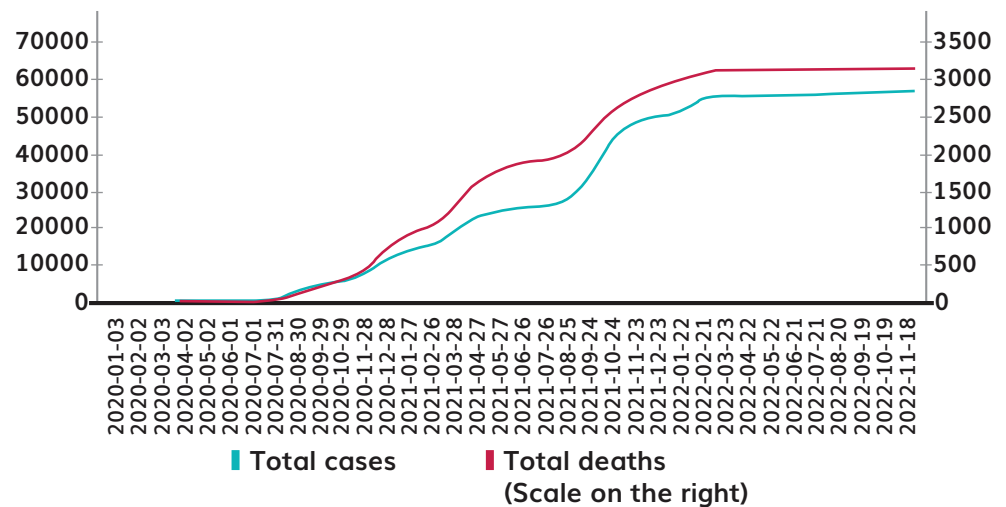
Confirmed cases of leishmaniasis also increased during the conflict. In 2021, the cases exceeded 78,000 cases, and were concentrated in Deir-ez-Zor and Aleppo, Hama, and recently in Hasakeh. This epidemic is associated with poor infrastructure, sanitation, and environmental degradation (WHO 2022).

The first COVID-19 cases appeared in March 2020 (Figure 6) and thereafter the Government of Syria imposed precautionary measures including curfews, as well as closing schools, public institutions, and private firms with the exceptions of vital public services and the productive firms such as manufacturing and agricultural companies. Internal trade almost stopped and external trade with Iraq, Lebanon, and Jordan dropped by almost 80% (SCPR 2020). Economic activities reduced sharply, and many people lost their jobs and sources of income. Poverty rates surged and the health system was not able to deal with the catastrophe. The Autonomous-Administration (AA) and opposition-held areas imposed a curfew as well in March 2020 and the suffering of people aggravated in their areas. However, with the reported low spread of the virus in Syria, the government, AA, and the opposition decided to remove most of the transmission control measures in May 2020. The commitment of people to the measures in most regions almost disappeared. The second breakout of COVID-19 during the summer from July-September 2020 had a huge impact on the health system and many infected people chose to stay at home. In the northeast the cases increased substantially since September 2020, and the AA imposed a lockdown from October 2020 to February 2021, while the northwest witnessed a rising number of cases since May 2021 (iMMAP 2021). The most

dangerous wave occurred mainly in the northeast and GoS-controlled areas during September and October 2021. Doctors without Borders (MSF) estimated that the cases in this region doubled between August and September 2021 (MSF 2021).

The lack of transparency of the institutions that are responsible to report the COVID-19 cases, in addition to the poor health system led to the conclusion that the burden of the Coronavirus on the Syrian population is underestimated.<sup>11</sup> Moreover, the fragmented and damaged health system cannot provide infected people with the necessary care due to the lack of infrastructure and medical staff and the inefficient and corrupt management (Abbara et al. 2020). Civil society played an important role at this stage through providing treatment in their facilities or supporting the patients at their homes.

**Figure 6. COVID-19 accumulated cases and deaths in Syria, March 2020 to November 2022**



Source: Our World in Data, 2022, [Link](#)

Notwithstanding the impact of COVID-19 on population health in 2020 and 2021, injuries and NCDs have been the major causes of death during the conflict. The main NCDs were cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes. Furthermore, the conflict led to an increase of risk factors that are associated with NCDs such as overweight, blood pressure, and blood sugar (WHO 2022).

In 2021, it was estimated that 25% per cent of the population have disabilities compared to 10-15% globally, likely a result of war injuries. Disabilities here refers to difficulties in at least one of the six functional domains: seeing, hearing, walking, cognition, self-care, and communication (Health Cluster & World Health Organization 2022). Disability affects individuals,

<sup>11</sup> WHO estimated the number of confirmed cases in Syria by Nov 2022 by 210324 cases and 7246 deaths, while the official data referred to 57423 cases and 3163 deaths in the whole of Syria.

households, communities, and countries for years to come. People with disabilities have a lower lifetime earning potential and may require additional support from both family and public services. Owing to the prevalence of disability in Syria because of the conflict, these issues will place additional strains on health services and propagate vulnerability in the future (SCPR 2020).

Mental health issues are another burden of the conflict. According to a nation-wide survey conducted by the WHO in 2020, "44% of Syrian participants living inside Syria [were] more likely to have a severe mental disorder, 27% had both likely severe mental disorder and full post-traumatic stress syndrome (PTSD) symptoms, [and] 36.9% had full PTSD symptoms" (WHO 2022). Another survey conducted in Germany with Syrian, Afghan, and Iraqi refugees reported that 74.7% of refugees experienced personal violence before or during their migration. More than 60% of people were traumatized by war experiences, with more than 40% being directly attacked by military forces. More than one in three people have had to cope with the disappearance or murder of relatives and people close to them. One in five was tortured and nearly 16% were held in camps or in solitary confinement, or witnessed killings, ill-treatment, and sexual violence. More than 6% were raped (Schröder et al. 2018). Children, as the most vulnerable group, suffer persistent feelings of fear of being surrounded by violence, experience frequent nightmares, and have difficulty sleeping. Additionally, children's behavior has become more aggressive. Children expressed how their high levels of stress manifest in physical symptoms such as headaches, chest pain, and difficulty breathing (Save the Children 2017).

The above mortality and morbidity rates show part of the health burden on the Syrians because of the conflict. It shows the severe violation of the right to health from a health outcomes perspective. This severe burden is associated with distortion of health system and deterioration of health determinants which will be discussed in the following sections.

## **DEVASTATING THE HEALTH SYSTEM**

The conflict has significantly damaged the Syrian health system through the destruction of healthcare infrastructure, the flight and killing of healthcare professionals, the lack of medical device maintenance and spare parts and the collapse of the pharmaceutical industry. One of the most visible impacts has been the fragmentation of health authorities across the country. The different fighting parties have created their own

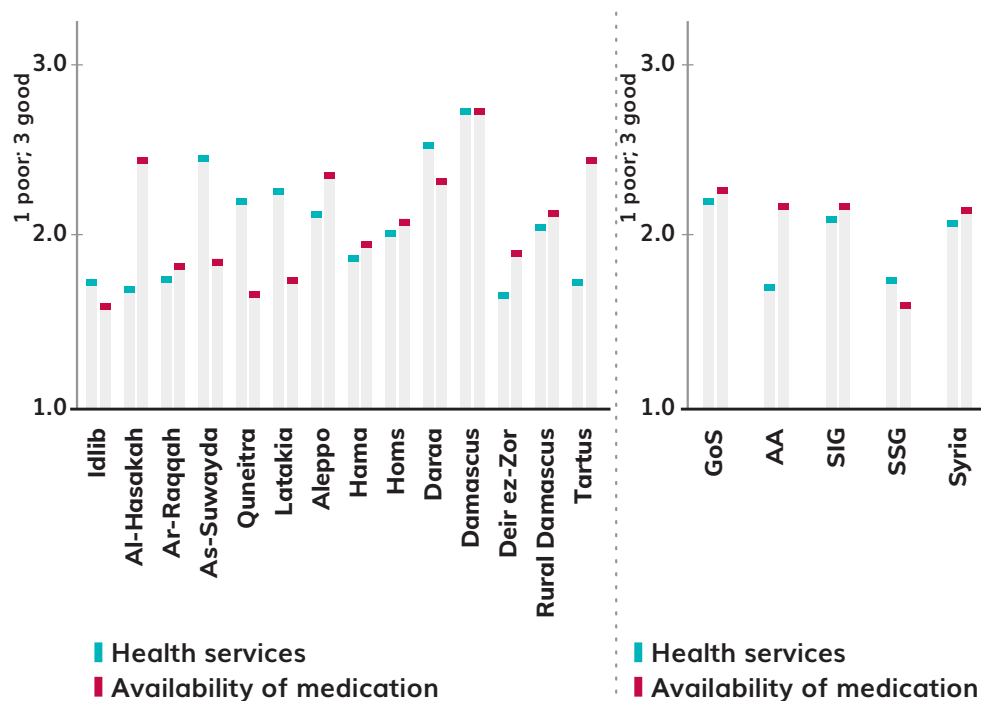
institutions which are often of weak governance. At the same time, the role of civil society has greatly increased in the field of health services and reproductive health, where hundreds of associations and initiatives concerned with health and humanitarian services have contributed to providing essential health services for people in many areas, especially those threatened by siege. However, civil organizations suffer from a lack of resources, poor coordination, and poor governance which has prevented civil society from being able to meet the increasing health needs of population (SCPR 2019).

### ■ HEALTH SYSTEMS PERFORMANCE

There has been a sharp decline in the availability of health services during the conflict. More than half of the Syrian population is unable to access appropriate health services. Moreover, the pre-conflict results highlight the huge disparities across regions in terms of accessing health services; particularly in the northern and eastern regions including Ar-Raqqa, Hasakeh, Aleppo, Idleb, and Deir-ez-Zor. The functionality of public hospitals has been assessed at three levels: fully functioning, partially functioning, or not functioning. By November 2022, out of the 203 reported public hospitals in the whole of Syria, 65% were fully functioning, 17% were partially functioning, including due to shortage of staff, equipment, medicines or damage of the building, while 18% were non-functioning. In terms of functionality of PHCs, by November 2022, 56% out of 1,941 centers were reported as fully functioning, 19% were partially functioning, and 25% were non-functioning (completely out of service) (WHO 2022).

Accessibility to health services goes beyond the readiness of health facilities, as people face different security, financial, and governance obstacles to fulfil their needs for healthcare. The socioeconomic survey 2020/2021 assessed the ability of the Syrian population to access health services. **Figure 7** shows that many segments of society cannot access quality services in different governorates and controlled areas.

**Figure 7. Accessibility to health services and availability of medication 2021**



Note: Participants were asked to rank access to healthcare services on a scale of 1: poor access for the whole population and 3: good access for the whole population. Participants were asked to assess availability of medication on the same scale.

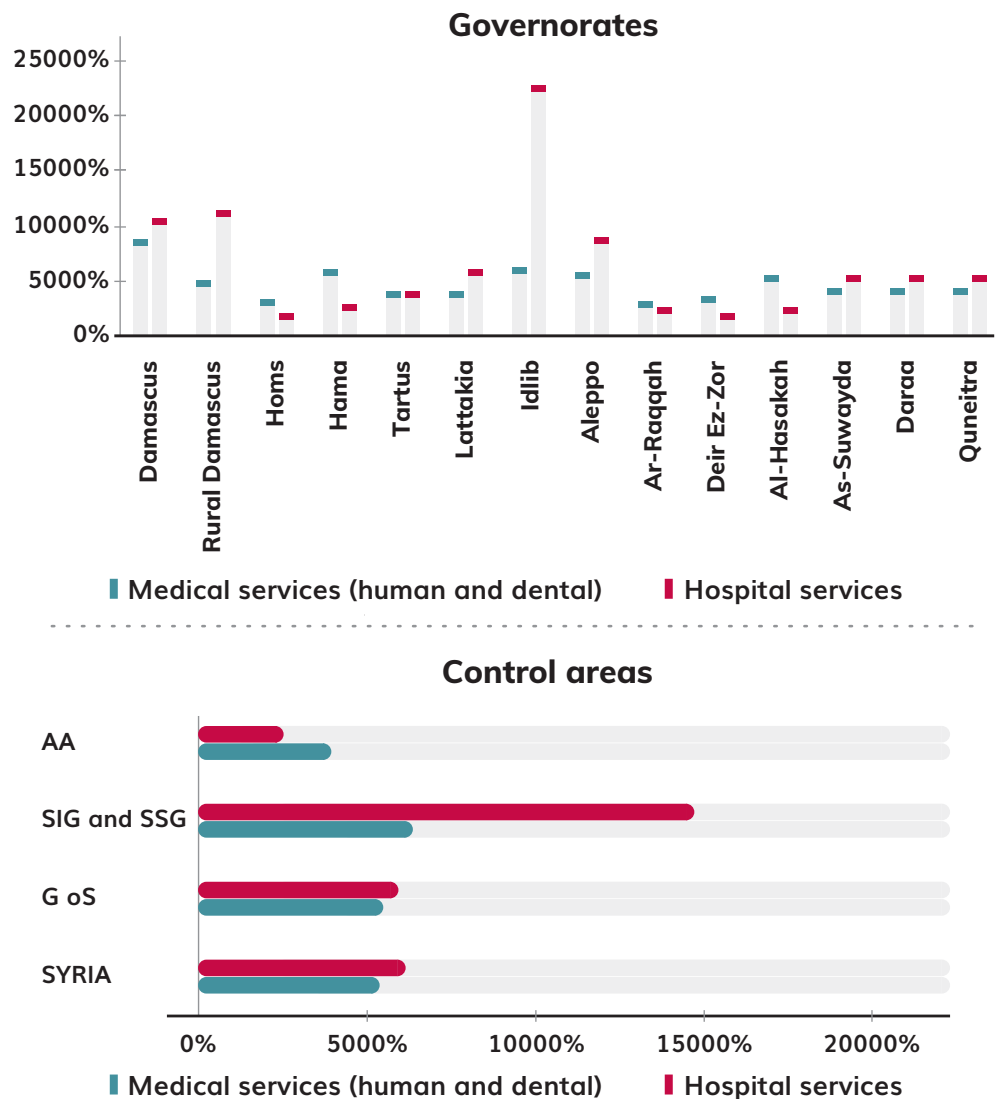
Source: SCPR, Socioeconomic Survey 2021

The earthquake has affected the already conflict-affected health sector, where 55 health facilities were damaged in northwest Syria (Assistance Coordination Unit 2023). In its current state, the health system was unable to meet the increasing needs of the injured and affected in many areas, such as the Badama and Harim regions (REACH 2023), and in the shelters. In GoS-controlled areas, 116 health facilities were directly damaged, including 14 in Aleppo, 54 in Latakia, and 48 in Hama, and they need infrastructure repairs and support with medical equipment. Reports on monitoring infectious diseases have also shown an increase in cholera, acute diarrhea, and respiratory diseases in various regions (UN-OCHA 2023).

The consumer prices monthly survey shows the enormous increase in the cost of private health services. Overall, the inflation rates between 2022 and 2009 reached 6,249% for the hospital services and 5,459% for medical services. The opposition-controlled areas witnessed the highest inflation rates for private services, while AA areas witnessed the lowest inflation rates (**Figure 8**). The surge in prices was associated with a drop in the household's income which created a severe

challenge for people to access health services and forced many of them to rely on public and civil society facilities which suffer in many cases from low quality, lack of necessary services, and mismanagement.

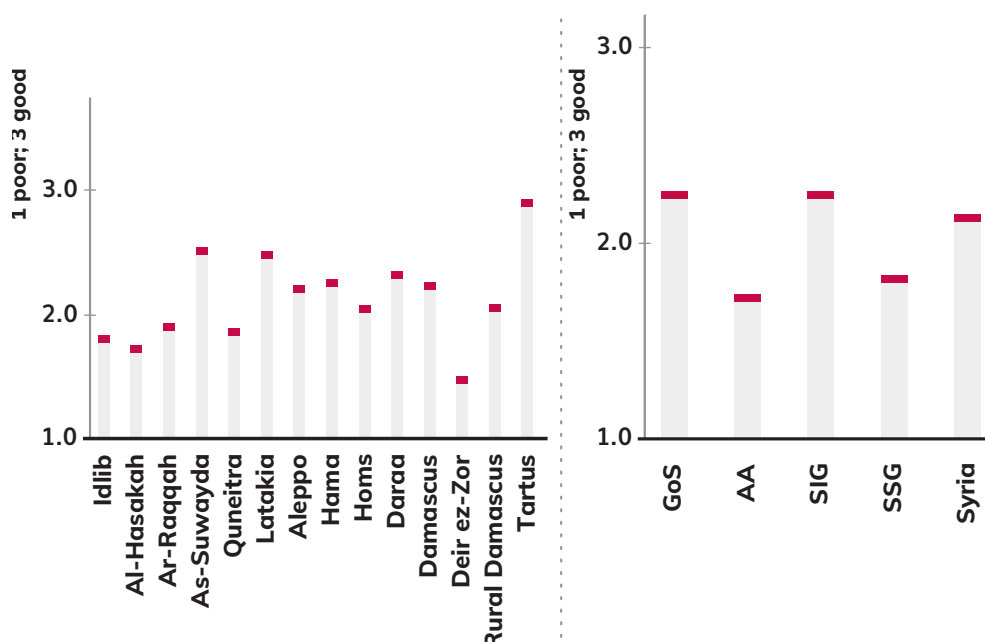
**Figure 8. Health group inflation rates 2022 compared to 2009 (%)**



Source: SCPR 2022, Monthly Survey of Consumer Prices in Syria

Women have specific challenges in accessing health services. The socioeconomic survey shows the poor access of women to reproductive health services due to the poor infrastructure, restriction on mobility, and the increase of prices of services in the private sector, the main provider of these services (Figure 9).



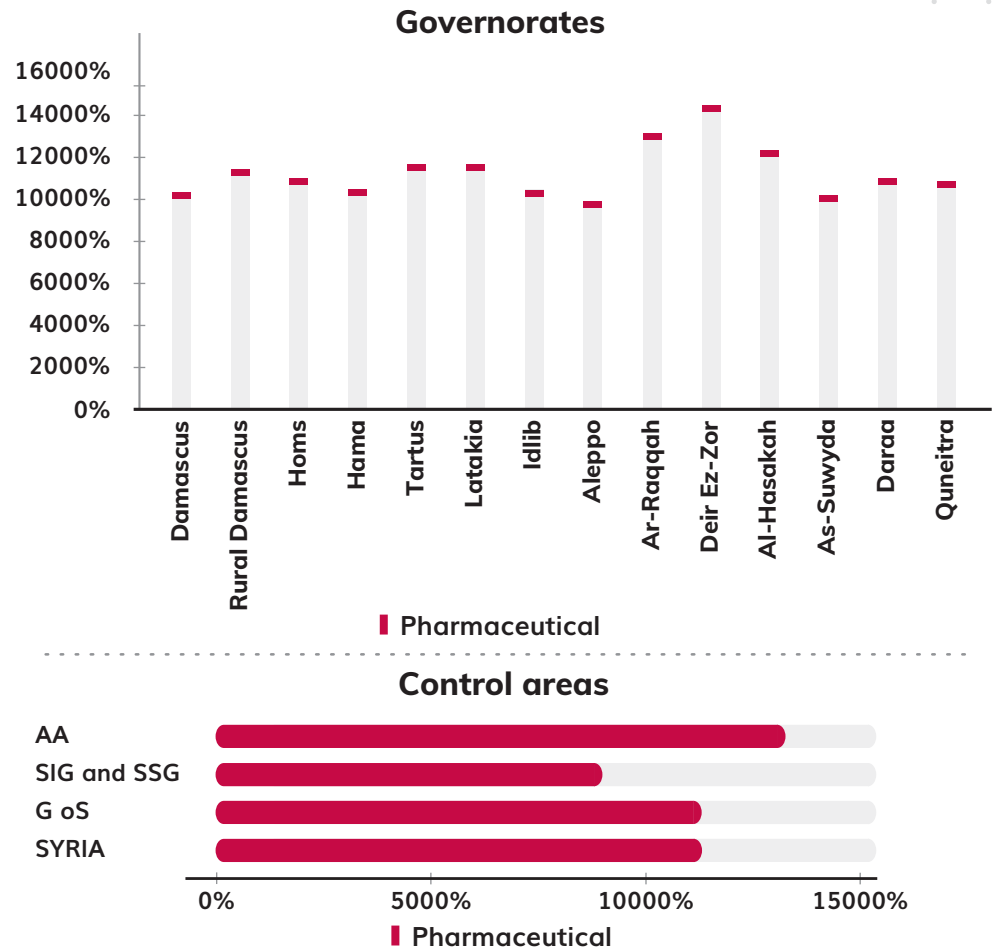
**Figure 9. Accessibility to reproductive health by women 2021**

Note: Participants were asked to rank access to healthcare services on a scale of 1: poor access and 3: good access.

Source: SCPR. Socioeconomic Survey 2021

There has also been a dramatic decline in the availability of medicine during the conflict reflecting a deterioration in the quality and effectiveness of health services. The socioeconomic survey 2020/2021 shows the poor unequal access to medicine across regions (Figure 7). The partial lack of access to medicines is mainly due to the decline of locally produced medicines. This in turn can be explained by the sharp decline in the sources of income for most people, and the surge of prices of medicines by 11,335% in 2022 compared to 2009 (Figure 10). Additionally, the destruction of the local pharmaceutical industries and necessary infrastructure, in addition to sanctions, which have blocked imports of equipment and components required to produce pharmaceuticals have all contributed to the poor access to medicines. The lack of medicines has severe adverse implications for people with chronic diseases such as diabetes, high blood pressure, and kidney disease (SCPR, 2022b). Furthermore, the quality of medicine dropped in all regions and especially in AA and opposition-controlled areas; as these regions face more restrictions on importing of medicines and do not have a well-established mechanism to monitor the quality of imported medicine.

**Figure 10. Medicines inflation rates, 2022 compared to 2009 (%)**



Source: SCPR 2022, Monthly Survey of Consumer Prices in Syria

The availability of trained medical staff is crucial to providing appropriate health services, particularly in times of armed conflict. The conflict led to a loss of healthcare professionals and reduced mobility between institutions. Based on WHO estimates, the number of medical staff dropped by two thirds during the conflict (WHO 2017). The availability of medical staff has varied notably between governorates. In 2020, based on the number of public medical doctors in public hospitals and public health centers (WHO, HeRAMS 2020a, 2020b), and on the estimation of population per governorate (SCPR 2021), the ratio of public medical doctors per 10,000 inhabitants at the country level was estimated to be eight. The ratio of public medical doctors per 10,000 inhabitants reached 24, 22, and 20 in Damascus, Lattakia, and Tartous respectively, compared to only six, five, and two in Aleppo, rural Damascus, and Daraa. Governorates that are outside of Government of Syria control severely lack public medical doctors (under the supervision of

GoS) and depend on the health systems that were developed by the opposition in the northwest and by the AA in the northeast. The factors driving the emigration of medical personnel from cities and areas under government-control such as Damascus and Lattakia include financial security, children's education, and avoidance of the military draft. In previously besieged areas such as eastern Ghouta, few doctors remain. In areas previously under the control of ISIS, doctors were exposed to assaults by the fighting parties, such as in Al-Boukamal in Deir-ez-Zor, and all hospitals prioritized combatants.

Year 2022 witnessed shocking rates of emigration with a number of well renowned doctors, praised in the community for their humanitarianism, eventually leaving the country. The dynamics affecting physicians appear to be similar across Syrian communities with some differences due to variations in their ability to emigrate (ability to obtain a passport and a visa), availability of credentialing mechanisms that allow re-credentialing abroad (i.e., recent graduates of nonaccredited medical schools in northeast and northwest Syria), and the availability of high-paying INGOs compared to the local market (in northeast and northwest Syria).

## ■ HEALTH SYSTEMS ACTORS AND POLICIES

### Health providers

Health in Syria is deeply rooted in a complex socio-political context. The extraordinary health disparities which emerged due to war strategies, as well as distorted and violent forms of governance in certain communities have radically disrupted and transformed the social determinants of health in the country. Social determinants of health are known to shift in conflict settings, as structural elements of society have profound impacts on health (Marmot & Wilkinson 2006). The breakdown in institutions created life-threatening forms of institutional discrimination and societal fragmentation. The transformation of power has produced new institutions where discrimination is the norm and the redistribution of resources and power favors special interest groups such as the regime's military and economic elite, the military opposition groups, and extremist militias (SCPR 2019).

The fragmentation and politicization of population and governance has led to different health systems across the country:

- a. In the Government controlled area, the Ministry of Health leads the sector; however, its role shrunk, while the role of

humanitarian international and local actors, civil society and the private sector has expanded dramatically. The health system is characterized by discrimination, corruption, and ineffectiveness. Furthermore, and as described in more detail in the section below on Health-related War Policies, the role of health system became part of the war, as a means to fuel the conflict, violate rights, and subordinate people. The targeting of health facilities and workers led to a severe damage to readiness, efficiency, and fairness of health system.

- b. In Autonomous Administration controlled areas, the political authority adopted a different governance health system compared to the opposition-held areas, as they established a health commission to supervise the health facilities and pay salaries for the health employees. Cross borders partners supported operations in the area. However, the GoS continues to operate in the region, which suffers from an unstable security situation and the ongoing displacement of civilians, in addition to a limited number of implementing partners. The AA was unable to match the needs for health services and medicines due to damaged infrastructure, weak administration, as well as lack of staff, medical equipment, and funds.
- c. In Salvation government areas, the Syrian civil society has become significantly important in providing health services, primary healthcare, and reproductive health. Hundreds of associations and initiatives concerned with health and humanitarian assistance have contributed to providing basic health services to people in many areas, especially those threatened by besiegement. As of 2015, health systems in the opposition-held regions continue to rely on the structure of the Syrian public health system but gradually expanded it, primarily through the active involvement of the health directorates, civil society, UN agencies and donors in the design and planning of the health sector in the region. After the control of Idlib by Al-Nusra, a Ministry of Health was established, an authority characterized by fragility and limited capacity to influence the sector, coupled with numerous restrictions on any support to sustain the health initiatives in this region. However, the health NGOs and health directorate continued to provide services in Idlib, but they suffer from severe attacks on health facilities, a lack of resources, sanctions, and poor coordination and governance.

- d. Turkish-Backed Opposition Areas follow the structure of the Turkish health system and have developed their public facilities and infrastructure accordingly. Prior to these operations, health NGOs played an important role in providing healthcare services in these areas. However, the Turkish government role has limited the role of civil society in providing public services. The Turkish role consists of supervising the sector and providing services and undertaking difficult treatments and operations and cases for which treatment is not available in local hospitals and clinics. In this area, the responsibility of obtaining medicines and healthcare shifted from the public sector to citizens, local and international organizations, or the private health sector, which exacerbated the economic situation of the people. Additionally, the restriction on cross border operations and on imports and exports through Turkey negatively affected the health conditions in these areas. The weakness of the administrative structure of the Interim Government, particularly in the field of the health sector, was associated with a set of challenges, including lack of funding, instability, damaged infrastructure, and a shortage of medical personnel.
- e. The work of the private health sector has spread widely across all regions in Syria during the conflict. The private sector consists of formal and informal healthcare providers, including pharmacies and specialized hospitals, which include for-profit entities, whether local or foreign. The results of socioeconomic surveys conducted by the Syrian Center for Policy Research in 2020 and 2021 shows a significant drop in public health services and an increase in the provision of private health services. Many challenges are associated with the role of the private health sector such as lack of accountability and monitoring of quality in addition to increase of cost of services.
- f. Civil society was a vital actor in providing health services. This is expressed through various forms of NGOs and community-based organizations (CBO), whether civil-based, faith-based, residence-based, or professional organizations/initiatives. Need statements expressed by such organizations are driven by requests received of humanitarian cases of patients in need of high-cost therapeutic interventions. Professional input, however, promotes preventive and primary care programs with variable levels of efficiency. It is important to note that the heterogeneity at the level of organized work

between communities, within and across areas of control, is significant. This is due to variable degrees of self-organization, which is dependent on the widely variable social structures, leadership, local community resources, professional experience, and international support, whether from diaspora communities or other donors. In addition, it is important to note that the reliance on such community organizations to compensate for the shrinkage in state public health services varies substantially based on the activity of health INGOs in filling this gap. The latter, which are much more advanced operationally and financially, are major providers in northeast and northwest Syria, but not in GoS controlled areas, in which CBO charities play a greater role in covering this gap in public health services.

- g. It is worth mentioning that the WHO and other UN agencies played an important role during the conflict in terms of maintaining information systems such as Health Resources and Services Availability Monitoring System (HeRAMS) and Early Warning, Alert and Response System (EWARS) that have provided vital information about health systems and morbidity. The WHO also supports local health providers with funds, equipment, and capacity building. The WHO role differs across controlled areas, as it directly supports the Ministry of Health in the GoS controlled areas, while it works through cross border mechanisms in the other regions. However, the role of the WHO and UN agencies was negatively affected with the severe compromises with the political actors which negatively affected their policies and programs. For instance, their response to the earthquake in February 2023 was widely criticized as their response was substantially different between Turkish affected areas and Syrian affected areas (Jabbour et al. 2023).

### **Health-related war policies**

Several local, regional, and international parties have been involved in prolonging and fueling the conflict through various wars waged on multiple fronts, whereby weapons prohibited by International Humanitarian Law (IHL) have been used repeatedly. This conflict is characterized by wide use of indiscriminate military tactics that have resulted in destruction and besiegement of cities without any guarantee of civilians' right to protection.

An empirical study,<sup>12</sup> conducted by SCPR based on the Human Status Survey 2014 showed that political governance, social capital, education, conflict economies, living conditions,

<sup>12</sup> Based on a background paper submitted to Lancet-AUB commission on health and conflict in Syria.

and displacement are the main determinants of health and outcomes.

The health determinants and health outcomes were severely and unevenly damaged during the conflict through war policies. The following are key health-related war policies:

- The warring parties are responsible for killing hundreds of thousands of combatants and civilians using all kinds of weapons and ammunition, including those that are internationally prohibited, such as chemical weapons. Millions of Syrians were injured during the conflict, some of them have become disabled or suffer from chronic disease.
- Torture, kidnapping, arbitrary arrests, and sexual abuse are part of the tools that have been used by the warring actors to subordinate their "enemies."
- Collective punishment is a core policy used during the conflict which inflicted stricter punishments on certain groups, communities, and regions. Since areas outside of governmental control are the most affected by the destruction of health services, they therefore have poorer health outcomes and systems (SCPR 2020).
- Besieging communities for up to seven years and depriving the population to the minimum conditions of decent living including access to health services, medicine, food, water, and energy. More than 2 million Syrians suffered from sieges for different time periods.
- Changing the function of the health system from providing healthcare to serving war and "loyal communities" and therefore distorting the ethical code of the healthcare sector.
- Adopting discriminative policies that prevent specific people from political, regional, or culture backgrounds from accessing healthcare facilities or medicine.
- Reallocation of resources from health and social protection sectors to conflict-related activities.
- Transferring the responsibility of healthcare from the state to civil society, private sector, and humanitarian organizations.
- The government removed subsidies of many basic goods, which increased the cost on producers and consumers and aggravated the deprivation.

- Targeting healthcare workers, which includes killing, kidnapping, and torturing among other violations. Healthcare workers have been a direct target during the war (Blanchet et al. 2016). At least 914 medical professional personnel have been killed in Syria during the war until November 2019, of whom 265 were doctors. Almost 55% were killed in aerial attacks or shelling, while 141 were either kidnapped or detained and subsequently killed (Physicians for Human Rights [PHR] 2023).
- Destruction of health facilities and infrastructure: The targeting of public hospitals and healthcare workers became a defining feature in the Syrian war strategy. Between March 2011 and March 2020, Physicians for Human Rights (PHR) has corroborated 595 attacks on at least 350 separate medical facilities (WHO 2020). These systematic attacks on health facilities are described as the weaponization of healthcare, with people's need and right to health being intentionally deprived (Fouad et al. 2017).
- Forced displacement of population groups: The conflict has caused more than 6.6 million people to flee the country to seek safety in Lebanon, Turkey, Jordan, and other hosting countries. By August 2019, the number of internally displaced people (IDPs) had reached 6.7 million (UNHCR 2021), which is the world's largest number of IDPs due to conflict. Also, refugees experienced multiple forms of injustice which can be categorized into three dimensions: entry and movement; human development; and status, voice, and representation. Though these three are interconnected and overlapping, examining each allows for understanding the numerous and increasing deprivations which refugees suffer (SCPR 2020).
- Distorting access and quality of education: The Syrian population lost millions of years of schooling as the children (5-17) who were out of school in 2019 numbered 2.4 million. The current outcome is still disastrous as millions of children will suffer from a lack of skills and knowledge, in addition to the impact of the conflict. The conflict created a lack of curriculum consistency across Syria, with different education systems established in different regions depending on the ruling power (SCPR 2020).
- Damaging social relations: Social capital has deteriorated significantly during the conflict, reflecting a substantial aggravation of social injustice as it deteriorated the wealth of social relations and common values, harmed



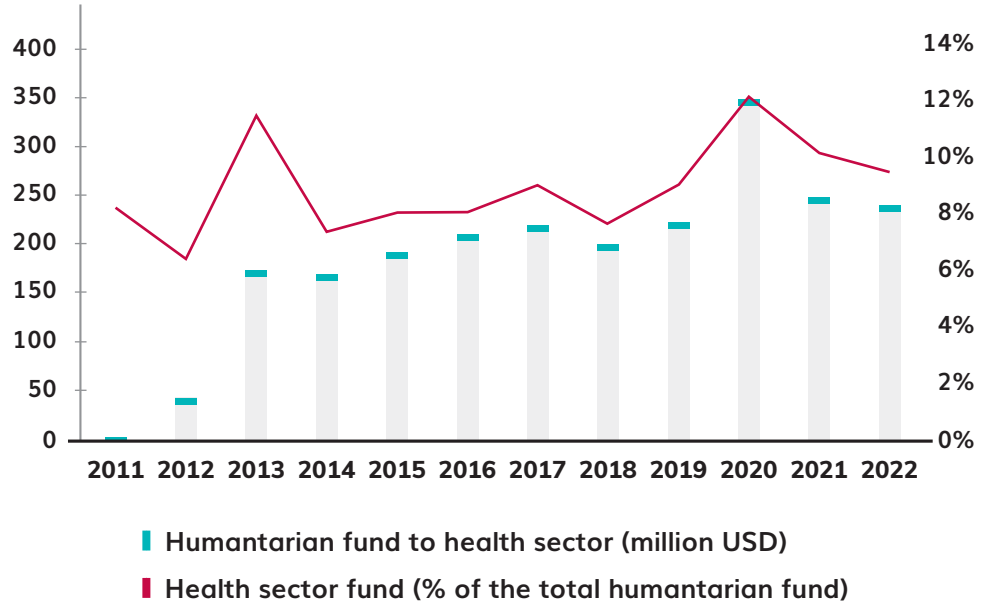
social solidarity, and diminished people's capabilities and agency. Moreover, the conflict created distorted relations based on hate and rejection of the other, lack of sympathy, cooperation, and trust.

- Expanding Gender Based Violence and inequality: Women are among the main victims of the conflict in Syria. They face severe violations including killing, detention, kidnapping, sexual violence, labor in harsh conditions, and increased economic responsibility. Women have also been affected by more frequent incidents of underage marriage, customary marriage, trafficking, and other forms of exploitation. They also suffer from political, social, and economic exclusion.
- Violence against children: Children have suffered from many grave violations during the conflict including killing, injuring, and torturing. They are subject to kidnaping, recruiting, displacement, and abuse. Children have been deprived of access to health, education, and decent living conditions (WHO 2022). These current health burdens on them also indicate to the enormous morbidity rates in the future.
- Expanding of conflict economies: The collapse of real income and expenditure have not been homogenous across Syria. Inequalities surged across regions as well as between political affiliations, gender, age, displacement status, cultural identities, and socioeconomic backgrounds. For instance, the sieged cities and regions suffered from severe hardship for years and subordinated to the war lords who control the smuggling channels. The warring parties played a direct role in depriving society and facilitating the creation of the conflict elite.
- Surging of overall poverty: SCPR estimated that the overall poverty rate reached its peak at 89.4% by the end of 2016. The poverty rate slightly dropped in 2019 to 86% due to positive economic growth. Yet, in the last quarter of 2019 the country witnessed further economic deterioration, before being hit by the COVID-19 pandemic, which has led to a surge in the unemployment rates and cost of living. The overall poverty rate exceeded 93% in 2021 and the poverty gaps doubled between 2019 and 2021 prices (SCPR 2021).
- Increasing food insecurity: A large percentage of Syrians are unable to access nutritious food due to high levels of poverty and deprivation, unjust public policies, discriminatory institutions, and the prevalence of conflict

economy. The results of a SCPR study on food security in Syria in 2019 (SCPR 2019) showed a sharp decline in food security during the conflict by about 42% between 2010 and 2018. In 2021, the World Food Program (WFP) highlighted that 60% of Syrians suffer from food insecurity.

- Degrading environment: The conflict, and the quantity and type of weapons used, poses a serious environmental threat to arable land, as toxic substances have caused soil contamination, which adversely affects the quality of agricultural land and its cultivability or productivity. The conflict has led to the waste of many natural resources such as forests and water resources as a result of destruction, vandalism or misuse, such as logging for heating or drilling of artesian wells in unsustainable ways. Waste and pollution factors affect the long-term potential of environmental sustainability and create intergenerational future injustice (SCPR 2020).
- Dependency on humanitarian support: The conflict caused a severe deterioration of public health services and fund, for instance, the public health expenditure dropped by 68% in real terms between 2010 and 2020 (SCPR 2021). This deterioration was associated with a substantial surge in the health needs, and increased the need for international humanitarian support for the health sector. In this regard and based on the UN-OCHA Financial Tracking Service (2022b), around 2.3 billion US dollars was directed to the health sector between 2011 and 2022, which accounted for 9.3% of the total humanitarian fund that was directed to Syria through humanitarian response plans 2011 to 2022 (**Figure 11**). Almost 50% of health sector funds were received by UN organizations, as the WHO received 29% of the health fund, followed by UNICEF (11%), UNFPA (5%), and UNHCR (1%). The other half of the health fund was received by INGOs, and NGOs led by Syrian American Medical Society (SAMS) (4%), Islamic Relief Fund (3%), and Union of Medical Care and Relief Organizations (UOSSM) (2%) (UNHCR 2022). Additionally, the health sector also benefited from funds directed to mutual sectors. The conflict changed the role of actors in the health system with the declining role of the public sector and expanding of the international sector (UN agencies and INGOs), in addition to the expanding role of local NGOs and private sector.

**Figure 11. Health Humanitarian Fund for Syria, 2011-2022**



Source: UN-OCHA, 2022b, "Financial Tracking Service"

## CONCLUSION

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This paper reads public health as a basic human right and as an aspect of human capability (as defined by Sen 1999) within the political, social, and economic context in the time of armed conflict in Syria. The paper analyzed the impact of conflict dynamics on right to health through the assessment of health outcomes, impact on health system, health related policies in the time of conflict, and the determinants of health.

The paper highlights how warring parties targeted public health, distorted the health system, and reallocated tangible and intangible resources away from healthcare to fuel the war. The conflict-centered institutions destroyed several determinants of health, such as governance, social capital, welfare, living conditions, food security, and environmental sustainability. Political authority is fragmented between several state and non-state actors and has become the "enemy of public health." Additionally, several regional and international actors involved in the armed conflict were complicit in the escalation of public health deterioration.

The burden of conflict on public health has included direct and indirect death, injuries, and disability. In addition, there are serious morbidity cases such as mental diseases, malnutrition, and infectious diseases. The health system witnessed a severe distortion in governance. The destruction and lack of maintenance and investment have negatively affected infrastructure, including power and water stations and networks, firms, residential buildings, and roads. The loss of human capital was substantial, as health workers have been targeted by the warring actors and many fled the country. The health system suffered a shortage of public and humanitarian funding. Finally, the system suffered from a lack of adequate and up to date statistics.

The damaging of health capabilities of the population will impact the future of development in Syria for generations to come, as most Syrians lost unevenly substantial elements of their health and wellbeing, which will affect their functions. Therefore, it is crucial to further investigate the health burdens and design prioritize the most affected population in all policies and interventions.

All health capability policies and programs should be linked

to a long-term strategy that addresses the root causes of conflict, as exclusive and inefficient institutions, social injustice, economic exploitations, and a weak rule of law and accountability can reproduce the conflict again.

The conflict created mechanisms that enable violence, injustice, and violations. Therefore, the needed institutional strategy should dismantle violent foundations and invest in peace building policies. The future of health in Syria will depend on the fair engagement of disadvantaged communities and the responsibility of the state, civil society, and private sector.

Health and wellbeing are the essence of human dignity and enable the prosperity of communities. Syria reconstruction public policy and activities must invest their focus on promoting health equity and reducing health disparities through the reconstruction of social institutions and infrastructure. Our evidence helps guide these discourses: (i) this paper locates the most vulnerable populations (i.e., the health disparities) and suggests that healthcare reconstruction be prioritized in areas which were outside of government control, (ii) it presents the core social determinants of health, which are rooted in political and social contexts and suggest that reducing discrimination and advancing social capital, economic opportunities and education has extraordinary potential to improve health disparities.

Better medical care and infrastructure alone will not generate major gains in population health or quality of life, but the future of health in Syria will depend on the surrounding socio-political landscape. Action on social determinant of health inequities is a political process that must engage both the agency of disadvantaged communities and the responsibility of the state.

The following are selected key policy options to target these interacting societal issues and improve population health:

- Restoring security by investing in re-building social institutions which promote social cohesion, the inclusion of women in the public sphere, trust building, community solidarity, and systems of reciprocity. Community driven reconstruction (CDR) is one mechanism for establishing human and community development in post-conflict settings (Fearon et al. 2009). Policymakers should widen their understanding of security threats and broaden the security mandate from a narrowly focused perspective on preventing land mines and terrorism to a focus on the relationship between social relations, interpersonal security, and wellbeing.

- Transforming oppressive institutions. The wide understanding of human security needs requires further efforts to transform the oppressive conflict-centered institutions and create a platform to end the conflict through a just and sustainable settlement that ensures democratic and inclusive governance and counters the foundations of the conflict.
- Establishing and enforcing rule of law which protects all people. It is critical to end and prevent the regime and actors' sponsored torture, imprisonment, and disappearance, which has clear negative impacts on physical and mental wellbeing of both victim and community. This includes shifting the distribution of power within societies to benefit disadvantaged groups and reducing discrimination in municipalities to rebuild community trust in political systems.
- Reconstructing a productive and inclusive economy with equal opportunities paves the way for healthy and decent living conditions for children and counters the conflict economic dynamics. The right to decent work and food security and decent living conditions are crucial determinants of sustaining an equitable and productive economy.
- Integrating health with other sectors and prioritizing the most affected people during the conflict. This requires a reinvestment in an efficient and just health system within the political and social context and assuring the integration between health and the comprehensive developmental landscape.
- Optimizing the function of NGOs and CBOs, especially those that are residence-centered, provides opportunities to catalyze more adaptive community health responses and better health outcomes. Many spontaneous initiatives emerge in response to crises. It is necessary to harness organic tendencies, empowering CBOs, and institutionalizing them into more enduring, community organized work. Such initiatives can be used to catalyze communities' organizational tools to advance their understanding of the root causes of their needs through knowledge-production and develop decision making tools to design practical programs that address amenable root causes to achieve community-wide and long-term returns. Progress in this direction will help promote equity and gradually restore notions of social rights, including that of health.

- Investing in human capital for the health sector and facilitating the return of displaced health workers and developing linkages with specialist diaspora. This requires a guarantee of protecting health workers and health facilities.

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# RIGHT TO HEALTH IN TUNISIA

## The challenges of universal healthcare

### Ines Ayadi

University of Sfax, Tunisia

Dr. Ines Ayadi is a university professor of economics, specializing in health economics at the University of Sfax in Tunisia. She was previously appointed as an advisor to the Minister of Social Affairs in 2020 and the Minister of Health in 2014. She participated in drafting and presenting the National Health Policy. She has worked as a consultant with the World Health Organization, the World Bank and the African Development Bank.

### Aida Caid Essebsi

Faculty of Juridical, Political and Social Sciences of Tunis, Tunisia

Aida Caid Essebsi, Doctor of Law. Lecturer at the Faculty of Juridical, Political and Social Sciences of Tunis. Director of the Master of Health Law in the aforementioned college. Specialized in health law. Legal advisor for the "Seha" project. She has written articles on medical responsibility, the right to health, and health sector governance, in both Arabic and French, published in Tunisian and foreign journals.

## METHODOLOGY

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This report aims to assess progress toward realizing the right to health in Tunisia according to the criteria of availability, accessibility, acceptability, quality, participation, freedoms, and entitlements while adopting a gender approach. After presenting a review of the current situation, the basis for the right to health and its consolidation in Tunisian law will be assessed. This will be followed by an examination of the right to health and its application by ascertaining the status of criteria and indicators related to this right.

## CURRENT SITUATION

### **POLITICAL TRANSFORMATIONS**

In 2011, following the emergence of a popular movement, Tunisia witnessed several political transformations. The regime was overthrown, and a Constituent Assembly was elected in October of that year. However, the political environment faced several disturbances throughout the transitional period. It was subjected to several crippling social, economic, and security pressures that impacted the right to health.

A national dialogue over these difficulties and the 2014 constitution produced a new political system. Legislative and presidential elections were organized in 2014 and 2019. Nevertheless, the political crisis continued to escalate. On 25 July 2021, the President of the Republic suspended Parliament and announced a new political path that led to the promulgation of a constitution approved by referendum on 25 July 2022.

### **DETERIORATING SOCIOECONOMIC SITUATION**

The country's economy has faced difficulties for years, especially indebtedness and deflation. According to recent Central Bank indicators, Tunisian public debt increased from 40% of GDP in 2010 to about 90% in 2020. Moreover, the economic growth rate did not exceed 0.6% over the past ten years, widening the financial gap and discouraging investment. In addition, the political situation made economic and social conditions even worse. Unemployment levels rose, particularly among women (20.5%) and higher-education graduates (30.1%) (المعهد الوطني للإحصاء في تونس 2022), resulting in the growth of informal migration (Forum Tunisien pour les Droits Economiques et Sociaux 2021). At the same time, precarious work was spreading, especially among women in agriculture. These women lack adequate health and social coverage (السفير العربي 2019) and face risks in transportation and the workplace in light of the ineffective implementation of Law No. 51 of 2019. Finally, high inflation rates led to a decline in citizens' purchasing power (البنك الدولي 2022) and a shortage of essential goods such as vegetable oil, flour, sugar, rice, and medicines.

COVID-19 deepened the social crisis. World Bank estimates for June 2021 indicated that the pandemic led the poverty rate to rise to 21% of the total population of Tunisia, compared to 15.5% before the pandemic. The poverty map in Tunisia (Banque Mondiale et Statistiques Tunisie 2020) confirmed the growing disparity between regions. The highest poverty rates were concentrated in rural areas, especially in the country's northwest and southwest regions.

The ongoing pandemic highlighted the need to strengthen efforts to address the social determinants of health as an integral part of the national, regional, and international response to social health crises. Despite the decline in severity, the pandemic's effects are still tangible. Today, Tunisia's economy continues to suffer from the repercussions of the pandemic, similar to many other countries. Moreover, the Russian-Ukrainian war exacerbated the economic crisis in the country due to global shortages in essential goods imported from the conflict zone (especially wheat).<sup>1</sup>

On the other hand, worldwide, global warming and climate change affect the economy in general and the social status of citizens in particular. However, they mainly impact the situation of those belonging to the poorer classes. Tunisia is not immune to this impact. Climatic changes are causing severe droughts and a decline in the water level, leading to a potable water shortage. In addition, many fires have broken out in several mountains, destroying parts of the forests in the north of the country, and threatening the interests and status of many citizens.

## ACCESSION TO REGIONAL AND INTERNATIONAL TREATIES AND AGREEMENTS

Tunisia has ratified most international treaties.<sup>2</sup> The texts, which have become part of its legal system, are more binding than domestic laws but do not supersede the Constitution.

## THE RIGHT TO HEALTH IN TUNISIAN LAW

Indeed, the right to health remains one of the most pertinent rights, requiring an examination of its establishment in Tunisian jurisprudence.

The right to health in Tunisia was enshrined and consolidated gradually, from mere care for citizens to their access to health services, to a fundamental right for all, which the state is

<sup>1</sup> Tunisia imports 30% of its need of durum wheat and more than 90% of common wheat. 80% of its imported grains come from the Russian and Ukrainian markets—984,000 tons from Ukraine and 111,000 from Russia.

<sup>2</sup> For example, the Tunisian state ratified the CEDAW 1985, which obliges the ratifying states to eliminate all forms of discrimination against women and provide ways to empower them in various political, economic, social, and civil fields. All reservations were lifted by 2014. In 1991, Tunisia was also one of the first countries to ratify the Convention on the Rights of the Child (CRC) issued in 1989. Tunisia signed the 1965 International Convention on the Elimination of All Forms of Racial Discrimination on April 12, 1966, and ratified it on January 13, 1967.

committed to guaranteeing and respecting. The Tunisian state considers health an essential sector and a right to be supported. The seeds of the right to health first appeared in the Preamble to the 1959 Constitution, promulgated at the dawn of independence. It expressed the choices of the emerging state at that time and considered health as a sector that the state should embrace and protect. However, despite its mention in the Preamble as a right for all citizens, its nature remained a matter of debate and controversy, and it did not establish a strict obligation for protection of this right by the state.

In 1974, as health concerns continued to arise, the Tunisian state established a Ministry of Public Health (MoPH) independent from the Ministry of Social Affairs through Decree 1064/1974, which defined the roles of interventions and officials in the field. Based on the decree's first article, the primary mission of the health ministry was to "watch over the health of the population to help them achieve a harmonious development of their physical and mental energies and find compatibility between them and the natural surroundings and the social environment of the country, by resisting all causes of deterioration of their physical or intellectual well-being, which may affect them individually or collectively." Thus, the MoPH would prepare the government's public health policy and planning, ensuring these are put into practice and monitoring their implementation in prevention, treatment, and occupational rehabilitation through a set of services to be enjoyed by citizens.

Article One of the Organic Law on Health Regulation No. 63 of 1991 (dated 29 July 1991) recognized the right to health. It stated that "every person has the right to protect his health in the best possible conditions." It also sought to protect fundamental human rights, especially human dignity,<sup>3</sup> during treatment. Furthermore, the first point in the Ministerial Circular No. 36 of 2009,<sup>4</sup> which adopted the Patient's Charter, established citizens' rights to protection and healthcare. It stated that:

*"Every person has the right to protect his health in the best possible conditions without discrimination based on religion, gender, color, age, or socioeconomic status, taking into account the specific nature of some patient categories whose health situation requires priority under enforced legislation, such as emergency cases, persons with disabilities, older people, children, and pregnant women."*

<sup>3</sup> Article 5 of Organic Law 63/91, dated 29 July 1991 states: "Public and private health structures and institutions must operate in conditions that guarantee fundamental human rights and the safety of patients who avail themselves of their services."

<sup>4</sup> Related to the issuance of the Patient's Charter.

On the other hand, the Patients Charter, required by the Circular to be posted in public and private facilities,<sup>5</sup> states in its first item that “every citizen has the basic right to health protection, regardless of social status, within the limits of what is guaranteed by enforced legislation.” Nevertheless, unless adopted as a Ministerial Decree, the obligatory nature of the Charter remains limited to being a code of conduct that defines workflow in health structures without being strictly mandatory.

The explicit consecration of the right to health as a fundamental right was one of the features of the 2014 Constitution. Article 38 of this Constitution recognized health as a “right for every human being.” As a specific right, its protection and guarantee became a state obligation.<sup>6</sup> Thus, Tunisian legislation has adopted the right to health, laid its foundations, and included it at the top of the hierarchy of legal texts. This constitutional nature of the right to health entails appropriate and consistent laws, meaning that no law may be adopted that diminishes or denies this right, or it would be considered unconstitutional, and could be challenged before the Constitutional Court. Furthermore, recognizing health as a fundamental right supports calls to access services and obtain treatment in appropriate conditions. It also pushes for adopting explanatory texts.

Finally, the 2022 Constitution consecrated the right to health further in Article 43, adopting the same content as Article 38 of the 2014 Constitution. According to Article 43 in the 2022 Constitution, the state guarantees prevention, care, and treatment, free to people with limited income and those who lack a supporter. It continues that the state shall provide services of adequate quality that take into consideration the situation and needs of citizens. The 2022 constitution preserved the rights stipulated in the 2014 constitution, such as the right to water, a healthy environment, protection of physical inviolability, and human dignity, supporting the right to health. In this regard, Article 24 of the Constitution considers that “the right to life is sacred. It may not be violated except in extreme cases determined by law.” Article 25 adds: “The state protects the human person’s dignity and the body’s inviolability, prohibiting moral and physical torture. The crime of torture is not subject to a statute of limitations.” These two articles implicitly refer to the right to health since the protection of the right to life and the protection of human dignity is through guaranteeing the right to health.

<sup>5</sup> Every health institution must place the charter’s summary at patients and their companions’ disposal in the reception desk, in addition to posters in highly crowded areas (such as reception hall, waiting rooms, etc.).

<sup>6</sup> Contrary to the 1959 constitution referring to the right to health in the preamble only, without defining the responsibilities of the state in this regard.

In addition, Article 47 of the 2022 Constitution guarantees the “right to a healthy and balanced environment.” Furthermore, it adds that “the state must provide the necessary means to eliminate environmental pollution.” The exact text appeared in Article 45 of the 2014 Constitution. It was considered a significant victory for Tunisia, which is one of the few countries that guarantee a safe environment in their Constitutions. Finally, Article 48 of the 2022 Constitution stresses the state’s obligation to “provide clean water for all, equally,” and that it “must preserve water resources for future generations,” which are the elements of a sound environment and good health.

On the other hand, public health could be used to justify restrictions on rights and freedoms (Article 55 of the 2022 Constitution). For example, if public health is threatened, the legislator may adopt the necessary measures, even if these measures limit freedom of movement, freedom of trade, or the protection of personal data, such as the limitations decreed during the COVID-19 crisis. It may also entail limiting the protection of physical inviolability, such as in mandatory COVID-19 vaccines through Decree 1/2021.



# ACHIEVING THE RIGHT TO HEALTH IN TUNISIA

## CRITERIA

The extent to which the right to health in Tunisia is respected shall be assessed based on several criteria since its consecration entails implementing health policies, strategies, and programs according to several indicators and the necessary accountability and follow-up.

These criteria include:

- **Availability:** The state must provide facilities for public health and healthcare, as well as goods, services, and programs, according to the specific needs.
- **Accessibility:** Everyone should access health-related facilities, goods, and services without discrimination. Accessibility includes four interrelated dimensions: non-discrimination, physical accessibility, affordability, and access to information.
- **Acceptability:** All health-related facilities, goods, and services should respect medical ethics, cultural differences,<sup>7</sup> people's requirements throughout life, and confidentiality.
- **Quality:** All health-related facilities, goods, and services must be scientifically and medically appropriate and of good quality, achieved by providing all the necessary drugs and supplies subject to the highest quality standards; health and medical sector employees must be highly skilled and responsible.
- **Participation:** Healthcare beneficiaries should have a say and be able to make their voice heard in formulating and implementing relevant health policies.
- **Freedoms:** Individuals should be free not to be subjected to non-consensual medical treatment, such as medical experiments, forced sterilizations, torture, and other cruel, inhuman, or degrading treatment or punishment.
- **Entitlements:** People have the right, among other entitlements, to enjoy the highest attainable standard of health, prevention, treatment, disease control, access to essential medicines, and reproductive, maternal, infant, and child health.

<sup>7</sup> The culture of individuals, minorities, and peoples.

## MANIFESTATIONS AND APPLICATIONS

Although Tunisia achieved several health gains, shortcomings remain and are growing. In 2020, for example, life expectancy at birth (المعهد الوطني للإحصاء التونسي 2021) was 75.3 years (72.7 years for males and 77.5 years for females), compared to 71.5 years in 1995 (69.5 years for males and 73.3 years for females). The development was due to improved healthcare, on the one hand, and better living conditions, on the other. However, life expectancy in 2020 was lower than in 2019 (76.3), possibly due to the COVID-19 pandemic.

National programs to combat infectious diseases eradicated deadly ailments such as malaria, schistosomiasis, ophthalmia, tuberculosis, infectious diarrhea, polio, neonatal tetanus, and diphtheria. In addition, integrated national programs for preventive and curative services were set up, making it possible to achieve reasonable coverage rates. As a result, under-five mortality rates declined (المعهد الوطني للإحصاء التونسي 2021) from 15.7 per 1,000 live births in 2013 to 13.3 per 1,000 live births in 2020. However, the gap between rural and urban settings remained (19/1,000 in the countryside compared to 11/1,000 in urban areas), as indicated by the cluster survey data (Le Ministère du Développement, de l'Investissement et de la Coopération Internationale (MDICI), l'Institut National de la Statistique (INS) et l'UNICEF 2019).

On the other hand, a rise was recorded in non-communicable diseases such as diabetes,<sup>8</sup> cardiovascular diseases, chronic lung diseases, and mental health ailments, pointing to risk factors<sup>9</sup> related to physical inactivity, pollution, and improper diets (such as those rich in sugars and salts). In addition, the number of cancer cases has also increased, with more than 19,000 new cases recorded in 2020 (The Global Cancer Observatory 2021), despite the national program to combat cancer. The leading cause of death is related to late diagnosis, which reduces the chances of survival.

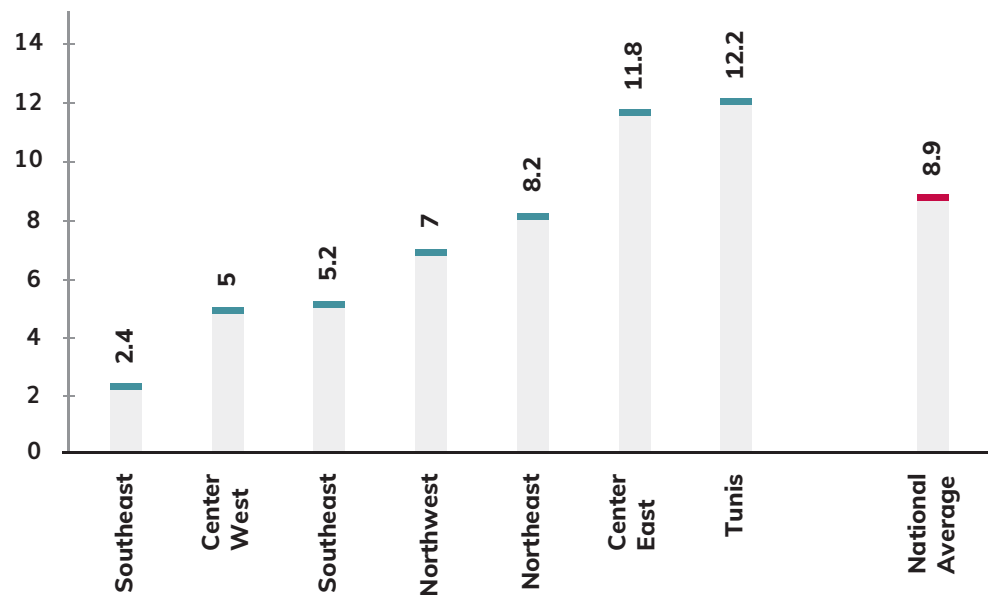
The 2016 National Health Survey (Ministère de la Santé en Tunisie et al. 2019) shows that only 8.9% of women over 30 have had a mammography in the last two years. The regional variation is striking, standing at 4% in rural areas compared to 11% in urban areas. As shown in **Figure 1**, access to the procedure is highest in Greater Tunis (12.2%) and lowest in the southeast (2.4%). Furthermore, the demand for examination is highest among women who can afford it (the wealthiest), as it exceeds 16.3%, compared to only 3% among the poorest women. This discrepancy is due to the imbalance in the

<sup>8</sup> According to the National Institute of Public Health, more than one in six older people have diabetes (15.5%) and more Available at this [link](#). than one in three have hypertension (28.7%).

<sup>9</sup> Among those aged 15 to 17, 60% are overweight, and 30% are obese. Smoking is prevalent among more than 30% of youth.

distribution of mammography machines (Ministère de la Santé en Tunisie 2021), despite the capacity-building program in the public sector. In 2017, there were only 20 machines available in the public sector; the number increased to 28 in 2019 and covered some internal regions.

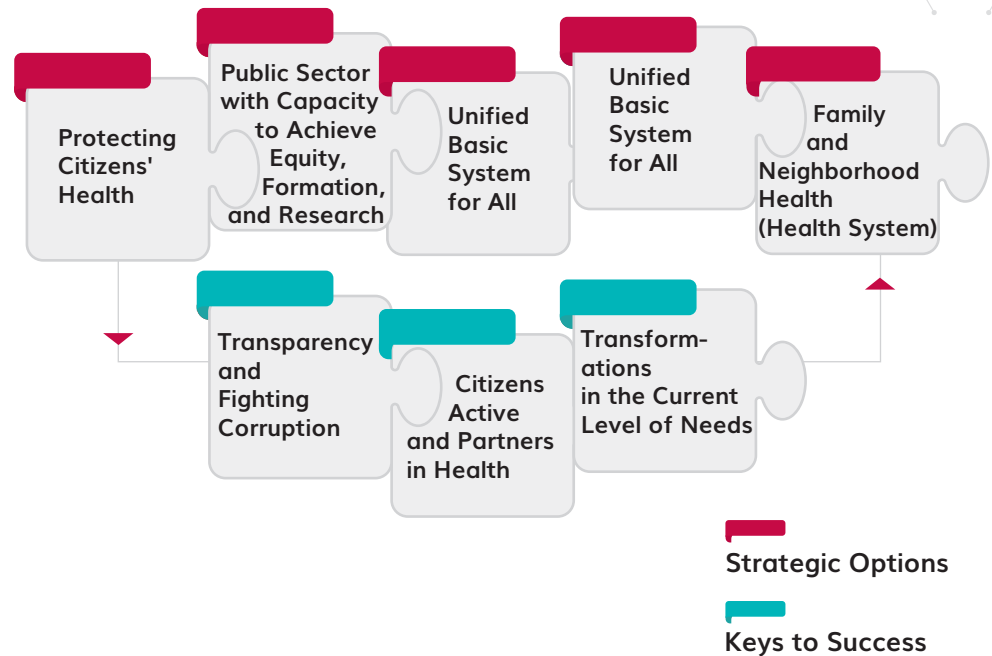
**Figure 1. Rate of mammography examinations in the past two years by region (2016)**



## THE NATIONAL HEALTH POLICY FOR HORIZON 2030

On 7 April 2021, the National Charter for Health System Reform was signed within the framework of the National Health Policy for Horizon 2030, prepared according to the societal dialogue involving various stakeholders in the sector, including national organizations, representatives of professionals, and civil society. The National Health Policy is based on the 2030 vision for universal health coverage, inspired by universal human rights values. It would allow everyone fair access to opportunities to enhance their health and well-being in the service of sustainable development. The national health policy includes strategic options and keys to universal health coverage (**Figure 2**). The five strategic options are related to reorganizing the health system, centering it around citizens, and effectively protecting their health, in addition to fairness, solidarity, and quality in access to services. The three keys to success are adjustment in the context of guiding an increasingly complex system, transparency and anti-corruption, and citizen participation.

Figure 2. Strategic options and keys to success

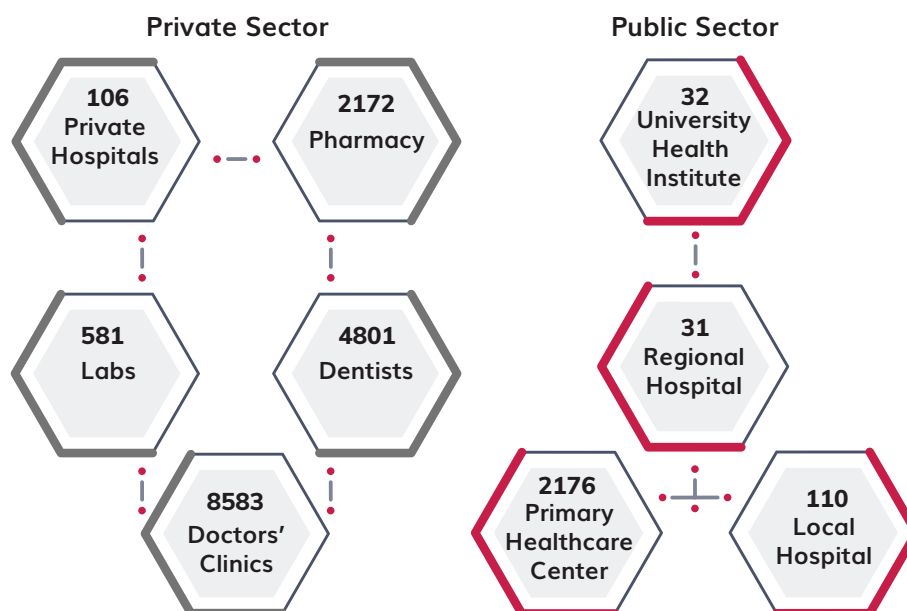


## ■ A DUAL HEALTH SYSTEM

The health system covers all territories through a public sector distributed into three lines and an active private sector (Figure 3). In addition, some specific services are also provided through the military, internal security services, and social security clinics.

According to Article 3 of Organic Law No.91-63 of 29 July 1991, related to health regulation:

*"Public and private health structures and institutions provide preventive, curative, and sedative services as well as those related to diagnosis and functional rehabilitation, whether with or without accommodation, in exchange for a fee or free of charge."*

**Figure 3. Organization of the health system in Tunis (2019)**

The public health sector, which has witnessed continuous development since independence, provides a set of structures that guarantee adequate coverage for the population. However, it suffers from several shortcomings. In this context, Article 4 of Law 63/91 stipulates that public health structures and institutions are based on the health map, which must be reviewed periodically at the beginning of each national development plan. Nevertheless, the health map is merely a statistical guide, not a planning tool. For example, in recent years, the concentration<sup>10</sup> of health structures was subjected to political demands without ensuring suitability for needs and actual operational capacity.

Moreover, health departments and structures were built without ensuring the necessary human resources. As a result, these departments and structures remain unused and do not provide the necessary care. According to Article 10 of Law No.63/91, public health structures are classified by function, equipment, technical level, and territorial jurisdiction, as defined in Ordinance No.846 of 2002, and are divided into three intertwined lines.

The first line consists of primary health centers and local hospitals. Primary health centers are the entry point to the health system, providing preventive<sup>11</sup> and curative health services and health education. Their geographical distribution is the least uneven between the regions, set at one center for every 5,000 people, with a variation coefficient estimated at 0.94 in 2019. Nonetheless, primary healthcare centers lack health

<sup>10</sup> Nealy 5000 hospital beds will be added.

<sup>11</sup> "Protection of motherhood and childhood, including family planning, prevention and control of communicable diseases, especially through vaccination, pre-school medical services, school and university health" (Article 11 of Law 63/91).

services, which are limited to a morning session, most do not provide daily medical clinics,<sup>12</sup> and there are disparities between the regions.

For example,<sup>13</sup> primary healthcare centers in the capital, Tunis, are open throughout the week (6 working days). However, in the Medenine governorate, only 8 out of the 119 centers in the district, a mere 7%, provide daily clinic services. On the other hand, vaccination takes place in primary healthcare centers and at schools, which guarantees equality among all children, regardless of their financial ability or area of residence (in the countryside or the city, in the interior or coastal areas), reducing disparities between regions.

In addition to services provided at primary healthcare centers, local hospitals provide general medical services, maternity units for regular deliveries, outpatient clinics, emergency services, and a primary technical platform (radiology, laboratory, dental chair, and pharmacy warehouse). Beds in local hospitals and maternity units represent 10% of the total in the public sector. However, they only cover 3% of regular deliveries. The scale of the activities is so small that it can affect the maintenance of professional skills and negatively affect patient safety. In 2019, 62,742 people were admitted, a decrease of 13% from 2017. As for efficiently utilizing human and financial resources, services in local hospitals are considered high cost. Moreover, although several of these facilities were promoted into regional hospitals for various reasons, they could not meet the criteria of this transformation, leading to wasted rare professional resources available and low usage rates.

Regional hospitals (the second line) play a dual role. On the one hand, they provide nearby services to citizens and act as a reference for the first line. On the other hand, they are responsible for referral to university hospitals, when necessary, and for reducing overcrowding. However, regional hospitals suffer from a mismatch between the allocated human resources and the available equipment, on the one hand, and the uneven distribution of medical specialists between the main coastal cities and the rest of the country, on the other.

Some measures were adopted to address the shortcomings. These included developing a support program for the regions based on the voluntary contribution of university hospital doctors to ensure continuity through paid service upon request. In the same context, university hospital medical assistants must spend one year in a public health facility in health-priority regions.<sup>14</sup> In addition, doctors practicing in priority areas may receive patients in specially-designated clinics in the

<sup>12</sup> According to the data of the 2019 health map: only 20% of the centers open their clinics for 6 out of 6 days (of which more than 60% are in coastal areas), while 49% of the centers open their clinic for only one day in 6 (90% of which are in the so-called deprived states).

<sup>13</sup> See the first line health map for 2015 at this [link](#).

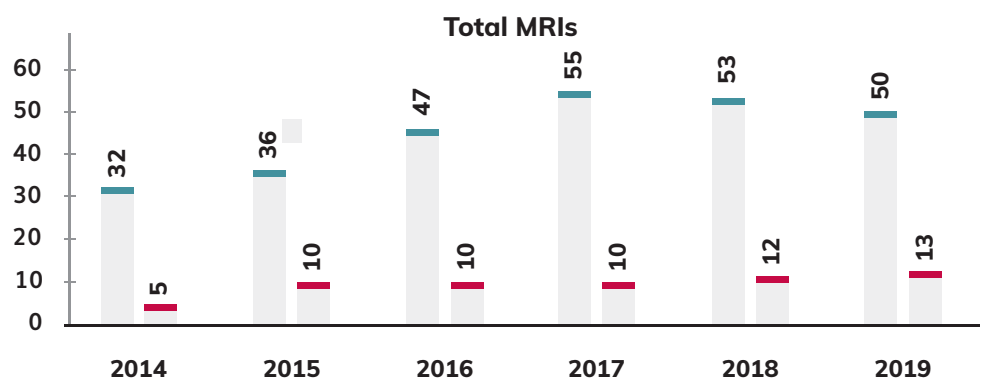
<sup>14</sup> Article 19 of Law 3353/2009 dated November 9, 2009, completing Law 772/2009 dated March 28, 2009, relating to the organization of medical, hospital, university staff.

institution.<sup>15</sup> This incentive aims to retain qualified doctors in the public sector to ensure a minimum level of quality and equal opportunity. However, it resulted in wasting public hospitals' human and material resources and redirected patients to the private sector. Moreover, many public-sector doctors licensed to undertake profitable activities are violating the regulations guiding these activities (Forum Tunisien pour les Droits Economiques et Sociaux 2021).

The primary mission of university health institutions (third line) is to provide highly specialized care. These institutions also contribute to university and post-university education (medical, pharmaceutical, and dental), the training of health professionals, and scientific research. However, given the cumulative failure of the first and second lines, this third general line is burdened with problems that could have been dealt with in the early stages, which are likely to affect the quality and continuity of care and limit the educational and training role that these hospitals are supposed to play. Furthermore, the structures of the third line are concentrated in 13 districts. They are absent in the northwest and south. Only one facility is available in the center-west (Kairouan) and the southeast (Medenine), adding to regional inequality.

The private sector saw significant development in the last few decades<sup>16</sup> due to external demand, especially from neighboring countries like Libya and Algeria, and financial and tax incentives. According to the 2019 health map, the private sector employs 54% of the country's doctors, 79% of its pharmacists, and 86% of its dentists. In addition, the sector operates most of the sophisticated equipment and advanced technologies.<sup>17</sup> **Figure 4** and **Figure 5** illustrate the severity of disparities between the public and private sectors and among the regions through data on availability and distribution of magnetic resonance imaging (MRI) machines.

**Figure 4. Availability of MRI machines (2017 and 2019 health maps)**



<sup>15</sup> Law 2156 and 2158 dated October 17, 1994.

<sup>16</sup> For example, in 1987, there were 28 private clinics with a capacity of 796 beds. In 2019, the number was 106 private clinics with a capacity of 6,704 beds.

<sup>17</sup> For example, of the 63 MRI machines in Tunisia, 50 are in the private sector.

**Figure 5. Distribution of MRIs in the private sector (2017 and 2019 health maps)**



Despite their role in improving the availability of health services, most private sector facilities are concentrated in coastal districts, adding to regional disparities. For example, 61% of private hospitals are in Greater Tunis (43), Souse (7), and Sfax (15).

Article 17 of the 2022 Constitution states, "The state guarantees coexistence between the public and private sectors and works to achieve integration based on social justice." Law No. 49 of 2015 defines the general framework for partnership between the public and private sectors. Health professionals in the private sector (doctors, pharmacists, dentists, and technicians) can practice in public health structures, specifically in priority areas, according to the salary scale (which is a weak financial incentive).<sup>18</sup>

Presidential Decree No. 318 of 2022 also recognizes the possibility of medical cooperation between the public and private sectors when practicing telemedicine.<sup>19</sup> However, this partnership remains limited today without agreements between the two sectors. Still, there are some signs of cooperation, such as the measures against the COVID-19 pandemic, where free vaccination took place in pharmacies and involved some doctors and dentists voluntarily.

Justice in the distribution of services remains a theoretical goal to be achieved. However, specialized health services provided by the private sector remain concentrated in coastal cities at the expense of the interior regions. For example, the only hospital specializing in tumors and cancerous diseases is in the capital, though surgery is possible in some other hospital departments. Thus, those living outside the

<sup>18</sup> Decree issued by the ministers of finance and public health dated 14 March 1992, defining the requirements, remuneration, and duration of practice for doctors, pharmacists, dentists, and senior technicians directly in the free sector in the public health structures, as revised and completed by the March 9, 1995, December 24, 2009, and December 31, 2015, Decrees.

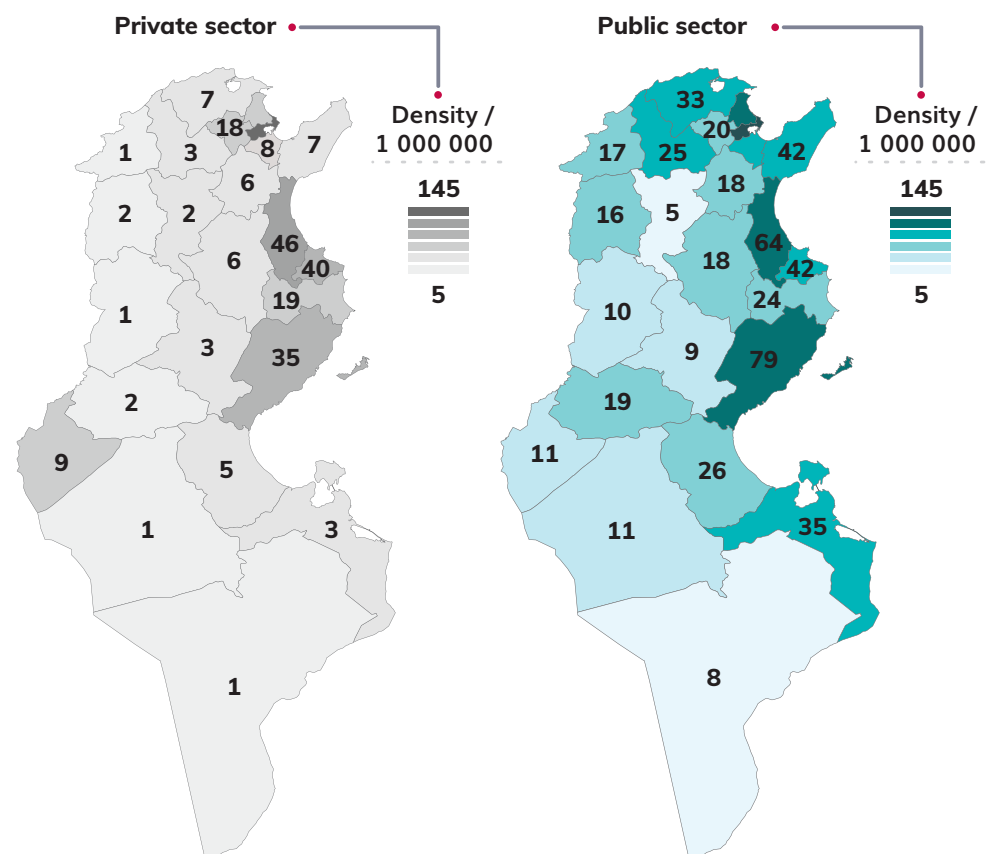
<sup>19</sup> Article 20 states that "Telemedicine is carried out in the public and private sectors within the framework of a platform, or within the framework of medical cooperation between public health facilities, between a public health facility and another public facility, or between a public health facility and a private health institution." hospital, university staff.



capital face difficulties accessing health services. Moreover, the concentration of these services in one hospital leads to overcrowding and poor quality (long waiting times for appointments and long waiting times in clinics).

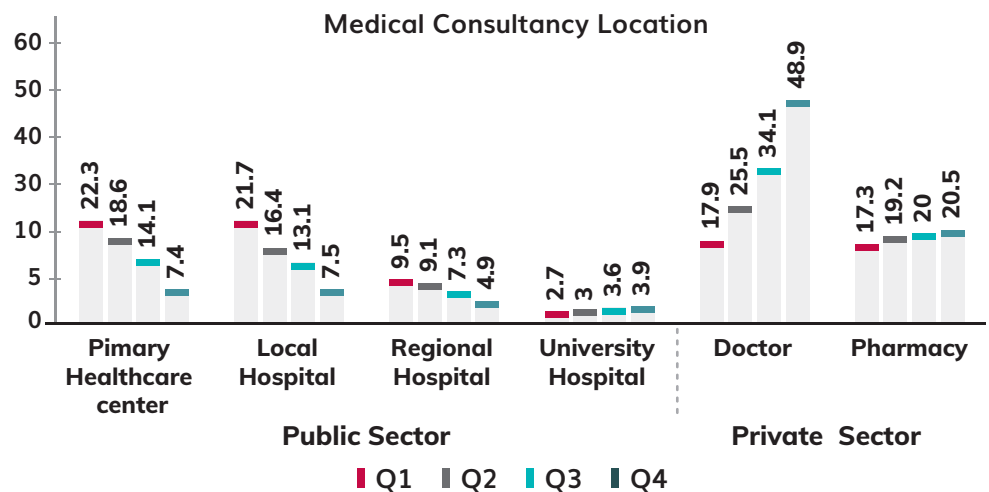
Many studies documented regional disparities (Banque Africaine de Développement 2014), such as in investigations carried out in the framework of the societal dialogue in 2014 (Le Comité Technique du Dialogue Sociétal 2014a). Imbalances and disparities also appear in the distribution of health professionals, in particular of specialized doctors, whose number exceeded 5,407 in the private sector, compared to 2,318 in the public sector in 2019. Notably, the number of health professionals in the private sector increased, while that in the public sector decreased compared to 2018 (5,212 in the private sector and 3,005 in the public sector). The decline is due to the growing emigration of physicians, especially in recent years, exacerbating the disparity between the two sectors and regions (**Figure 6**) (Forum Tunisien pour les Droits Economiques et Sociaux 2021). Furthermore, with the improvement in incomes more doctors are attracted to the private sector (Banque Mondiale 2016).

**Figure 6. Proportion of specialized physicians per 100,000 residents**



Differences in economic and social status, whether on an individual basis or between regions, increase disparities in access to health services, as indicated by a study conducted by the Tunisian Forum for Economic and Social Rights in 2021. The study found that the location of medical consultation is linked to wealth (expenditure segments) (Forum Tunisien pour les droits Economiques et Sociaux 2021). Moreover, a study conducted in 2015 on financing care for poor and low-income groups showed that these groups tend to use primary healthcare centers and local hospitals due to their geographical proximity compared to other facilities, which entails travel and additional expenses (Figure 7).

**Figure 7. Choice of medical consultation facility according to expenditure bracket**



Source: National Survey on household expenditures, consumption, and livelihoods, 2015

## SEXUAL AND REPRODUCTIVE HEALTH: GAINS AND CHALLENGES

Family planning in Tunisia has always been a fundamental approach in politics and health. For decades, the country was an example to follow in reproductive and sexual health. Polygamy was abolished in 1956, and the right to abortion was allowed at a later stage. In 1965, married women with at least five children were allowed abortions upon their husbands' consent. The law was amended in 1973 to allow terminating pregnancies for all women in the first trimester, regardless of their civil status and the number of children they have. The law also enabled women to terminate a pregnancy outside the first three months and without any time limit in the event of a threat to the mother's physical and mental health or an expected risk to the newborn's health.

In this regard, Tunisian law is considered to be advanced compared to some Arab, Islamic, and even some developed countries. The procedure is conducted in public health and family planning centers for free or in the private sector for a fee. Doctors must ensure the mother's prior and informed consent, regardless of the father's consent. However, the consent of a guardian is required for minors.

Nonetheless, the actual application of this right has faced several difficulties in the past few years due to refusal by health professionals to perform the procedure or lack of required medication. Disparities by region and socioeconomic status are also present, as indicated in a 2022 study (انكفاضة 2022). Furthermore, a study by the National Office for Family and Human Population in 2020 (UNFPA et al. 2020) showed that 60% of nurses, 50% of midwives, and 30% of doctors in primary healthcare centers in rural areas are against abortion for religious reasons.<sup>20</sup> Total rejection is increasing in such centers in the south of the country. In the same context, single women are considered the most vulnerable to discrimination in the right to abortion. Testimonies refer to the humiliation and "moral lessons" that single women undergoing abortions are subjected to in some health institutions (Maffi 2022). In the face of this refusal, some women resort to the private sector, where violations are registered. They include disrespecting the actual cost of the operation, encouraging the most profitable surgical abortion, and sometimes performing abortions after three months without a health cause.

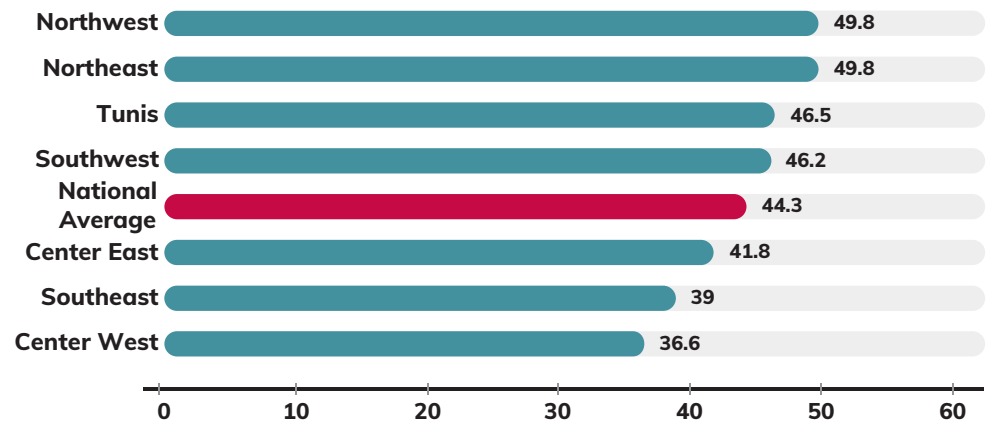
Although years have passed since the establishment of the right to abortion, there is a lack of knowledge about services that provide abortion free of charge among young people. A study by the TAWHIDA Ben Cheikh group found that around 50% of young people do not know that abortion is available and legal in the first trimester of pregnancy (53% of young women and 43% of young men said that abortion was illegal) (Groupe TAWHIDA Ben Cheikh Recherche & Action pour la Santé des Femmes 2019).

Since independence, Tunisia has pursued a policy of family planning and birth control. In the early 1960s, the colonial-era law forbidding the advertising and sale of contraceptives was repealed. The first family planning campaign was launched in 1966. Mother and childcare centers and permanent and mobile family planning centers affiliated with the National Office for Family and Human Population were established to reach rural and remote areas. Awareness campaigns were conducted, and contraceptive methods were provided to women for free.

<sup>20</sup> The religious and ideological components were emphasized as a reason to refuse abortion in the cited study.

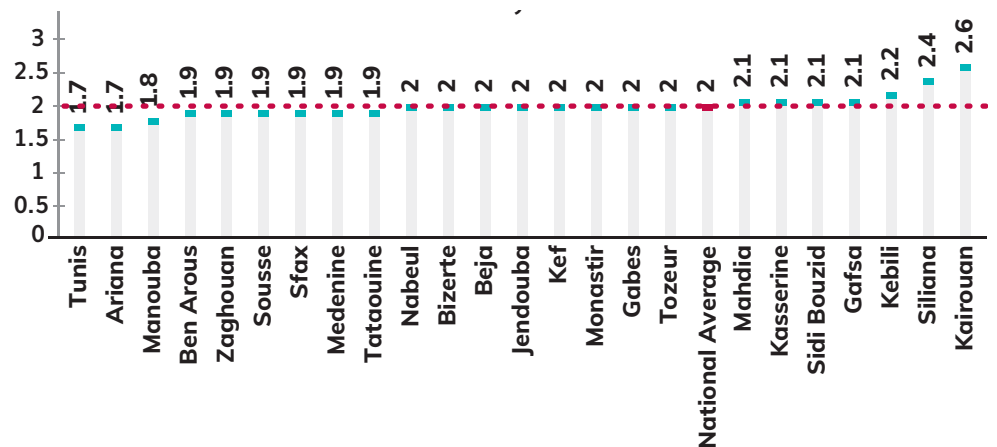
The 2019 cluster survey data also indicated that the rate of demand for family planning using modern methods, monitored through SDG 3.7.1, is estimated at 62.8% (61.4% in urban and 65.7% in rural areas). The use of modern contraceptive methods shows a disparity with data available from the authorities, as shown in **Figure 8**. The intrauterine device is the most used method in urban areas (21.9%). In rural areas, the pill is the most used method (21.2%) (UNICEF 2019). The difficulties encountered in accessing contraceptive methods are similar to those related to abortion.

**Figure 8. Use of modern contraception (2019)**



Due to these measures, fertility rates in 2020 (**Figure 9**) were close to replacement rates, estimated at two children per woman during her fertile age,<sup>21</sup> despite some regional disparities (L'Institut National de la Statistique 2020).

**Figure 9. Fertility rates (2020)**



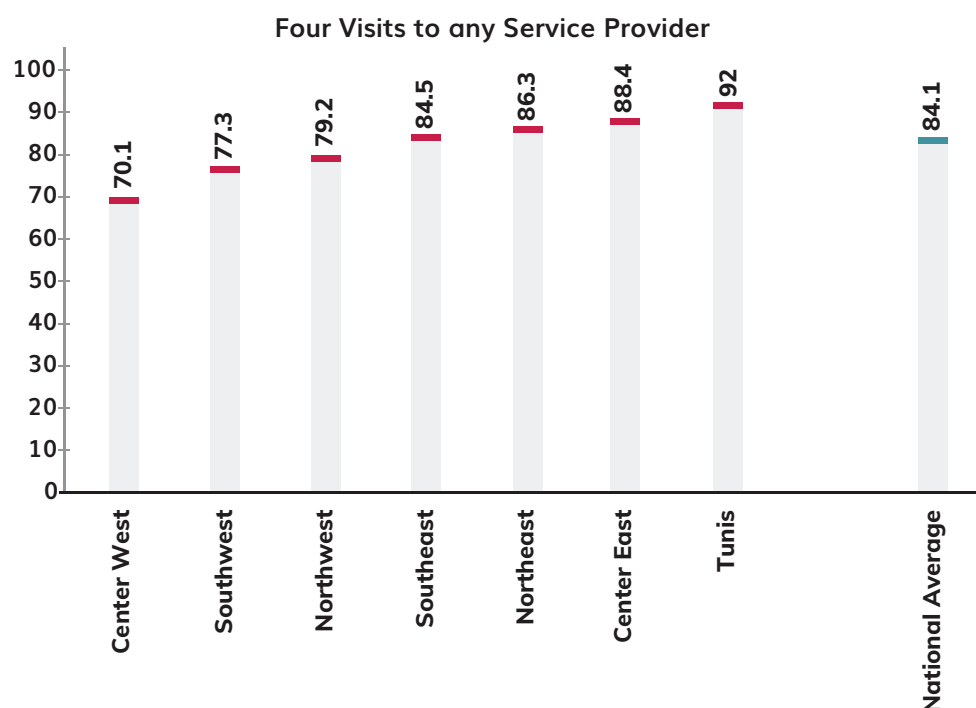
Reproductive health also includes monitoring pregnancy and post-partum follow-up through the National Plan to Reduce Maternal Deaths. These services are provided for free in Mother

<sup>21</sup> Every woman between 15 and 49.

and Child Care Centers, Family Planning Centers, and Primary Healthcare Centers and for a fee in the private sector<sup>22</sup> (UNFPA et al. 2018). Thus, 84.1% of women between 15 and 49 years received four or more checkups by qualified health workers during their most recent pregnancies (**Figure 10**). However, according to the 2019 Cluster Survey, access to these services varied between urban (88.5%) and rural areas (76.6%). Regional disparities were more pronounced in western regions, where women's access to pregnancy monitoring clinics was the lowest (UNICEF 2019).

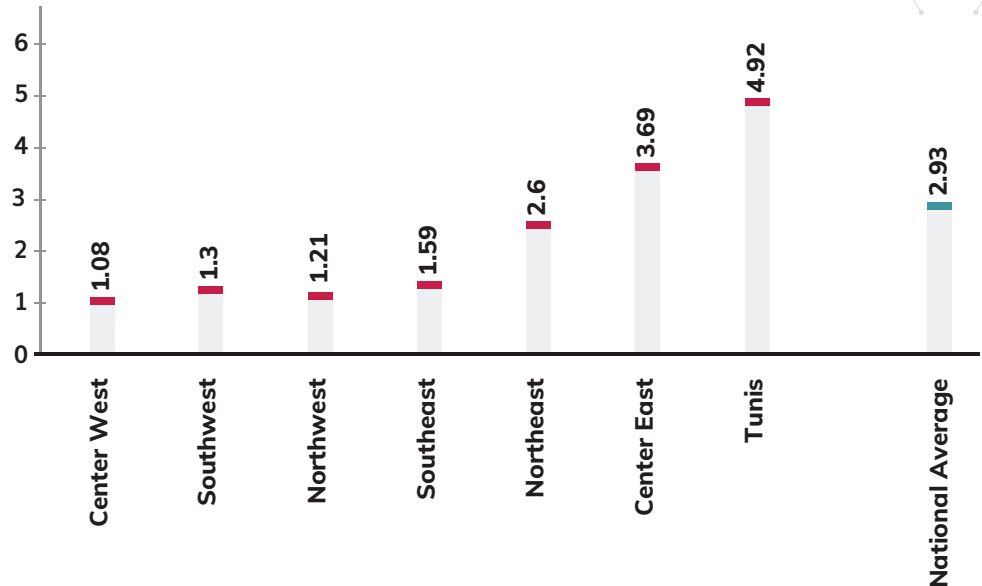
On the one hand, the above situation is due to the working hours of public health facilities, which coincide with working hours. Women who need to visit the clinics could lose a day's work and their daily wages. On the other hand, those areas do not have enough obstetricians, whether in the public or the private sector. While the national average is 2.93 obstetricians for ten women of fertile age, regional disparities are enormous (**Figure 11**). According to the 2019 Demographic Health Map, the average for the district of Tunis is 4.92 per 10 women. However, it drops to 1.08 in the center west (Ministère de la Santé en Tunisie 2019).

**Figure 10. Percentage of women receiving four or more checkups by qualified health workers during their most recent pregnancies**



<sup>22</sup> For those with social security, 150 Tunisian Dinars are added to the annual ceiling, which does not cover the 5 recommended clinical visits for pregnancy follow-up.

**Figure 11. Average number of obstetricians per 10 women of fertile age (2019)**



More than 99% of women between 15 and 49 were assisted by qualified health staff during live births. A similar number applies to deliveries in health facilities without significant disparities between rural (99.2%) and urban (99.7%) regions. However, cesarean births were more prevalent in urban areas (46.4%, compared to 37.7% in rural areas). The discrepancy is attributed to the higher number of specialists in urban areas and affordability. The 2019 Cluster Survey indicated that 58% of women from the wealthiest families prefer cesarean sections, compared to 32.5% of women from the poorest families.

Nevertheless, surveys reveal a significant decline in the proportion of breastfeeding women. According to the 2019 Cluster Survey, only 13.5% of women resorted exclusively to breastfeeding. The percentage was as low as 5% in the northwest. While women staff and workers in the public sector are granted<sup>23</sup> maternity leave and paid "nursing" breaks for an additional six months after giving birth, allowing them to arrive to work one hour late and leave one hour early, this right does not extend to women in precarious sectors who get paid on a daily basis, such as those working in agriculture.

## THE HEALTH SECTOR AND PROTECTION FROM VIOLENCE AGAINST WOMEN

The health sector may also contribute to protecting women from violence through prevention and early detection. The law on violence against women prescribes<sup>24</sup> a role for the MoPH

<sup>23</sup> Article 48-bis of Law 83/97, dated 20 December 1997.

<sup>24</sup> Law 58/2017 dated 11 August 2017 on the elimination of violence against women states in its first Article that "this law aims to put in place measures to eliminate all forms of violence against women based on gender discrimination in order to achieve equality and to respect human dignity, by adopting an integrated approach based on addressing its various forms through prevention, monitoring and punishing the perpetrators, and protecting and entrusting the victims."

in supporting women victims of violence and establishing an integrated policy to combat such practices and provide the necessary care.<sup>25</sup> In theory, the law was a significant gain for Tunisian women. Through its text, lawmakers intervened to combat violence against women and protect them from all forms of violence (physical, moral, sexual, and political). It also ensured the establishment of an integrated system for women victims of violence, including healthcare.<sup>26</sup>

Due to the vulnerability of women victims of violence, their preliminary medical reports are provided for free. They are also exempt from paying hospital deposits and provided with payment facilities when discharged,<sup>27</sup> specifically in the case of spousal violence, based on Circular 39 of 2014. In 2022, Circular 5/2022 expanded<sup>28</sup> the list of women who could benefit from the above to include women victims of violence. However, obtaining the preliminary report, which proves the harm, still requires an endorsement from a police station. The cooperation of security forces is not guaranteed<sup>29</sup> since, contrary to the law, units specialized in violence against women have not been established in all security facilities. Similarly, the stipulation of employing women to interview victims is not respected in several facilities.

Associations and NGOs are also highly involved in protecting women victims of violence since most public institutions do not have the financial capacity to provide services and shelter for victims. These associations play an essential role in sheltering women victims of violence and their children in secure locations. They also offer mental health services, legal support, and guidance on filing criminal complaints or civil claims for compensation or divorce. Volunteer lawyers provide the latter services for women in difficult financial situations. A report by the Ministry of Women, Children and Seniors points to the significant contribution of associations and NGOs of most services to women victims of violence during the COVID-19 pandemic in 2020 and the related lockdown (وزارة المرأة 2021 والأُسرة وكبار السن التونسية).

## HEALTH SERVICES WITHOUT DISCRIMINATION

According to Article 19 of the 2022 Constitution, discrimination on any basis is a crime punishable by law.<sup>30</sup> In this regard, Law

<sup>25</sup> Article 8: "The Ministry in charge of health shall set up integrated programs to fight violence against women in medical and paramedical teaching, as well as covering the training of health workers at all levels to detect and evaluate all forms of violence against women and its prevention, examination, treatment, and follow-up to support women and children under their care. It shall also establish spaces for receiving victims of violence and providing them with health and mental health services."

<sup>26</sup> A framework convention was signed between the relevant ministries, including the MoPH. See [link](#).

<sup>27</sup> Circular 39/2014 relating to the free initial medical certificate for women victims of intimate partner violence, and the facilitation of procedure for obtaining medical examination and residency fees.

<sup>28</sup> Joint Circular 5/2022 issued by the Minister of Health and the Minister of Women, Children, and Seniors, dated 14 March 2022.

<sup>29</sup> Article 10 of this law states: "The Ministries of Justice and Interior shall establish integrated programs to combat violence against women in teaching and training in the institutions under their jurisdiction, in order to develop methods to deal with complaints and cases of violence against women."

<sup>30</sup> Article 19 of the 2022 Constitution states that "Public administration and all state services are available to the citizen based on impartiality and equality. Any discrimination between citizens because of any affiliation is a crime punishable by law."

No. 71 of 27 July 1992, related to communicable diseases, states in its first article that "no person can be subject to discrimination in treatment in the field of prevention or treatment of communicable diseases." Moreover, Decree No. 1155 of 17 May 1993, relating to the physician's duties, states that patients must be treated without discrimination. Furthermore, the Patients Charter<sup>31</sup> refers to the need for non-discrimination in its first point. It states that "every person has the right to protect his health in the best possible conditions without discrimination because of his religion, sex, color, age, or socioeconomic status."

The Constitution calls for the mandatory protection of specific groups: children,<sup>32</sup> women,<sup>33</sup> older people,<sup>34</sup> and people with disabilities.<sup>35</sup> The Patient Charter also seeks to protect vulnerable groups whereby it stipulates the need to "take into account the privacy of some groups of patients whose health condition requires priority under the legislation in force, such as urgent cases, people with disabilities, older people, children, and pregnant women."

Directive Law No. 83 of 2005, related to the advancement of persons with disabilities, also affirms the protection of this group from all forms of discrimination<sup>36</sup> and the need to provide the necessary mechanisms to monitor disabilities and develop scientific research in the field of disability and prevention, which is a way to protect the health of citizens. In addition, the state guarantees social welfare and free treatment or treatment at a low cost for persons with disabilities.<sup>37</sup> Finally, the decision by the public health and finance ministers, issued on 25 April 2006, set the cost of treatment, residency in public health facilities, prosthetics, and rehabilitation for persons with disabilities who meet the conditions for free or low-cost treatment."

On the other hand, Law No. 114 of 1994 protects older people by "protecting their health and guaranteeing their dignity"<sup>38</sup> and "resisting all forms of discrimination and exclusion in the family and social milieu." They also benefit from "social and health services at their place of residence" or "old people's homes, which must provide adequate sanitary conditions." Moreover, older persons "who benefit from social and health services at their residence are also exempted from contributing to the costs of these services."<sup>39</sup>

<sup>31</sup> Government's Circular N° 2009-36 relating to the Patients Charter.

<sup>32</sup> Article 52 of the 2022 constitution: "The state protects the rights of the child and takes care of abandoned children or those of unknown parentage. The rights of the child depend on the parents, and the state must guarantee dignity, health, care, and education. The state must also provide all kinds of protection to all children without discrimination according to the best interests of the child."

<sup>33</sup> Article 51 of the 2022 constitution: "The state commits to protecting women's established rights and works to strengthen and develop those rights. The state guarantees equal opportunities for women and men to access all responsibilities and domains. The state seeks to achieve parity between women and men in elected councils. The state takes measures to eliminate violence against women."

<sup>34</sup> Article 53 of the 2022 constitution: "The state guarantees assistance to elderly people without support."

<sup>35</sup> Article 54 of the 2022 constitution: "The State protects persons with disabilities against all discrimination and takes all appropriate measures to guarantee their full integration into society."

<sup>36</sup> According to Article 1 of the law herein.

<sup>37</sup> Article 15 and 14 of the law herein.

<sup>38</sup> Article 2 of Law 114/94.

<sup>39</sup> Article 16 of the law herein.



The National Program to Control acquired immunodeficiency syndrome (AIDS) and sexually transmitted infections (STIs) focuses on providing prevention and care services for groups most vulnerable to human immunodeficiency virus (HIV) infection. These include intravenous drug users, sex workers, men who have sex with men, prisoners, and immigrants. The services include education, distribution of prevention tools, prophylactics, and clean syringes through associations financed by the Global Fund. In addition, the state provides free treatment in four medical centers.

The 2007 revision<sup>40</sup> of the 1992 Law on Communicable Diseases<sup>41</sup> approved the possibility of conducting an anonymous voluntary test for HIV and other communicable diseases. The measure is expected to encourage those infected or suspected of being infected to visit health centers and use clinics anonymously, where doctors are not required to divulge their patients' names. However, despite the free treatment, the availability of means of prevention, and the gradual transition towards new services such as the provision of Dolgitravir DLG and Pre-Exposure Prevention (PrEP) services, the targeted groups are still victims of stigma and discrimination by service providers, which makes access to services difficult and leads to high rates of lack of access to services.

## **MULTIPLE COVERAGE AND FINANCIAL DIFFICULTIES FACED BY VULNERABLE GROUPS**

The health sector has enjoyed significant support since independence. It was primarily oriented towards free treatment. In the 1990s, however, it experienced a fundamental transformation through the Health Regulation Law. The law retracted the option of universal free care and began to distinguish between free and low-cost users. It aimed to secure revenues to allow hospitals to become financially independent.<sup>42</sup> Today, the law guarantees the right to treatment, free of charge for some vulnerable groups and at a low cost for others. All Tunisians in need, their spouses, and their children under their care<sup>43</sup> are assigned a free treatment and hospitalization card to be used in public health facilities. Free treatment is also provided to all resistance fighters,<sup>44</sup> soldiers,<sup>45</sup> internal security officers,<sup>46</sup> and customs officials.<sup>47</sup> In addition, the right to free treatment was accorded to those injured in the 2011 Revolution.<sup>48</sup>

<sup>40</sup> The law was amended on February 12, 2007.

<sup>41</sup> Law 71 dated 27 July 1992, relating to the above STIs.

<sup>42</sup> Primarily institutions with legal personality, that is, public health institutions.

<sup>43</sup> Article 1 of Decree 1812/98 on the requirements and methods of issuing and acquiring the free health card.

<sup>44</sup> Law 9/74, dated 9 March 1974, relating to reforming the pension scheme for resistance fighters.

<sup>45</sup> Law 20/67, dated May 31, 1967, on the general status of military personnel.

<sup>46</sup> Law 70/82 of 6 August 1982 on the general status of the internal security forces, amended and supplemented by Law 58/2000 of 13 June 2000.

<sup>47</sup> Law 46/95 of 15 May 1995 on the general status of civil servants, amended and complemented by Law 102/96 of 18 November 1996.

<sup>48</sup> Decree No. 2011-97 of 24 October 2011 on compensation for martyrs and wounded of the revolution of January 14, 2011 (Article 8 - Paragraph 2).

The 2022 Decree also set forth the right to free treatment and care for victims of terrorist operations, including military personnel, internal security officers, civil servants, and those entitled to justice among the martyrs and wounded of the Revolution.<sup>49</sup> In addition to free treatment in public facilities, the decree also allowed referral to private facilities or abroad based on a medical committee's recommendation.<sup>50</sup>

Finally, Decree 409 of 1998 grants low-income families the right to low-cost treatment if they are not covered by a social security scheme. However, although such schemes cover more than four out of five people, about two million remain without coverage. According to Part 3 of the 2015 National Survey on Household Budget, Consumption, and Standard of Living, 16.7% of the population did not benefit from health coverage and 0.5% of the population did not answer the survey (Statistics Tunisia).

## **SICKNESS INSURANCE SCHEME**

Social health insurance was established in the 1950s. The first compulsory health insurance system in the public sector was established in 1951, extending to the private sector in 1960. In 2004, a compulsory sickness insurance scheme was established for those benefiting from social security and dependents<sup>51</sup> based on "principles of solidarity and equality within the framework of an integrated health system that includes services provided by the public and private health sectors."<sup>52</sup>

The scheme determined medical and paramedical specializations and tasks, medications, machinery, and health transportation expenses incurred by grassroots systems, administrations, and services requiring prior approval.<sup>53</sup> The grassroots sickness insurance system covers health services according to the beneficiary's preferred<sup>54</sup> formula<sup>55</sup> under an annual ceiling.<sup>56</sup> Following is an overview of the systems available to social security beneficiaries:

<sup>49</sup> Decree 22/2022 of 9 April 2022 concerning the Fidaa Foundation for the support of victims of terrorist attacks among the military, internal security forces, and civil servants, as well as beneficiaries among the martyrs and wounded of the revolution.

<sup>50</sup> Article 11 of Decree 20/2022 of 9 April 2022 states that "Victims benefit from free healthcare in public and military health facilities and those under the responsibility of internal security forces and customs, in accordance with an agreement concluded for this purpose with the Fidaa Foundation. The Fidaa Foundation may, if necessary, cover the costs of care in private health facilities or abroad based on the advice of a competent medical committee. The right to care includes all types of treatment, psychological support and the acquisition of medication as well as medical devices and prosthesis facilitating reintegration".

<sup>51</sup> Non-divorced spouses who do not benefit from compulsory health insurance, children of social health insurance beneficiaries including: minor children provided that they do not benefit from compulsory health insurance, girls regardless of their age as long as their guardian's obligation does not fall on their husbands or as long as their husband does not have a source of income, children with a disability rendering them incapable of carrying out a remunerated activity and who do not benefit from compulsory health insurance in case of illnesses in respect of their activity, beneficiaries of a survivor's pension under a legal social security scheme and who do not enjoy compulsory health insurance in respect of their activity, and dependent relatives not subject to compulsory health insurance.

<sup>52</sup> Article 1 of Law 71/2004.

<sup>53</sup> Joint Decision Between the Minister of Social Affairs and the Minister of Public Health on 13 April 2007.

<sup>54</sup> The choice of health plan remains valid for at least one year as long as a request to change it is not submitted before September 30 of each year. Beneficiaries who do not declare a preference are registered in the public system.

<sup>55</sup> According to Article 4 of Decree 1376/2007.

<sup>56</sup> On 8 February 2021, Article 2 of the Minister of Social Security decision sets the annual ceiling at 300 Dinars for beneficiaries with no dependents, 375 Dinars for beneficiaries with 1 dependent, 450 Dinars for beneficiaries with 2 dependents, 525 Dinars beneficiaries with 3 dependents, 600 Dinar for beneficiaries with 4 dependents or more. Pregnant women enjoy free external health services related to pregnancy follow-up up to 150 Dinars throughout the pregnancy.

- **Public Medical Health System:** This system enables social security beneficiaries to access all external treatment services provided by public health facilities, the military hospital, and social security clinics, according to paying party's formula and payment of the difference.
- **Private Medical Health System:** Social security beneficiaries may choose a family doctor contracted with the Fund in this system. However, the system obliges beneficiaries and their registered dependents to visit the contracted doctor before visiting other practitioners unless the clinics are exempted from referral.<sup>57</sup> Moreover, beneficiaries who contract a severe or chronic disease from the designated list<sup>58</sup> may visit specialists directly without referral by the family doctor. Incurred expenses are paid by the Fund based on the chosen formula. In that case, social security beneficiaries pay the difference based on the contractual tariff<sup>59</sup> and percentage of coverage. The Fund is obliged to pay the difference directly to the service providers.
- **Reimbursement System:** The reimbursement system enables social security beneficiaries to be treated by contracted public and private health service providers. Accordingly, beneficiaries pay the total amount of the contractual tariff and then apply for reimbursement.

Hospitalization in public or private facilities is based on the same conditions and procedures regardless of the treatment scheme. For example, the National Fund for Sickness Insurance (CNAM) covers all hospital stays in public hospitals up to the scheme's ceiling. In private clinics, however, CNAM covers surgeries based on the specified official list<sup>60</sup> and deliveries. In this case, beneficiaries must obtain CNAM's prior approval. A range of outpatient therapeutic services such as scans and MRIs, medical machines, particular medicines, and hemodialysis are also uniformly covered.

The WHO (2023) estimated public spending on health in 2019 at 4570 million Dinars,<sup>61</sup> equivalent to 3.9% of GDP, 57.1% of health expenditures, and 12.6% of total government expenditures.<sup>62</sup> This public money comes mainly from CNAM (51.3%), followed by the state budget (7.48%). The percentage of public spending on health is less than the approved recommendations,<sup>63</sup> although public health spending falls within the framework of the state's commitment to perpetuating

<sup>57</sup> Ophthalmology, pediatrics, gynecology, and dentistry.

<sup>58</sup> Joint Decision between the Minister of Social Affairs and the Minister of Public Health on 25 June 2007 defining a list of 24 chronic illnesses that are entirely taken care of by the National Health Insurance Fund.

<sup>59</sup> Governmental Decree 381/2021-381 of 4 May 2021 amending Decree 2007-1367 of 11 June 2007.

<sup>60</sup> Joint decision between the Minister of Social Affairs and the Minister of Public Health dated 29 June 2007. Governmental Decree N°. 2021-318 of May 4, 2021 amending Decree N°. 2007-1367 of June 11, 2007 defining the formulas, procedures and percentages of health services coverage within the basic National Health Insurance Fund Framework. See link.

<sup>61</sup> Domestic General Government Health Expenditure GGHE-D.

<sup>62</sup> Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure GGE.

<sup>63</sup> According to the Abuja Declaration, public spending on health should be at least 15% of government spending.

the right to health and providing the health system with the necessary resources for quality health services and achieving equity.

Consequently, public health facilities suffer from an imbalance between increasing tasks,<sup>64</sup> political pressures, and public demands on the one hand, and the failure to provide the required financial resources, recent liquidity problems,<sup>65</sup> and the ceiling set for each public health facility on the other hand. However, the recently established Public Health Support Fund<sup>66</sup> provided additional funding to patients holding free or low-cost treatment cards.

## ■ HIGH RISKS IN DIRECT HEALTH PAYMENTS

In 2019, out-of-pocket (OOP) spending by households accounted for 37.9% of current health expenditures (CHE) compared to 42.5% in 2005 (WHO 2023).<sup>67</sup> The decrease could be due to the health system's coverage. However, the rate remains high, increasing the risk of catastrophic spending<sup>68</sup> and falling into poverty for the most vulnerable groups.<sup>69</sup> In addition, the inability to cover the costs could lead some to avoid the necessary treatment and fall into a spiral of illness and dangerous complications that may be more expensive. The increase in OOP spending is due to several factors. They include the unavailability of all services in the public sector and their high cost in the private sector, even for those with social security who have to pay the difference,<sup>70</sup> reducing their access to health services.

## ■ RIGHT TO HEALTH INFORMATION AND PRIVACY

The 2014 constitution recognized the right to access information protected by a state institution.<sup>71</sup> It also established the right to health. Their dual application leads to the right to access health information. The only limitation is found in another constitutional principle regarding the protection of privacy and personal data. Consequently, the 2014 Constitution<sup>72</sup> and prior<sup>73</sup> and later laws established the right of all citizens to access health information as long as it does not violate the protection of personal data.

<sup>64</sup> Equitable access to quality care for all and in all areas, with training of health professionals and development of research.

<sup>65</sup> The liquidity squeeze is due to the non-transfer of sickness insurance contributions by the National Social Security Fund and The National Fund for Retirement. Debt accumulated due to structural deficits within the pension systems, despite the direct deduction of contributions in the public sector since 2017 according to Law 47/2017.

<sup>66</sup> Government Decree 383/2019 and 381/2019.

<sup>67</sup> Out-of-pocket (OOP) spending as a % of Current Health Expenditure (CHE)

<sup>68</sup> Approximately 200,000 people in 2014.

<sup>69</sup> More than 100,000 people in 2014.

<sup>70</sup> Under the Private sector and Reimbursement systems.

<sup>71</sup> Access to Information Authority.

<sup>72</sup> The 2022 constitution maintained the principles herein.

<sup>73</sup> The 2004 Law on the Protection of Personal Data.

Doctors are required to inform patients of everything related to their illness, diagnosis methods, and treatment. Although the right to information is not enshrined in the Physicians Code, many of its articles lead in that direction.<sup>74</sup> Most prominently, the code defines cases where doctors may refrain from informing patients, such as fatal and urgent cases. In addition, the dentists' Moral Code and the law regulating pharmacology adopted the same principles.<sup>75</sup>

The right to information was also addressed in some texts. For example, the law related to communicable diseases obliges doctors to inform patients of the infection,<sup>76</sup> its symptoms, and its risks.<sup>77</sup> It also obliges health professionals to inform the health authorities tasked with such cases. The notification is compulsory, and its violation entails a penalty.<sup>78</sup> However, it considers the "privacy of voluntary, anonymous examinations."

Furthermore, the Doctors' Duties Code emphasizes the respect of obligatory notifications. The Patient Charter also recognizes the right to information. Finally, the presidential decree on telemedicine stressed the need to respect patients' right to information and obtain their free, informed consent.<sup>79</sup>

## QUALITY ASSURANCE AND CONTROL

The third clause of the Patient Charter stipulates that "health facilities and institutes [are obliged to welcome patients and their companions and provide them with the best possible services while respecting their rights and freedoms." Moreover, the Doctors' Duties Code prohibits the practice of the profession in circumstances that may prejudice the quality of treatment and medical work, except when justified by the patient's interests.<sup>80</sup>

Quality is monitored through internal structures set up at the MoPH. They include medical supervision, pharmacy supervision, and financial and administrative control. On the other hand, CNAM monitors the quality of services provided by its contracted health professionals.

On 6 September 2012, Decree No. 1709/2012 established the National Health Accreditation Authority. The Authority was charged with developing the quality of services through "the

<sup>74</sup> Articles 35 and 36. Article 36 lays out the cases where the prognosis may be concealed from the patient. Or by interpreting several provisions contained in this code that regulate the freely given informed consent of patients to therapeutic or non-therapeutic trials (Article 106 to 111 of Decree No. 1155/93 on 17 May 1993 relating to the obligations of doctors).

<sup>75</sup> Law No. 73-55 of 3 August 1973 on regulations of pharmaceutical industry, amending and supplementing the Law No.76-31 of 4 February 1976, Law No. 76-62 of 12 July 1976, Law No. 89-24 of 27 February 1989, Law No. 89-101 of 11 December 1989, Law No. 92-75 of 3 August 1992, Law No. 2008-32 of 13 May 2008, and Law No. 2010-30 of 7 June 2010.

<sup>76</sup> Law 71 of 27 July 1992, amended on 12 February 2007.

<sup>77</sup> Article 6.

<sup>78</sup> Articles 7, 8, and 17.

<sup>79</sup> Article 21 of the presidential decree No. 318/2022 of April 8, 2022, setting the general conditions of practice of telemedicine and its application fields. "Before performing any telemedicine work, the free and informed consent of the patient or his legal guardian must be obtained, after informing him of the necessity, importance, results and scope of that work, in addition to the means designated for carrying it out."

<sup>80</sup> Article 4.

external evaluation of the functioning of public and private health institutions and their services and applying accreditation procedures by independent experts." Article 3 of this decree establishes the need to "set rules, standards, and procedures for good professional practices in all phases of prevention, detection, and treatment, and approving them, including setting quality standards that must be available in the health sector."

Government Decree 792/2020 assigned the Authority the additional task of "evaluating health technologies and interventions" and considered it "the only national structure for assessment and accreditation in the health field." The above allows it to conduct international evaluations "according to international evaluation and accreditation standards and the principles of neutrality, transparency, and integrity." Moreover, the Authority has already established 24 treatment paths and professional recommendations, albeit optional and unmonitored. Thus, safety and quality in the health sector were enshrined in 2016 through a system to manage the quality of services in 31 health facilities (16 public and 15 private).

The Accounting Department also prepares an annual report that monitors financial and quality of service violations, including in public and private health services. For example, report 32 indicated that monitoring private institutions (by mandated structures) is lacking with regards to "establishment and installation of heavy and radioactive instruments." It also mentioned the "lack of oversight over hygiene, hospital waste, medicines, and medical supplies in those facilities." On the other hand, the Audit Court identified several violations in private hospitals related to sterilization, maintenance, and medical and hospital waste disposal.

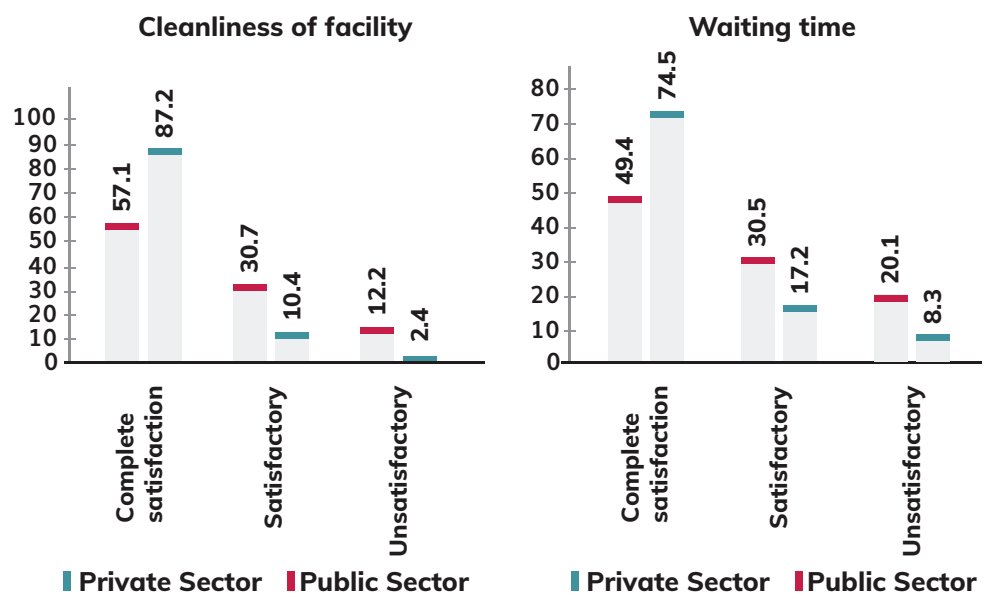
Several factors impede the health sector's response to individual and social needs. The excessive centralization of decision-making and the decline in the MoPH's role in providing services could be the most prominent. The existing healthcare system is fragmented, uncoordinated, and not wholly digitized. It focuses on curative services and neglects prevention. Moreover, public sector services are provided in a limited timeframe. For example, outpatient clinics are only open in the morning. Finally, public health facilities remain less attractive due to a lack of organization and governance.

In 2017, research in areas targeted by the European Support Program highlighted the lack of services, predominantly medication, and difficulties obtaining additional checkups. Sessions usually involve many patients, and appointments for specialized consultations need to be booked far in advance. The

research also registered dissatisfaction with available services (including ER, reception, communication with staff, waiting time, the long booking time for specialized consultation, and infrastructure issues).

The above results confirm the findings of a 2016 survey<sup>81</sup> where users above 15 were asked about their satisfaction level with various health services and facilities (**Figure 11**). The survey found that 13.1% of users were unhappy with the time spent in the waiting room. The dissatisfaction was much higher in the public sector (20.1%) than in the private sector (8.3%). In addition, 6.4% of patients mentioned problems related to the facility's cleanliness. Dissatisfaction with public facilities (12.2%) was also higher than with private ones (2.4%).

**Figure 12. User satisfaction with healthcare facilities (%)**



Several reports<sup>82</sup> documented the mistreatment of patients, the lack of respect for their data, the difficulty in obtaining medical records, the loss of paper medical files, the lack of communication between different departments of the same hospital or between hospitals, and the presence of bacteria, which could spread to many.

## MANIFESTATIONS OF CORRUPTION AND INEFFICIENCY

The health sector in Tunisia has some of the highest corruption levels (UNDP 2011), whose impact falls on vulnerable groups. Field studies have shown the prevalence of bribery,

<sup>81</sup> Surveys on 7 elements: (1) waiting time between arrival at the health facility and treatment (2) general respect for the patient by health personnel (3) clear explanations given by the doctor (4) participation in decisions about care or treatment (5) respect for confidentiality (6) selection of health workers and (7) cleanliness of the health facility. See [link](#).

<sup>82</sup> For example: see [link](#). (Link is invalid)

corruption, and nepotism in the health sector when obtaining appointments, treatment, and medicine. Moreover, public deals and employment processes do not always consider the needs of health structure facilities. Thus, In November 2016, a project to "Strengthen Democratic Governance and Public Accountability in Tunisia" was launched in the public health sector (برنامج الأمم المتحدة الإنمائي 2020).

The project followed a diagnosis of the sector's governance. The first stage focused on evaluating corruption risks in various services provided by public facilities and the drug supply chain. The second stage established a model experience for developing governance and combating corruption through the "islands of integrity" approach.<sup>83</sup> The "Sehha" (health) project, signed between the MoPH, the US Embassy, and the International Center for Private Enterprises (CIPE), is also concerned with the same issues. As a result, the CIPE monitored corruption and governance needs in the health sector in a report issued in October 2021 (WEBMANAGERCENTER 2021).

There is also a trend towards excessive medical treatment in the public and private sectors, such as cesarean sections, representing 43.2% of all deliveries (46.4% in urban areas and 37.7% in rural areas) due to profit opportunities.<sup>84</sup>

## TUNISIA DURING COVID-19

Like the rest of the world, COVID-19 was included in the list of communicable diseases to control and limit its spread.<sup>85</sup> Tunisia adopted a dynamic strategy to combat the pandemic based on the epidemiological situation, the spread of the virus on the national level, and its socioeconomic dimensions. It established coordination mechanisms based on several committees.<sup>86</sup> Several measures were adopted regarding border health control, monitoring incoming passengers, full and partial curfews,<sup>87</sup> and banning travel between cities. On the other hand, it enhanced its investigative activities, testing in the public and private sectors, and patient care and vaccination capacities.<sup>88</sup> These measures were implemented despite the absence of a proactive strategic plan and the sector's

<sup>81</sup> Surveys on 7 elements: (1) waiting time between arrival at the health facility and treatment (2) general respect for the patient by health personnel (3) clear explanations given by the doctor (4) participation in decisions about care or treatment (5) respect for confidentiality (6) selection of health workers and (7) cleanliness of the health facility. See [link](#).

<sup>82</sup> For example: see [link](#). (Link is invalid)

<sup>83</sup> This experiment included 3 hospitals: Rabat University Hospital, Jendouba Regional Hospital and Djerba Regional Hospital. After evaluation, the experiment will hopefully be implemented in other health structures.

<sup>84</sup> According to the recommendations of the World Health Organization and UNICEF, the percentage of cesarean deliveries should not exceed 10% to 15% in any country.

<sup>85</sup> According to Governmental Decree 152/2020.

<sup>86</sup> A multi-sectoral national body was first established comprising the relevant ministries and chaired by the prime minister, and a scientific committee under the supervision of the MoPH, which provided scientific opinion to the national body and sub-committees in the MoPH. Operation rooms were then established to manage the COVID-19 pandemic by Presidential Decree No. 77/2021 under the leadership of the Director General of Military Health and with the participation of some ministries.

<sup>87</sup> A total lockdown was approved from March 22 to May 4, 2020.

<sup>88</sup> For example, the number of intensive care beds in the public sector was increased from 96 in September 2020 to 504 in June 2021.



structural problems, particularly in public facilities. Moreover, the response was partially digitized through the “e7mi” (protect) application, which monitored the infected population to reduce spread, and the EVAX platform to organize vaccination, which allowed setting vaccination priorities, transparency in implementation, and reducing nepotism.

As each wave peaked, the state suffered from poor material and human capacities, preventing public health facilities from treating COVID-19 patients in appropriate conditions. Thus, the health sector received global support<sup>89</sup> from international organizations, other states, and civil society organizations. They provided the needed support to public facilities, either directly (medical equipment, oxygen concentrators, and PPE) or by donating to a special fund.<sup>90</sup>

The COVID-19 pandemic also shed light on the inflexibility of regulatory texts related to public procurement, which hinders the health sector from responding promptly and effectively in times of crisis. Current regulations require submission to the Public Procurement Law, which establishes complex procedures and slows the acquisition of medical supplies. However, public procurement rules do not conform to the medical field’s needs, and the speed facilities require to respond to crises.

## COMMUNITY PARTICIPATION AND THE ROLE OF CITIZENS

Tunisian law includes many texts establishing good governance in several fields, including health. For example, Framework Decree No. 120/2011 aims to “combat corruption in the public and private sectors, in particular by developing efforts for its prevention, facilitating its detection, ensuring that perpetrators are tracked and deterred, and supporting the international effort to limit corruption, reduce its effects, and work to recover its revenues.” Article 1 of the Decree emphasizes the participatory dimension in combating corruption.<sup>91</sup> Another example is the Government Decree regarding the creation of the “Citizen Oversight” team, which assigns citizens a role in monitoring the quality of services (including health).<sup>92</sup>

Community participation in health matters was established through the social dialogue involving the sector’s various participants, including the ministries, national organizations,

<sup>90</sup> A special account (06) was established for the COVID-19 response, called the Prevention and Response to Health Epidemics (Fund 18-18), by the Finance Minister’s Decree on 25 March 2020, amended on 22 July 2020 and 9 November 2020. See [link](#).

<sup>91</sup> Article 3: “The state guarantees the inclusion of combating corruption as a main theme in human, economic, and social development programs based on an approach that is (1) comprehensive, directly or indirectly covering all areas of intervention, (2) participatory, allowing the mobilization of all social potentials from individuals, organizations, and the public and private sectors, (3) interactive, enabling the exchange of information among the various stakeholders and coordinating their efforts.

<sup>92</sup> Government Decree No. 1072/2016 of August 12, 2016, amending Decree No. 147/93 of 18 January 1993, creating the “citizen oversight” team.

professional associations, and prominent civil society components. Arbitration committees were chosen from among participating citizens in both stages of the dialogue. They presented their recommendations (Le Comité Technique du Dialogue Sociétal 2014b) to the national seminars in September 2014 and June 2019. The WHO considered the initiative a pioneering experience and an example to be followed (WHO 2019). The dialogue was supposed to be institutionalized in the framework of health law and the promotion of citizen participation in monitoring the National Health Policy's implementation.

## RECOMMENDATIONS FOR UNIVERSAL HEALTH COVERAGE

### ACCELERATE THE IMPLEMENTATION OF THE NATIONAL HEALTH POLICY

The indirect and specific measures urgently taken in recent decades did not change the situation, and instead, in some cases, created more problems. Thus, the achievement of the constitutional right to health requires a policy “that adopts references to respect for human dignity, fairness, quality, and solidarity, and represents the basic values on which it is built” (2019 مشروع السياسة الوطنيّة للصحة في أفق 2030). However, the policy’s strategic options and keys to success are contingent on major political decisions, which entail consultations with the concerned parties and arbitration processes without prejudice to the complementarity between the options. Therefore, the directive law for health must be issued to legitimize these options and avoid tensions.

In this context, the Health Sector Development Plan 2023-2025 chose four main intervention spheres: prevention and health promotion, developing health services and health insurance coverage, developing the pharmaceutical sector, and the leadership and governance of the health system. The plan is a phased implementation mechanism for the National Health Policy.

The aforementioned plan and policy inspire many of this paper’s recommendations. However, the National Health Policy focuses on current priorities in the Tunisian health sector, mainly covering solutions and measures clearly and efficiently supporting the right to health.

### ADOPT THE ONE HEALTH APPROACH

The state’s general policy must prioritize health and sustainable development by including health in all sectoral policies and integrating human, animal, and environmental health in health strategies. In addition, awareness and prevention programs must be boosted<sup>93</sup> to protect health, reduce the spread of diseases, and limit their impact on the state’s economy. For example, activities could include providing “public spaces suitable for positive health practices and behaviors such as

<sup>93</sup> Implement existing strategies, for example: the National Strategy for the Promotion of Mental Health and Combating Addiction and the National Multisectoral Strategy for the Prevention of Noncommunicable Diseases and its Action Plan for 2020-2025.

walking, sports, and recreational activities for children” and educating young people on health-friendly behavior (2030 مشرووع السياسة الوطنية للصحة في أفق 2019). In addition, awareness and educational programs should encourage citizens to detect fatal diseases like cancer at an early stage.

## ENHANCE HEALTH SECURITY

The COVID-19 pandemic demonstrated the critical nature of the health sector and the need to prepare a comprehensive and integrated national strategy for prevention, response to disasters and health emergencies, and monitoring through international health regulations. The continuous availability of essential medicines must also be ensured. The role of Tunisia’s Central Pharmacy must be strengthened. Furthermore, drug security must be promoted through the local pharmaceutical industry, including vaccines.<sup>94</sup> Finally, a legal framework is required for dealing with health crises and emergencies.

## IMPROVE THE AVAILABILITY OF QUALITY HEALTH SERVICES BASED ON NEED

According to the National Health Policy, “it is necessary to make family and neighborhood health the focus of the health system and to ensure the provision of a set of high-quality basic services for all” (مشرووع السياسة الوطنية للصحة في أفق 2030 2019). These choices are expected to improve availability over time, fulfill health needs throughout the life cycle, and facilitate appointments remotely, reducing overcrowding and improving reception conditions, especially in public health facilities.

A unified, integrated digital health record<sup>95</sup> must be adopted to reduce the spread of bribery and nepotism. It entails using family and neighborhood health as the main entrance to the healthcare system through a close-contact network linking the public and private sectors. It also requires establishing a regulatory framework for family medicine, institutionalizing it with incentives, and strengthening continuous training and undergraduate curricula. Telemedicine<sup>96</sup> is also a way to enhance coordination and integration between different service providers. Moreover, to ensure quality, oversight of all health institutions (private and public) must be strengthened and subjected to a system of evaluation and gradual accreditation. Finally, accreditation must become mandatory, which would upgrade services and improve their quality.

<sup>94</sup> The WHO selected Tunisia as a candidate for the coronavirus vaccine industry. A feasibility study was carried out and production was decided to be in the form of a public-private partnership (PPP).

<sup>95</sup> Some public hospitals started using digital medical records and the MoPH is preparing a decree in this regard, a step forward towards transparency, fighting corruption, and improving quality.

<sup>96</sup> Presidential Decree No. 318/2022 of 8 April 2022, setting the general conditions of practice of telemedicine and its applications.

## ENSURE ACCESS TO HEALTH SERVICES BASED ON NEED THROUGHOUT A PERSON'S LIFE CYCLE

Reproductive and sexual health must be strengthened in the primary health package by ensuring that the rights guaranteed by law are protected and supported in practice. These include the right to abortion and access to contraceptives while continuing to adopt the family planning and health education approach pursued since independence by providing the necessary financial and human resources in coordination with civil society organizations.

Breastfeeding should also be encouraged through ongoing media campaigns to raise awareness of the issue. Furthermore, the circular banning the promotion of formula milk in public and private health structures must strictly be applied with its related penalties.

In addition, the provisions of Law No. 58, establishing an integrated system to combat violence against women, must be implemented. It includes establishing medical briefing centers in all health facilities to cover all forms of violence against women while continuing to provide listening services by health professionals and expediting tests and certificates. In this context, the training of health professionals in caring for women victims of violence must be accelerated and increased.

An effective monitoring system medicines and their path and how they are used must be introduced. The consumption of generic drugs could also be encouraged. In parallel, citizens must be educated about the dangers of self-prescribing (especially antibiotics) and the need to rationalize consumption, which would benefit citizens' health and the country's economy.

## PROVIDE MORE EQUITABLE HEALTH SERVICES

A universal basic system for all would allow benefiting from health services without entailing financial risks. It involves integrating those who enjoy free or low-cost treatment through CNAM with informal sector workers. In parallel, a complementary insurance scheme would cover treatments not included in the basic universal system.<sup>97</sup> The basic system would be funded sustainably by expanding the contribution base and taxes earmarked for health. In this regard, the Public Health Support Fund should be enhanced, and its administration handed over to CNAM. On the other hand, the "Aman" and

<sup>97</sup> Article 19 and 20 of Law No. 71/2004.

"Labas" cards could be expanded to cover the health sector, allowing control over actual expenditure and further efficiency. It could also help to find radical solutions to the pensions scheme so that the CNAM can obtain its dues and recover its debt from various health service providers.

## PROTECT THE RIGHTS OF PATIENTS AND PROFESSIONALS

A draft law was prepared to enshrine patients' rights and medical responsibility,<sup>98</sup> which adopts patients' rights unequivocally. It also defines health professionals' civil and criminal liability under specific rules that consider professional requirements. Most prominently, the draft law states the following:

*"In addition to the patients' rights stipulated in this law, health professionals, facilities, and institutions must take into account the rights enshrined in the Constitution, the treaties and agreements ratified under the legislation in force, and the rights contained in special texts related to some segments of patients such as children, older people, people with disabilities, and those with mental illnesses."*

The draft also sets the scope of the right to be informed in Article 15, which states:

*"The treating doctor or dentist must inform patients, their legal guardians, or representatives before the various examinations, proposed treatments, and necessary preventive measures. They must listen to their opinion and honestly inform them of the possibilities, methods, and means available for treatment and the systematic and grave risks associated with the condition."*

This text also enshrines the principle of participation, recognizing the involvement of professional associations in some decisions (such as determining the composition of some committees).

In 2015, a draft law was prepared to protect health professionals from violence in health facilities. It establishes criminal penalties for attacks against doctors and health staff in public health facilities while performing their duties. The draft also aims to reduce violence, which would improve conditions and, thus, the quality of services.

<sup>98</sup> It was discussed by successive health committees in the House of Representatives, and a vote was imminent. However, the changes in the political system and the suspension of Parliament on July 25, 2021, prevented the decision.

Nevertheless, a fundamental law must be issued to organize biomedical research, adopting regulations to protect the bodily sanctity and human dignity of patients and anyone who undergoes such experiments.<sup>99</sup>

## **ENGAGE AND EMPOWER PATIENTS AND CITIZENS**

The National Health Policy includes some recommendations to make citizens active partners in health. The recommendations include establishing listening units and committees of health facility users, representatives of health professionals, and the administration to enhance communication between the various stakeholders. Civil society organizations could also play an essential role in the matter. In addition, citizens must take ownership of the health service and feel responsible for public facilities and maintenance. This feeling of belonging and responsibility could be developed by involving citizens in decision-making, providing them with a space to express their opinions, and allowing their participation in running health facilities through representation in its governing bodies and boards.

## **PROVIDE HEALTH PROFESSIONALS WITH INCENTIVES**

The COVID-19 pandemic reminded everyone of the crucial function of the health system. Thus, its health professionals must be encouraged and supported through continuous professional development. They should also be incentivized to perform and innovate, providing them with the needed equipment. Best practices, processes and standards developed by the National Committee for Health Assessment and Accreditation should become the reference framework for their activities, which must be protected to reduce the temptation of corruption.

## **BUILD AN EFFECTIVE HEALTH SYSTEM BASED ON GOOD GOVERNANCE**

The right to health is achieved by strengthening the MoPH's leadership and corrective role. Services must meet quality standards and the requirements of users and health professionals. On the other hand, some decisions and actions must be handed to local and regional structures through

<sup>99</sup> A related draft law brings together the various texts and unifies the rules applicable in this field.

decentralization. The 2023-2025 Development Plan suggests several examples of activities in this regard:

- Develop a forward-looking health map and review health-regulation texts to update the roles of the three lines and include regional health hubs;
- Develop a Health Gazette to ensure the coordination and the integration of legal texts, which are numerous<sup>100</sup> and vary in obligatory powers,<sup>101</sup> leading to confusion and difficulties when provisions intersect or contradict each other. The situation calls for a Health Gazette to develop the health sector's legal framework;
- Establish the National Agency for Medicines and Medical Supplies to improve their flow;
- Support partnerships between the public and private sectors (PPPs) by establishing transparent and framed cooperation formulas to reduce regional disparities and conflicts of interest.

Digitization is the most effective means to ensure good governance and combat corruption. Therefore, planned projects related to hospital information systems in all public facilities must be expedited, along with expanding the digital platform for vaccination by integrating children's and seasonal influenza vaccines for adults.

## **PROVIDE THE HEALTH SYSTEM WITH THE REQUIRED CAPACITY**

The health system's performance could be enhanced by providing financial resources. Therefore, the MoPH's budget should be raised and geared towards performance. In addition, public financing could be mobilized by expanding the contribution base, raising tax allocations for health, and establishing efficient PPPs. On the other hand, the needed human resources could be mobilized by developing capacities and supporting training in all fields, especially new professions. Furthermore, public service in health facilities should be organized by law, and scientific research must be encouraged. Finally, special texts should be adopted regarding public procurement related to health, considering its specific requirements and the speed of acquisition.

<sup>100</sup> More than 700 legal texts.

<sup>101</sup> Varying between Texts, Laws, Decisions, Decrees.



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# ENDING THE WAR IN YEMEN AS A PREREQUISITE TO REALIZING THE RIGHT TO HEALTH

The impact of war  
and political conflicts  
on health indicators  
and determinants

## Dalia Hyzam

YOHR, Yemen. Women's Center for Research and Training, University of Aden, Yemen

Researcher and Academic; she is a pharmacist by background. She holds a master's degree in Feminist Studies and Development; a Ph.D. in Maternal, Child and Adolescent Health Care. She is currently working as a consultant in Feminist Studies and a lecturer in reproductive health at the Women's Center for Research and Training - University of Aden. She is a member of the advisory board of the Yemeni Observatory for Human Rights (YOHR). She also has published scientific papers in high impact factor journals.

## Abeer Shaef

Public Health and Community Medicine Department, Faculty of Medicine and Health Sciences, University of Aden, Yemen

Doctor, Instructor, Public Health/Community Medicine Specialist and Consultant; working in Health, Nutrition and the Humanitarian field with local, international and United Nations organizations. A Certified trainer at several organizations and the Ministry of Public Health and Population, especially in infectious diseases (Dengue fever, Cholera, COVID-19). Co-author in several research papers published in peer-reviewed scientific journals.

## INTRODUCTION

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The right to health, enshrined in the Universal Declaration of Human Rights, is the foundation underpinning fair and equitable health systems. Health is sometimes defined as modern hospitals and well-equipped medical centers, which is partly true. However, the concept of health is much more comprehensive. The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. In other words, health is a state where a person enjoys the highest attainable health standards that lead to a life of dignity (WHO 1948).

The right to health entails healthcare based on the availability, acceptability, quality, and accessibility of health services. It also encompasses related determinants such as safe drinking water, adequate nutrition, healthy and adequate livelihoods, and access to health education and information (United Nations 1948). Moreover, in its General Comment No. (14), the United Nations Committee on Economic, Social, and Cultural Rights (ECOSOC) has affirmed the primary principles of the right to health: non-discrimination, participation, and accountability. On the other hand, the WHO Constitution states that the responsibility for the right to health rests with governments, Civil Society Organizations (CSOs), agencies, and individuals collectively (WHO 1948).

The health system in Yemen faces several challenges in providing health services and enabling community access to these services, albeit at a minimum level of quality. The war and blockade have also had a devastating impact on many health indicators in Yemen including; mothers and children healthcare. For instance; low vaccination coverage for children, high incidence of diarrhea, anemia, and mortality among children under five years of age, and high maternal mortality rate. Furthermore, the already fragile health system's provision of routine primary healthcare services has been diminished by the urgent need to respond to the threat of food insecurity and the recent cholera epidemic (El Bcheraoui et al. 2018). In addition, many routine services were suspended amid the COVID-19 pandemic due to mismanagement, causing a decline in the urgent response to infected cases (Zawiah et al. 2020).

The conflict in Yemen escalated in 2010, followed by large

protests, infighting, and a war that began in September 2014 and continues to this day. Before the outbreak of the war between the Saudi-led coalition and the Houthis, Yemen was already the poorest country in the Middle East and one of the poorest in the world. The humanitarian crisis harmed all of Yemen's vital sectors, including health (El Bcheraoui et al. 2018). The conflict expanded after the Houthis' military takeover of the capital in September 2014. War broke out, and the Saudi-led coalition began its military operations. Consequently, Yemen was placed under Article VII of the United Nations Charter and classified in a state of war/ conflict. The humanitarian affairs in Yemen including health are now coordinated through the annual Humanitarian Needs Overview (UN OCHA-HNO 2022), the annual Humanitarian Response Plan, and donors contributions (UN OCHA-HRP 2022). Coordination to implement these plans is carried out across various clusters (health, nutrition, water and sanitation, food security and agriculture, protection, and education). Although most of these plans and activities guarantee health for all groups, especially those with conflict-related particularities, notwithstanding these plans and activities generally focus on relief, urgent support, and emergencies (UN OCHA 2022). A public health expert noted:

“ The leadership and governance policy of the Ministry of Public Health and Population (MoPHP) and its offices in the governorates toward health cluster is weak. The leadership of the health cluster is given to international organizations, although these organizations are not entrusted for this task...The concept of clusters paved the way for working through a multi-sectoral approach, yet not in a formal manner as long as there is no law guaranteeing this approach in Yemen. Working through a multi-sectoral approach is still within the framework of humanitarian emergency responses in Yemen” (Participant 2: Public Health Expert and Academic, 2022).

Yemen is experiencing the worst humanitarian crisis in the world. Current data indicates that nearly 80% of the population requires some form of humanitarian assistance and social protection (ICRC 2022). Since Yemen has not officially achieved the reconstruction stage and sustainable development, broadening the concept of right to health has not been targeted yet, especially in affairs related to development, social protection, supportive infrastructure, governance, and effective

community participation. The comprehensive national dialogue outcomes and the new constitution of Yemen remain subject to ending the war, achieving peace, and the transitional phase of governance. A reproductive health care expert confirmed that:

“Yemeni citizens do not enjoy the right to health for all, not even at its lowest level since before 2015. Health national policies and strategies have been formulated; however, they are not applicable on the ground and have not been implemented. We still believe that health is a person’s who is free from disease. We have not defined health as a right in our programs and projects nor reached the stage of thinking about well-being”  
(Participant 1: Expert in Reproductive Healthcare, NGO, 2022)



## STUDY OBJECTIVES

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This report aims to provide an impartial analysis of the status of the right to health in Yemen. It addresses the articles of the Yemeni constitution related to the right to health, national strategies and health laws, and relevant literature and data, shedding light on the following:

- Yemen's health system and national strategies
- Yemen's constitution, treaties, and the international convention related to the right to health
- The war's impact on Yemen's health sector
- The gap in data and health indicators in Yemen
- The right to health from the perspective of social protection in Yemen
- The role of the health sector in light of the COVID-19 pandemic



## METHODOLOGY

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In light of the report's objective, the report relied on an exhaustive desk review supplemented by a qualitative analytical approach by using a prepared interview guideline. This approach can explore the research question under investigation by answering the "what," "how," and "why" questions according to participants' points of view. Accordingly, In-Depth Interviews (IDIs) were conducted with four health experts (representing the MoPHP, the University of Aden, Hadramout University, and international organizations). All interviews were audio-recorded, transcribed verbatim and uploaded into Atlas.ti (version 8) for the analysis. A content analysis was applied to find meaningful relationships between emerging themes. Six main themes emerged from the desk review and interviews:

- The constitution, international treaties, and national strategies and their relationship to the right to health in Yemen
- Monitoring, evaluation, and accountability
- The impact of war on health indicators
- The health sector's role during COVID-19
- Emergency response mechanism
- Recommendations for realizing the right to health in Yemen

## BRIEF HISTORICAL OVERVIEW OF YEMEN'S HEALTH SYSTEM

Yemen's current health system dates back to the last quarter of the 19th century, during the British colonization of the southern part of the country. It also dates back to the second half of the 20th century after the September 1962 revolution in the northern part of the country and October 1963 revolution in the southern part of the country. After the unification between the south and the north in 1990, the health system was also unified, despite some differences between two systems: while the Yemen Arab Republic (North) had allowed the private health system to develop alongside the state-supported public health system, the People's Democratic Republic of Yemen (South) did not. As such, the public system remained the primary health system in the South (Aulaqi 2014).

The MoPHP was responsible for healthcare delivery and the overall governance of the health system. However, the MoPHP assumed a supervisory role after the Yemeni Parliament adopted the Local Administration Law in 2000, which granted 22 governorates the autonomy to manage some services at the local level (UN DPADM 2004). Thus, the governorates health offices became the bodies responsible for health at the governorates level. Accordingly, healthcare in Yemen before the conflict was administered at three levels: MoPHP (formulation of health policies), governorates health offices (planning and implementing health plans at the governorates level), and districts health offices (implementing health activities at the districts level). The MoPHP's governance mandate extended to four sectors: primary healthcare, population health, curative care, and planning and development (Qirbi & Ismail 2017).

The health system's structure was based horizontally on health centers and units and vertically on preventive health programs and projects against communicable and non-communicable diseases. However, there is no evidence regarding integration or coordination at the lowest level between health centers and preventive health programs and projects. Furthermore, one of the persistent difficulties facing the MoPHP's efforts to implement the reform strategy is the lack of support from other government agencies, particularly the Ministry of Finance. The MoPHP also lacked authority over private hospitals, clinics, and human resources due to the lack of enforcement of relevant laws. Thus, the private sector functioned without oversight and

continues to do so today (WHO-EMRO 2006).

Primary healthcare services are provided in rural and urban settings through a network of government health facilities, which are geographically distributed and vary between health units, health centers, and hospitals (rural, district, provincial, and reference hospitals) according to population size and geographical distance (MoPHP 2000). However, public health facilities have historically suffered from a shortage of human resources and health workers, not to mention weak leadership, causing some health facilities in rural areas to remain closed for months (Aulaqi 2014).

Yemen adopted the primary healthcare approach in 1978, the same year as the Alma-Ata Conference. It incorporated the approach into its national constitution, stating that “all citizens shall have equal access to free primary healthcare services” (MoPHP 2010). However, high poverty, population growth rates, and a weak health sector budget paved the way for a health sector reform strategy formulated between 1998 and 2000. The strategy included decentralization plans, redefining the role of the public sector and the essential medications policy, encouraging responsible participation by the private and non-governmental organization (NGO) sectors, and cost-sharing (MoPHP 2000).

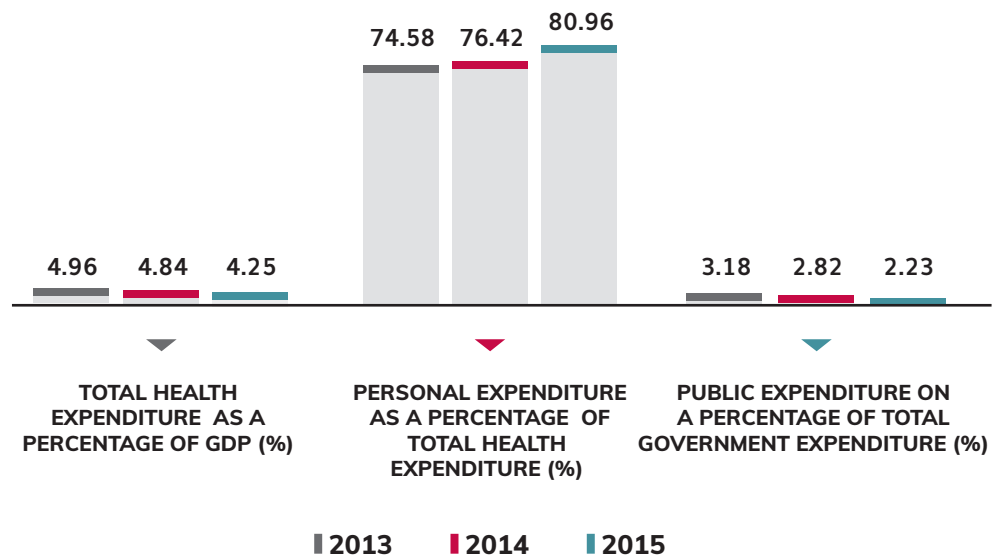
In 2000, Yemen began marketing health services in the private health sector to reduce the financial burden of health services provided free of charge at the public health sector. The decision had direct repercussions on poor citizens, especially those in rural areas (Aulaqi 2014). Accordingly, the private health sector flourished after unification in 1990, and the number of private hospitals increased from 167 to 746 between 2002 and 2012 (Aulaqi 2014). However, cost-sharing also reduced citizens' access to health services. A study on maternal and child health services before and after the cost-sharing system indicated that despite not having an impact on utilizing preventive health services, fees tended to be a significant barrier to access and benefit by the poor, particularly in hospitals (Alshaibani 1998). On the other hand, reports from al-Hodeidah governorate showed a decline in the use of preventive health services after cost-sharing introduced (UNICEF 1998).

Another challenge appears in medical staff moving from the public health sector to the private health sector. In addition to the low material return in the public health sector, the move was due to the promotion of the private sector, the continuous modernization of its equipment, and the availability

of various specializations. As a result, public health facilities were frequently bypassed by patients in rural areas. Although, healthcare users prefer services close to their homes and perceive that most nearby facilities are less expensive than those requiring transportation, which constitutes an additional burden on them, around 42% - 73% of households bypassed public health facilities that were close to their houses to access care at private facilities. (World Bank 1998). Another study indicated that 95% of citizens sought health services from the private sector (Aulaqi 2014). Consequently, the proportion of out of pocket expenditure on health increased (MoPHP 2000).

**Figure 1** shows the spending on health in Yemen between 2013 and 2015. Out of pocket spending on health increased from 74.58% to 80.96%, respectively, in parallel to the decrease in health spending out of total government spending and GDP (WHO-GHO 2022). According to estimates, total spending on health amounted to 35 USD per capita in 2018, of which personal expenditure per capita was 25.19 USD. By 2050, it is estimated that total expenditure on health is expected to reach 46 USD per capita, and personal expenditure will be equivalent to 31.61 USD per capita (IHME 2022).

**Figure 1. Spending on health in Yemen (2013-2015)**



| Source: Data compiled by authors from WHO-GHO, 2022

The experts interviewed expressed their opinions in this regard as follows:

“ In fact, citizens cannot purchase health services, neither from the private sector nor the public sector.

The services are available to many citizens, but they cannot use them due to cost. Before the war, personal spending was estimated at 67-70%, which citizens deducted from their children's food. Many citizens are in a catastrophic financial situation due to illness (Participant 3: Public Health Expert - MoPHP, 2022).



In Yemen, in terms of citizens' right to obtain health as a service, whether in the city or countryside, those provided by the government and the private sector are 100% paid by citizens. The financial aspect is a major obstacle to health services for citizens in Yemen. It goes against the new worldwide strategy based on universal health coverage (Participant 4: Public Health Expert and Academic, 2022).



In 2000, the healthcare system was developed at the district level to reduce personal expenditure on health. Some additional services were implemented to enhance coverage, including outreach, mobile clinics, and house-to-house campaigns. However, these services were sometimes insufficient or intermittent in some areas due to mismanagement, lack of oversight, lack of accountability, and widespread corruption (Aulaqi 2014). A public health expert commented on the poor state funding on health compared to what it allocates from its budget to the security services, the army, and ministers' salaries, saying:



Spending on the health sector is weak, while huge sums of money are spent on the security services such as the army and the police. Many expenditures and sums are wasted by the government itself (expenses of ministers) (Participant 3: Public Health Expert - MoPHP, 2022).



National health strategies are in line with achieving national and international health goals. However, progress remains weak, particularly regarding maternal and child health. In addition, although ensuring access and use of healthcare services is mentioned in all national health policies, the term "how" is missing, and its factors are not addressed (Alaswadi 2013).

Shortcomings in managing crucial areas such as mental health and psychosocial support services also prevailed. For example, the weak adherence to policies was evident in the fact that although there were national plans for mental health, the plans had not changed since the early 1980s. Moreover, there was no

formal legislation governing mental health in Yemen (Okasha et al. 2012).

The principal plans and strategies related to health development include:

- First five-year plan for economic and social development (1996-2000)
- Public Health Sector Reform Strategy (2000)
- Second five-year health development plan (2001-2005)
- Third five-year plan for health development and poverty reduction (2005-2010)
- Fourth five-year plan for health development and poverty reduction (2011-2015)
- National Reproductive Health Strategy (2006-2010).
- National Nutrition Strategy (2009)
- National Health Strategy (2010-2025)

There was a consensus among experts on that national health-related policies and strategies exist but are not applied on the ground due to the unstable political situation that prevented the achievement of the Millennium Development Goals (MDGs) and indicates Yemen's inability to achieve the Sustainable Development Goals (SDGs). The respondents also pointed out some inconsistencies in the MoPHP health policy, legislation, and administrative regulations. They expressed the following:

“ The lack of a clear health policy has negatively affected performance [of the health sector]. For example, the private sector greatly affects the public sector, meaning that qualified and trained doctors prefer to work in the private sector. Hence, the public sector deteriorated and provided poor services to citizens. This factor is not related to war (Participant 2: Public Health Expert and Academic, 2022). ”

“ The MoPHP lacks documented strategies. For example, the National Health Strategy is available on the MoPHP's website in Sana'a, but it is not available on the MoPHP's website in Aden. Although, the MoPHP in Aden is affiliated with the legitimate and internationally recognized government! (Participant 3: Public Health Expert - MoPHP, 2022). ”

# CONSTITUTION, INTERNATIONAL TREATIES, AND THE RIGHT TO HEALTH IN YEMEN

## YEMEN'S CONSTITUTION 1991

### Section One: The Foundations of State - Chapter III: Social and Cultural Foundations

- **Article 30:** The state shall protect mothers and children, and shall sponsor the youth and the young.
- **Article 33:** In cooperation with society, the state bears responsibility for consequences resulting from natural disasters and public crises.
- **Article 35:** Environmental protection is the collective responsibility of the state and the community at large, it is a religious and national duty of every citizen.

### Section Two: The Basic Rights and Duties of Citizens

- **Article 55:** Healthcare is a right for all citizens. The state shall guarantee this by building various hospitals and health establishments and expanding their care. The law shall organize the medical profession, the expansion of free health services, and health education among the citizens.
- **Article 56:** The state shall guarantee social security for all citizens in cases of illness, disability, unemployment, old age, or the loss of support. The state shall especially guarantee this, according to the Law, for the families of those killed in war.

The Yemeni Constitution of 1991 guarantees health for all citizens, with considerations for people with special needs and vulnerable groups, and takes into account Yemen's commitment to other international treaties. This right includes everyone on Yemeni territory without discrimination and in exceptional circumstances, including during conflicts and wars. Healthcare and the right to health are also linked with other rights such as education and the right to physical and mental integrity and other related sectors such as the environment, housing, and safe drinking water. Nevertheless, available indicators point to the deteriorating humanitarian situation in Yemen even prior to the conflict. As a result of the scarcity of data, it is impossible to monitor the lack of justice and equality between citizens and non-citizens in accessing and obtaining

these rights. Experts expressed their opinions in this regard:

“ Our legislation and administrative procedures are very far from the WHO’s definition of the right to health. Yemen has signed these charters and agreements guaranteeing citizens’ right to health. However, when implementing administrative procedures concerning legislation and resource allocation, this matter is not reflected on the ground as desired. As for the rights of non-citizens (refugees), we are, in fact, refugees in our country (Participant 3: Public Health Expert - MoPHP, 2022). ”

“ Our problem in Yemen is accessing [the right to health]. One of the criteria guaranteeing citizens this right, which must be considered, are the availability of health services, ease of access, the ability to obtain health services, and the quality of health services (Participant 2: Public Health Expert and Academic, 2022). ”

“ There is a discrepancy in the numbers (data) of basic health indicators, such as morbidity indicators, mortality indicators, and indicators of services available to citizens of different groups. [This discrepancy] also exists in many direct and indirect indicators through which programs and plans can be prepared and activities evaluated to build a vision matrix or a long-term strategic plan for the health system. The conflicting and incomplete indicators constitute the biggest defects of the health system, and some data has not been reached in real-time for decision-making, and these indicators or numbers always come late (Participant 4: Public Health Expert and Academic, 2022). ”

A previous study indicated that access to therapeutic services was limited to 68% of the population, while 32% did not receive any service (Aulaqi, 2014). There is also unequal access to health services between urban and rural residents, as only 25% of residents in rural areas have access, compared to 80% in urban areas (MPIC, CSO 2004). Because most public and private hospitals are concentrated in urban areas, about 70% of the total population does not have easy access to care and faces significant expenses traveling to urban facilities (Gericke et al. 2005). According to the UN OCHA report - 2016, half of



the Yemeni population is still deprived of access to essential health services (UN OCHA 2016). Moreover, about 17.8 million people need support to obtain clean water and basic sanitation (UN OCHA HNO 2022).

About 1.7 million Yemeni women and children are estimated to suffer from chronic malnutrition (UNICEF 1998). The prevalence of stunting, wasting, and underweight children under five was 53%, 13%, and 46%, respectively (DMCHS 1997). Child malnutrition in Yemen shows residential and regional disparities in its prevalence. It was higher among the rural population (56%) than the urban population (40%). Although there has been a basic package of services in Yemen focusing on maternal and child health since 2004, the extent to which these services were provided in the pre-conflict period is uncertain (Wright 2015). In addition to the scarceness of literature on healthcare quality in Yemen, available evidence indicates that curative care services were of poor quality in general, particularly concerning patient perceptions of care (Anbori et al., 2010; Webair et al., 2015). Furthermore, evidence was not readily available or accessible across the country, particularly data from rural areas (Bawazir et al. 2013; MoPHP-DHS 2013). Consequently, tracking the impact of health system activity on health outcomes in pre-conflict Yemen is complex due to limitations in available health information.

## **NATIONAL DIALOGUE DRAFT DOCUMENT (NEW YEMEN CONSTITUTION)**

After the outbreak of the February 2011 youth revolution, political, social, and military elites agreed on a negotiation process. On November 23, 2011, the elites signed the Gulf Cooperation Council (GCC) Initiative and its executive mechanism, which included initiating a national dialogue between March 18, 2013, and January 26, 2014. The comprehensive National Dialogue Conference came out with a document prepared by all Yemeni political forces, components, and social groups. There was also an agreement on issues that meet the aspirations of most Yemeni citizens. They included promoting good governance principles, including transparency and accountability; empowering the role of the private sector in development; promoting social justice and equality between citizens; equal opportunities; improving the provision of educational, health, and social welfare services; achieving food security for citizens; improving their living standards; and respecting and protecting their fundamental rights and freedoms.

Concerning the right to health, several decisions and recommendations related to rights, freedoms, and development (comprehensive, integrated, and sustainable) were adopted. The decisions recommendations included health in general (prevention, treatment, and rehabilitation) and other related sectors: social protection, environmental protection, safe drinking water, food security, housing, education, regulating laws, trade unions, monitoring, governance, and community participation. These decisions and recommendations ensured the health of all citizens, specifically women, children, youth, the elderly, and special groups (those with special needs, orphans, the marginalized, the displaced, victims of conflict/war, residents of rural and remote areas, detainees/prisoners, immigrants, refugees, and minorities) (National Dialogue Draft 2014).

Unfortunately, these outputs have not yet seen the light. The draft outputs of the national dialogue remained a document agreed upon nationally, supported by the Gulf, and internationally recognized. The text of the new Yemeni constitution resulting from the National Dialogue draft included many articles that target health directly, through relevant sectors, or through the concepts of social protection, development affairs, and special rights. Among them:

### **Section One (General Principles): Chapter Three (Cultural and Social Foundations):**

- **Article 43:** The state guarantees high-quality healthcare for all citizens without discrimination by establishing the basic infrastructure, qualifying and caring for the medical staff, allocating a specific percentage of the general budget to the health sector, encouraging the contribution of the private sector and civil society organizations in this field, and establishing a comprehensive health insurance system. (National Dialogue Draft 2014).
- And other articles, for example, **Article No. (102-107, 121, 122)** Part Two (Rights and Freedoms) Economic and social rights.

## **RELEVANT TREATIES RATIFIED BY YEMEN**

Yemen has ratified several international treaties/agreements related to health, especially for vulnerable groups or in exceptional circumstances, including:

- International Convention on the Elimination of All Forms of Racial Discrimination (October 18, 1972).

- Convention Relating to the Status of Refugees and Protocol Relating to the Convention Relating to the Status of Refugees (January 18, 1980).
- Convention on the Elimination of All Forms of Discrimination against Women (May 30, 1984) (Articles 10, 11, 12, and 14).
- Universal Declaration of Human Rights (1986).
- International Covenant on Economic, Social and Cultural Rights (February 9, 1987).
- Protocol I Additional to the Geneva Conventions, Relating to the Protection of Victims of Armed Conflicts (April 17, 1990).
- Convention on the Rights of the Child (May 1, 1991).
- Convention on the Rights of Persons with Disabilities (March 26, 2009) (Articles 25 and 28).
- The Arab Charter for Human Rights (November 12, 2011), especially Article (39) (OHCHR 2014; 2014 المركز الوطني للمعلومات)

These obligations might seem like noble aspirations especially among poor Yemeni citizens since their most basic needs and rights are not being met or achieved. However, these rights are a moral and legal commitment on the part of Yemen as a state, an entity with the foundations of power, and must be a goal for the state to improve conditions and rights in the country. Unfortunately, these commitments are not accompanied by any planning, directives, or budget provision as a result of the extension of Yemen's inability to provide material and financial needs for plans and strategies in general, the effects of which are particularly felt in critical sectors such as health, education, and social affairs.

Furthermore, Yemen has not adhered to all the agreements it has ratified. The current statutory laws resulted from several changes and amendments that combined what was in the legal systems of the two parts of Yemen before the union. For example, the Personal Status Law issued in 1992 set the age of marriage at 15 years for both males and females. However, Article 15 was amended in 1998, removing the age limit. In addition, the amended Article 15 stipulated that "the [marriage] contract by a young girl's guardian is valid, and the one who is contracted cannot have intercourse with her except after she is fit for intercourse, even if she is over 15 years old. Furthermore, the contract is not valid for the minor except for interest." This text is considered a reversal of what was decided before the amendment. Although CEDAW's ratification entails

specifying a minimum age for marriage in laws and legislations, the matter was neglected in Yemen's laws.

As a result, almost 4 million children in Yemen were subject to early marriage. Around 1.4 million were married before they turned 15. The 2013 Yemen Demographic Health Survey data indicate that one-third (32%) of women (20-24 years) got married before turning 18, and 9% before turning 15. UNICEF's analysis based on the 2013 Demographic and Health Survey (DHS) health behaviors among the different groups of society. The respondents expressed the situation above as follows:

“ The war contributed to the collapse of the health system, which was fragile since before 2015. We noticed that most health facilities were closed in areas that suffered from armed conflict, and these facilities faced a shortage of medical and non-medical supplies. Health workers would have stopped working had it not been for incentives. Most health facilities would have stopped working had it not been for international support (Participant 2: Public Health Expert - and Academic, 2022). ”

“ The war has impeded people's movement and access to health services, regardless of their poor quality, in addition to the economic cost. After the war, the cost of health services increased, and access became more difficult. Since 2012, that is, for nearly ten years, the health sector has not been supplied with new personnel, despite the migration of doctors in search of a dignified living and the injuries and fatalities among health sector cadres. Moreover, monitoring and evaluation of health facilities remain absent, and health workers are choosing the private sector instead of the public sector (Participant 3: Public Health Expert - MoPHP, 2022). ”

“ Today, priority is for living and food, not treatment. However, as it is known, if any service conflicts with a person's right to preserve their life, preserving life takes precedence over any other service. So now, we buy all the health, water, sanitation, or transportation services (Participant 4: Public Health Expert and Academic, 2022). ”



Without a doubt, the war has multiplied the incidence of poverty and low education levels. The war caused displacement, and the displaced cannot enjoy their right to education or access to health services. The war has also contributed to the spread of drug abuse among young people, a severe social disease that caused an increase in unemployment and a deterioration in the psychological state of citizens due to the tense political situation (Participant 2: Public Health Expert and Academic, 2022).



# HEALTH INDICATORS, DATA GAPS, AND TRENDS

Analyzing trends in pre-conflict health indicators in Yemen points to a fragile health system. The last DHS was conducted in 2013. Thus, indicators related to life expectancy, fertility, maternal mortality, and infant mortality are based on estimates according to trends in pre-conflict indicators. Current data points to the low coverage of basic health services and the absence of social protection that guarantees Yemeni citizens a dignified life (الجهاز المركزي للإحصاء, صندوق الأمم المتحدة للسكان 2016-2018).

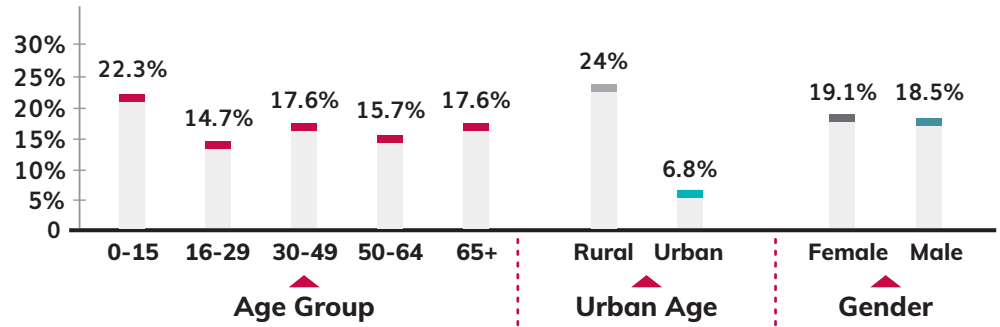
This report presents the data for several indicators related to the first three SDGs: no poverty, zero hunger, and good health and well-being.

## GOAL 1: NO POVERTY

The financial situation of Yemeni citizens has always been poor despite a slight improvement in the early 1990s. Per capita income is currently facing a clear setback, as one-third of Yemenis live below the poverty line. The weakness is due to several reasons, including the conflict, consequent displacement, loss of livelihood, currency inflation, and the cessation of salaries to public sector employees who live in areas governed by the de facto Houthi authority. The situation was exacerbated as exports stopped, which could have increased the state's income, strengthened the budget, and secured the central bank and the local currency.

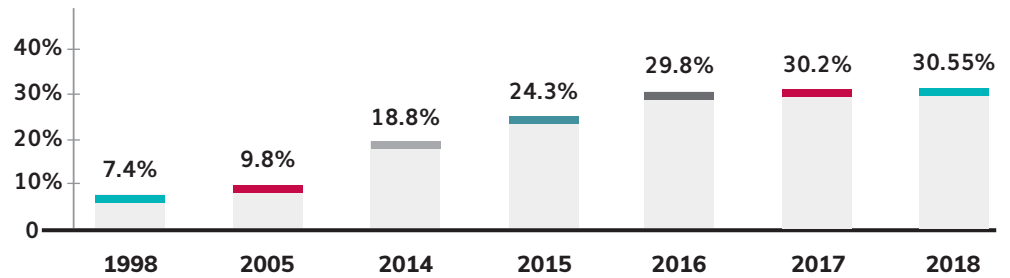
**Figure 2** indicates the percentage of the population living below the international poverty line by gender, age, and urban status in 2014. In 2018, 30.55% of the population lived below the global poverty line (1.9 USD) (See **Figure 3**). The proportion of the poor was expected to rise at an accelerated rate due to the conflict (2016-2018 الجهاز المركزي للإحصاء؛ صندوق الأمم المتحدة للسكان لجنة الإنقاذ). Currently, 53% of Yemenis live in extreme poverty (الدولية 2020).

**Figure 2. Percentage of Yemen's population living below the international poverty line by gender, age, and urban status (2014)**



| Source: Household Budget Survey 2014 - Central Statistical Organization

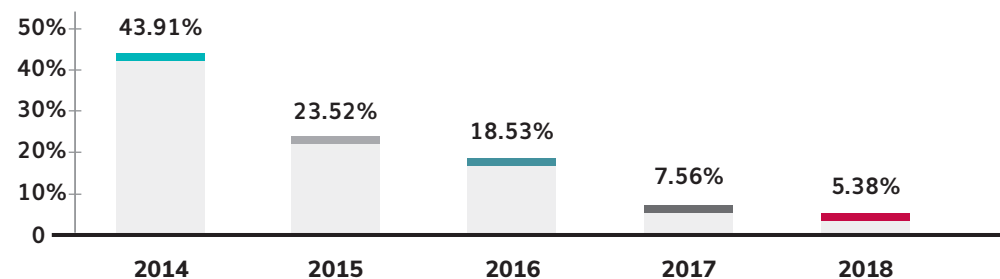
**Figure 3. Percentage of Yemen's population living below the international poverty line (1.9 USD)**



| Source: Household Budget Survey 2014 - Central Statistical Organization

**Figure 4** demonstrates the deterioration of government spending on education, health, and social protection between 2014-2018. The share of government spending on basic services decreased from 43.91% in 2014 to 5.38% in 2018.

**Figure 4. Share of government spending on basic services (education, health, social protection) in Yemen out of total government expenditures between 2014 and 2018**



| Source: Central Statistical Organization, Statistical Yearbook, 2017

With regard to spending on health, the respondents expressed the following:

“ We are still working based on the 2014 budget, where the health sector is allocated between 3% and 4%. Some say the percentage is much lower, and I think it does not exceed 1%. The budget was around 4.5% in 2010. But this contradicts the health indicators that we have now, which indicate that the health sector budget is much lower. Currently, Yemen is divided into North and South, so it is difficult to calculate per capita GDP (Participant 2: Public Health Expert and Academic, 2022). ”

“ We cannot say that government spending on health is 4.5% or 4.3%. Some reports indicated that it was 3.7%, and others reports mentioned that it is around 2.8% of the Gross Domestic Product (GDP). In fact, we do not have a real number for the state budget. These figures were provided by the World Bank in 2012, 2014, and 2015, when the state budget still existed (Participant 4: Public Health Expert and Academic, 2022). ”

## GOAL 2: ZERO HUNGER

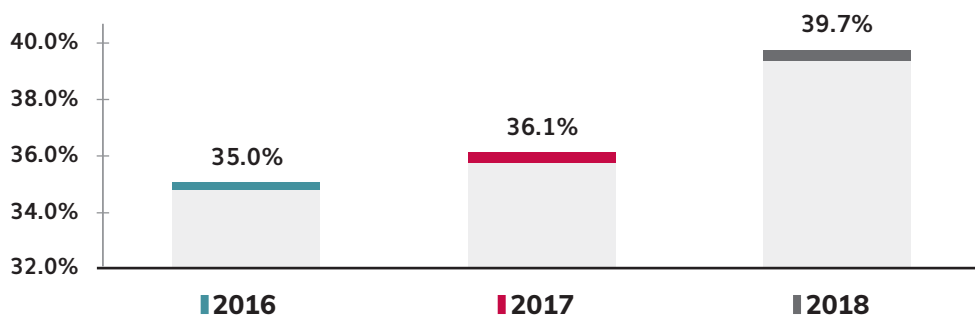
Although the rate of stunting as an indicator of chronic malnutrition in children is stable, it remains high at 46.5%. On the other hand, acute malnutrition continues to accelerate among children under five and pregnant and lactating women, adding to acute food insecurity. Surveys and reports have shown that preventive and curative interventions, programs, and food aid are insufficient to cover needs and have deteriorated due to the disruption of health services during the COVID-19 pandemic. Food insecurity worsened with the outbreak of the war in Ukraine, as food aid reached less than half of those in need. There was a sharp decline in providing preventive and therapeutic nutritional items for children under five and pregnant and lactating women. Nearly 2.2 million children between 6 and 59 months were expected to suffer from acute malnutrition throughout 2022, with an additional 1.3 million cases of pregnant and lactating women.

As a result, 91% of districts in Yemen could be in Phase III of acute malnutrition (severe) and above. The situation in the Abs and Hiran regions is expected to reach very critical levels.



Economic decline, reduced humanitarian food assistance, reduced access to essential services, and morbidity are considered the most significant drivers of this situation (IPC 2022; UN OCHA-HNO 2022). Other factors include the impact of the conflict on agriculture, the closure of ports, import and export restrictions, and the scarcity of fuel, including highly-priced domestic gas (FAO et al. 2016-2018). **Figure 5** shows the food shortage rates in Yemen between 2016 and 2018, showing an estimated increase of 4.7% between the two years.

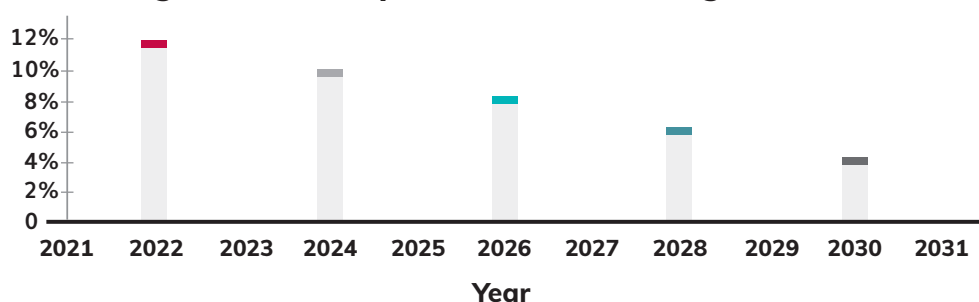
**Figure 5. Food shortage (hunger) rates in Yemen (2016-2018)**



| Source: FAO-WFP-UNICEF-IFAD-WHO, 2016-2018

**Figure 6** estimates the required yearly decrease in rate of acute malnutrition in order to achieve the SDG2 target of 3%.

**Figure 6. Required decrease in acute malnutrition to achieve SDG2 target - National prevalence of wasting**

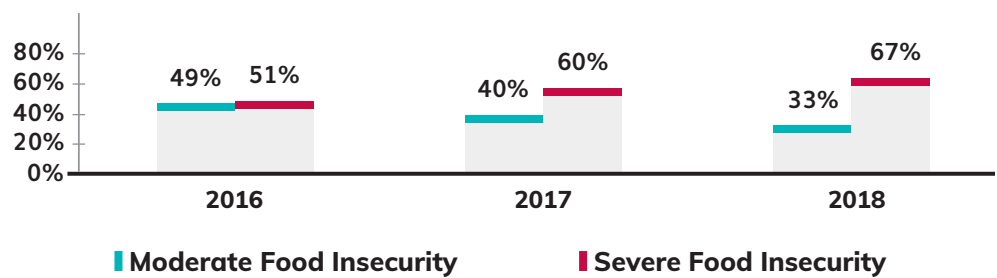


| Source: UNICEF, 2021

Reports indicate the presence of significant disparities in food insecurity between urban areas (26% of the population) and rural areas (48% of the population) (World Food Program 2014). About half of the population faces high levels of acute food insecurity (Phase III rating or higher), which amounts to 17.3 million people (54% of the total population). The number

is expected to rise to 19 million (60% of the total population) in 2022. Food insecurity is very acute and intensifies in active combat areas, particularly affecting displaced and marginalized groups, and despite continued humanitarian assistance. Five districts have proportions of the population in the dangerous phase, which points to the possibility of famine, specifically in Abs in Hajjah governorate (UN OCHA-HNO 2023). Conflict is the primary driver of food insecurity in Yemen, in addition to economic shocks and the reduction of foreign reserves (IPC 2022). As shown in **Figure 7**, food insecurity rose from 51% of the population in 2016 to 67% in 2018.

**Figure 7. Moderate and severe (acute) food insecurity in Yemen (2016-2018)**



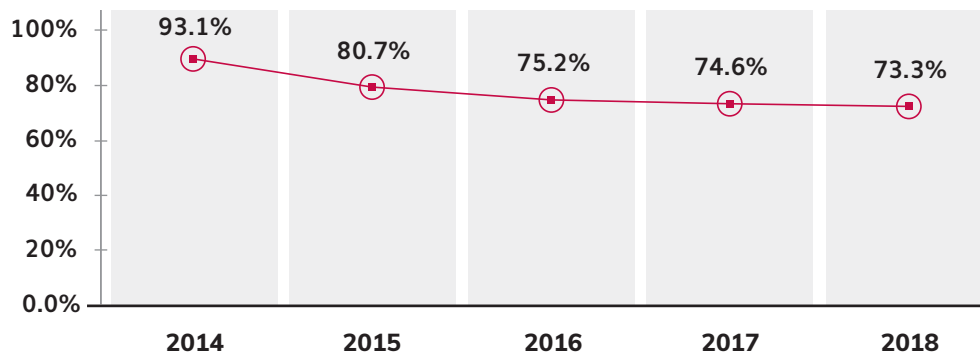
Source: FAO-WFP-UNICEF-IFAD-WHO, 2016-2018

In addition to the impact of food insecurity on health status, lack of adaptation or negative coping mechanisms and the urgent need for food directly affect the priority of spending and health-related decisions and behaviors, which are ignored until home remedies for malnutrition cases fail or become aggravated. Therefore, food security remains a priority for humanitarian interventions that pave the way for a safe life and dignified living, even if it is temporary and immediate (UN OCHA-HNO 2022).

Drought and groundwater depletion are among the reasons for the deterioration of agricultural productivity, as 75% of the population consumes groundwater for agriculture, which is a source of livelihood. Qat<sup>1</sup> cultivation also consumes large quantities of water, and 70% of the area is used for sustainable cultivation (CSO 1999). Moreover, the spread of locusts, especially in dry and coastal areas, compounds the threat to agricultural productivity (UN OCHA-HNO 2022). Finally, the agricultural area allocated to productive agriculture decreased from 93.1% in 2014 to 73.3% in 2018 (See **Figure 8**).

<sup>1</sup> Qat is a mild narcotic leaf popular in Yemen and the Horn of Africa. Excessive qat-chewing has negative impacts on health, education, and productivity.

**Figure 8. Agricultural area of productive and sustainable agriculture in Yemen (2014-2018)**



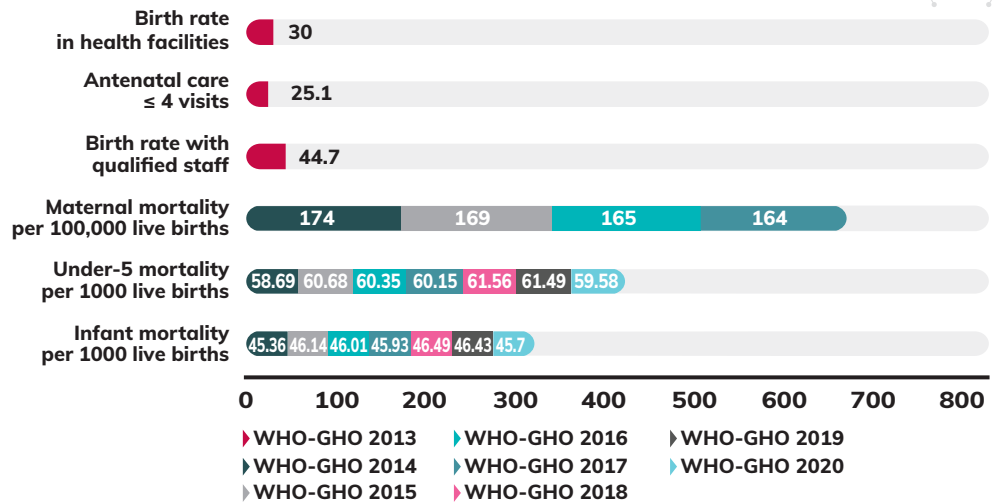
Source: Central Statistical Organization, Yearbooks from several years, data from the Ministry of Agriculture and Irrigation

### GOAL 3: GOOD HEALTH AND WELL-BEING

Countries aspire to reduce the maternal mortality rate to less than 70 deaths per 100,000 live births by 2030. Although the rate in Yemen has gradually decreased from 301/100,000 live births in 2000 to 164/100,000 in 2017, Yemen was included among 15 countries in the high-level alert circle in 2017. The rate was estimated to reach 385/100,000 if the causes remained uncontrolled. Causes include severe bleeding, high blood pressure during pregnancy, obstructed labor, infections, and unsafe abortions. It follows that women should have access to quality healthcare during pregnancy and childbirth under the supervision of qualified health personnel and antenatal healthcare, including family planning (WHO 2019).

The distance to facilities significantly impedes rural women's access to health services (Bawazir et al. 2013; MoPHP-DHS 2013), in addition to the scarcity of equipment and qualified personnel, specifically gynecologists and rural obstetricians (Al Serouri et al. 2012). **Figure 9** shows the indicators related to maternal and child health according to the different sources available between 2013 and 2021.

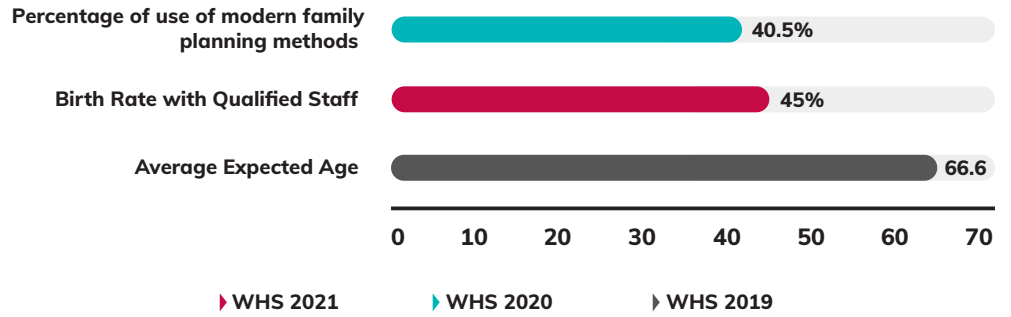
**Figure 9. Mother and child health indicators (2013-2016)**



Source: WHO (GHO), 2022

The last DHS conducted in Yemen in 2013 indicated that the under-five mortality rate was 53/1000 live births and the infant mortality rate was 43/1000 live births (DHS 2015). The mortality rate of children under five and infants is expected to remain high due to the war and economic collapse. **Figure 9** shows that infant and under-five mortality rates have increased since 2014 (WHO 2022). The rate for births attended by skilled health staff was 44.7% in 2013 and did not improve much in 2021 (45%) (see **Figure 10**). The percentage of women who visited health facilities during pregnancy at least four times was 25.1%. In contrast, the birth rate in health facilities was 30%. It is also estimated that the percentage of women who use modern family planning methods did not exceed 40.5%. The average life expectancy was 62.9 in 2004. However, it was less than the average life expectancy of 71 years in the MENA region in the same year (MPIC & CSO 2004). The average age in Yemen was 66.6 in 2019 (**Figure 10**). These weak indicators are attributed to the war and its repercussions on the economy and the infrastructure of health facilities.

Figure 10. Maternal health indicators between 2019-2021



| Source: World Health Statistics, 2022

## THE HEALTH SECTOR DURING COVID-19

The first laboratory-confirmed case of COVID-19 in Yemen was announced on April 10, 2020 (UN OCHA 2020). As of mid-April 2020, there were about 5,300 confirmed cases and more than 1,100 confirmed deaths. However, these official numbers are likely lower than in reality, as testing remained limited. By that time, only 2,000 tests had been conducted, which is less than one test per 1,000 people, much lower than the average in other countries in the region (كوم بيسون وآخرون 2020). The national laboratory system is also rudimentary and relies on a few central laboratories, such as the Central National Laboratory for Public Health in Sana'a and its four branches in the governorates of Aden, Taiz, Hadramout, and al Hudaydah (Dureab et al. 2019).

The fragile situation and scattering of authorities were among the main challenges impeding the implementation of the International Convention on Health Regulations and related legislation and policies during the outbreak. Since the outbreak of COVID-19 in Yemen, the government has been unable to prepare adequate isolation sites at entry points into the country, nor has it been able to meet the standards of the International Health Regulations for responding to the pandemic. Some non-pharmaceutical interventions, such as social distancing rules, lockdowns in cities and regions, mask-wearing, and movement restrictions between governorates were adopted, but adherence was weak. In addition, some health facilities were employed as units to isolate and care for people infected with the virus, which impeded citizens' access to other essential healthcare services (نوشاد والسقاف 2020).

The government established an intersectoral high committee involving relevant ministries to control the outbreak. However, performance was suboptimal, and there was a heavy reliance on personal initiative and humanitarian organizations. In addition, Yemen suffers from structural weaknesses that have developed over a long period of conflict and mismanagement, and its health system has been hardest hit (Dureab et al. 2019). In this context, the respondents reported:



There was great confusion, and the preparations for the pandemic were insufficient. The situation was catastrophic in the first and second waves,

resulting in many deaths. Psychological impact on the citizen caused by social media and unofficial media outlets led some people to die at home rather than go to isolation centers for fear of stigma. Health workers gained good experience in how to deal with the epidemic. We now have isolation centers ready for any other epidemic, and rapid response teams are ready. This is a good opportunity. Nevertheless, those in the first lines to confront the epidemic did not receive any financial or moral remuneration (Participant2: Public Health Expert and Academic, 2022)



“ The COVID-19 pandemic was given an extraordinary impetus and huge sums of money. The MoPHP manages more than 13 types of vaccines with a cold chain<sup>2</sup> that extends from central warehouses to the farthest health unit in the farthest region. They cover the needs of mothers and children within 24 hours for a full year. They are also regularly documented. However, international organizations and the WHO wanted to find a completely independent structure for the COVID-19 vaccine, which was a waste of resources... So why is the COVID-19 vaccine not included in the national immunization program? (Participant 3: Public Health Expert - MoPHP, 2022).



“ Institutions, committees, and bodies are preparing for emergencies, but learning from experience is very slow. Yemen does not have a system for responding to emergencies in a real and effective manner. We respond and deal with natural and human-made emergencies only as a health system or as other systems supporting the health system. However, it is always according to our capacity (Participant 4: Public Health Expert and Academic, 2022).



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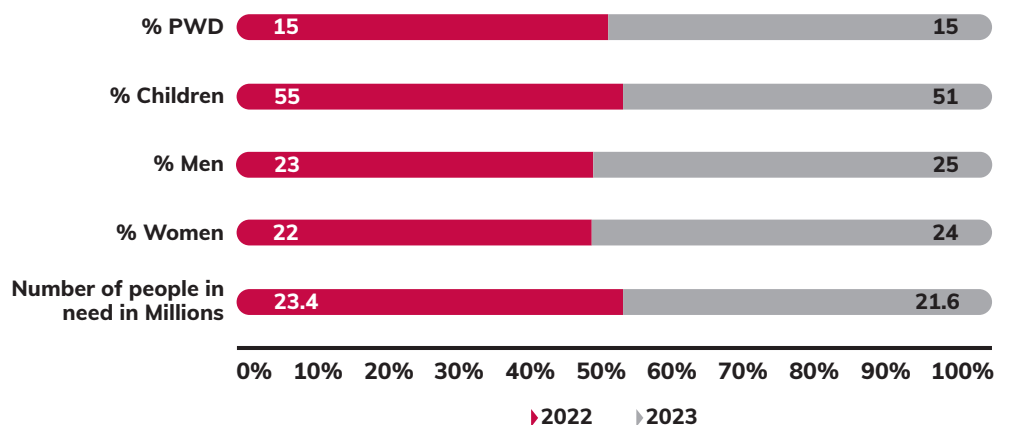
<sup>2</sup>The cold chain is a process that keeps vaccines within the required temperature range at all times of storage and transport.

# RIGHT TO HEALTH FROM A SOCIAL PROTECTION PERSPECTIVE



As mentioned, the right to health and healthcare loses priority in humanitarian situations as do urgent needs such as shelter, security, food, and water. According to UN OCHA’s Humanitarian Needs Overview (HNO) in Yemen in 2022 and 2023, food insecurity, malnutrition, health issues, water and sanitation, and protection were the main factors explaining the increase in the number of people in need of some form of humanitarian assistance. The 2022 report stated that out of the total population of 31.9 million, the number of people needing some form of humanitarian assistance and protection reached 23.4 million (22% women, 23% men, 55% children, and 15% people with disabilities). Of those, 12.9 million were in dire need, and about 3.3 million were displaced. On the other hand, the 2023 report indicated that out of a total population of 32.6 million, the number of people who might need humanitarian assistance is 21.6 million (24% women, 25% men, 51% children, 15% people with disabilities). Of those, 13.4 million were in dire need, and 3.1 million were displaced. The decrease in the estimate of the number of people in need of assistance between 2022 and 2023 by about 1.8 million was recorded only in the category of children. Nevertheless, the percentage of need increased for women and men by 2%. The percentage of needs of people with disabilities remained the same at 15% (UN OCHA-HNO 2022; UN OCHA-HNO 2023). **Figure 11** presents a comparison between the number of people in need in 2022 and 2023.

**Figure 11. Comparison between the number of people in need in 2022 and 2023**



| Source: UN OCHA-HNO, 2022; UN OCHA-HNO, 2023



On the other hand, **Table 1** points to the number of people in need of humanitarian assistance by sectoral group, gender, and age. The number of people needing assistance in the health sector was as high as 20.3 million, 17.7 million in the protection sector, 17.3 million in food security and agriculture, and 15.3 million in the water and sanitation sector (UN OCHA-HNO 2023).

**Table 1. People in need of humanitarian assistance and protection, by sectoral group, for the year 2023**

Subcategories				People in Need (Millions)	Sectoral Group
Girls	Boys	Women	Men		
0.5	0.5	0.4	0.4	1.9	Camps Coordination Department
4.0	4.6	-	-	8.6	Education
4.4	4.6	4.2	4.3	17.3	Food Security and Agriculture
5.1	5.3	4.9	5.0	20.3	Health
6.7	2.7	2.6	-	11.9	Nutrition
4.4	4.6	4.3	4.4	17.7	Protection
0.03	0.04	0.08	0.16	0.3	Multi-sectoral group for refugees and migrants
1.9	1.9	1.8	1.9	7.5	Shelter/NFI
3.9	4.0	3.7	3.7	15.3	Water, sanitation and hygiene

The high displacement rate, economic decline, acute food insecurity, and the collapse of public services and institutions due to weak rule of law and ineffective health strategies, war, and the COVID-19 pandemic have created a serious humanitarian crisis in Yemen. The crisis is exacerbated by natural disasters, such as the severe torrential rains that swept the southern regions in early 2020, destroying the infrastructure of several health facilities, drinking water networks and wells, and roads and causing material losses in housing and sources of livelihood. As a direct result of these torrential rains, health services were interrupted or faltered in the affected areas, and epidemics such as cholera and other infectious diseases broke out. A possible environmental and humanitarian catastrophe is also looming large on the Yemeni Red Sea coast, which is

the Safer oil reservoir that threatens the livelihood (fishing) of mainly the inhabitants of the western coast, whose fishing output feeds more than half of the population (UN OCHA-HNO 2022).

The epidemics that have spread in Yemen in the past ten years are a direct reflection of the low coverage of preventive health services and the weakness of the health system and related sectors. A public health expert noted:

“ Despite the success achieved by the malaria control program before the conflict, when Hadramout was almost devoid of the disease, its cases returned to rise and spread. It also happened with programs to control other diseases such as dengue, schistosomiasis, rabies, diarrhea (especially cholera), measles, and diphtheria. It increased the budget needed by the health system to confront these epidemics and saw an increase in the number of morbidity and deaths that could have been avoided. It should be noted that the worst scenario for an outbreak of such epidemics is what Yemen has been suffering since 2019 from the high number of cases of vaccine-derived polio, despite Yemen being completely free of polio since 2006 (Participant 2: Public Health Expert and Academic, 2022). ”

The outbreak of new polio cases in Yemen is attributed to the low vaccination coverage against polio and the weak immunity of infected people. However, funds are being spent on awareness and national vaccination campaigns, which could be in vain due to poor management. Disabilities and deaths continue, and unmanageable virus outbreaks may occur that will take years and millions of dollars to overcome.

Women - especially those who head families - and girls are highly affected by the deterioration of the social and economic situation, extreme poverty, living conditions, and the associated repercussions of various forms of violence and harmful coping mechanisms such as child marriage and other cases of exploitation. Women are also forced to deal with the impact of reduced access to food through unsustainable coping strategies such as reducing their food intake to feed family members, selling assets, or taking up life-threatening jobs. In addition, child protection risks remain high, either due to the direct impact of the conflict or their families' weak resilience, making children more vulnerable to exploitation, violence, and

human rights violations (UN OCHA-HNO 2022).

**Table 2** refers to gender-related indicators in 2021. Yemen ranked 155 out of 156 countries in the global gender gap index and 154 out of 156 in the gender economic empowerment index. In addition, the percentage of Yemeni women who suffer from poverty is 72% in rural areas and 20.1% in urban areas, and the percentage of displaced women and children is 73%.

**Table 2. Gender-related indicators (2021)**

#	Indicator	Rank (%)
1	Global Gender Gap Index	155/156
2	World Development Index	179/189
3	Gender economic empowerment gap index	154/156
4	Educational attainment gap between the sexes	152/156
5	Gender political empowerment gap index	154/155
6	Feminization of poverty	72% rural - 20.1% urban
7	—	73%

| Source: World Economic Forum, 2021

About 20% of internally displaced persons (IDPs) living in the 2,358 displacement sites are estimated to be at risk of conflict. In addition, 30% of them lack sanitation facilities. The percentage of those who lack fire safety measures was 90% (إدارة تنسيق المخيمات 2021).

Yemeni law guarantees the rights of people with disabilities, such as free physical rehabilitation and monthly social assistance. However, due to the ongoing conflict, these entitlements are rarely used due to lack of awareness, burden of movement, and damage to health facilities and public services (UN OCHA-HNO 2022).

There are many advocacy movements for issues related to

women's rights and vulnerable groups, in addition to the CEDAW agreement that South Yemen ratified in 1984, and to which North Yemen automatically joined after unity, with reservations to Article 29. However, these reservations prevent other countries from intervening in any violations against Yemenis' rights and freedoms. There are significant efforts in reality, but the disappointment for essential and emergency interventions. Therefore, no sustainable development programs are included when planning and identifying needs. A public health expert noted:

“ There was no legalization and legislation for using the huge funds provided by donors from the beginning of the war until 2021, estimated at 21 USD billion; the share for healthcare was about 8 USD billion. Unfortunately, 80% of these funds go to operating expenses, salaries, and wages for experts, and 20% goes to citizens. Even this percentage does not reach citizens completely (Participant 3: Public Health Expert - MoPHP, 2022). ”

The work of clusters, such as the Health Cluster, Nutrition Cluster, and Water and Sanitation Cluster, is based on meeting urgent and emergency humanitarian needs in countries suffering from conflict. The respondents pointed out the pros and cons of this mechanism as follows:

“ The positive side of clusters is that they are not centralized. They facilitate finding a common base between people and reality. Decentralization must be organized. In fact, the experience of clusters has not been evaluated, but I think it is better than being centralized. The work of clusters extends from the base to the top. [The work] is closer to society and more knowledgeable about its problems. Cluster response helps to build a multi-sectoral system to some extent. The disadvantages of clusters are that they are unclear; sometimes we need to clarify plans and coordination (Participant 1: Reproductive Health Expert - NGO, 2022). ”

“ Clusters are fads made up by UN organizations. It is not logical that the person who finances the service is the one who reviews its results without approval from the beneficiary of the service. What guarantees that results presented in the routine meetings are correct, real, and realistic? The MoPHP's role is always ignored (Participant 3: Public Health Expert - MoPHP, 2022). ”

## CONCLUSIONS AND RECOMMENDATIONS

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The world trends for the last decade of 2030 pay more attention to the effective implementation of quality management that enhances a sustainable profit in place of passive coping strategies in developing and conflict-affected countries, such as Yemen. Strengthening the health system through improving the quality of health programs and interventions is required to achieve the Sustainable Development Goals. Therefore, calling on all conflicting parties in Yemen to stop the war and strengthening state building are an urgent necessity for realizing the right to health. Furthermore, it is of utmost importance to:

- Study the population's health needs by region and develop a clear vision to work on health priorities by decision-makers in the MoPHP, the Ministry of Higher Education, research centers, authorities in the governorates and local councils, partners, and donors.
- Strengthen the role of the statistical system in monitoring health indicators through the commitment of all parties, whether leaders at the country level, partners, or donors, to use a unified methodology and mechanism for collecting data and monitoring indicators and numbers.
- Form advisory committees with expertise in multiple sectors (Ministry of Public Health and Population, Ministry of Finance, Ministry of Planning and International Cooperation) to develop a clear strategic vision for the next governance transitional stage. Set actionable goals by decision-makers in the short and long term.
- Strengthen the role of oversight, supervision, evaluation, follow-up, and impact measurement by the MoPHP.
- Strengthen monitoring, evaluation, and accountability by the House of Representatives, the MoPHP, Central Organization for Control and Accounting, and local councils.
- Strengthen and develop the Research Department at the MoPHP to study the health situation through reliable data. The research department should analyze the data and indicators and define interventions based on those indicators.

- Intensify efforts by the MoPHP to support training programs for health personnel in health facilities and outreach (midwives) on a permanent and continuous basis, in addition to supporting the health education program and the health rights of citizens.
- Amend laws and regulations to reduce conflict with state activities.
- Implement legal regulations and controls for hospitals in the governmental and private sectors, and limit trading in medical work.
- Reconsider legislation and laws related to the right to health, for example, Article 15 of the Personal Status Law, related to determining the age of marriage.
- Integrate all activities related to the COVID-19 vaccine campaign or any possible pandemic immunization campaigns within the national immunization program.
- Activate national plans related to mental health and psychosocial support services.
- Find a transparent, controlled, and precise mechanism for the management process and the optimal use of aid, grants, and loans granted for health, in addition to encouraging the gradual introduction of the national health insurance system and establishing an independent health support fund.

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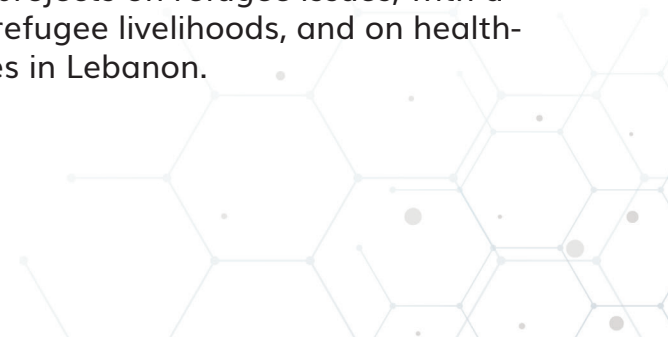
# RIGHT TO HEALTH IN TIMES OF CRISIS

A review of barriers  
and challenges to  
achieving the right to  
health in Lebanon

## Maysa Baroud

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Maysa Baroud is a Senior Program and Research Officer at the Arab NGO Network for Development, where she coordinates the Arab Watch Report on Economic and Social Rights. She has contributed to several research projects on refugee issues, with a focus on refugee livelihoods, and on health-care issues in Lebanon.



## INTRODUCTION

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Lebanon's current economic crisis, compounded by the COVID-19 pandemic and the August 4 Beirut Blast, has had a profound impact on all aspects of life and, in turn, on the living conditions for many. The currency has lost over [90%](#) of its value, with consequences on the purchasing power of most of the population. Inflation is soaring—the overall consumer price index increased by 253.55% from June 2022 to June 2023, and food and non-alcoholic beverage prices increased by 279.54%, while the health prices (including services, medicines, and medical equipment) increased by 284.27% (Central Administration of Statistics [CAS] 2023). In addition, the government has lifted subsidies on basic commodities, including certain [medicines](#), [fuel](#), and [infant formula](#). Import tariffs have also been [raised](#), impacting the price of commodities and their affordability, noting that Lebanon relies heavily on imports for most goods, including food and medicine.

The crisis was years in the making and exposed a weak political and economic system upheld by a corrupt political class. Lebanon's liberal economic approach, adopted after the country's independence, has enriched a small proportion of the population while perpetuating inequities. Available welfare and social protection programs are fragmented, complex or non-functional and continue to promote reliance on the political class (Proudfoot 2021a, 2021b). Furthermore, what should be public services have often been provided by the private sector. Even before the crisis, the quality of public services in Lebanon was poor—with regard to health, the crisis exposed already existing structural problems in Lebanon's healthcare system. The quality of public services has continued to deteriorate since the onset of the compounded crisis at the end of 2019, while governorates other than the capital Beirut, and part of Mount Lebanon remain underdeveloped. Indeed, the greatest consequences of Lebanon's crisis have been especially felt by those most vulnerable (Bourhrous 2021).

Against this backdrop, this report seeks to shed light on the impact of Lebanon's ongoing economic crisis and weak public services on the health of individuals and the right to health for all in the country. The report provides a review of (select) cross-cutting issues that impact the attainment of the right to health, focusing on issues related to healthcare access

and management. The report also provides a brief overview of the development of Lebanon's health system. Based on the findings, it concludes with recommendations to facilitate the attainment of the right to health for all in Lebanon. The report relies primarily on a review of available literature and secondary data (the limitations of which are discussed in a later section of this report).

# A BRIEF HISTORY OF LEBANON'S HEALTHCARE SYSTEM AND ITS DEVELOPMENT

The development of Lebanon's healthcare system, spanning from its pre-independence in 1943 to the onset of the civil war in 1975, highlights significant regional disparities in access to healthcare and medical education, growth of the private sector, and a focus on infectious diseases and related factors, in line with medical advancements of the time. Public-health related reforms and legislation introduced during this period resulted in a highly bureaucratic, centralized system characterized by duplication and inefficiency. The reforms also promoted increased dependence on the private sector for healthcare services, deepening disparities in the system and inequalities across communities, with repercussions on the right to health in Lebanon felt to this day. Given the limited availability of writings on the history of public health in Lebanon, this section relies heavily on a few key works (see Kronfol & Bashshur 1989; Kronfol 2006; Ammar 2003; Ammar 2009).

## HEALTHCARE PRE-CIVIL WAR

The period from the French mandate to independence in 1943 set the foundations for the healthcare sector's privatization, thus contributing to inequitable access to healthcare services among the population. In 1918, Lebanon's first Department of Health was established as an entity within the Ministry of Interior (Kronfol & Bashshur 1989). The French invested very little in health during their mandate, instead promoting the provision of health through missionaries and the private sector (Abi-Rached & Diwan 2022). In line with the French state administration, Lebanon's healthcare system became highly bureaucratic and centralized. Two elite medical education institutions run by Western missionaries were established during this time, serving as "private voluntary organizations." The Syrian Protestant College (today, the American University of Beirut) and the Jesuit (St. Joseph) University, located in the capital Beirut, charged those who could pay and provided free care to the poor. In addition, several small for-profit private hospitals were established during this period, which catered to private patients from the middle and upper classes (Kronfol & Bashshur 1989).

In 1932, a health law was passed mandating that the Municipality of Beirut would be the only provider of public services within its jurisdiction, including health, greatly diminishing the role of the national ministry. The law focused on “protection of the public’s health” and focused primarily on “environmental sanitation, quarantine and control of infectious diseases.” Its introduction hindered national-level healthcare reform (Kronfol & Bashshur 1989, p. 379), facilitating development in some areas (such as the capital) over others. It was not until 1943, upon independence from France, that Lebanon’s Ministry of Health and Public Relief was established, responsible for “the supervision, coordination, legislation and fostering of environmental sanitation and the control of communicable disease” (Kronfol & Bashshur 1989, p. 380).

Starting in the 1950s, and as a result of Lebanon’s recession, the ministry started to provide public assistance and established a network of public hospitals exclusively for the poor, which by 1971 had reached 21 hospitals. Nevertheless, several regions in the country remained without a public hospital (Kronfol & Bashshur 1989). Besides generating regional disparities and furthering fragmentation, the creation of hospitals “exclusively for the poor” likely propagated class differences. Legislation pertaining to human resources for health and public health, including legislation related to licensing health workers’ degrees, aiming to strengthen the public health sector, was also introduced in the 1950s (Kronfol & Bashshur 1989).

Instigated by nationwide protests in 1958, several health-related reforms were introduced up until the mid-1960s through a plan developed by the “Institut International de Recherche et de Formation en vue du développement intégral et harmonisé”<sup>1</sup> (IRFED). The reforms targeted health, among other sectors, to ensure the development of the “human potential” for all across the country, especially for those less economically privileged (Kronfol & Bashshur 1989, p. 382). Reforms were based on the findings of a socioeconomic study conducted by IRFED, which highlighted significant regional disparities in health standards, sanitation infrastructure, schooling conditions, and housing conditions across the country, and poor living conditions for a large proportion of the population, including in certain pockets within Beirut, with direct repercussions on public health (Merhej 2021), and on the attainment of the right to health, especially for poorer communities and those living outside the capital Beirut and some areas of Mount Lebanon. In 1959, the government

<sup>1</sup> International Center for Training and Harmonized Development

established the Office of Social Development, tasked with enhancing “health, education, social welfare and community development” toward social recovery and ensuring community participation, and acknowledging the “role of women in health and welfare” (p. 382); efforts were also made to build partnerships with the private sector (Kronfol & Bashshur 1989).

Other health-related reforms introduced during this period included the establishment of the National Social Security Fund (NSSF) in 1963 under the tutelage of the MoL. The NSSF is a contributory form of social insurance that provides end-of-service indemnity for Lebanese citizens who are formally employed in the private sector and also covers sickness (effective from 1971) and maternity and family compensation. The scheme was supposed to cover workplace accidents and occupational hazards, but the branch was never activated (Centre for Social Sciences Research & Action [CeSSRA] 2022; Osmat 2023). It was also in 1963 that social security coverage, including healthcare coverage, was introduced for public sector employees through the establishment of cooperatives for civil servants, security forces, and military personnel (CeSSRA 2022). In total, there are six publicly managed employment-based social insurance funds in Lebanon contributing to fragmentation in the system: the NSSF, the Cooperative for Civil Servants covering public sector employees, and four cooperatives covering the military, Internal Security Forces, Special Security Force and General Security Force (Ammar 2003; El-Jardali et al. 2023a).

This period also saw the promotion of primary healthcare through the establishment of a regional referral network facilitating access to primary, secondary, and tertiary care through both the public and private sectors (Kronfol & Bashshur 1989). The introduction of a fee-for-service reimbursement scheme by government entities (such as the NSSF and civil servant cooperatives) coupled with poor regulatory mechanisms resulted in the proliferation of privately owned hospitals and over-utilization of services. In parallel, the role of the Ministry of Health was to provide supervision, legislation, quality control, health planning, and care for the poor, as set forth by the 1961 Decree regarding the Organization of the Ministry of Public Health (MoPH). Still, the ministry continued to provide care through its facilities while simultaneously financing care for patients in private facilities (Kronfol & Bashshur 1989).

Attempts to regulate Lebanon’s pharmaceutical sector toward the end of the 1960s (at the time, monopolized by four companies) were thwarted by pharmaceutical importers, who



halted the adoption of Resolution 361/1971 and Circular 411, proposed by the Minister of Health at the time, Emile Bitar. The resolution and circular aimed to control the prices of imported medicines by placing a cap on profit margins, diversify the medicines imported, ensure their quality, and support the growth of the local industry. At the time, pharmaceutical importers had inflated their prices and contributed to the introduction of high customs duties on the materials and equipment necessary for local pharmaceutical production, thus hindering the local industry (Merhej 2021; بطرس/Boutros 2021). The loss of this “battle” likely enabled today’s pharmaceutical crisis by bolstering the industry’s oligopoly and leading to uncontrolled medication prices, described further below. It also resulted in Emile Bitar’s resignation (بطرس/Boutros 2021).

## LEBANON’S CIVIL WAR AND POST-WAR RECONSTRUCTION

The attempts to improve Lebanon’s public healthcare sector during the 1960s were lost during its civil war (1975-1990). The war resulted in significant destruction of infrastructure and public health facilities and impacted both the private and public sectors. Many healthcare providers left the country seeking better opportunities and safety abroad (Kronfol & Bashshur 1989’0. Due to the severe destruction of health facilities in the public sector, the MoPH and other government entities, such as the NSSF, increasingly depended on the private sector to provide care to the population, resulting in a depletion of reserves and savings (Ammar 2003; Kronfol 2006; Kronfol & Bashshur 1989). At the same time, the lack of regulation in the sector resulted in “price inflation for all types of health services” (Kronfol & Bashshur 1989, p. 386).

The private sector boomed during the war, with over 50 new private hospitals developed during the first few years since its onset, aiming to capture public funds (Kronfol & Bashshur 1989). Public spending on private healthcare for patients increased from 10% of the ministry’s budget in 1970 to over 80% in the 1990s (Ammar 2003; Kronfol 2006). Outside of the capital Beirut, especially in poorer regions, healthcare deteriorated significantly, as the highly bureaucratic and centralized nature of the system (through the MoPH) halted the functioning of public institutions. Furthermore, the lack of healthcare providers created a space for political parties and armed militias to gain constituents by providing them with pharmaceuticals and minor or emergency healthcare (Kronfol & Bashshur 1989).

The war also destroyed other types of public infrastructure, including of telecommunications, energy, transportation, water, and education infrastructure (World Bank 1994)—all underlying determinants of health. It also left hundreds of thousands homeless or internally displaced persons and resulted in the migration of hundreds of thousands more, including of highly skilled individuals (Stewart 1996). Reconstruction after the civil war was primarily funded through private financing – mainly for real estate (Stewart 1996) and loans from international finance institutions, such as the World Bank for physical infrastructure reconstruction, such as of education and health facilities (Kronfol 2006; World Bank 1994). Most reconstruction efforts (and funding) were concentrated in the capital Beirut, and failed to address economic disparities (Stewart 1996). Development in the health and education sectors post-civil war was marred by unequal regional development and social inequity (Makdisi 2007), reinforcing historical regional disparities and widening health inequities.

## THE HEALTHCARE SYSTEM TODAY

Van Lerberghe et al. (2018) recently described the “commodification” of Lebanon’s healthcare sector, where care and services are influenced by supply and demand dynamics “ruled by lobbies and political clientelism” (p. 15). This vested interest by the political class, in addition to the uncontrolled growth of the private sector, prevents the shift toward a more just system. Today, Lebanon’s healthcare system continues to be dominated by the private sector, while the public sector suffers from poor quality and continues to be underfunded (Ministry of Public Health [MoPH] & World Health Organization [WHO] 2022a; El-Jardali et al. 2023a). At the level of governance, institutions are weak, as are accountability mechanisms (El-Jardali et al. 2023a). Healthcare in Lebanon is mainly curative and aimed at hospitalization and secondary and tertiary care (Hemadeh et al. 2019a; Ammar 2009). There are 137 private hospitals in the country compared to 29 public hospitals (MoPH 2023). In addition, 86% of beds are in the private sector (Van Lerberghe et al. 2018).

Current health expenditure as a % of GDP was 7.95% in 2020, the highest in the Arab region and above the regional average of 5.32%. Still, only 3.27%<sup>2</sup> of the state’s budget was allocated to the MoPH that same year (**Table 1**), down 10.10% from the previous year. In 2017, the bulk of the MoPH budget went to reimburse contracted hospitals and curative care (45.1%) and to cover pharmaceuticals (27.2%).<sup>3</sup> In addition, less than 10% of public health expenditure went to cover primary and preventive services (ESCWA 2021). Several other entities also finance health, including the Ministry of Social Affairs, the Ministry of Labor (MoL) in the case of the NSSF, and other ministries in the case of the army and civil cooperatives, contributing to fragmentation (MoPH & WHO 2022b; International Labour Organization [ILO] 2020).

The MoPH introduced several reforms throughout the 1990s and early 2000s to decrease out-of-pocket (OOP) spending. The MoPH focused its main efforts on decreasing OOP spending on ambulatory care and medicines. Other reforms included introducing flat rates for consultations and certain procedures, performance-based pricing, decreased unit prices, and financial ceilings for hospitals (Lerberghe et al. 2018). These reforms successfully decreased OOP spending from 57.79% in 2000 to

<sup>2</sup> In comparison, the state’s budget on military spending for 2020 was 14.61%.

<sup>3</sup> Data based on the 2017 National Health Accounts, available at this [link](#).

an estimated 38.28% in 2018 (World Bank 2023a). But by 2020, OOP spending had risen to 44.2% (World Health Organization 2023; see **Table 1**), likely a result of the devaluation of the Lebanese pound and decreased coverage by relevant social insurance funds, noting that all six funds are de facto bankrupt, and lifted subsidies on pharmaceuticals (Medecins sans Frontieres 2022; Isma'eel et al. 2020; Amnesty 2023). In 2022, Doctors Without Borders estimated that patients were covering as much as 90% of their hospital expenses out of their own pocket. Furthermore, private hospitals have begun to dollarize their fees. This has significant repercussions for those who are not able to afford healthcare. An indicative rapid assessment conducted by UNICEF in April 2023, found that 75% of the households participating in the study were reducing health spending as a means of coping with the crisis (UNICEF 2023).

Significant efforts were also made by the MoPH to enhance Lebanon's primary healthcare (PHC) network, in part aiming to ensure that care is more accessible and affordable to the poor (Van Lerberghe et al. 2018). In 2021, there were 258 PHC centers in the network, most of which were located in the Mount Lebanon (n=71) and North Lebanon (n=40) governorates. Almost 70% of PHCs in the network are run by the private sector and NGOs, which are reimbursed by the MoPH based on a performance and quality contracting scheme (MoPH 2023), while the MoSA and some association-run dispensaries, which are not directly connected with the MoPH. Recent research by Cammett (2019) on Lebanon's PHC network demonstrates how deeply embedded political and religious organizations are in Lebanon's welfare system, as in 2019, they operated around 25% of centers in the network. In the absence of high-quality, publicly run healthcare institutions, low-income individuals become dependent on political and religious organizations to meet their basic needs (including care) (Cammett 2019). This dependence on one's political or religious affiliation to secure basic needs is a major factor hindering the achievement of the right to health for all in Lebanon and can contribute to discrimination in access to care.

Syrian refugees and vulnerable Lebanese households are the main users of the national PHCs network (Hemadneh et al. 2019b). Still, the majority of Lebanese (who can afford it) opt for ambulatory care through the private sector (Kronfol 2006; Isma'eel 2020). The PHC network faces several challenges that impact the quality of care provided, including lack of funding, poor management, poor accountability, inadequate referral mechanisms, high staff turnover, difficulty in managing the drug

supply chain, and low resources, among others (Hamadeh et al. 2021; El-Jardali et al. 2023a). While identifying a shortage in family medicine physicians and nurses, a study by Hemadeh et al. (2020) assessing PHCs in the MoPH network (212 at the time) found that 89% were delivering all services required by national standards, and 89% of them had all basic equipment needed for care delivery. The study also found regional disparities regarding the availability of human resources for health between PHCs in urban and rural areas, with a shortage of human resources in rural PHCs (Hemadeh et al. 2020). The economic crisis has further limited the funding available for the MoPH, which has restricted the ministry's ability to import essential medicines, supplies, and equipment needed for the PHC network. Restricted funding also limits healthcare facilities' capacities to secure water and electricity, which are necessary for operation. As a result, efforts to minimize inequalities and facilitate access to basic services for the most vulnerable through the network have not been completely successful (Hamadeh et al. 2021).

Health institutions in the public sector continue to lack qualified human resources for health and other resources (MoPH & WHO 2022a; El-Jardali et al. 2023a). According to the MoPH, there were 33.3 physicians per 10,000 population and 38.6 nurses and midwives per 10,000 population in Lebanon prior to the crisis in 2019 (**Table 1**).<sup>4</sup> Since then, the [World Health Organization](#) has estimated that around 40% of physicians and 30% of nurses had emigrated by September 2021 (World Health Organization 2021). This mass emigration of healthcare workers can have negative repercussions on healthcare provision and access, and in some cases, has resulted in the closure of specialized departments or units at large healthcare centers in the country, including units for neonatal care (Ramadan 2022; WHO 2021; UNICEF 2022b). In 2022, a UNICEF Bed Capacity Assessment found that there had been a decrease in maternal and pediatric bed capacity, including pediatric and neonatal intensive care unit beds, affecting access to healthcare and capacity to treat mothers and children. The study also found that 58% of hospitals reported medicine shortages, while 39% reported medical consumables shortages (UNICEF 2022b). Reasons for the latter include hiring freezes and limitations on imports linked to the economic crisis, as described previously (UNICEF 2022b).

In the absence of a functioning public healthcare system due to the current crisis, numerous charitable health centers and associations are filling in gaps by expanding coverage and

<sup>4</sup> These numbers should be interpreted with care, considering that there are different estimates for the total population of Lebanon (including migrants and refugees).

providing affordable or free care and medicines to those in need, particularly among their constituents (the issues with this have been discussed previously). Nevertheless, the high number of non-governmental organizations, political and religious charitable organizations, the large private sector, the UNHCR, UNRWA, international organizations, and others, which all provide care and services in addition to public sector providers, all contribute to fragmentation in the system (Hamadeh et al. 2021; Kreichati 2020). At the systems level, fragmentation has contributed to inefficiency and ineffectiveness through the duplication of services (Hamadeh et al. 2019a; Hamadeh et al. 2021). At the population level, fragmentation hinders the attainment of the right to health through increasing disparities and inequities in access, with individuals accessing different (quality) services and benefits based on their ability to pay, coverage status, or political or religious affiliation. Fragmentation can also contribute to further marginalizing some individuals, such as the poor or informal workers, who are excluded from coverage schemes or have limited access to acceptable and quality health services nearby.

**Table 1. Health system indicators**

Current health expenditure, as a % of GDP, 2020 <sup>a</sup>	7.95%
% MoPH budget out of state budget (including Directorate of Public Health, Public Hospitals, and Central Public Health Laboratory), 2020 <sup>b</sup>	3.27%
Current health expenditure per capita, (US\$), 2020 <sup>a</sup>	994
Out-of-pocket expenditure on health (as a % of current health expenditure), 2020 <sup>a</sup>	44.2%
Number of hospitals, private sector <sup>c</sup>	137 (82.5%)
Number of hospitals, public sector <sup>c</sup>	29 (17.5%)
Hospital beds (per 10,000 persons), 2017 <sup>d</sup>	27.3
% of beds in private hospitals <sup>e</sup>	86%
Physicians (per 10,000 population), 2019 <sup>c</sup>	33.3
Nurses and midwives (per 10,000 population), 2019 <sup>c</sup>	38.6
MRI machines, in the public and private sector, 2012 <sup>c</sup>	41

<sup>a</sup> World Health Organization, Global Health Expenditure Database, Lebanon Country Profile: [Link](#).

<sup>b</sup> Gherbal Initiative, State Budget: [Link](#).

<sup>c</sup> Ministry of Public Health, Hospitals Directory: [Private](#), [Public](#); Health Indicators: [Link](#).

<sup>d</sup> World Health Organization, The Global Health Observatory: [Link](#).

<sup>e</sup> Van Lerberghe et al., 2018: [Link](#).

## INEQUITIES IN HEALTHCARE COVERAGE AND ACCESS

The absence of a universal social protection system or universal healthcare coverage is a significant barrier to attaining the right to health for all in Lebanon, as they contribute to unequal access to care and health outcomes among the population. In emergency situations, the cost of healthcare can be catastrophic for poorer households, especially considering that in 2022, 51%<sup>5</sup> of residents in Lebanon did not have any type of health insurance coverage (Central Administration of Statistics 2022). Indeed, several vulnerable groups, such as retirees, the unemployed, agricultural workers, migrants, refugees, and those working informally, are not covered by available formal social protection schemes.

Regional disparities regarding healthcare insurance coverage also exist, reflecting overall disparities in development across the country. For example, the percentage of uninsured in South Lebanon is 61.2% and 59.5% in Baalbeck-El Hermel, compared to 43.8% in Mount Lebanon and 47.8% in the capital Beirut (Central Administration of Statistics 2022). Lebanese without any type of insurance are eligible for health coverage through the MoPH, which acts as an "insurer of last resort," and to a lesser extent from the MoSA (Hemadeh et al. 2019a).<sup>6</sup> A limited number of extremely poor households are eligible for health coverage through social safety net programs, such as the National Poverty Targeting Program (NPTP) and the Emergency National Poverty Targeting Program (ENPTP), which provide a waiver of the 10-15% co-payment required by other coverage schemes. Lebanon's primary healthcare network, which provides a comprehensive package of essential services, is open to all residents of the country. Notably, the number of Lebanese visiting PHCs has increased since the onset of the crisis, as they are unable to afford care in the private sector (Sader 2021).

As for older persons, the stigma surrounding mental health, along with geographical distance and disability, all act as barriers to accessing healthcare. The majority have limited access to healthcare coverage after retirement, while only a small percentage benefit from a social pension (those who worked in the public sector or who worked formally in the private sector), but with the devaluation of the currency, their pension has lost its value; those who continue to work also face similar issues regarding the value of their salaries. Older persons are also often denied coverage through private insurance schemes, which cite their risky health status as a

<sup>5</sup> Data does not include domestic workers.

<sup>6</sup> From 2017-2019, just over [68% of social protection spending](#) targeting the poor and vulnerable was from the MoPH, and 20% was from the MoSA.

reason (MoSA & UNFPA 2021). The situation has had a direct impact on the mental health situation of older persons in Lebanon. A study by Phenix Center and HelpAge International (2023) conducted among older Lebanese and Syrian refugees found that participants were feeling depressed and anxious and faced post-traumatic stress disorder related to their living situation. Older Lebanese worry about their health and access to medicines, while older Syrian refugees worry about being able to secure food, shelter, and medication (Phenix Center & HelpAge International 2023).

Regarding non-citizens, Palestine refugees can access healthcare services, partially covered through UNRWA and the Red Crescent Society (UNRWA 2023), and Syrian refugees, through the national PHC network and 33 contracted hospitals across the country, or the MoSA Social Development Centers (SDCs), subsidized by the [UNHCR](#). At the primary-care level, refugees pay a consultation fee ranging from 3,000 LBP to 30,000 LBP, depending on the service received, while at the secondary and tertiary care level, the UNHCR only provides partial coverage for life-saving emergencies or limb-saving cases. Some urgent, life-threatening conditions (such as cancers treatable by surgery) are considered on a case-by-case basis. Coverage is only available at select hospitals, the majority of which are governmental hospitals (UNHCR 2023). Refugees and migrant workers can receive care through international organizations and NGOs, with a small co-payment or free of charge, depending on the service available through partnerships between these organizations and the MoPH. For example, refugees and migrant workers can access healthcare services through [MSF](#) and [ICRC](#), including medical consultations, medicines, sexual and reproductive health services, mental health services, etc. The latter services are also available to Lebanese.

Migrant workers, and in particular women migrant domestic workers, face additional challenges that hinder their achievement of the right to health. Their status as documented, freelancer, or undocumented migrants dictates their access to healthcare (Fernandez 2018). In addition, migrant workers face various levels of discrimination, whether based on race, sex, or class, with an impact on their health (Fernandez 2018). Under the Kafala (or sponsorship) system, migrant domestic workers are at risk of exploitation and abuse. Their employers set their work contracts and conditions and can control their access to healthcare (Medecins sans Frontieres 2023). Live-in migrant domestic workers are often locked in the house, with their



passports withheld from them—their situation can block them from accessing protection or support services. Moreover, the standard insurance scheme that they are provided with does not cover outpatient care, dental care, sexual and reproductive health, or mental healthcare (Mezher et al. 2017; Fernandez 2018).

Similarly, members of the LGBTQ+ community also face significant barriers limiting their access to essential services, including healthcare, in Lebanon, with negative repercussions on their sexual and mental health (Naal et al. 2020; Abboud et al. 2023). Members of the community, particularly transgender persons, face discrimination at health centers and are sometimes denied care (Lebanese Union for the Physically Handicapped [LUPD] 2020). Members of the LGBTQ+ community, and particularly transgender persons, may avoid care due to the fear of discrimination and negative attitudes they face (Naal et al. 2020; Wright et al. 2017); although a more recent study found that physician attitudes toward LGBTQ+ individuals have changed, some physicians still hold discriminatory beliefs toward the community (Naal et al. 2020). Refugee members of the LGBTQ+ community face an added layer of discrimination due to their refugee status (Abboud et al. 2023; Moussawi 2023). Furthermore, available insurance or social security schemes do not cover gender-affirming surgeries or hormone replacement therapy for transgender persons, the cost of which is often prohibitive (Helem 2020).

Physical accessibility, that is, being able to safely reach and access healthcare services, is a core component of the right to health, as is financial accessibility. Nevertheless, cost remains a primary barrier to accessing care for refugees and migrant workers, including the costs of consultations, treatment, and medicines, and indirect costs related to transportation and distance to healthcare centers (UNHCR 2019; UNHCR, UNICEF, & WFP 2023; Norwegian Refugee Council 2020). In particular, UNICEF found that parents are no longer able to afford the costs of transportation to take their children to health centers to receive needed care or vaccines—this has contributed to the more than 30% reduction in vaccination rates among children, particularly among vulnerable groups (UNICEF 2022b). An additional challenge faced by Syrian refugees and migrant workers is limited freedom of movement, especially among those who do not have the proper paperwork (for example, residency permit), which, in turn, can limit their access to livelihoods, healthcare, and other necessities (International Commission of Jurists 2020).

**Table 2. Select demographic and health indicators**

Total population in millions, 2020 <sup>a</sup>	4.8
Life expectancy at birth, years, 2023, male <sup>b</sup>	74
Life expectancy at birth, years, 2023, female <sup>b</sup>	78
Neonatal mortality rate, per 1,000 live births (nationals) <sup>c</sup>	4.37
Neonatal mortality rate, per 1,000 live births (non-nationals) <sup>c</sup>	8.11
Infant mortality rate, deaths per 1,000 live births <sup>d</sup>	7
Mortality rate of children younger than 5 years <sup>d</sup>	8
Maternal mortality rate (deaths per 100,000 live births), (nationals) <sup>c</sup>	6.1
Maternal mortality rate (deaths per 100,000 live births) (non-nationals) <sup>c</sup>	21.99
Maternal mortality rate (deaths per 100,000 live births) (total) <sup>c</sup>	15.76
Births attended by skilled health personnel, per cent, 2004-2020 <sup>b</sup>	98%
Proportion of population using basic sanitation services <sup>d</sup>	74%
Proportion of population using safely managed drinking water services <sup>d</sup>	48%

<sup>a</sup> CAS & ILO, 2020: [Link](#).

<sup>b</sup> UNFPA, 2023: [Link](#).

<sup>c</sup> MoPH Vital Data Observatory and Health Indicators, data for 2022: [Link](#).

<sup>d</sup> UNICEF: [Link](#).

## ■ MORTALITY RATES

There has been a rapid rise in maternal and infant mortality rates since the onset of the crisis. The maternal mortality rate rose from 23.7 to 47 deaths per 100,000 live births between 2019 and 2021 and was higher among non-national (51.33) than Lebanese women (43.15) (MoPH 2023c; see **Table 2**). Increased maternal mortality rates in 2021 were in part due to COVID-19. In 2022, a decrease in maternal mortality rates was recorded among both Lebanese and non-Lebanese women, at 15.76 and 21.99 per 100,000 live births, respectively—still significantly higher among non-national women and still higher than the 2018 (pre-crisis) rates (MoPH 2023c; MoPH & WHO 2022b). Similarly, neonatal mortality rates increased from 5.3

to 5.5 per 1,000 live births between 2018 and 2020 and were higher among non-Lebanese than Lebanese. In 2022, the neonatal mortality rate per 1,000 live births for Lebanese was 4.37, compared to 8.11 for non-nationals, also significantly higher than for nationals (MoPH Vital Data Observatory). These differences in the mortality rates between Lebanese and non-nationals point to likely disparities in access to healthcare, whether due to socioeconomic status or locality. In a study assessing maternal mortality trends among Lebanese and Syrian refugee women from 2011-2018, El-Kak et al. (2019) suggest that slight increases in the maternal mortality rates in the North and Bekaa governorates, where Syrian refugees are concentrated, are likely due to a lack of referral centers. The authors also mention the low quality of maternity care as a potential cause of maternal mortality in Lebanon (El-Kak et al. 2019).

## COVID-19 AND HEALTH SYSTEM DISPARITIES

COVID-19 and the response to the pandemic perpetuated health system disparities. With the private sector initially refusing to provide beds and care to COVID-19 patients, the burden of care fell on the public sector, which, by the time the pandemic hit in early 2020, was already reeling from the impact of the economic crisis. In April 2020, the MoPH provided a list of 15 hospitals<sup>7</sup> qualified to perform COVID-19 RT-PCR tests. Of these hospitals on the list, only the Rafic Hariri University Hospital (RHUH) was providing tests for free. The majority of hospitals on the list were located in the Beirut and Mount Lebanon areas, and none were located in rural areas, such as in the Bekaa region, South Lebanon (besides Saida), or Akkar. In addition, 129 laboratories were certified to provide testing, with prices as high as \$100. Coverage of care was limited, whether by the MoPH and other public funds or insurance companies; as such, households had to pay for tests and care out-of-pocket (Kreichati 2020).

The RHUH (and the public sector in general) had limited capacity to receive COVID-19 patients. In turn, private hospitals set up units for COVID-19 patients, however, at a hefty price—unaffordable for the large majority of Lebanese who were not covered by any type of insurance scheme (Kreichati 2020). Vaccine rollout was also slow, and administration was inequitable. By the end of 2021, only 18% of vaccine doses had been administered to non-nationals, compared to 81% of Lebanese (MoPH 2023b).<sup>8</sup> A further breakdown of doses administered reveals that 10% of Syrians, 4% of

<sup>5</sup> See the list [here](#).

<sup>6</sup> Nationality information was missing for 1% of vaccine-takers.

other nationalities, and only 2% of Palestinians had received the vaccine (MoPH 2023b). Possible explanations for low registration on the MoPH vaccine platform by non-nationals include fear of detention or deportation (for example, due to issues with residency paperwork), lack of trust in the Lebanese government, lack of information about the vaccine and registration, or inability to afford transportation fees (Kaloti & Fouad 2022; Human Rights Watch 2021). For migrant workers, cultural appropriateness and the language of information provided may also have played a role (Human Rights Watch 2021). There were also disparities in vaccine administration at the district level, with the vast majority of vaccine doses administered in Beirut and Mount Lebanon (MoPH 2023b). Whether based on nationality or district, disparities in vaccine administration reflect deeply entrenched inequities that hinder the right to health. Furthermore, data from the United Nations demonstrated that Syrian refugees and Palestinian refugees died from COVID-19 at rates well above the national average (Azhari 2021a, 2021b).

Regarding healthcare workers, limited personal protective equipment (due to lack of foreign funds and inability to import the needed quantities) placed them at increased risk of infection (El Jamal et al. 2021), while the increased workload (reflective of poor planning) caused high levels of burnout among physicians and nurses, particularly in the public sector, impacting their mental health. Several characteristics were associated with high burnout: being a woman, being a physician, being married, having a poor health status, having a dependent at home (such as a child, older person, or household member with comorbidity), and having a low income (Youssef et al. 2022). The impact of the pandemic on healthcare workers highlights the absence of laws and strategies to ensure a safe working environment for them (El Jamal et al. 2021). It also highlights inequalities between private sector and public sector employees, as well as potential discrimination among healthcare workers, as demonstrated by the study on burnout (Youssef et al. 2022).

## **MENTAL HEALTH**

The COVID-19 pandemic also had an impact on the mental health of individuals, and in one study, fear of COVID-19 was found to increase stress and anxiety among participants (Salameh et al. 2020). Notably, Salameh et al. (2020, p.) found that stress and anxiety increased among participants also facing “financial hardship” during the pandemic, pointing to

the dual effect of Lebanon's multiple crises. Indeed, mental health was found to have deteriorated or to be poor among several communities across various studies conducted after the onset of Lebanon's multiple crises, but studies conducted before 2019 also point to poor mental health among residents, including refugee communities.<sup>9</sup> Yet, mental health services in the country continue to be inadequate and insufficient, despite the establishment of a National Mental Health Program in 2014, and the adoption of a mental health strategy in 2015, while individuals face significant barriers to accessing mental health services and medication.

About 50% of the MoPH budget allocated to mental health services is spent on hospitalization in the private sector, and mental health is not yet sufficiently integrated into Lebanon's primary healthcare network (El Khoury et al. 2020). Furthermore, services are concentrated in the capital (Farran 2021), and tend to focus on mental health as a clinical and medical condition and do not consider the structural and contextual factors (Noubani et al. 2021). Mental healthcare services and medicines are expensive and out of reach for many, but coverage remains limited. Regarding coverage, mental health services and psychotropic medicines are not covered or only partially covered by available insurance schemes (El Khoury et al. 2020). The latter all affect the accessibility of mental health services and medicines, especially among the vulnerable. The bulk of mental healthcare is provided through NGOs and international organizations that target specific communities, such as Syrian refugees, or provide short-term mental health services or psychosocial support programs (Farran 2021; Noubani et al. 2021).

## PHARMACEUTICAL SECTOR

Issues with the pharmaceutical sector in Lebanon predate the current crisis (as described previously). The neoliberal policies that encourage privatization and profit in the health sector also apply to the pharmaceutical sector, which is also characterized by corruption and influenced by political clientelism. Ten importers dominate the market, four of which have over 50% of the market share, limiting competitiveness and increasing prices (Consultation & Research Institute 2020; Kreichati 2020). Close to 95% of medicines in Lebanon are imported as these companies hinder local production, and the market is dominated by brand-name medicines over cheaper generic alternatives (El-Harakeh & Haley 2022; Amnesty International 2021).

<sup>9</sup> See Farran, N. 2021. "Mental Health in Lebanon: Tomorrow's Silent Epidemic," for an overview of these studies.

The current crisis has further limited access to and affordability of medicines in Lebanon. Initially, the devaluation of the LBP, and a shortage of foreign currency, and limited bank credit lines affected medication imports and, in turn, medicines' availability. In November 2021, the government lifted subsidies off several essential medicines that it had introduced at the beginning of the crisis. This contributed to a significant increase in the price of medicines. It was estimated in 2021 that at least 70% of the population could not afford needed medicines (Amnesty International 2021; Amnesty International 2023). Shortages have also resulted in an informal market for medicines, facilitating the import of counterfeit or expired medicines (Amnesty 2023). Distributors and pharmacists have also been accused of hiding medicines, waiting for subsidies to be lifted to sell at a higher price, or smuggling the medicines out of the country (El-Harakeh & Haley 2022).

The unaffordability and inaccessibility of essential medicines can have a direct impact on the health of individuals. For example, the shortage in medicines has had tangible effects on the health of patients suffering from chronic or severe illnesses who are at risk of facing complications (Amnesty 2023). Those who can afford it have resorted to personally purchasing or importing necessary medicines from abroad, while NGOs have also been donating medicines to those in need. Still, the situation has contributed to inequitable access to essential medications among the population, thus hindering the attainment of the right to health for all.

## LEGAL AND REGULATORY FRAMEWORK PERTAINING TO THE RIGHT TO HEALTH

The legislation and reforms introduced pre-civil war continue to dictate Lebanon's health policy-making, while the absence of health-related language in the Constitution continues to impact the right to health today. Across other sectors (determinants of health), laws, decrees, policies, and strategies fail to incorporate language on health. Despite a lack of right to health language in Lebanese legislation, the country is a party to several conventions and treaties that include provisions on the right to health, including the 1966 International Covenant on Economic, Social and Cultural Rights (Article 12), 1990 Convention on the Rights of the Child, 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW; with reservations to three articles), among others and is a signatory of the 2006 Convention on the Rights of Persons with Disabilities (Article 25). Notably, and despite hosting large refugee and migrant communities, Lebanon is not party to the relevant conventions aiming to protect refugees or migrant workers, such as the 1951 Refugee Convention.

The Lebanese Constitution was promulgated under the French mandate in 1926. The Constitution does not mention the right to health, nor is there a direct reference to health in the Constitution. Nevertheless, the preamble of the Constitution protects against discrimination between citizens, stating that "Lebanon is a democratic parliamentary republic...of social justice and equality in rights and duties among all citizens, without distinction or preference." Protected characteristics are not explicitly mentioned, except for freedom of belief and religious practice; as such, the Constitution does not necessarily protect against discrimination based on gender or sex. Further, the preamble dictates that the "even development among regions on the educational, social, and economic levels shall be a basic pillar of the unity of the state and the stability of the system." Equality is also referenced in Article 7 of the Constitution, which states that "All Lebanese are equal before the law. They equally enjoy civil and political rights..." (Lebanese Constitution 2004). Of note, the Constitution extends these rights and protection to citizens only with little reference to non-national residents of the country. This is of concern considering that just over 20% of the 4.8 million residents in the

country were non-nationals in mid-2018 (Central Administration of Statistics [CAS] & International Labour Organization [ILO] 2020).<sup>10</sup>

Public health in Lebanon today is governed by Decree No. 8377/1961, which, similarly to the Public Health Decree of 1932, focuses on the environment and sanitation and the control and prevention of infectious diseases and quarantine. Article 2 of the decree stipulates that the MoPH is responsible for “maintaining and improving public health through disease prevention, treatment of patients in need, and supervising private health institutions per the related provisions. The ministry is in charge of preparing proposals of regulation and amendments of existing laws and regulations relating to all fields of public health.” The decree focuses more on the organization and operation of the ministry and does not mention the right to health for all, though it does extend free healthcare services to those in need (through the MoPH fund). Regarding Patient’s Rights and Informed Consent, Law No. 574/2004 states that “The patient has the right, within the framework of a health system and social protection, to receive rational and appropriate medical care for his condition,” focusing again on healthcare. More recently, in 2019, a draft law for universal healthcare coverage for Lebanese citizens was submitted to parliament but was repealed and has yet to be adopted (El-Jardali et al. 2023a).

In 2022, the MoPH, in partnership with the WHO, launched a National Health Strategy with a Vision 2030 for health (MoPH & WHO 2022a). The strategy acknowledges Lebanon’s ongoing crises and the impact they have had on health and its determinants, and recognizes the importance of the determinants of health through its goal of “[Seeking an] intersectoral approach to address social determinants of health inequity, and promote the Health in All Policies concept.” In line with this, the strategy highlights the need to “target regions with below average indicators” to promote population health, though the strategy mentions that this is not currently being done, nor is there a plan for achieving this goal yet. Building on the 2016-2020 strategy and previous MoPH efforts, this strategy also has as one of its main objectives the achievement of universal healthcare coverage. Though the strategy addresses fragmentation and the multiplicity of funding mechanisms as major challenges to the system, it does not aim to unify the six available social insurance funds as one of its objectives, rather proposing the development of a “unified essential benefits package.” To this end, the strategy

<sup>10</sup> The Labour Force and Household Living Conditions Survey only covers residents and households living in residential dwellings. In the context of this survey, non-Lebanese residents refers to all those not holding Lebanese citizenship, irrespective of nationality.



aims to grant “all residents a basic common benefits package of essential primary healthcare and hospital services,” to be financed by national sources (available funds) for Lebanese and by respective entities for non-Lebanese, namely, UNRWA for Palestinian refugees, UNHCR for Syrian refugees, and employers through a private insurance scheme for migrant workers (MoPH & WHO 2022a, p. 24). Implementation of this objective is likely to leave out groups such as the stateless and undocumented migrants and refugees and those who are working informally—groups that already face multiple layers of vulnerability. The strategy has several other limitations and requires a “feasible” action plan (El-Jardali et al. 2023b).

The extension of a basic package of essential healthcare services is also a key component of Lebanon’s National Social Protection Strategy,<sup>11</sup> which has not been adopted and is pending amendments by the government. Among its objectives, the strategy aims to capitalize on existing SDCs to extend inclusive and quality social welfare services, including health, to the most marginalized and vulnerable groups and to introduce a social protection floor. The strategy uses rights-based language and aims to address some of the challenges that hinder attaining the right to health in Lebanon, including addressing fragmentation and current gaps in insurance coverage.

## LEGISLATION RELATED TO VULNERABLE GROUPS – SOME EXAMPLES

Some legislation in Lebanon aims to extend 1) healthcare to vulnerable communities through extending the right to coverage, healthcare services and/or insurance, and/or 2) protection to them, but fails to comprehensively address the political, economic, social, and cultural determinants of health and the right to the highest attainable standard of health. Furthermore, current legislation is still discriminatory against Lebanese women and children, non-citizens residing in Lebanon, persons with disabilities, older persons, and the LGBTQ+ community, and contributes to their social exclusion. We present a few examples below.

For example, Decree No. 1692/1999 and Decree No. 4265/2000 ensure that children have medical care and mandate that hospitals and medical centers should include special sections for children. Children whose parents are registered with the NSSF or other public social funds are eligible for services under these funds, including health and education. However, this

<sup>11</sup> The National Social Protection Strategy was developed by Beyond Group in collaboration with UNICEF, the ILO, and the MoSA through a consultative process with national civil society and other relevant stakeholders. The final draft was completed in January 2022 but is still under discussion by the government.

right is not extended to children born to a Lebanese mother and a foreign father. Indeed, women in Lebanon face several levels of discrimination that hinder their right to the highest attainable standard of health and which also impact the health of their children. Lebanon has reservations against three articles of the CEDAW: Article 9 on nationality rights, Article 16 on personal status and the marriage of a child, and Article 29 on arbitration in case of related disputes. Firstly, Lebanese women married to a foreigner cannot extend their nationality to their spouse or their children, thus excluding their children from the rights they would otherwise be entitled to as citizens; as such, they face difficulties in accessing healthcare and education. Regarding early marriage, Lebanon has no legal minimum age for marriage, as this is left to the religious courts (Human Rights Watch 2017; Manara Network for Children's Rights 2011). Early marriage is still common in some pockets of Lebanon among Lebanese and non-citizen communities, with refugee and poorer communities most at risk. Early marriage is enabled by religious and cultural norms, and economic reasons, and has known negative effects on health outcomes, such as childbearing. It also increases the likelihood of dropping out of school and places girls at risk of marital rape and domestic violence (Abdulrahim et al. 2017; Human Rights Watch 2017; Moussawi 2023; El-Husseini Dean 2023).

Legislation pertinent to women and children in Lebanon is very much influenced by Lebanon's patriarchal religious establishment. This is most visible in the Lebanon Penal Code of 1943, which, among other issues, criminalizes abortion (Articles 539-546) and permits parents to discipline children within "general customs" (Article 186). With regard to abortion, in 1969, a presidential decree modified the Penal Code to allow abortion only in the case where a pregnant woman's life is in danger. In all other situations, abortion is illegal, and women face imprisonment. The majority of women participating in a research study by Fathallah (2019) were able to access a safe abortion; however, they faced judgment and blame by the physicians. Among study participants, socioeconomic background and financial constraints acted as a barrier to accessing a safe abortion. Along with a shortage of other medicines, the current crisis has resulted in a shortage of oral contraceptive pills (OCPs), with implications for the mental health and sexual and reproductive health of women. A study by Itani et al. (2023) found that among women who were not able to find their preferred OCP, 9.5% experienced an unplanned pregnancy, and the majority opted for an abortion. With no sexual and reproductive health rights under the Kafala

system, migrant domestic workers have little protection when they get pregnant; they risk being fired and can end up living in irregularity, or may be forced to have unsafe abortions (Mezher et al. 2021).

The influence of Lebanon's establishment is also visible in Law No. 205/2020 to criminalize sexual harassment and for the rehabilitation of its victims and Law No. 293/2014 on the protection of women and other family members from domestic violence, and their implementation (Moussawi 2023). Neither law protects non-citizens, including refugees and migrant workers. Furthermore, follow-through has been an issue with these laws, especially with regard to their implementation on the ground—particularly as women seek protection, but also due to additional legal obstacles, discriminatory practices, and economic, social, and cultural barriers, such as cultural and social biases from investigators and police officers, among other issues (International Commission of Jurists 2019; Moussawi 2023). This is alarming, as the prevalence of domestic violence has increased significantly in recent years among Lebanese and non-citizens, as a result of the financial crisis and especially during the COVID-19 pandemic (UN-Women et al. 2021; El-Husseini Dean 2023). Moreover, the Law No. 293/2014 does not criminalize marital rape, instead leaving decisions regarding this issue to the religious courts and one of 15 personal status laws (dependent on one's religious affiliation). Personal status laws are discriminatory and inequitable toward women with regard to divorce, child custody, and inheritance (Moussawi 2023). The latter has direct public health implications, as women may feel forced to stay in abusive relationships out of fear of losing their children at a young age due to child custody laws (Dabbous 2017). As for migrant domestic workers (99% of whom are women), they also face abuse, sexual harassment, rape, and violence at the hands of their employers, but in light of the Kafala system, have no legal recourse or protection (Mezher et al. 2021). Along with ongoing contextual factors, this systemic violence against women hinders them from attaining the right to health.

Similarly, systemic violence against members of the LGBTQ+<sup>12</sup> hinders them from attaining the right to health. For example, article No. 534 of the Penal Code criminalizes "sexual acts against nature." It has been used to penalize same-sex relations among members of the LGBTQ+ community, and gender expression among transgender persons, with a possibility of imprisonment of up to one year. Other articles of the Penal Code (209, 521, 526, 531, 532, and 533) have

<sup>12</sup> Lesbian, Gay, Bisexual, Transgender, Queer, and other categories.

also been used to arrest members of the LGBTQ+ community, with direct implications on their rights and freedoms. There have been reports of physical and other types of violence faced by members of the community by law enforcement or during arrest, with victims also facing degrading practices at police stations (Lebanese Union of the Physically Handicapped [LUPD] 2020; Helem 2020; Moussawi 2023). Transgender persons face several barriers to changing the gender markers on their identity cards, including high legal fees, a requirement to undergo sterilization, and prohibitive surgery fees (Helem 2020). Members of the community also face societal stigma perpetuated by Lebanon's overarching patriarchal structures (Moussawi 2023). Furthermore, increasing negative rhetoric in recent months by politicians, religious leaders, and civilian-led religious groups has resulted in increasing violence against community members, further marginalizing them and limiting the few safe spaces they can access. Lack of legal protection, a discriminatory environment, lack of availability of sexual health education, and fear of discrimination among members of the community when seeking healthcare, among other factors, can hinder their access to healthcare services and the attainment of the right to health, with a potential impact on their health outcomes (Assi et al. 2019; Abboud et al. 2023; Wright et al. 2017; LUPD 2020; Naas et al. 2020).

Regarding persons with disabilities (PwDs), Lebanon is a party to the Convention on the Rights of Persons with disabilities, which states that PwDs have "the enjoyment of the highest attainable standards of health without discrimination based on their disability." Health is referenced in Law No. 220/2000 on the Rights of People with Disabilities. Nevertheless, there is no implementation decree for Law No. 220/2000, nor are its provisions aligned with or reflected in other relevant laws. Specifically, Article 27 of the law states that "Any PwD has the right to fully benefit from the health, rehabilitation and support services, at the government expenses, represented by all administrations and bodies providing these services," and Article 28 states that "A PwD has the right to benefit from the full coverage provided by the Ministry of Public Health as a main provider..." In addition to its focus on the right to healthcare services rather than on the right to health, the law includes a limited definition of disability, focusing on an individual's medical condition, and does not take into consideration the physical, social, and legal barriers which stand in the way of PwDs leading a normal life. The provisions of this law are only extended to those who are holders of the Ministry of Social Affairs (MoSA) disability identification card

and who fit the limited definition of disability proposed by the law. Furthermore, although Law No. 220/2000 does not explicitly mention that only Lebanese are eligible to obtain a disability identification card, in practice, this is the case (Baroud & Mouheildine 2018; UNESCO 2013; Lebanese Civil Society's Coalition 2015). Although Law No. 220/2000 also calls for the right to an enabling environment, commute, housing, education, work and employment, and social benefits, these are not applied in practice. PwDs in Lebanon are not able to live an independent life with dignity—these factors are also important to ensuring that a PwDs' right to health is respected (Tayar & Etheredge 2020; Handicap International 2022; see also Abu Srour 2023 for the AWR2023).

Regarding older persons, the majority lose their health benefits upon retirement when they need them the most. For example, in 2018, 56% of older persons lived in households that did not benefit from any type of social protection benefits. This percentage increases to around 85% when considering older persons living in households in the lowest income quintile (HelpAge International & International Labour Organization 2022; International Labour Organization 2022). This is alarming considering that the estimated age dependency ratio in 2022 was 60% (World Bank 2023a).<sup>13</sup> Such a high dependency ratio has implications on households' healthcare burden, considering Lebanon's weak social security and public health systems. Several laws and decrees were introduced that extend coverage or healthcare services to older persons. For example, Law No. 248/2000 established an optional social insurance fund for older persons, which failed soon after its implementation due to structural issues (MoSA & UNFPA 2021). Another law, Law No. 27/2017, grants formal permanent private sector retirees with 20 years of service who had previously been enrolled in the sickness and maternity branches of the NSSF the right to benefit from this coverage after retirement. Retirees wishing to benefit from this coverage are expected to contribute to the fund to benefit from this coverage. While not addressing the right to health or the determinants that can lead to its achievement, these laws also fall short of providing older persons with fair and comprehensive social protection guarantees and do not address their specific vulnerabilities (HelpAge International & International Labour Organization 2022; Phenix Center & HelpAge International 2023).

<sup>13</sup> Compared to an estimated 55.4% as per [Central Administration of Statistics Demographic Data](#) in 2019, which is still considerably high.

# DETERMINANTS OF HEALTH

## INCREASING UNEMPLOYMENT AND POVERTY

Unemployment rates have increased significantly due to the crisis, rising from 11.4% in 2019 to 29.6% in 2022 (CAS & ILO 2022). Unemployment was recorded at 47.8% among youth, and stood at 32.7% among females. Informality is high—in 2021, 62.4% of the population worked informally, and 48.3% was employed in the informal sector (CAS & ILO 2022), thus falling outside available social protection schemes. Even for employees working in the private sector, non-compliance and lack of implementation of the law have resulted in low registration rates in the NSSF, with employers opting not to register their employees to avoid co-payment (Dara 2020). The majority of non-citizens, particularly Palestinian and Syrian refugees, also work informally since they face several barriers to obtaining a legal work permit (for example, prohibitive cost) or regarding the sectors in which they are allowed to work. Although a small number of Palestinian and Syrian refugees who have official work permits are expected to contribute to the NSSF, they do not benefit from its protections (including healthcare coverage) due to the principle of reciprocity,<sup>14</sup> among other barriers (International Labour Organization 2021; International Labour Organization 2020).

Another consequence of Lebanon's multi-faceted crisis has been a significant increase in the poverty rate, which, as mentioned previously, remains a significant challenge to achieving the right to health. Poverty is a significant determinant of health and the right to health and is likely to deepen health inequities, as it also affects (access to) other determinants of health, including food, water, sanitation services, adequate housing conditions, education, etc. In the first quarter of 2022, when the dollar exchange rate was close to 25 LBP to the dollar, the Central Administration of Statistics estimated that more than 80% of families lived on less than 430 USD. This is reiterated by multiple international and national bodies, which estimate that between 75% and 80% of families are considered in need of some form of assistance to enable them to meet their basic living needs. Among Palestinian refugees, the poverty rate was estimated at 93% as of September 2022 (UNRWA 2022). Among Syrian refugees,

<sup>14</sup> In the case of the NSSF, the principle of reciprocity has been interpreted to mean that only workers from countries with which Lebanon has a bilateral agreement on social security can benefit from NSSF provisions. To date, only nationals of Belgium, France, Italy, and the United Kingdom can benefit from NSSF provisions.

67% were living below the Standard Minimum Expenditure Basket (SMEB) (UNHCR, UNICEF, & WFP 2023). As a result of such high poverty rates, households have had to prioritize basic necessities and have resorted to negative coping mechanisms to ensure survival, which has an impact on their health; for example, by reducing food portion sizes, discussed in the next section (UN Women et al. 2020; UNICEF 2023). Two programs aim to provide extremely poor Lebanese families (immediately following the COVID-19 period) with cash assistance and social services toward expanding social safety net coverage at the national level. The NPTP and Emergency Social Safety Net Program (ESSNP) programs cover nearly 160,000 families living in extreme poverty, but a significant proportion of the population remains without needed support (World Food Programme 2022; World Bank 2023b). Notably, a distribution monitoring survey found that families were spending their cash transfers primarily on food (43%), followed by healthcare (12%) (World Bank 2023b).

Women and girls have been especially hard hit by the crisis. For example, with subsidies lifted off menstrual hygiene products, these have become unaffordable for many, resulting in what has been termed period poverty (Moussawi 2023). Not able to afford these products, women may turn to unhealthy alternatives, which has an impact on their health (Moussawi 2023). Similarly, a study by Aouad & Abed (2021) for Oxfam found that members of the LGBTQ+ community, particularly trans- and non-binary individuals and queer refugees, reported difficulties in accessing employment and income, particularly post the August 4 Beirut Blast, which resulted in significant destruction of LGBTQ+ safe spaces. As discussed previously, issues such as discrimination against the LGBTQ+ community, lack of protection from the government, and legal restrictions, exacerbate the situation (Aouad & Abed 2021). With limited resources, members of the community participating in the study reported difficulties in securing basic services, such as housing and healthcare, including mental health and sexual and reproductive health services (Aouad & Abed 2021).

## FOOD INSECURITY

The United Nations estimated that between September – December 2022, some 2 million residents (including Lebanese nationals and Syrian refugees) were struggling with food insecurity—partly due to the lifting of food subsidies and increasing cost of living (United Nations 2023). A national nutrition survey conducted in 2022 found that households

were resorting to negative food-related coping strategies, such as reducing portions of meals when not having enough food, particularly common among adults in favor of their children (FAO, FSC, UNICEF & WFP 2022). The survey also found that 70% of the children participating in the study are missing their best start in life-exclusive breast feeding, while 90% are missing at least one dimension of a quality and nutritious diet (FAO, FSC, UNICEF & WFP 2022). 30% of the Lebanese, Syrian, and Palestinian households participating in a rapid assessment conducted in April 2023 reported that at least one of their children was going to bed hungry, up from 23% the previous year (UNICEF 2023). Among Syrian refugees, 57% of households had inadequate food intake (UNHCR, UNICEF, & WFP 2023). Furthermore, over 80% of Syrian households living in non-permanent shelters reported not having consumed iron-rich foods in the week before the VASyR survey, while 19% reported not having consumed vitamin A-rich foods; percentages were equally poor for refugees living in non-residential shelters (UNHCR, UNICEF, & WFP 2023).

Inadequate nutrition can have dire consequences on a child's health and development, thus hindering the attainment of the right to health. Up until 2022, stunting levels were low to medium across all governorates, averaging 7% nationally, but were higher among Syrian children living in informal tented settlements, where the prevalence of stunting was 25.8% (FAO, FSC, UNICEF & WFP 2022; UNICEF 2022b). As for wasting, the national nutrition survey found that wasting among children was low to very low across the country (<5% across all strata) (FAO, FSC, UNICEF & WFP 2022). In addition, 41% of women and 43% of children participating in the national nutrition survey were found to suffer from some degree of anemia (FAO, FSC, UNICEF & WFP 2022), likely due to food insecurity and inadequate nutrition (UNICEF 2022b). Nevertheless, with food insecurity rising, children remain at risk of undernutrition and its consequences.

## **DETERIORATING PUBLIC SERVICES**

With decreasing currency value and the ensuing fuel crisis, the government has been unable to maintain operations of public electricity and water infrastructure (Ferrando 2022). Poor or completely unavailable public utilities, including electricity, water, and sanitation services, have aggravated poverty and inequality. While access to private or commercially run generators is available for those who can afford it, a study by Human Rights Watch (2023) found that generator services



were unaffordable for almost 20% of low-income households. Low-income households were spending a much greater share of their monthly income on generator access, with an impact on their access to other basic needs. Increasing dependence on generators for power has also resulted in an increase in air pollution from diesel burning, especially in urban and overcrowded areas, impacting health, particularly of vulnerable groups, including children, older persons, and those with respiratory diseases (Human Rights Watch 2023). Lack of electricity also has an impact at the healthcare level itself; for example, electricity is necessary to maintain the cold chain needed for vaccines (UNICEF 2022), while some healthcare centers and hospitals limit their services to emergency care to ration power (Hamadeh et al. 2021).

The electricity crisis is directly linked to the water crisis, as electricity is necessary to power water pumps and wells. Since 2019, the daily water supply in Lebanon has dropped below the recommended 35 liters per capita (UNICEF 2021; UNICEF 2022a). Private water trucking businesses are also available to facilitate water access for households, albeit only for those who can afford it (Ferrando 2022; UNICEF 2022a). Furthermore, a large percentage of refugees (Palestinian=45%, Syrian=58%) live in overcrowded or poor shelter conditions (UNRWA 2020; UNHCR, UNICEF, & WFP 2023). Poor shelter conditions, water resources, and sanitation services can directly impact health, particularly of children, who are at risk of water- or sanitation-related diseases (UNHCR, UNICEF, & WFP 2023; UNICEF 2022a; UNICEF 2022b). For example, a significant indicator of Lebanon's deteriorating public health situation (and, more broadly, its infrastructure) is the recent cholera outbreak, the first such outbreak in almost three decades. Starting in the informal tented settlements of North Lebanon, the cholera outbreak quickly spread and was identified in cultures from potable water sources, irrigation, and sewage in the informal settlement, and later, in sewage water in two other regions of the country (World Health Organization 2022). As of June 2, 2023, there have been over 8,000 confirmed cholera cases in the country, with children among the most affected (MoPH 2023a).

## THE ENVIRONMENT

In recent years, Lebanon has witnessed significant environmental deterioration with an impact on public health. Forest fires, polluted water resources and air pollution, poor waste management, an ongoing garbage crisis, and land

degradation, and uncontrolled quarry digging are only some of the environmental issues faced (UNDP, UNHCR, UNICEF, & MoE 2021). It is expected that climate-induced extreme weather events, such as floods, forest fires, and drought, will likely increase, impacting food security and disproportionately affecting lower-income households (Ferrando 2022). As mentioned previously, fuel consumption due to diesel generators, poor quality fuel from power plants, and land transportation (traffic jams) are significant contributors to air pollution in Lebanon (Baayoun et al. 2019; Human Rights Watch 2023), while ineffective wastewater treatment and untreated industrial waste and sewage are significant polluters of water resources in Lebanon. For example, pollution of the Litani River is among the largest contributors to food and well water contamination in the country, posing a threat to public health and agricultural production (Darwish et al. 2021). Also of note is Lebanon's ongoing solid waste crisis, which in the past has resulted in solid waste accumulation in cities across the country due to political deadlock and poor management (Human Rights Watch 2020). Both air pollution and improper waste management have a direct impact on health, particularly with regard to respiratory diseases such as chronic obstructive pulmonary disease and asthma, and skin conditions in the case of the latter.

## DATA (UN)AVAILABILITY AND ITS IMPACT ON THE RIGHT TO HEALTH

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At the national level, Lebanon's last census was conducted in 1932, and national-level data and indicators disaggregated by gender, age, ethnicity, rural or urban status, and socioeconomic group are generally unavailable to inform health policy and planning. A [National Health Statistics Report](#) published over a decade ago in 2012 provided some insight into the health status of Lebanese nationals and provided data on healthcare access and services available for refugees from the respective agencies, the UNRWA and UNHCR, but did not cover the health of migrant workers. Other national level or representative surveys are conducted, such as the [Vulnerability Assessment of Syrian Refugees in Lebanon](#) survey, and shed light on challenges and disparities faced by some vulnerable or non-citizen groups, including on health. Nevertheless, some vulnerable groups who face specific challenges, such as those who are unregistered or undocumented, are underrepresented in these surveys or excluded from them altogether. Available data lacks standardization (with, for example, different actors relying on different indicators and definitions), is outdated, and at times even contradictory, while relevant actors do not always share data (Badr & Asmar 2016).

Furthermore, the MoPH produces periodic statistical and epidemiological reports for several health indicators, including surveillance data for communicable and non-communicable diseases, as well as maternal and neonatal data (see the MoPH [Vital Data Observatory](#) and [Health Indicators](#)). Maternal and neonatal data is disaggregated by district and nationality, although non-nationals are grouped into a single group. The latter has implications for attaining the right to health for groups such as refugees and migrant workers, whose living conditions and determinants of health vary and whose access to healthcare is also limited. Moreover, the lack of standardized data collection methods and indicators does not allow for inter-group comparisons and can hinder policy and program development. In addition, there is no up-to-date official national data that researchers or advocates can access to assess the inequities in healthcare access or attainment of the right to health. This makes it difficult to hold the government accountable regarding its duty to ensure the right to health for all.

## CONCLUSION AND RECOMMENDATIONS

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Though the ongoing crisis has certainly exacerbated the situation, the foundations for Lebanon's inequitable health system predate the current crisis. Overall, progress (in health and other sectors) has been far from even across regions, as has development, and residents of Lebanon, to this day, do not enjoy equal rights, including the right to health. Instead, national policies and reforms have contributed to high levels of income inequality, engendered regional disparities across the determinants of health, and resulted in various left-behind groups. The main challenges and barriers hindering the attainment of the right to health in Lebanon can be summed up as follows:

- The promotion of a liberal economy—facilitated by the political class, corruption, and cronyism—has contributed to the proliferation of the private healthcare sector and hindered the development of the public healthcare sector. Similarly, it has hindered development in other sectors, affecting the underlying determinants of health, such as water and sanitation, energy, and the environment.
- Despite progress on certain fronts, weak governance, weak infrastructure, poor planning, underfunding, and poor quality of services have caused further deterioration of the public healthcare sector. The latter, along with fragmented financing and healthcare delivery, contribute to inequities in health access and provision among different segments of the population.
- Current health laws, decrees, policies, and strategies focus more on access to healthcare rather than on health as a right. Although Lebanon is a signatory to various conventions and treaties that provide for the right to health, these provisions are not implemented in practice. Furthermore, several laws and policies result in the social exclusion of certain groups, such as those related to the elderly, women, children, PwDs, and the LGBTQ+ community, hindering the attainment of the right to health.
- Health system development over the years has perpetuated a culture of curative care over preventative care.
- Lebanon lacks a comprehensive social protection strategy and universal healthcare coverage, and a functional primary

healthcare network able to provide a basic package of essential healthcare services to all.

- The situation has contributed to inequity and discrimination with regard to opportunity and access to health and healthcare based on what should be protected characteristics (such as gender, income level, political or religious affiliation, citizenship status, and nationality), especially for vulnerable and marginalized communities.

## TOWARD THE RIGHT TO HEALTH FOR ALL IN LEBANON

**Create a culture of health as a right:** It is of utmost importance to constitutionalize or introduce the necessary national legislation that ensures the right to health for all, to raise awareness among residents about their rights, and to empower them to hold the government accountable to ensure this right is being fulfilled. In practice, efforts should be made to raise awareness about and promote the use of available complaints mechanisms in the public health sector, including the MoPH national complaint and inquiry hotline, website, and application, and the PHC network national grievance handling system.<sup>15</sup> The former must be made toll free, and its scope must be expanded to cover questions and complaints regarding a person's health rights. Individuals must be able to participate in decisions regarding their health (as laid out in Law No. 574/2004 on Patient's Rights and Informed Consent), but more broadly, civil society and the public must be engaged in public health programs and policy development, whether through national consultations, or local health committees. Efforts should be made to ensure that consultation and committees also engage the most vulnerable or marginalized members of our community and/or the CSOs that represent them. Health equity also requires reforms addressing the determinants of health, such as issues that hinder fair and equitable access to education and employment, clean water and proper sanitation, nutritionally adequate food, renewable energy resources, and a healthy environment. To this end, ensuring health is incorporated into all policies is important. The right to health also requires enhancing the acceptability of facilities and services in the public healthcare sector—which should be the primary provider of care in the country—and increasing awareness at the cultural and societal levels around the value of preventive services over curative services.

<sup>15</sup> Hammoud et al. (2021) provide an overview of the available complaints mechanisms, discuss the current gaps, and provide recommendations for improvement in the article, "Setting up a patient complaint system in the national primary healthcare network in Lebanon (2016–2020): Lessons for Low- and Middle Income Countries."

**Strengthen Lebanon's primary healthcare network:** Efforts should be made to strengthen Lebanon's public healthcare sector and its national primary healthcare network. The MoPH should improve the capacity, availability, and quality of services in its facilities, which requires ensuring that health staff have the proper qualifications. At the PHC level, services must include preventive care, sexual and reproductive care, and mental health services, which should be budgeted for adequately. Improving quality and ensuring patient safety are essential to building trust in the sector. To improve quality in the sector and enhance patient safety, the government must adopt a comprehensive policy for quality improvement and patient safety.<sup>16</sup> Furthermore, primary healthcare should be made accessible for all, both physically and financially. Practically, this means ensuring that centers are equitably distributed across governorates. It is also important to address issues with public transportation (for example, ensuring that it is accessible to PwDs, affordable, and safe for women and girls) to ensure that individuals are able to reach their nearest center. Centers must be equipped (for example, in terms of human resources for health, facilities, equipment, physical accessibility, etc.) to provide individuals with the care they need at an affordable price. It is also important to address the influence of political and religious institutions and corruption within the system.

**Work toward a universal healthcare system:** Adopting a universal healthcare law that extends basic healthcare services to all residents of Lebanon, and not just citizens, is a necessary step toward enhancing health equity and minimizing discrimination. Basic healthcare services and essential medicines should be available for all and affordable. Adoption of a universal healthcare law may minimize out-of-pocket spending, thus reducing the potential for catastrophic health expenditures on poorer households.<sup>17</sup> Furthermore, it is important to introduce legislation to control market prices and place a cap on profit margins in the healthcare sector, especially for medicines and specialized tests. Efforts should be made to minimize dependency on and further regulate the private sector. In parallel, it is of utmost importance to adopt the National Social Protection Strategy, as it provides coverage and a basic benefits package that includes essential healthcare services for all, including for vulnerable and marginalized groups. Financing for universal healthcare can be secured through introducing a progressive tax, among other financing mechanisms, but must be preceded by efforts to

<sup>16</sup> Jardali & Fadlallah (2017) describe how this can be achieved in practice in their study, "A Review of National Policies and Strategies to Improve Quality of Health Care and Patient Safety: A Case Study from Lebanon and Jordan."

<sup>17</sup> See this [Evidence Summary](#) by the Knowledge to Policy Center at the Faculty of Health Sciences at the American University of Beirut on accelerating progress toward universal healthcare coverage.

unify current financing mechanisms and enhance coordination among the various actors involved in the sector. This is crucial to minimizing fragmentation, duplication, inefficiency, and ineffectiveness, which significantly hinder the attainment of the right to health for all in the country.

**Data availability and transparency:** Making disaggregated data (based on gender, nationality, age, geographic location, urban/rural, type of shelter, etc.) available and possibly digitizing patient records through a national health information system can help to minimize discrimination and inequity, increase efficiency and decrease medical errors at the healthcare institute level, and improve the quality of care. Furthermore, data can facilitate national-level planning and budgeting to ensure that community and individual health needs are being met. Data is essential to developing an inclusive national public health strategy. Such a strategy must include health indicators and targets. In addition to epidemiological data, information on MoPH contracts, budgets, spending, etc., should be easily accessible to the public. This data can be used by the public and civil society to hold the government accountable through a national monitoring mechanism. In practice, efforts should be made to address the obstacles that hinder proper implementation of the Law No. 28/2017 on Right to Access Information, which obliges state institutions to share information regarding budgets, studies, reports, decisions, instructions, circulars, memos, etc., with the public, if requested (with few conditions). Obstacles include excuses from the relevant public institutions to not have to provide data and the absence of a national-level Anti-Corruption Commission. The former related to public institution resistance has been addressed, to a certain extent, through the introduction of amendments to law introduced in 2021 through Law No. 233/2021, but an Anti-Corruption Commission has not yet been established.<sup>18</sup>

Health equity cannot be achieved without addressing some of the endemic issues in our system, including corruption. Strengthening accountability and transparency mechanisms is key to minimizing corruption and regulating the healthcare sector, including public and private healthcare providers and the pharmaceutical sector. At the public healthcare level, transparency is important to ensure fair allocation of healthcare funds. Regarding the private sector, it is important to promote fair competition, ensure proper implementation of anti-corruption laws, and ensure transparency in the public procurement process.

<sup>18</sup> Merhej (2021) reviews the Access to Information Law in his [article](#), "Lebanon's Access to Information Law Has Been Amended... What's New?"

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## RELATED ARTICLES

# WOMEN AND THE RIGHT TO HEALTH IN THE ARAB REGION

*Fatima Moussawi*

## INTRODUCTION

Three factors intersect in the Arab region impacting the status of women's health: 1) The deterioration of the general health landscape,<sup>1</sup> which affects all members of society;<sup>2</sup> 2) The accumulation of various aspects of oppression to which women are subjected,<sup>3</sup> and the fact that they are deprived of most of their rights; and 3) Requiring women, directly or implicitly, to provide care and healthcare, both physically and psychologically, to others while neglecting themselves, in line with a recurring normative social and cultural system (Morgan et al. 2018). "Gender" or the concept of "social construction"<sup>4</sup> of the roles of individuals is a main factor in determining people's access to protection and gains; thus, impacting women's access to their right to health within a human rights system. Gender factors also determine and

<sup>1</sup> The health landscape is advancing in some Arab countries but deteriorating in others. However, it remains behind in data that does not reflect the global development rate, the 2030 Sustainable Development Goals, or even the long- or short-term local government schemes. According to the study by Morgan et al. (2018), this includes low- and middle-income countries.

<sup>2</sup> Certainly, by taking into consideration the educational, social, and economic differences that form the basis of access to the right to health and the ability to discuss all conditions that would guarantee the right of individuals, including women, to health rights within the human rights system.

<sup>3</sup> We particularly mean oppressive practices that are initially manifested in social and gender norms and through regimes and laws that foster discrimination and work to institutionalize it for a long time until it becomes a pillar of the regime.

<sup>4</sup> It is referred to in other reviews as gender as well as in several accompanying publications and reports. I choose to use the term gender or social construction because it is closer to the concept of what impedes access to health as a right and in the current framework as a privilege on a discriminatory basis based on roles.

shape access to health services and information, and their effectiveness and ease, and contribute to paving or obstructing the way for women in need to use and resort to this right (Dejong & Al-Haidari 2017). On the other hand, health systems in the Arab region, as in all countries around the world, are "gendered" (Habib et al. 2022). The degree of ease, effectiveness, and availability with which services are provided differs between men and women, as well as between women of different socioeconomic backgrounds, in terms of the way health services are provided or received (Al-Dosari 2017). This contributes to the emergence of gender disparities in health services, in a context where aspects of health governance and political agendas are manifested in health services and social protection for all individuals (Van Ullman et al. 2012).

The health status reality of women and girls in the Arab region cannot be separated from their economic, educational, and professional participation. The deteriorating status of women in these areas leads to a great decrease in women's awareness of their health needs and rights and their ability to claim them. Similarly, they are unable to face the systems hindering their access to the right to health on an equal basis with men or even with other women of different educational and socioeconomic conditions. In most Arab countries, women's health lacks essential material and often logistical and knowledge resources as well. Additionally, many issues related to women's health are not openly discussed, or remain overlooked even in their private lives, due to the lack of a safe space and adequate awareness to discuss these issues (Assi 2020). Women in the Arab region face multiple obstacles in accessing the right to health under both the legal and political frameworks, as they fight against sexual harassment, gender-based violence, denial of custody and inheritance, and other basic rights that they are robbed of in light of patriarchal and capitalist regimes. The denial of access to adequate healthcare is only one episode in a series of gender violations rooted in the state structure.



## EXISTING CHALLENGES

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Challenges to women's access to the right to health are manifold, ranging between cultural, ethical, economic, and political. Gender cultural norms play a role in creating an environment that directly impacts women's relationship with the health system and access to its services as one of their rights. A set of cultural and social factors are key to understand the decline in Arab women's relationship with their health-related rights. Beliefs rank on top of these factors. For instance, while many women believe in the importance of early detection of types of tumors such as breast cancer and cervical cancer, they also believe that cancer is a matter of fate. This is why some women do not undergo a preventive examination. Despite awareness campaigns, these beliefs are still deeply rooted in women's health behavior. The same applies to linking mental illnesses and their reactions, due to ingrained cultural beliefs, to envy, the evil eye, and the jinn. This inevitably leads to women not seeking medical help and psychological treatment, and resorting instead to methods unrelated to medicine (Assi 2020). Health systems cannot be blamed when it comes to beliefs, but it is necessary to understand the risk that may arise from health systems which overlook the impact of such beliefs and their resulting practices, especially since these systems pretend that disregarding this impact is not costly, and instead approach it as a way to reduce the costs incurred when women seek care.

A large number of women in the region suffer from health conditions that could have been prevented or treated. However, they preferred to wait long periods before undergoing or accepting treatment, which usually happens when the symptoms become concerning rather than when they appear. This situation is due to many structural, material, psychological, social, and cultural causes. Women and girls in the Arab region are brought up to neglect themselves and their problems; they are used to ignoring their pain and struggles. Women are also used to prioritizing caring for their husbands, children, and the family as a whole, which delays taking care of themselves. In a case study of [Yemen](#), Hyzam and Shaef (2023) indicate that in light of the socioeconomic situation, extreme poverty, deteriorating living conditions and related repercussions, women in Yemeni households are forced to deal with food scarcity by reducing the size of their own meals in order to feed

family members, selling assets, or taking on jobs that could put them at risk.

Furthermore, health insurance and access to healthcare centers are done through transactions carried out by or with the permission of men, which obstructs women's access to treatment centers, if they seek treatment at all. Al-Shahrani et al. (2014) indicate that Saudi women are admitted to the hospital approximately 13 hours after suffering a heart attack, in contrast to men who are admitted within five hours. Despite the increased awareness of women in multiple Arab countries regarding the need to respond to the health risks of individuals, this gender structural cultural differentiation in the approach to women's health and well-being compared to men remains a struggle that is not limited to discussing the right to health, but also covers acquiring health knowledge.

One of the factors preventing women from undergoing treatment procedures is the issue of resorting to a female doctor instead of a male doctor. Women are often embarrassed to see a male doctor, or prohibited to see one by their spouses. Given that there are fewer female doctors compared to male doctors, especially in some Arab countries, this factor constitutes a major barrier to women's access to the necessary healthcare. In his study of the situation in [Iraq](#), Hassan (2023) states that gender and social norms hinder the access of women and girls to adequate health services. Indeed, in the countryside of Iraq, married women or women coming from religious families only see a female gynecologist, regardless of the case, in order to avoid the embarrassment of a medical examination by a male doctor. Moreover, the norms in some hospitals in Iraq require the consent of a male member of a woman's family before any female patient can undergo any sort of surgical intervention. "For example, hospitals often deny women of surgical procedures without the consent of a male family member, fearing tribal retribution," according to Hassan's study (2023).

## POOR INFORMATION AND FINANCIAL SITUATION: REPERCUSSIONS ON HEALTH AWARENESS AND HEALTH SERVICES' DEMAND

The deteriorating economic conditions and hardships of life gravely affect women's access to health services and their understanding of health as a basic right in terms of human rights and dignity. This fact is made more evident in cases of households' low general income, when they are distant from major urban centers, and in cases of paucity of health centers and scarcity of logistical resources. According to studies by Abdulrahim and Bousmah (2019) and Hassan (2023), traditional rural gender norms also contribute to the rise of disparities in women's access to health services between urban and rural areas, as major health risks faced by women are being ignored and the importance of educating them about the necessary steps for prevention and treatment are disregarded. In fact, women struggle to access information related to family planning, health, and routine prevention through radiography and scans. Many women do not consider these tests and are not asked to perform them in many Arab cities, while they are often prescribed in other places governed by different and more prosperous knowledge and economic systems. It all goes back to health expenditure, where governments and ministries of health are responsible for allocating a significant part of their budgets and donations to push women's awareness forward and support their preventive health measures — but, is health expenditure really equitable or in women's favor (Aldosari 2017)?

## POLICY AND PRACTICE LEVELS IN THE ARAB REGION

Data, especially after the pandemic, indicate that the biggest expenditure on women's health in the Arab region occurs in the Gulf Cooperation Council states. However, the cultural

factors related to passing, from one generation to another, men's guardianship over women, their decisions, and their access to services are still linked to their right to healthcare access. These social aspects interplay with financial factors that largely impact the context of accessing health services and information (Aldosari 2017). As for the other countries in the region with weaker incomes and implemented austerity policies, they are unable to meet women's health needs. Rather, they deduct from what is originally allocated to women and at their expense in favor of other groups. Perhaps this is what women in Lebanon majorly suffer from today due to the severe economic crisis, as women's health coverage was affected by the decline in incomes and the amounts allocated for health expenditure (Moussawi 2022). Within this context, period poverty arises as women and girls in Lebanon have become largely unable to secure the resources that allow their access to sanitary pads and most personal hygiene items. They are forced to use unhealthy alternatives that may harm their bodies and human dignity, especially since the subsidy policy associated with austerity completely disregarded including women's health requirements in the subsidy basket (Saqa 2023). The same applies in other Arab countries such as Morocco, where 30% of women suffer from period poverty, and thus from the health consequences of the use of alternatives to sanitary pads.<sup>5</sup>

Within the health austerity context and its impact on women and their health, especially their reproductive health, it seems that reducing government subsidies for health services provided to women comes at the expense of women's general health and reproductive health, where health services remain exclusively limited to reproductive health related to pregnancy and childbirth. Resources thus go to women who seek reproductive healthcare within the pregnancy and childbirth framework. The actual subsidy is linked to child's birth<sup>6</sup> and safety, not to the mother as a woman who has the right to take care of her body, regardless of the importance of pregnancy and childbirth (Moussawi 2022). This is the case in several Arab countries. Sexual, reproductive, and maternal health are at the core of Arab government policies that are either aiming to adopt and highlight them or to show that they are partially or completely inexistent. Today, this situation is due to compelling circumstances, such as asylum-seeking, economic collapse, wars, climate change, and the resulting violence and displacement (Igaziz et al. 2021; Sanubar & Duman 2016). In this reality, women pay the price as they give up their right to take care of themselves in order to prioritize and take care of

<sup>5</sup> Medfeminiswiya website, "Poverty in Morocco" article, available at this [link](#).

<sup>6</sup> From the [mapping published by Heinrich Böll Foundation, written by Fatima Moussawi](#), in which Tamar Kabakian spoke about the crisis' impact on reproductive health.

the health of their families, children, and husbands (Awad & Shuja Al-Deen 2019). Subsidies for access to contraceptives is at the core of political practices or “non-practices” that were excluded from the political decision-making agenda in Lebanon with the onset of the economic crisis, significantly hindering women’s access to these means.

The decrease in maternal mortality<sup>7</sup> cases is an indicator of the development of health systems and policies. Arab countries have achieved remarkable progress within this context over the past decades. However, maternal mortality has been exacerbated today by COVID-19 and the resulting difficulty to visit care centers or follow up with specialists during pregnancy as a result of lockdowns and security measures. This has led to an alarming increase in maternal mortality rates among Lebanese women, refugees and residents in Lebanon, in light of the country’s collapse, according to a study by Kabakian et.al (2022). In parallel, Al-Shaar (2023) reports that the maternal mortality rates in [Palestine](#) have been sharply increasing during and after the COVID-19 pandemic, due to the lack of basic services related to maternal safety.

These developments reflect the regimes’ political view regarding women’s right to health and their status in political priorities. Women’s right to health in the Arab region is very much dependent on women’s positioning within the human rights framework as a whole. This right also depends on Arab countries’ vulnerability to wars, turbulences, and worsening economic decline. In Yemen, a country that is about to emerge from a devastating war that has destroyed its health infrastructure, there is a critical gap in the provision of therapeutic, nutritional, and preventive materials for pregnant and lactating women, which has led to an additional 1.3 million women facing malnutrition in 2022. Maternal mortality cases in Yemen have reached 385 deaths out of 100,000 live births due to the failure to treat the symptoms associated with pregnancy and childbirth. In parallel many obstacles face rural women in Yemen, preventing them from accessing health services, especially with the decline in resources and the paucity of female doctors, as women’s check-up visits during pregnancy are decreasing (Hyzam & Shaef 2023). [Tunisia](#) has established a national plan to reduce maternal mortality rates and supported it by ensuring health monitoring of women during pregnancy. However, inequalities persist in the access to these services between urban and rural areas, where services are free in the public sector and paid for in the private sector. Notably, Tunisia

<sup>7</sup> 2023 update issued by the World Health Organization, click on the following [link](#).

recognized the right to abortion years ago, despite recent restrictions (Ayadi & Caid Essebsi 2023).

In [Mauritania](#), the 2019 National Health Information System data revealed that only 13.3% of married women used contraception and that only 25% of health authorities provided family planning services (Al Mahboubi & Al Atigh 2023). The study by Al Mahboubi and Al Atigh (2023) lays out the steps taken by the Ministry of Health in adopting several programs to deal with reproductive health, combatting cervical diseases and birth complications, in addition to establishing specialized health programs, providing health insurance for women, and other programs that have not yet contributed to bridging the gender gap at the health level. This is because structural problems exist and are deeply rooted, including the strong influence of customs and traditions, health violence, violence against women, and early marriage. In Tunisia, for example, there have been successive laws and government procedures that are often incomplete, either in terms of incomplete texts or lack of implementation. The Tunisian labor law includes a clause that guarantees the right of women working in the public sector to obtain paid leave after maternity, and rest for breastfeeding for a period of six months, and after that, an hour of breastfeeding every day during working hours for all women in the workplace. However, this does not apply to women working in the agricultural sector, in fragile sectors and for daily wages in the context of a safe birth system (safe in 95% of the birth cases), whether in urban or rural areas, according to the study conducted by Ayadi and Caid Essebsi (2023).

## THE VISION FORWARD

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Efforts are poured to improve the health status of Arab women, but they often do not consider women's complex conditions and often ignore their strengths on the personal or collective level. Within the framework of some international programs, a woman is considered a person who needs protection, as there is no deep delving into the social and political structures that create their health reality (Assi 2020). In light of this, we present some recommendations that can serve as the foundations of

a comprehensive health vision that guarantees rights in legal texts and their implementation:

- The political, health, and social institutions in Arab countries should grant importance to women and girls' health education and raise awareness among them from an early age about their needed healthcare services, starting from schools, universities, and decentralized facilities such as municipalities. This may be important in terms of guaranteeing that the information has a wide and systematic reach. Women need better education about their health needs, to be able to claim them, have their needs met and preserved.
- Essentially, this education requires the creation and expansion of individuals' health data. These data should link health facts and phenomena with gender factors to facilitate a sound assessment and identify differences and problems in both diagnosis and treatment.
- Such data would be the main pillar for guiding policies and working on their development and implementation later, especially in the absence of an agenda aiming at pursuing women's right to health or in the existence of a political agenda that is opposing or austere to this proposition.
- Work to encourage speaking about health issues and women's health rights in a way that helps overcome fears and to break patterns as much as possible, especially outside urban areas, in order to establish practical responses and change women's attitude toward accepting and asking for treatment.
- Dive into further analysis and research on economic, environmental, and cultural factors, as well as the barriers that prevent women and girls in rural areas or areas that are less covered in terms of services and support, from accessing health services.
- Civil society organizations should unite and work to participate in raising awareness and continue advocating for improving the health conditions of women and providing them with currently prohibited rights, working to pass laws related to gender-based violence, sexual harassment, and the right to work and employment procedures that consider maternal health and reproductive conditions, and to promote them.
- A large and thorough networking between local civil society

actors and international health and women's organizations is important to raise the implemented health standards and to monitor both the preventive and treatment systems within the larger framework of women's right to health.

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*Fatima Moussawi is a Lebanese writer, researcher, and academic. Her work focuses on gender issues, feminism, and the sociopolitical history of women in the Arab region.*



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# UNDERSTANDING MENTAL HEALTH IN THE ARAB REGION: CHALLENGES AND BARRIERS TO ACCESSING THE RIGHT TO MENTAL HEALTH

*Lea Zeinoun*

## INTRODUCTION

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Over the past decade there has been a global growth in the recognition of the importance of mental health and well-being, and a demand for better mental healthcare. Mental health is an integral component of the right to health, a human right recognized in international law, declaring that everyone has the right to the highest attainable standard of physical and mental health. Despite these developments, mental health education and resources are neglected even in the wealthiest countries, in turn, impacting the right to mental health (Arab Center Washington 2022). As a result, advocates call for parity with general health funding, so that people with mental health problems have access to the same level of care as people with physical health problems. They are also calling for a reduction in the treatment gap, so that more people who need mental healthcare can get it, particularly in low- and middle-income countries (Puras et al. 2019).

Mental health is an important part of overall health. It refers to a state of well-being in which individuals can realize their own potential, cope with the stresses of life, work productively, and contribute to their communities. Mental health problems

can have a significant impact on a person's ability to function, leading to impaired social functioning, decreased productivity, and increased risk of suicide.

The right to health includes the right to access mental health care. This refers to equitable access to affordable, quality mental health services, regardless of a person's financial capacities and life circumstances, delivered with dignity and respect to the individual accessing it. However, between the provision of mental health care services and access to such services, several barriers impact the consideration of mental health and the right to access mental healthcare. While some barriers are universal such as restrictions in legislation and resource availability, other barriers are contextual and vary across communities and their unique experiences.

The Arab region is diverse, comprised of 22 countries, with a population of 400 million Arabs across the Middle East and North African region, and another 34 million immigrants (The World Bank 2022), as well as large populations of refugees and internally displaced persons (UNHCR 2022). To our knowledge there are no projections on the burden of mental illness in the Arab region. Through public surveys, the Arab Center Washington (2022) estimates that 30% of people in the region reported suffering from depression and warns against an imbalance between the increasing need for mental health services and their availability over the years to come. There is also extensive research on the prevalence of stigma around mental health, alongside a prevalence of increasing psychological distress (Khatib et al. 2023), leading individuals with mental illness to encounter the added challenges of poverty and further marginalizing them due to their condition (Dardas et al. 2015).

A review of access and barriers to healthcare delivery in the Arab region found that the developments in access to health were not uniform across diverse populations, more specifically across different socio-economic levels. The article also highlighted that in the region's work on health services and their delivery, mental health is often excluded (Kronfol 2012). These factors, among others, impact access to health services and the right to mental health for individuals in the Arab region. Understanding the challenges and barriers to attaining this right in the Arab region increases the understanding of mental health in the region, improves the development of more effective interventions and treatment programs, and can reduce related stigma, ultimately increasing access to mental healthcare as a health right.

## LOCAL ACTORS

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Public-sector organizations in the Arab region often become ineffective due to a number of factors, including limited political accountability, inefficient allocation of resources, over-politicization of bureaucracy, lack of proper skills, massive corruption and more (Jianxiu 2006). Often, this has led to the emergence of local actors, such as civil society, Community Service Organizations (CSOs), and Non-Governmental Organizations (NGOs) working on filling the gap between governments and the population. Local actors have comparative advantages such as the capacity to reach rural poor and outreach to remote areas, promotion of local participation, and cost effectiveness. Their advantages are numerous and have resulted in their current success and expanded roles. Without government bureaucracy, local actors can act more quickly, with less restrictions, giving them the capacity to pilot larger government projects, and develop a technical assistance and training capacity to assist governments (Jianxiu 2006). Over the past decade of expansion of the role of local actors, they have increased inclusion by facilitating communication upward from people to the government and downward from the government to the people and transferring knowledge and power to relevant sectors aiming to improve people's quality of life and access to rights.

## LEGISLATION

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Almost all countries in the region have a mental health policy, substance use policy, mental health program and legislation in place. A lot of this work was completed between the years of 2014- 2020 marking a significant period in the Arab region's development in terms of accepting, understanding, and responding to mental health as a right. The only countries without a policy are Mauritania and Comoros as mental health remains a challenging topic to address in government, while Lebanon and Somalia do not have mental health legislation (Mental Health Atlas 2020). Policies and legislation are

important in the field of mental health because they can help to protect the rights of people with mental illness and ensure that they have access to the care they need. The presence of these documents officially at a national level also helps to promote awareness on the topic and facilitates the normalization of addressing the topic, ultimately reducing the stigma around mental illness.

A recent review on the stigma of mental illness in the Arab region found that the lack of effective monitoring of mental health legislation and policies in the healthcare setting increased the stigma surrounding mental health. Healthcare professionals were not aware of the rights of people with mental illness and this lack of awareness was due in part to the poor enforcement of mental health policies (Merhej et al. 2019). The development of mental health policies and legislations needs to be complemented with relevant training, surveillance tools, and strategy alignment to ensure the policies and legislations are effectively playing their role in protecting the right to mental health (Merhej et al. 2019). This complementary responsibility is often difficult to accomplish in countries where social and economic instability take precedence on political agendas. Due to the national scale of these activities and the need for authority to implement policy related activities such as training of trainers, implementation of surveillance programs, and the development of national strategies, local actors, such as CSOs, are often not able to fill in the gap between governments and the population in the right to health and mental health (Merhej et al. 2019). Despite this limitation, CSOs can invest in advocacy against the violation of the right to mental health by presenting the importance of legislation and its surveillance using the consequences of its absence.

## RESOURCE INVESTMENT



Only three Arab countries have provided estimates of their mental health expenditure as a percentage of total health expenditure: Qatar (1%), Egypt (less than 1%), and Palestine (2.5%). For the remaining Arab countries, the WHO estimates that the mental health expenditure is less than 1% of total health expenditure (Mental Health Atlas, 2020). Without formal tracking of mental health expenditure, it becomes difficult

to accurately estimate the burden of mental illness, allocate adequate resources, and monitor effective mental health interventions.

Within the countries of the Arab region, health services, including mental health, are covered mostly via a hybrid model of public, private and out-of-pocket payments. In Sudan, Egypt, Yemen, Morocco, Syria, and Lebanon, out-of-pocket payments are at a rate of 55% and above (Okasha et al. 2012). In some countries, private insurance (either paid personally or through an employer) covers health services, but these companies rarely cover mental health. This is confined to companies in wealthier countries of the region such as the United Arab Emirates. This profiling of healthcare systems in the Arab region limits the right to health, as financing schemes are described to be limited to contributions and formal employment and are often complex and difficult to navigate, and they may not be available in rural areas or in the informal sector (Alami 2017). As a result, many people who need mental health services are either unable to get these services, or pay out of pocket resulting in financial hardship and even impoverishment. This can be particularly detrimental in chronic conditions of mental illness where treatment is expensive and long term. Under these circumstances, governments and local organizations, should prioritize universal health coverage to reduce inequities in accessing the right to mental health services through the provision of funded or low fee services geographically as needed.

## ACCESS

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Overall, the region struggles from inadequate resources in the field of mental health due to the limited number of mental health professionals and an unclear and insufficient amount of funding invested in the field. Over the past two decades, there have been major changes in the field of mental health in Arab countries. Countries like Morocco, Saudi Arabia, United Arab Emirates, and Lebanon have started working on the de-institutionalization of mental health: a cost-effective model for resource limited settings that moves mental health services away from central institutions and into community-based

settings. While deinstitutionalization and prioritizing community care have been found effective in mental health reformation in resource limited settings, their effectiveness is found to be significantly impacted by financial abilities, available healthcare workers and infrastructure supporting access to community services (Cohen et al. 2020).

A study on stigma as a barrier to mental health services found that healthcare professionals in the Arab world often hold negative attitudes towards people with mental illness. These attitudes were often based on cultural beliefs and stereotypes, where some healthcare professionals believed that people with mental illness are dangerous and not capable of living independently (Merhej et al. 2019). While the integration of mental health services into primary healthcare is a step towards destigmatizing mental illness, more needs to be done to change the stigmatizing attitudes of healthcare professionals such as capacity building education and training programs.

A systematic review on mental health seeking experiences among Arabs, representing seventeen studies from countries including but not limited to Lebanon, Saudi Arabia, Jordan, Egypt, Oman, and Sudan, identified logistical barriers to accessing mental health services. The barriers included long waiting time for mental health appointments, availability of the service and/or staff, transportation costs, financial constraints to cover the cost of the service and medication. These barriers restrict individuals' perceptions of their capacity to continue with care and either hinder or halt access to services (Khatib, et al. 2023). Working on accountability and inclusion when implementing mental health interventions can improve access to mental health as a basic right in several ways. First, it can help to identify and address the barriers that prevent people from accessing mental health care. Second, it can ensure that interventions are delivered in a way that is respectful of human rights. Third, it can make interventions more accessible to all people, regardless of their background or circumstances.



## CONFLICT AND INSTABILITY

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Most of the countries within the region are currently experiencing ongoing wars and social upheavals or their spillover effects. The consequences of conflict result in instability in most sectors resulting in economic strains, which often translate into recession and unemployment, and social disruption, and in turn, into isolation and decreased safety. Both the direct impact of conflict and the indirect impact it has on the economy and society increase the chances for the onset of mental health symptoms. For individuals with diagnosed mental illnesses, conflict and instability can result in deterioration of mental health progress, interruption of mental health treatment and/or the presentation of new diagnoses (Elshahat et al. 2022; Li et al. 2016; Maalouf et al. 2019; Sweileh et al. 2018).

While the need for mental health services in settings of conflict and instability increases, the capacity to provide such services decreases exponentially. Infrastructural damages, resource limitations, and a shift in priority towards immediate health sectors such as food, hygiene and shelter all limit public and private sector capacities to develop, invest and implement mental health services. Governments and local actors working in settings of conflict and instability should advocate for the inclusion of mental health in emergency response plans alongside the right to shelter, food, water, etc. This is because mental health problems are common in conflict and post-conflict settings, and they can have a significant impact on people's ability to cope with stress, rebuild their lives, and participate in society.

## CULTURE

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Mental health is still a taboo topic in many Arab countries and this stigma can prevent people from seeking help, while also making it difficult to provide effective mental health services. While the source of mental illness has been studied as a

combination of genetics and environmental risk factors (Hosak et al. 2023; Uher et al. 2017), some communities in the Arab region have culturally developed beliefs that mental illness is a punishment from God or a supernatural force, as presented in a study on Palestinian women (McKell et al. 2017) and another on Somalis (Said et al. 2021). Noteworthy, these beliefs can have negative repercussions on individuals, and can increase stigma around mental health (Ahmad et al. 2016). Further exploration of stigma links it to gender, decreasing the right to access mental health services among males in the Arab region. Males were found to be more socially cautious about discussing mental health and disclosing their mental health challenges with friends and family, and less likely to access formal mental health services (Wendt et al. 2016), this was apparent in a study on students in Saudi Arabia (Alajlan et al. 2016).

Similar to the global research on gender difference in attitude and access to mental health, studies on the Arab region report that females have more positive attitudes towards mental health and higher help seeking intentions (Khatib et al. 2023), as presented in a study on students in Tunis (Fekih-Romdhane et al. 2021). With a deeper understanding of the cultural barriers, mental health interventions can be contextually adapted to increase mental health literacy in efforts to increase individual access to their right to mental health. In their efforts to increase access to care, some countries have considered integrating religious and traditional healers' roles into formal medical care, such as in Jordan, where an informal relationship is created between healers and mental health professionals of patients, and in Saudi Arabia, where religious texts and recitations are used during the provision of mental healthcare (Okasha et al. 2012). Such integration of religious and cultural beliefs into healthcare provision and the adaptation of mental health interventions to target hard to reach groups such as men on their mental health are a few approaches local actors can use to support their efforts in increasing the access to the right to mental health.

## CONCLUSION

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Understanding the challenges and barriers to mental healthcare in the Arab region is essential to improving access to the right to mental health for the population. By addressing these challenges, we can create a more supportive environment for people with mental health problems and ensure that they have access to the care they need. With most countries in the region struggling with conflict and instability, the main actors in the field of mental health are local actors, including CSOs and NGOs. The impact of projects implemented by these local actors has given them credibility with diverse populations and international funding bodies, making them participants in discussions of national strategies and investment plans. Accordingly, this article presents diverse recommendations for local actors in response to challenges and barriers to the right to mental health.

Under the umbrella of advocacy, local actors should be advocating for legislation and its surveillance, formal tracking of mental health expenditure and the inclusion of mental health in emergency response plans to help ensure that everyone has the right to mental health. Throughout service provision, local actors are recommended to work on prioritizing universal health coverage for mental health, as a cost-effective way to improve the mental health of the population and reduce inequities in access to care. Furthermore, working on accountability and inclusion when implementing mental health interventions improves access to mental health as a basic right by providing more experiential evidence on the barriers to accessing this right and from diverse perspectives with an emphasis on vulnerable populations such as women, children, LGBT individuals and refugees. Information from the study of these barriers should be used by local actors to drive future investments to support the access to the right to mental health for people in the Arab region.

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*Lea Zeinoun is a public health professional working in the mental health field and is currently the Director of Strategic Partnerships at Embrace, Lebanon.*

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# HEALTH RIGHTS IN THE ARAB WORLD FROM THE PERSPECTIVE OF DISABILITY INCLUSION

*Shatha Abu Srour,  
The Arab Forum for the Rights of  
Persons with Disabilities*

## INTRODUCTION

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The right to health for citizens in general, and persons with disabilities in particular (being the subject of this paper), closely relates to the right to life and the right to an adequate standard of living, ensuring citizens enjoy the basics of a dignified life. In addition to the correlations between the right to health and all other remaining rights, the right to health is one of the main entry points into the different fields of life.

Furthermore, and before tackling the subject of health rights in Arab States from a disability inclusion perspective, it is necessary to briefly refer to a set of variables that affect this right, as well as other rights, for persons with disabilities, and other groups, on a policy, programmatic, and service level. The first variable relates to the various instances of colonization that many Arab States have been subjected to at different times, in the varied forms of occupation, which brought on wars, conflicts, the domination of resources, and destruction of key sectors, including the health sector; or in the dependence of many of these States on external donor funding, which influences priority-setting and intervention design on

different levels. This necessitates examining the extent to which these health-related interventions include components and requirements that are related to disability inclusion. The second variable is that most national policies, strategies, and interventions emanate from an individual approach to disability (i.e., the care/charity-based and medical approach),<sup>1</sup> widely evident, whether in sector-regulating policies, including the health sector, or in practice. The third variable is a set of questions regarding the maturity level of the state as a concept and in practice, in many regimes, including the Arab systems. This naturally reflects on the relationship between the ruling systems and their citizens and what the relationship entails in terms of roles and responsibilities, including the ruling systems' role in responding to the health rights and needs of citizens, including those with disabilities. Regardless of the fact that this variable applies to the majority of citizens, similarly to the other variables, it must be reminded that persons with disabilities, like others among the least-represented groups, often pay the higher price for the declining role of the ruling systems and the distortion of concepts relating to civic service.

The fourth variable is the vulnerable, disintegrated, and fragmented state of social protection systems or the like in numerous Arab States, leading to inquiries regarding the nature of these systems, if found, and how universal they are, and whether they are compliant with health rights, inclusive of persons with disabilities, and responsive to the requirements of the least-represented groups.

Many of the aforementioned variables deeply affect health sectors in Arab States on a policy and programmatic level. However, this paper is strictly concerned with presenting the most prominent aspects of the health sector in certain Arab States as an example. Specifically, it looks at the aspects which most impact the experience of persons with disabilities in enjoying their health rights with fairness, dignity, and independence. It is worth noting that the preparation of this paper adopted a rights-based approach to disability, established and promoted by the United Nations Convention on the Rights of Persons with Disabilities, systematically relying on literature review, observation, and a number of interviews with representatives of the Arab Forum for the Rights of Persons with Disabilities in certain Arab States.

We probably ought to briefly elucidate what we mean by an individual approach and a rights-based approach to disability, as they are essential to understanding disability

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<sup>1</sup> Clough, B., & Herring, J. (Eds.). 2021. "Disability, Care and Family Law." Routledge.

as an experience on the one hand, and dealing with it on all levels on another. The individual approach (in general) is based on the concept that disability is an experience in terms of causes and effects. A matter that is exclusive to individuals with restricted sensory, mobility, intellectual/learning, and psychological functional capacities, whereby – according to this model – those different characteristics or restrictions result in hindering persons' participation in and execution of daily life tasks, without taking into account any other external variable or factor. This concept translates into policies, programs, and interventions (if found) that solely focus on rehabilitation and relief/care services, as well as establishing special institutions.

In contrast, the rights-based approach is based on the fact that the rights of persons with disabilities are exactly all human rights ones. They are universal, integral, and indivisible, in addition to their interdependence. Thus, disability as an experience is shaped through the existence of a set of individual characteristics (sensory, mobility, intellectual/learning, and psychological difficulties) which are combined with a set of architectural, environmental, societal, and institutional obstacles and barriers, away from an acceptance of diversity, response to individual differences, and inclusion. This results in a negative interaction that prevents persons with disabilities from or restricts their enjoyment of rights and participation in society to the same extent as other citizens. This requires policy, programmatic and societal interventions, which not only target persons with disabilities, but also seek to fight discrimination, achieve justice and equality by overcoming the aforementioned obstacles and barriers, and incorporate disability inclusion requirements in all public policies, national and sectoral strategies, programs, and services.

## THE FOUNDATIONS OF UNDERSTANDING AND ANALYZING THE RIGHT TO HEALTH OF PERSONS WITH DISABILITIES

There is a set of principles and pillars upon which we base our understanding, monitoring, and analysis of the rights of persons with disabilities, in theory and in practice. We shall go



over these pillars in the following paragraphs succinctly.

If we are to define disability from a rights-based approach, we start by asserting that it is an evolved concept and an experience that emanates from the negative interaction between persons with disabilities and the environmental, policy, institutional, societal, and informational barriers, in a way that hinders or prevents their effective participation in society and their enjoyment of their rights with fairness, dignity, and independence. One of the most significant factors that could result in a paradigm shift in the reality of persons with disabilities with regards to their rights and their living conditions is the States' adoption of this concept on a legislative, judicial, and administrative level.<sup>2</sup> It is worth noting that most Arab States, such as Palestine, Lebanon, Tunisia, Yemen, and others, still apply the medical approach towards disability, the one that determines participation, the enjoyment of rights, and the ability to perform daily activities according to a person's individual sensory, mobility, intellectual/learning, and psychological differences. In other words, laws pertaining to persons with disabilities in these countries adopt a definition which focuses on the difficulty itself (i.e., the disability, whether mobility, sensory, intellectual/learning, or psychological), considering this difficulty as the factor that hinders the person's ability to perform daily functions like their peers, while neglecting the environmental, institutional, societal, and other barriers and obstacles, which greatly influence the disability experience. A few Arab States, such as Morocco, Jordan, and Egypt, have adopted more of a rights-based and social approach to disability, without taking the measures that may, in practice, affect policies, strategies, programs, and services, including those that regulate and form the health sector. The absence of this concept could lead to real crises on the levels of policies, roles, attitudes, authorities, and other.

For instance, ministries of health have a common belief that their role ends once the type and the severity of the disability is determined (regardless of any questions regarding the extent to which this service complies to quality standards). Moreover, ministries of health in most Arab countries often neglect responsibility for any disability-related programs and services, such as early detection, empowerment, rehabilitation, reconstructive plastic surgeries, and others, namely the interventions which when absent could affect persons with disabilities and threaten their right to an independent and dignified life.

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<sup>2</sup> Blanck, P., & Flynn, E. (Eds.). 2017. "Routledge Handbook of Disability Law and Human Rights." Routledge.

As is the case in most countries around the world, the diagnosis of the type and the severity of the disability determines the set of rights and benefits that a person with disabilities is entitled to have. Many other variables that could deeply impact the formation of the disability experience are disregarded, such as the aforementioned set of barriers, in addition to the socio-economic reality surrounding the disability, gender, and other. Also, the adoption of a charity/medical approach in dealing with persons with disabilities, their rights, and their interests has resulted in the ministry of social affairs or ministry of social development (as it is called in certain countries) taking over the management of all affairs related to persons with disabilities in most Arab States. As such, persons with disabilities are simply considered as social cases. Consequently, other official institutions fail to honor their commitments towards persons with disabilities and their rights.

In the same context, accessibility, universal design standards, and the provision of reasonable accommodations, are examples of a set of principles and conditions that should be regarded as the foundations and pillars upon which all other rights are based, including the right to health. Therefore, the State and its institutions are obligated to include them in the design and implementation processes of health policies, programs, interventions, and other, considering the role they play in ensuring that persons with disabilities enjoy these rights. Many reports refer to the limited availability of access requirements for persons with disabilities to the health sector, whether in terms of the built environment (architectural structures), information, or services. In addition, medical staff lack effective communication means to deal with persons with disabilities, further preventing them from enjoying their health rights. Not to mention that they receive these services under inadequate conditions.

Furthermore, non-discrimination, equality, full and effective participation, transparency, and equal opportunity for remediation and grievance processes are some of the most important conditions for governance in public institutions, including health sector institutions. Persons with disabilities are subject to many violations. These are put forth by reports monitoring the implementation of the UN Convention on the Rights of Persons with Disabilities and other international conventions issued by organizations concerned with persons with disabilities,<sup>3</sup> as well as other international and national organizations. Often times, these violations result from the predominant negative stereotypes and attitudes that strip

<sup>3</sup>The Tunisian organization for the Defense of the Rights of Persons with Disabilities. 2023. "Shadow Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities in Tunisia."

citizens of their humanity and rights if they happen to have a disability. This is evident in many circles of society, even among health workers. These violations occur in conditions that are devoid of monitoring and accountability mechanisms, especially that complaint systems, if existent, lack the necessary components for persons with disabilities to be able to use them independently, fairly, and effectively, and benefit from them. Moreover, disability-based discrimination, including exclusion, neglect, rejection, and deprivation of possible reasonable accommodations, has not been legally prohibited, prompting accountability in numerous Arab States. This jeopardizes the ability of persons with disabilities to receive health services in a way that guarantees their right to self-determination and the respect of their dignity. It also questions the nature, quality, and the provision methods of these health services to persons with disabilities.

Lastly, persons with disabilities have the right to affordable, if not free, health services (as do their compatriots) especially if we take into consideration the close link between disability and poverty and the vulnerability of social protection systems and the (lack of) inclusion of persons with disabilities in the labor market, not to mention the limited opportunities for inclusive education. We should also remember that persons with disabilities, like other people, may catch a number of diseases that have no relation with their disability. Therefore, health systems must provide them with comprehensive health services with fairness and equality. However self-evident this fact may seem, some may find the rationale for its inclusion outrageous, noting that the latest World Health Organization (WHO) Global Report on Health Equity for Persons with Disabilities has mentioned it.<sup>4</sup> The fact remains that the health sector in many Arab States lacks most requirements that enable persons with disabilities to receive all services with dignity and independently. This is evidenced by the limited measures – or lack thereof – to ensure the access of persons with disabilities to preventive services and treatment during COVID-19. A study conducted by the Arab Forum for the Rights of Persons with Disabilities that is yet to be published on social protection systems and their inclusion of disability focuses on this reality, using this specific period of time as a sample in Lebanon, Tunisia, Morocco, and Yemen. All of this to say that the predominant approach perceives disability as a variable that is separate from all other variables and circumstances.

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<sup>4</sup>World Health Organization. 2022. "Global Report on Health Equity for Persons with Disabilities." [Link](#).

## POLICIES AND LEGISLATION ON THE RIGHT TO HEALTH FROM A DISABILITY INCLUSION PERSPECTIVE AND HIGHLIGHTING CERTAIN PRACTICES

The policies on health rights for persons with disabilities in many Arab States are in reality a set of characteristics and representations that we shall try to summarize in this part of the article.

First, our readings of the current policies and legislation on health rights for persons with disabilities show that, regardless of their premise and content, they have a common denominator. They are almost completely detached from the policies and approaches used to design and enact the country's public budgets. And as allocated budgets for any given item, sector, or societal category are a conclusive indicator of the State's level of care towards that item, sector, or category, we can deduce at least two things: first, the health sector is not a key priority for many Arab States; and second, the policies and legislations on health rights for persons with disabilities are mostly symbolic, and do not exceed the acknowledgement of these rights.

Second, disability is a quasi-absent variable in the design and adoption of public policies, including health policies. It seems as if it rarely crosses the minds of legislators and public policy makers, which leads to its systematic exclusion from the drafting process and content of these policies. If we look at the Palestinian law on public health for instance, we find that it does not include any mention or provision taking into account the need to take legislative measures in response to disability. The general direction seems to be the design of a separate law regulating the rights of persons with disabilities alone in order for them to be taken into account, without paying the necessary attention to ensure that this law is in harmony with other laws. In other words, despite the Palestinian Disability Law No. 4 of 1999 stipulating a number of health rights, Public Health Law No. 20 of 2004 does not include any text linking it to the former. Division and exclusion on a policy level increase with the constrictive pressure many Arab regimes exert on civil society. This results in limited opportunities for persons with

disabilities to fully, effectively, and truly participate in public policy making, including health-related policies.

Third, the adoption of the UN Convention on the Rights of Persons with Disabilities by many Arab States cannot be ignored, prompting the amendment of many laws regulating the rights of persons with disabilities, as was the case in Egypt and Jordan, in compliance with the Convention. Adhering to this Convention, and others, is an effective instrument used by persons with disabilities to advocate for their rights. It is a tool to exert pressure on the one side, and a reference to regulate the content of public policies to ensure this content is more in line with the rights-based approach on the other.

For example, after a 63-day open sit-in inside the Palestinian Legislative Council, demonstrators succeeded in pressuring the Council of Ministers into adopting a government health insurance system for persons with disabilities and their families, largely based on the Convention on the Rights of Persons with Disabilities. However, the States' commitment to applying these laws and regulations remains a concern, especially amid the limited indicators that could reflect the extent or lack of this commitment. To this day, the system's administrative measures, which are the catalyst for the system's implementation, have not been implemented. Moreover, the state of both the enjoyment of rights and service provision has not changed since the adoption of the health insurance system, except for its gratuitous aspect (free of charge services) and other minor entitlements.<sup>5</sup>

Fourth, certain States, regardless of their adoption of the medical approach in their policies, affirm that they have decisions and instructions issued by the ministry of health and ministry of social affairs aiming to implement the law regulating the rights of persons with disabilities, as is the case in Tunisia. However, many challenges and issues hinder their implementation, namely the ability of persons with disabilities to cover the required costs, especially under the ineffective person-with-disability card system. We add to this the many forms of discrimination and mistreatment persons with disabilities face when seeking health services or filling in relevant paperwork, and the hospitals' non-compliance with criteria related to building access and other application specifications.<sup>6</sup>

<sup>5</sup> The Palestinian Disability Coalition, 2023. "Parallel report to the United Nations Convention on the Rights of Persons with Disabilities in Response to the Official Report of Palestine."

<sup>6</sup> Universal Periodic Review on the Rights of Persons with Disabilities in Lebanon, 2020 Report.

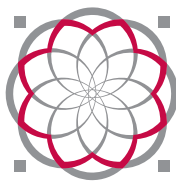
Lastly, considering the stance on drafting an endless list of recommendations, we shall simply highlight the following:

- The need to take the necessary measures to allow the full, effective, and real participation of persons with disabilities in the process of public policy-making, especially those relating to health rights, as the subject of this paper, whether the politicians consider it relevant to persons with disabilities or not, as no public policy is irrelevant to persons with disabilities, considering they are part of the social fabric of any country.
- There is also a pressing need for civil servants to reconsider the way they deal and perceive citizens with disabilities, for a disability does not lessen the value of a human being or a citizen. Rights cannot be divided, fragmented, and monopolized based on individual differences. Having inclusive, fair, and non-discriminatory health rights is one of the most important steps towards building a progressive State, as is the case for education rights.

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*Shatha Abu Srour, Palestine, has a Bachelor's degree in Social Sciences and Psychology and a Master's in Public Administration and Civil Society Organizations' Management. She has been working for over 15 years, including on a voluntary basis, in the field of rights for persons with disabilities, particularly facilitating empowerment projects, capacity-building, advocacy, protesting, networking, building alliances, and contributing to knowledge production, and other. She is now a member of the executive staff of the Arab Forum for the Rights of Persons with Disabilities and a volunteer rapporteur in the Palestinian Disability Coalition.*

*The Arab Forum for the Rights of Persons with Disabilities is a grassroots regional organization of persons with disabilities. It is comprised of 12 Arab States represented by organizations for persons with disabilities and the coalition of these organizations. The Forum aims to contribute to the protection and promotion of the rights of persons with disabilities in accordance with the UN Convention on the Rights of Persons with Disabilities and the Sustainable Development Goals, by building capacities, conducting studies, national, regional, and international advocacy, and influencing national policies and practices, allowing persons with disabilities the opportunity to participate in decision-making processes.*



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