3 GOOD HEALTH AND WELL-BEING

SDG 3

Ensure healthy lives and promote well-being for all at all ages

A. Introduction

Overall, the Arab region is making good progress on SDG 3 "Good health and well-being", with gains achieved on a number of health indicators, such as maternal and infant mortality, the incidence of tuberculosis and access to vaccines. Challenges persist in areas such as universal health coverage, sexual and reproductive health, and access to affordable health care. The burden of non-communicable diseases is high and continues to grow across the region.

Health inequalities are deepening between and within countries, and are largely driven by gender, geography, levels of education and poverty, and migration status. Protracted conflicts, forced displacement and occupation are disrupting health systems, with major direct consequences on populations, notably women and girls. These are adversely affecting mental health and well-being, reproductive and maternal health, nutrition and non-communicable diseases. The occurrence of long-term injuries has increased.[1]

Impact of the COVID-19 pandemic and global crises

The COVID-19 pandemic clearly demonstrated that people marginalized before the virus ran a higher risk of infection. Workers who could not afford to stay home and migrant workers living in difficult housing conditions were cases in point. Gender disparities in terms of income, literacy, access to the Internet and ability to quarantine put women at a higher health risk. Response measures often did not consider these factors.

The pandemic put health systems under immense pressure, exposing vulnerabilities in infrastructure and revealing deficiencies in funding, equipment and workforces. This was more the case in countries in conflict such as **Iraq,** the **Syrian Arab Republic** and **Yemen,** and under occupation as in **Palestine,** where the pandemic further destabilized already weakened health systems. Stark inequalities in COVID-19 vaccine distribution emerged, with high-income countries like the **United Arab Emirates** administering 264 doses per 100 people compared to 4 per 100 in **Yemen.**

Limited fiscal resources forced some countries to divert funding from essential health areas such as non-communicable diseases, reproductive health and mental health, redirecting it to immediate COVID-19 response efforts. This posed significant threats to the health of the region's population overall.

More recently, the war in Ukraine and concurrent global inflation have affected the availability and affordability of critical health-care items, including pharmaceuticals and medical equipment.

Sources: Dejong and Fahme, 2021; CNN COVID-19 vaccine tracker, accessed on 23 October 2023.

The One Health approach

Zoonotic diseases, such as COVID-19, present a substantial threat to global health. Factors such as increased human mobility, international travel and trade, urbanization and climate change provide opportunities for diseases to pass between animals and people and to spread fast across borders. The effective management of threats to health at the human-animal-ecosystem interface calls for the integrated, multisectoral and multidisciplinary One Health approach. It allows a greater understanding of the drivers of disease and encourages suitable strategies to manage health risks originating at the human-animal-ecosystem interface.

Qatar has effectively implemented the One Health approach for investigating zoonotic diseases such as the Middle East respiratory syndrome coronavirus (MERS-CoV) and others. It is currently working on a national plan, in the context of the Qatar National Vision 2030, to better sustain and advance One Health activities, and avert and manage health threats from the human-animal-ecosystem interface.

Sources: Centers for Disease Control and Prevention, 2023; Bansal and others, 2023; Sharek, 2023.

What the data say

Data included in this section are from the ESCWA Arab SDG Monitor, unless otherwise indicated (accessed on 24 January 2024).

The Arab region has reduced **maternal mortality** but the current ratio remains high, roughly double the global target of 70 per 100,000 live births. This issue is particularly challenging in the least developed countries, where slightly less than one in three women gives birth without skilled health personnel.

Neonatal and under-5 mortality rates have declined in the region, to 16.5 per 1,000 live births and 34.4 per 1,000 live births, respectively, in 2021. But rates remain higher than global targets. The rate in the least developed countries is around double that of the regional average for both indicators.

Mortality attributed to non-communicable diseases[2] is slowly declining in the region (from 16.2 per cent in 2015 to 14.7 per cent in 2019). It affects men slightly more than women (16.5 per cent compared to 12.7 per cent, respectively, in 2019).

The region is far from achieving **universal access to sexual and reproductive health-care services, including for family planning.** The proportion of women of reproductive age who have their family planning needs satisfied with modern methods has increased (from 61.4 per cent in 2010 to 64.1 per cent in 2023) but remains below the world average (77.6 per cent). The situation is challenging in the Gulf Cooperation Council countries (52.5 per cent) and least developed countries (39.3 per cent).

The **adolescent birth rate** is slowly decreasing in the region (43.6 per 1,000 adolescent girls aged 15 to 19 in 2023, down from 52.7 in 2015). But the rate remains higher than the global average (41.3 per 1,000), notably in the least developed countries.

Progress towards **universal health coverage** is improving at different paces, but the regional average remains below the global average. Almost two in three people (63 per cent in 2021) benefit from universal health coverage. Progress has been difficult in the least developed countries and countries in conflict.

Out-of-pocket health expenditure in the region is twice the world average (31.3 per cent compared to 16.4 per cent in 2020).[3] The percentage tends to be higher in the least developed countries and lowest in the Gulf Cooperation Council countries.

Access to vaccines in the region is at the global average or better for diphtheria-tetanus-pertussis (DTP), measles and pneumococcal conjugate (PCV) but not for the human papillomavirus (HPV).

The least developed countries struggle with **malaria**; incidence is above the world average and has continued to increase since 2015.

Trends in the **harmful use of alcohol** among adults are mixed. Since 2010, alcohol use has increased in the Maghreb and risen slightly in the Gulf Cooperation Council countries while decreasing in the Mashreq and least developed countries. Use is higher among men. Overall, the regional average (0.4 liters in 2019) remains negligible compared to the world average (5.5 liters).

Traffic deaths in the region (20.2 per 100,000 population in 2019) surpass the global average (16.7 per 100,000). Mostly men are affected, at a rate almost three times that for women.

New HIV infections remain well below the global average, with 0.036 new HIV infections per 1,000 uninfected population compared to 0.192 globally in 2021. The trend is upward, however, especially among young people aged 15 to 24 in the Gulf Cooperation Council countries, which had 0.104 new HIV infections per 1,000 uninfected population in 2021, compared to 0.065 in 2015.

Mortality caused by air pollution is an increasing concern. **Mortality due to unsafe water and sanitation** continues to be a high risk in the least developed countries and countries in conflict.

The region's **capacity to prevent, detect, assess, notify and respond to public health risks and acute events** according to the International Health Regulations has been declining[4] since 2016 and is presently at the world average. Capacity in the least developed countries is particularly low.

For an up-to-date view of SDG 3 data at the national and regional levels and an analysis of data availability, please visit the ESCWA Arab SDG Monitor.

On the road to 2030 – suggested policy approaches to accelerate progress on SDG 3

- Better targeting of subsidized health insurance schemes and other health policy measures based on more and better-quality disaggregated data, and the expansion of mandatory health insurance programmes.
- Improving the infrastructure of primary health-care centres in rural and remote regions and refugee camps while offering incentives to qualified health workers to deploy to these locations.
- Strengthening digital health and health information systems and developing digital health laws and regulatory standards to support data security and interoperability.

- Accelerating health accreditation programmes, regulating the private health-care sector and building public-private partnerships to meet needs for affordable, responsive and quality health services.
- Introducing programmes to improve health workforce governance, regulation, information and skills to increase the production and retention of health professionals.
- Supporting the more integrated delivery of sexual and reproductive health programmes and services and enhancing coordination mechanisms among different providers (Government, private sector, development partners and civil society).
- Escalating the policy response to non-communicable diseases as well as policy coordination and enforcement for more effective prevention and control.
- Strengthening the application of mental health policies, bolstering funding for related services and implementing mental health promotion and educational activities to end stigma around mental health.
- Exerting greater efforts at the international level to enforce international humanitarian law to protect health-care systems and personnel from targeted attacks in conflicts.

B. The policy landscape for SDG 3

Achieving SDG 3 is intricately intertwined with the realization of other SDGs that affect key determinants of health. For instance, SDG 1 (no poverty) and SDG 2 (zero hunger) can significantly impact health outcomes. SDG 4 (quality education) shapes behaviours and lifestyles with high impacts on health. SDG 5 (gender equality) is crucial for addressing gender-based health disparities, while SDG 6 (clean water and sanitation) underpins disease prevention. SDG 10 (reduced inequalities) supports equity in access to care through universal health coverage grounded in primary health care. SDG 11 (sustainable cities and communities) is essential for improving physical and social environments, and securing resources for health and well-being. SDG 13 (climate action) supports more climate-resilient and environmentally sustainable health systems, and helps ensure that health is at the centre of climate change mitigation policies. SDG 16 (peace, justice and strong institutions) empowers national institutions to put in place and monitor ambitious SDG responses. SDG 17 (partnerships for the goals) mobilizes partners to follow-up on and support the achievement of health-related SDGs.[5]

The majority of Arab countries have included the right to health in their constitutions.[6] All have adopted legislation and/or national policies and plans on health. The region's SDG 3 policy landscape has more commonalities than differences.

Most States are extending the coverage of health insurance schemes to reach more people. Common approaches have included reviewing income levels under subsidized civil health insurance schemes and expanding coverage to more population groups, such as migrants and refugees, older persons, the unemployed, the self-employed and informal sector workers.

Across the Gulf Cooperation Council countries, health systems offer nationals free or highly subsidized health insurance. Policy approaches are evolving to secure the coverage of migrants. In **Saudi Arabia,** for example, the 1999 Cooperative Health Insurance Law requires all non-Saudis to be covered by mandatory health insurance.[7] Disparities in enrolment fees and coverage modalities, however, both between nationals and migrants[8] and between those working in the public and private sectors, remain critical barriers to universal coverage.

Middle-income countries are extending health insurance coverage to the most vulnerable groups by subsidizing their contributions. For example, the Universal Health Insurance Law issued by **Egypt** in 2018 provides coverage to everyone except military personnel.[9] Those unable to pay

Subsidized health insurance systems face challenges in terms of targeting efficiency. Criteria for identifying beneficiaries often do not effectively use means-tested benefit approaches, such as household-adjusted equivalent expenditure or needs-based assessments, to accurately target and help intended groups. Limited access to accurate and up-to-date data on the health status, income levels and health-care needs of the population also hinder the effective targeting and tailoring of interventions. Inefficiencies and fragmentation within health systems combined with poor coordination result in duplicated efforts and increased costs.

Source: ESCWA, 2022b.

their contribution fees receive free health care funded by the Government. The programme is to be implemented over a 15-year period. Enrolment is optional for Egyptian nationals residing abroad and for foreigners living or working in Egypt. By 2019, approximately 56.9 million Egyptians were covered by this scheme, up from 51.1 million in 2015.[10] In **Tunisia,** health-care insurance was extended to low-income families, persons with disabilities and unsupported children under the National Programme of Assistance to Needy Families[11] at no or reduced fee.

Similar policies are being adopted in the least developed countries. For example, the **Comoros** enacted a law in 2017 on a compulsory national health insurance system[12] being established with donor support.[13] The National Health Insurance Fund of **Mauritania** extended its coverage in 2019 to benefit all citizens, including those in the informal sector, on a voluntary basis against a fixed fee. But this remains out of reach for the poorest due to high cost.[14]

◆ **Countries of different income levels are strengthening primary health-care delivery systems at the community level,** including in underserved rural areas and refugee camps, to reduce the burden on public hospitals, increase access to comprehensive health services and achieve universal health coverage. Key efforts[15] include infrastructure development, particularly the construction and renovation of primary health-care facilities, and improved referral networks between primary health-care centres and hospitals.

Based on its National Health Strategy, **Saudi Arabia** has built new clinics and upgraded existing facilities, leading to tangible improvements in child and maternal health, infectious diseases and non-communicable diseases, especially in rural and remote communities.[16]

Algeria established a network of 1,714 polyclinics that offer, at a minimum, medical consultations, dental care, care for mothers and children, nursing care, health education and prevention activities, vaccination and care for first-line emergencies.[17] In **Lebanon,** the primary health-care network grew to 212 centres by 2020. Syrian displaced persons were granted access to these services with funding from the United Nations High Commissioner for Refugees (UNHCR). The Plan Santé 2025 of **Morocco** focuses on strengthening primary health care, particularly in rural regions, with an emphasis on maternal and child health and non-communicable disease interventions. The policy involves developing health-care infrastructure, including new health centres, and enhancing governance and resource allocation. It has increased access to services, aided by mobile medical units and improved quality of care at primary facilities. The policy also promotes preventive health care through awareness campaigns, resulting in more individuals seeking preventive services. Implementation has exceeded targets,[18] with notable increases in antenatal care, child visits, diabetes diagnosis and treatment, and rural primary health-care visits.

A family health model centred on multi-professional teams within primary care centres has been adopted particularly in the least developed and some conflict-affected countries to enhance overall population health and alleviate the burden of high out-of-pocket expenditures. Such an approach is prioritized, for example, in the National Health Policy (2014–2023) of **Iraq,** the first Roadmap Towards Universal Health Coverage (2019–2023) of **Somalia** and the National Health Sector Strategic Plan (2017–2020) of the **Sudan**.

In **Mauritania,** the Government sought to address the high percentage of out-of-pocket health expenditures borne by households (constituting almost 47 per cent of current health expenditure in 2020) through the national social transfer programme, *Tekavoul*. It provided cash transfers to the poorest households, linked to health-care usage and participation in awareness sessions. Although such measures aim to widen coverage and address financing challenges, potential barriers such as care quality need consideration to enhance effective enrolment and implementation.

Source: WHO Global Health Expenditure database, accessed on 7 April 2023.

Sustainable financing is still needed to improve the infrastructure of primary health-care centres in rural and remote regions and refugee camps, ensure the availability of medical treatments and supplies, and offer incentives to qualified health workers to deploy to them.

In almost all Arab countries except **Palestine,** rural areas have a higher likelihood of experiencing health-care deprivation. Rural residents lack insurance coverage for extended periods and have lower access to certain services, such as tests for chronic illnesses. Most government health-care spending is directed towards hospitals primarily situated in urban regions, disproportionately benefiting urban areas over rural ones.

Source: ESCWA and Economic Research Forum, 2019.

Recent efforts to improve primary health care in the **Sudan** were challenged by the insufficient transfer of funds from the central Government, and the lack of written policies for health directorates to manage such a transformation. Protracted unrest, particularly with the rapid escalation of violence since early 2023, could potentially impede all ongoing efforts and hinder progress that has been made.

Source: As reported by the Federal Ministry of Health in the Sudan, Sudan Common Country Assessment, 2016.

Most countries have policies on sexual and reproductive health, maternal health, and the health of infants, children and adolescents, but lack integrated services[19] for improved outcomes. A global World Health Organization (WHO) policy survey shows that with few exceptions, Arab countries have covered between 75 and 99 per cent of 16 related policy areas.[20] Typically covered areas include family planning and contraception; antenatal, childbirth and postnatal care; and child health. Less covered areas comprise cervical cancer prevention and control, early childhood development, adolescent health and violence against women (see chapter on SDG 5 for legislation on combatting violence against women).

In most countries, sexual and reproductive health programmes continue to be managed independently from the national health-care system. Responsibility within the Government for these programmes may be with a ministry other than the health ministry. The private sector, development partners and civil society organizations play key roles in several countries (e.g., **Egypt, Jordan, Lebanon, Morocco, Palestine** and the **Sudan**), resulting in fragmented service planning and implementation.[21]

The focus of sexual and reproductive health services integrated in primary health care in most countries is maternal health care, child health and family planning.[22] Other essential services, such as screening for reproductive cancers and sexually transmitted infections, are offered in primary health-care facilities in some countries, such as **Lebanon, Morocco, Oman, Palestine, Tunisia** and the **United Arab Emirates.** Some also include services related to the prevention and management of gender-based violence; in **Lebanon,** these services are delivered in humanitarian aid programmes.[23] HIV/AIDS services are integrated into existing sexual and reproductive health services in primary health-care facilities in a few countries, including **Morocco, Oman, Tunisia** and the **United Arab Emirates. Oman** is the only country that incorporates all elements of sexual and reproductive health into primary health-care services, promoting an optimal use of human, financial and infrastructure resources.[24]

In the least developed countries, the focus continues to be on reducing morbidities and mortalities related to sexual and reproductive health. Examples include the new 2021 strategy of **Djibouti,** which emphasizes capacity-building and incentives to enhance sexual and reproductive health services. the 2019–2023 strategy of **Somalia** aims to reduce in-country disparities and improve access to these services as part of primary care.

Most countries in the region have plans, strategies or programmes on family planning and other reproductive rights but these are not always supported by a legal framework. For instance, although **Egypt, Jordan, Morocco** and **Tunisia** have plans, strategies or programmes on family planning and are dedicated to securing access to a wide range of family planning methods, they do not have regulations that guarantee access to contraception for women. The Criminal Code in the **Syrian Arab Republic** prohibits advertising, promoting, selling or procuring contraception and its use. Nonetheless, relevant national strategies and development plans commit to family planning.

Abortion on demand is only legal in Tunisia. It is permitted in some countries based on certain legal grounds, such as saving a woman's life, the preservation of her mental or physical health, rape or incest and foetal impairment. Post-abortion care in all countries is lacking given that abortion is not legal.[25,26]

Many countries do not have policies that comprehensively cater to the sexual and reproductive health needs of adolescents and youth, notably young women, youth in rural areas and youth with disabilities.[27] Where policies exist, multiple challenges discourage access to care and result in poor outcomes, including sociocultural norms and taboos, gender power dynamics and inequalities, and conflict and fragility. Remarkably, in 2019, **Tunisia** adopted its National Strategy for the Promotion of the Health of Teens and Young People. In 2020, it established a network of youth-friendly clinics to facilitate access to sexual and reproductive health services.

The integration of sexual education in school curricula has been slow. Policies exist in some countries,

such as **Lebanon, Palestine,** the **Syrian Arab Republic** and **Tunisia.** In 2010, **Lebanon** issued a decree to introduce reproductive health education and a gender curriculum in schools yet implementation lags.[28]

Most countries have national policies and guidelines that support high-quality midwife-led care as well as sound midwifery education and training programmes. They limit the range of interventions that midwives are authorized to provide, however, even though global standards allow them to perform most sexual and reproductive health interventions. Given these constraints and an overall shortage and inequitable distribution of care providers, especially in rural and underdeveloped areas, the region meets only an estimated 79 per cent of needs for essential sexual and reproductive health interventions. This shortfall is particularly acute in least developed countries and countries in conflict.[29]

Youth and men are not included in sexual and reproductive health services in primary health-care facilities focused on women and children.

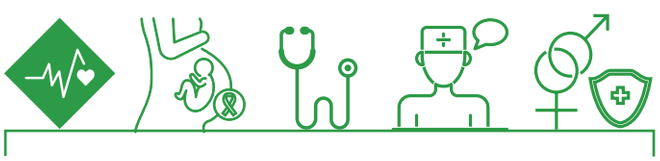
Sociocultural norms often hinder women and couples from making free and responsible decisions about family planning and contraception. Choices often hinge on factors such as education, income level and geographic area.

The accessibility and quality of sexual and reproductive health services vary depending on social class, displacement status and geographic location, and on marital status, with unmarried youth continuing to be left out of services and education.

New sexual and reproductive health problems resulting from vulnerabilities due to conflict and forced displacement are emerging in countries affected by protracted crises (see more on harmful practices in Chapter on SDG 5).

The least developed countries have limited reliable data on sexual and reproductive health. In some instances, as in the **Sudan,** cultural norms, social stigma and traditions contribute to the lack of evidence on critical health indicators and impede efforts to address harmful practices, such as female genital mutilation.

Sources: UNFPA and MENA Health Policy Forum, 2017; UNICEF, 2021.



◆ **To address the increasing burden of non-communicable diseases, many Arab countries have developed multisectoral strategies or action plans for various diseases and common risk factors, including unhealthy diets, sedentary lifestyles, smoking and alcohol consumption.** Countries without an integrated policy are mostly those that are least developed or in conflict, namely **Djibouti, Libya, Somalia,** the **Sudan,** the **Syrian Arab Republic** and **Yemen. Jordan** lacks an integrated policy[30,31] but monitors non-communicable diseases and related risk factors.

Access to health-care services and medications for non-communicable diseases continues to be a challenge for refugees. In **Jordan,** the proportion of Syrian refugees suffering from such diseases and unable to access health-care services and medications due to high cost increased from 24 per cent in 2014 to 58 per cent in 2015.

Source: The United Nations Country Team Common Country Assessment of the Hashemite Kingdom of Jordan, 2017.

A common approach entails integrating the treatment of non-communicable diseases into primary health-care centres, as stipulated in the National Action Plan for the Prevention and Control of Non-communicable Diseases (2013–2017) of **Iraq** and the Non-communicable Diseases Prevention and Control Plan (2016–2020) of **Lebanon. Tunisia** developed and validated a Multisectoral Strategy for the Prevention and Control of Non-communicable Diseases (2018–2025) to mobilize resources for equitable access to early diagnosis and treatment. The **Comoros** recently adopted a National Policy to Combat Non-communicable Diseases (2020–2029), with a particular focus on the prevention and coverage of treatment for diabetes.[32]

In the Gulf Cooperation Council countries, where non-communicable diseases are responsible for almost 75 per cent of all deaths and disabilities,[33] there is a clear focus on the promotion of healthy lifestyles. For example, the National Programme for Healthy Living (2013–2017) of **Kuwait** emphasizes obesity and diabetes. **Saudi Arabia** implemented a comprehensive strategy on healthy eating in 2018 as part of its broader efforts to encourage healthier living. The Saudi Government launched the Obesity Control and Prevention Strategy 2030, which establishes national targets to reduce obesity and diabetes by 3 per cent and 10 per cent, respectively, by 2030.

All countries except Somalia and the State of Palestine are parties to the WHO Framework Convention on Tobacco Control, which entered into force in 2005; Morocco has yet to ratify it.[34] Only some countries have

implemented the convention, however, and enforcement differs widely,[35] falling short on SDG target 3.a, which requires stepping up implementation. The convention requires parties to take both demand- and supply-side reduction measures. Among the general obligations is the adoption of a comprehensive multisectoral national tobacco control strategy; only the **Comoros** and **Lebanon** have yet to take this forward.[36] Some convention measures that have been introduced include:[37]

- **Imposing taxes on cigarettes:** all countries with data available[38] have taxed cigarettes to reduce their affordability. Only four countries, namely, **Egypt,**[39] **Jordan, Morocco** and the **State of Palestine,** have set the tax rate at equal to or more than 75 per cent of the retail price, which is the rate proven effective in reducing demand for tobacco products. Taxes work especially well in deterring the young, who are more sensitive than adults to price increases.
- **Banning smoking in public places:** six countries, **Egypt, Iraq, Jordan, Lebanon, Libya** and the **State of Palestine,** have completely banned smoking in all public places. Other countries have partial or no bans. Compliance is mostly low to somewhat moderate.
- **Introducing health warnings on cigarette packages:** five countries (**Djibouti, Egypt, Mauritania, Qatar** and **Saudi Arabia**) require large health warnings on cigarette packages with specific characteristics.[40] **Saudi Arabia** requires plain packaging, a policy that scraps promotional, marketing and advertising features on tobacco packs. Other countries have introduced warnings that do not fully conform to appropriate criteria.
- **Banning tobacco advertising, promotion or sponsorship:** several countries (**Algeria, Bahrain, Djibouti, Iraq, Jordan, Kuwait, Libya, Mauritania, Qatar, Saudi Arabi,** the **State of Palestine,** the **Sudan,** the **United Arab Emirates** and **Yemen**) have introduced bans on all forms of direct and indirect advertising. Others have bans that are not as comprehensive.
- **Implementing mass media campaigns:** five countries (**Bahrain, Jordan, Morocco,** the **State of Palestine** and **Tunisia**) have recently[41] implemented mass media campaigns to educate the public on the harmful effects of tobacco use and second-hand smoke for a minimum period of three weeks in line with specific standards.[42] Other countries have undertaken media campaigns that do not completely follow these standards.
- **Improving access to tobacco cessation services: Qatar** established a national help line to assist those seeking to quit smoking, along with an informative website and various options for nicotine replacement therapy. The anti-smoking programme of **Saudi Arabia,** offered in smoking clinics, resulted in nearly 30 per cent of participants successfully quitting smoking in 2019.[43]

In terms of non-communicable diseases, more needs to be done to strengthen the policy response, enforcement efforts and multisectoral action. Cooperation with sectors such as education, agriculture, transport, urban planning and finance is critical since prevention goes beyond the health sector. Coordination is required to address the structural and environmental factors that influence these diseases.

Gaps in government funding and a lack of regulatory measures to promote healthy diets are evident, particularly in middle- and low-income countries. There is untapped potential for using digital health for surveillance. Fragmented data systems hinder effective reporting and management.

Greater monitoring and assessment of intervention programmes and policies is required. This would enhance data availability and relevance, and better inform programme and policy design.

Reorienting services to non-communicable diseases is needed and can be managed by enhancing the skills, numbers and composition of primary health-care personnel, and integrating prevention and management into well-established primary health-care services.

The region is way behind on interventions that address the commercial determinants of health and make a difference in terms of nutrition and non-communicable diseases. The media's role in marketing unhealthy food to youth necessitates particular policy action.

Source: Abdul Rahim and others, 2014.

◆ **Several countries have developed a national digital health/e-health strategy or policy to institutionalize the use of information and communications technology for health and well-being.** They include **Bahrain, Egypt, Qatar, Saudi Arabia** and the **Sudan.**[44] **Oman** has embedded its digital health strategy in its national health strategy. Progress in implementation varies among these countries.[45]

A few other countries, namely, **Kuwait, Lebanon, Libya, Somalia** and the **State of Palestine,** are developing digital health strategies.[46] **Lebanon** has elaborated a Vision for Digital Health Transformation that paves the way to a comprehensive digital health strategy and action plan, accompanied by results and monitoring and evaluation frameworks. The vision is guided by the National Health Strategy launched in early 2023. One strategic direction is the strengthening of the national health information system to enhance the resilience and adaptability of health care,[47] and achieve more efficient, effective and targeted delivery.

Many countries progressed in using digital health solutions as part of the COVID-19 response. Nevertheless, such use was relatively limited given the potential of digital health to dramatically improve health systems and health-care delivery. Examples include the following:[48]

- **Telemedicine,** a health-care service delivery tool, was used mostly by the private sector in various countries, including **Egypt** and **Saudi Arabia,** among others, for online consultations, patient referrals, diagnostics, and inpatient care and management.
- **Mobile applications,** such as the Electronic Mother and Child Health application (e-MCH) and the application for non-communicable diseases (e-NCD), were used in **Jordan, Lebanon, Palestine** and the **Syrian Arab Republic** for the diagnosis and management of patients.
- **Electronic contact tracing** was used in **Tunisia.**
- **Electronic inventories and registries** were deployed in the **Sudan** to support the home delivery of medicines, mainly to patients with non-communicable diseases.

In the Gulf Cooperation Council countries, the digitization of health-care systems predates the COVID-19 pandemic and was already bringing substantial benefits, including improved health-care quality and physician performance, more accurate patient health monitoring, and better chronic disease management, diagnostics and preventive care. These technologies were instrumental in crisis management during the pandemic, enabling data-driven decisions and efficient resource allocation. Examples of selected measures to promote digital health include:

- The National E-health and Data Management Strategy (2016–2020) in **Qatar,** which sets standards and policies to improve the national e-health ecosystem, ensure the availability of high-quality digital health information and enhance patients' safety and engagement in managing their health.
- The Health Sector Transformation Programme[49] in **Saudi Arabia,** under its Vision 2030, which plans to restructure and digitize the health sector and enhance the quality of care by expanding e-health services. A suite of applications, including Sehhaty, Seha, Mawid, Wasfaty and Tabaud, provides effective virtual programmes such as health consultations, specialized clinics and virtual home care services.
- Investment in technology and digital health infrastructure by the **United Arab Emirates.** Malaffi, a health information exchange platform initiated by the Department of Health in Abu Dhabi, now connects the entire health-care sector, linking 45,000 authorized users with hospitals and 2,000 public and private health-care facilities.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Data security concerns and risks to people and health systems emanating from conflict and political unrest hamper the use of digital technologies.

The weakness or fragmentation of digital governance in most countries; the lack of national digital architecture plans, policies and standards to attain interoperability; and inadequate strategic planning limit the impact of investments in digital health.

Weak public-private partnerships in implementing digital health projects in several countries leave the private sector as the main provider but without sufficient supervision and coordination, leading to further fragmentation.

Inadequate national capacities for managing digital health limit the ability to implement solutions suitable for national contexts. Further, language, socioeconomic factors, disability status and digital literacy can all be barriers and must be considered in developing applications.

Source: WHO, 2022a.

◆ **Most countries continue to expand the capabilities of their health data collection and management systems.** These efforts are critical in fighting communicable and non-communicable diseases, and guiding evidence-based health programme planning and policymaking. The compilation of quality health data remains a challenge for several middle-income and least developed countries due to government coordination challenges, the fragmentation of health information systems, and low human and technical capacities. The following are some examples of efforts to enhance health data collection and management:

- **Tunisia** continues to increase the coverage of its information system on causes of death and to enhance the quality of registered data. Through

collaboration with different partners and active data collection efforts, the rate of coverage increased from 40 per cent in 2017 to 61 per cent in 2020. Quality remains at a medium level, however; further efforts are needed to achieve intended results.[50]

- The Ministry of Health of **Libya,** in collaboration with WHO, plans to improve its health information management by expanding district health information software to reach all municipalities.[51] Nonetheless, further comprehensive reporting is needed, particularly in light of the absence of a national health data repository and standardized guidelines for data management and assessment. Financial constraints pose a significant challenge.
- A fragmented health information system was reported in **Somalia** until 2017, when district health information software was introduced for the collection, reporting and analysis of health data. A Health Information System Strategic Plan for 2018–2022 addressed monitoring gaps. By 2021, reports indicated that the system was more updated and efficient in integrating disease surveillance, response mechanisms and public health alerts.

◆ **Over the past decade, almost all countries[52] have developed a standalone policy or plan and/or legislation on mental health or have integrated mental health into policies for general health,[53]** recognizing the importance of mental health as a right.

Mental health services are mostly integrated into primary health care. This can help to destigmatize mental illness but may require capacity-building and training to change stigmatizing attitudes among health professionals. Financing schemes for mental health are mainly limited to contributions and formal employment. They are mostly covered, like other health services, through a hybrid model of public, private and out-of-pocket payments.[54] A trend towards the de-institutionalization of mental health care has picked up in some countries. **Lebanon, Morocco, Saudi Arabia** and the **United Arab Emirates** have moved mental health services into community settings.[55]

Although some least developed countries and countries in conflict have developed a mental health policy or plan and/or legislation, the extent to which these have been operationalized is debatable, given insufficient human and financial resource allocations. Civil society organizations and non-governmental organizations (NGOs) are the main actors in the field. Payment for mental health services in most countries is almost entirely out-of-pocket.[56]

Examples of policies, plans and legislation on mental health include the following:

- The National Plan for the Promotion of Mental Health (2017–2020) in **Algeria,** which focuses on strengthening the regulatory framework for mental health, training health personnel, developing mental health research and establishing a mental health information and communications system.[57]
- The Mental Health and Substance Use Prevention, Promotion and Treatment Strategy (2015–2020) in **Lebanon,** which prioritizes strengthening mental health governance and the provision of mental health services in community based-settings for all, especially vulnerable groups. It underscores coordinated research on mental health and the implementation of activities to promote mental health and prevent substance abuse disorders.[58]
- The provision of mental health support under primary health care in **Bahrain** to make mental health services more accessible and reduce stigma associated with seeking help for mental health issues.
- The issuing of the first mental health law in 2019 (Law No.14) in **Kuwait** to improve treatment and rehabilitation and to protect individuals suffering from mental health issues.
- The development of a national policy on mental health in the **United Arab Emirates** in 2019 to foster public and private efforts to promote comprehensive care, including preventive, curative and rehabilitative services. A mental health-care draft law was passed in 2021 to protect the rights of people who seek mental health care and to facilitate the rehabilitation of psychiatric patients into society.

The region has poor enforcement of mental health policies and no effective monitoring in health-care settings.

Resources are generally inadequate, both in terms of the number of mental health professionals and the amount of funding. Services are limited.

There is still stigma around mental health in many countries, including among health-care professionals. This can discourage people from seeking help and prevent the provision of effective mental health services.

Differences in perceptions of mental health have gender dimensions, with women generally having more positive and open attitudes.

In countries affected by conflict and crisis, mental health issues are more prevalent among female youth, partly due to sociocultural norms that permit boys to spend more time outside homes than girls.

Sources: Zeinoun, 2023; UNICEF, 2021.

The health workforce and governance

Despite the health workforce being a key health system resource, the region faces constraints related to workforce production and availability of skills. While Gulf Cooperation Council countries and least developed countries (**Djibouti, Somalia,** the **Sudan** and **Yemen**) have limited production capacities, middle-income countries (**Egypt, Jordan, Lebanon, Morocco** and **Tunisia**) and countries in conflict (**Iraq, Libya,** the **State of Palestine** and the **Syrian Arab Republic**) have imbalances in the mix of skills. The increase in the number of institutions for health education has not kept pace with population growth, keeping the density of health professionals low, especially in **Djibouti, Egypt, Iraq, Morocco, Somalia,** the **Sudan** and **Yemen.**

In the Gulf Cooperation Council countries, a continual increase in the density of health professionals has been largely due to the recruitment of expatriate health workers. These countries face high turnover as a result, however. Middle-income, least developed and conflict-affected countries struggle with the unmanaged migration of health workers and their mobility from the public to the private sector due to limited employment options, among other issues. The geographic distribution of health workers is inequitable within countries, with low retention in rural and remote areas. Concerns with performance and motivation also exist.

Health workforce governance in the region is marked by common challenges, including:

- Inadequate workforce development policies and strategies: very few countries (**Jordan, Somalia,** the **Sudan** and **Yemen**) have developed health workforce strategic plans.
- Inadequate regulatory frameworks.
- Limited health workforce governance capacities: responsible departments in health ministries are generally weak, and lack leadership and management capacities and adequate cross-sectoral cooperation.
- Lack of effective health workforce management systems: strong systems, including staffing norms; strategies for recruitment, deployment and retention; regulations on the working environment and performance management; and data for planning and training are prime elements to deliver quality health services. They require improvement in most countries.
- A dearth of accurate and up-to-date data and information on the health workforce, labour market dynamics and health workforce financing.
- A lack of strategic planning to address health workforce challenges.

Sources: WHO, 2018, 2020a, 2023b.

C. Policy trends by subregion

1. Gulf Cooperation Council countries

The Gulf Cooperation Council countries have relatively well-developed health systems providing quality health services to their citizens. All countries score high on the Universal Health Coverage (UHC) Service Coverage Index, ranging from 70 in **Oman** to 82 in the **United Arab Emirates** in 2021. Out-of-pocket expenditure is low, even below the global average. Health insurance for expatriates is extended mainly through an employer-funded package, creating a dual-tier system and a shift from collective risk-sharing to a private insurance model.

◆ **Several Gulf Cooperation Council countries are initiating reforms to encourage private sector and foreign participation in health care.** This transition[59] marks a strategic shift from Governments being both investors and operators of health-care facilities to primarily focusing on strategic governance, planning and oversight, acting as policymakers and regulators. In tandem, private sector expertise and resources are leveraged to meet growing health-care needs, including by significantly contributing to infrastructure development, efficiency, innovation and service quality as well as the production and distribution of medicines

and health technologies. By emphasizing patient experiences, the private sector could also help position some Gulf Cooperation Council cities as global medical hubs. Examples of reforms to promote private sector and foreign participation include the following:

- **Saudi Arabia** introduced amendments to private health-care regulations. Resolution No. 683151 of 1436 H (2015 G) opened the door for foreign parties to own hospitals, pharmacies and medical treatment centres in the kingdom, provided that they already operate health-care facilities outside Saudi Arabia.
- In the **United Arab Emirates,** Law No. 22 of 2015 was introduced to facilitate the regulation of partnerships between the public health system and the private sector in Dubai. A similar law in 2019 regulates public-private partnerships in Abu Dhabi. The operationalization of both laws has faced delays and a lack of clear implementation procedures.

Greater reliance on the private sector in health-care delivery, particularly in a dual-tier system, can potentially exacerbate disparities due to higher costs. This necessitates government oversight and comprehensive regulation to ensure quality, access and affordability for all. Governments need to ensure that increased private funding does not automatically result in the deterioration of public sector services for marginalized populations.

Source: Kronfol, 2012.

2. Arab middle-income countries

Arab middle-income countries face increasing demand for health services from growing populations and challenges in financing the sector. Health systems confront the re-emergence of infectious diseases in some cases as well as an increasing burden from non-communicable diseases.

Middle-income countries have a relatively high share of out-of-pocket health expenditure. All are above 30 per cent of current health expenses and, in some cases, are as high as 55 per cent, such as in **Egypt.**[60] Despite reforms, significant inequalities in accessing affordable treatments and paying for health-care services and medications remain. Particularly vulnerable populations include poor households, older persons, people with chronic diseases, people with disabilities and refugees.

◆ **While middle-income countries have largely managed to end epidemics of communicable diseases, they must maintain and develop national programmes to closely monitor, prevent and treat these diseases,** some of which have recurred among refugee populations. For example:

- Facing one of the highest hepatitis C infection rates in the world, **Egypt** in 2014 launched a nationwide initiative (100 Million Healthy Lives) through which it tested some 60 million high-risk people and treated some 4 million. This helped to bring down the infection rate considerably. Egypt plans to sustain its efforts until the epidemic is eradicated.[61]
- **Jordan** in 2020 established the National Epidemiology and Infectious Diseases Centre to enhance the country's readiness to face emerging and re-emerging infectious diseases. One priority for the Centre from 2023 to 2025 is to expand the availability and integration of high-quality monitoring data to guide national policymaking.[62]
- **Morocco** continues to increase resources for its National Tuberculosis Control Programme, mobilizing national and international partners around the eradication of the disease. Tuberculosis continues to take lives in Morocco due to social, economic and environmental determinants of health that require combined efforts under a multisectoral framework.[63]

◆ **Middle-income countries are investing heavily to expand health system infrastructure and workforces.** For example:

- **Morocco** is upgrading its network of public hospitals, allocating 1 billion dirhams annually since 2016. To address its medical staffing deficit, it has increased the budget allocated to the Ministry of Health to hire more medical and paramedical personnel, including for university hospital centres.[64] Complementary efforts are still needed to enhance the performance and distribution of existing personnel.


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Collaboration with international and civil society partners to extend health care to refugees

Partnerships among various stakeholders have been instrumental in extending and maintaining health-care services for vulnerable populations in the middle-income countries. International donors provide crucial support by strengthening health-care infrastructure, building capacities, increasing preparedness for future health crises and bridging funding gaps. In **Jordan** and **Lebanon,** where prolonged refugee crises have strained health-care systems, collaboration with the United Nations system and NGOs has been pivotal. The health response strategy in Lebanon, A New Approach: 2016 & Beyond, focuses on coordinating efforts among the United Nations, international NGOs and civil society to prioritize essential health-care services for both Syrian refugees and Lebanese host communities. Similarly, Jordan has engaged in partnerships with the United Nations and actively involved civil society organizations in health-care planning to ensure continued free and subsidized access to health care for Syrian and Palestinian refugees.

The presence of multiple actors in health care can lead to fragmentation and inefficiencies in service delivery, especially with short-term projects. The lack of sustainable funding may also hinder the continuity of services, while the influence of donors may divert resources from local needs. There is consequently a need for careful coordination, sustainability planning and efforts to ensure that long-term domestic investment in health care is not neglected.

Source: Atrache, 2021.

3. Arab least developed countries and countries in conflict

Arab least developed countries have low levels of government health spending. Households remain the main source of health financing, which results in health-related expenses pushing people into poverty. In the **Sudan,** households contribute to nearly 57 per cent of health financing, the highest rate of out-of-pocket expenditure among Arab countries with data available.[65] Persistent health challenges include high under-5 child mortality in the least developed countries; at 68.4 deaths per 1,000 live births, the rate is nearly twice the regional average and more than double the 2030 SDG target 3.2 of under 25 deaths per 1,000 live births. Almost 30 per cent of women in the least developed countries still give birth with unskilled health personnel.

Protracted conflicts have devastated already fragile health-care systems in all conflict-affected countries. They have experienced deteriorating bed capacity and constraints on delivering critical inpatient care, responding to the re-emergence of communicable diseases and providing needed care to patients with non-communicable diseases, especially given large numbers of refugees and internally displaced persons. The destruction of health facilities (see box), limitations on emergency transport and restricted access to operational health-care centres have cut supply for primary health care. Extended conflicts have hindered sufficient medical supplies and led to a rapid shortage of qualified health-care personnel.

◆ **Rehabilitation of health infrastructure and the improved availability of essential medications are top health sector priorities for the least developed countries and countries in conflict.** For example:

- The National Development Programme for Post-War Syria (Syria Strategic Plan 2030) in the **Syrian Arab Republic** focuses on rebuilding medical facilities using digital health maps that incorporate morbidity rates and population density. The plan also aims to relocate pharmaceutical manufacturing facilities to safe areas to enhance national coverage.
- The Well and Healthy **Libya:** National Health Policy 2030 seeks to address systemic issues causing shortages and limited access to medicines. The availability of medicines in hospitals stands at 41 per cent, and at only 10 per cent in primary health-care centres and 13 per cent in warehouses.[66] Libya faces recurrent stockouts of vaccines, reproductive health supplies and family planning medications, and medicines to treat mental illnesses. The implementation of related health reforms remains heavily dependent on unified governance and funding allocations.

◆ **International partners are increasingly major players in supporting the least developed countries in strengthening their national health systems and enhancing access to health care, including for vulnerable populations.** For example:

- The **Comoros** received $30 million from the World Bank in 2019 to strengthen its national health system and improve primary health-care quality.[67]
- The World Bank granted $19.5 million in 2022 to **Djibouti** for enhancing reproductive, maternal and child health for both refugees and local communities.[68]

The targeting of health-care systems in conflicts

Deliberate attacks on health-care systems and medical personnel have characterized wars in Arab countries in conflict. This goes against international humanitarian law, which calls for protecting care workers and facilities in all circumstances.

The latest war on the Gaza Strip is no exception. The first three months saw close to 600 attacks on health-care facilities in **Palestine** (304 attacks in the Gaza Strip and 286 in the West Bank). More than 600 deaths and 700 injuries were reported on premises. Around 118 health institutions (94 in the Gaza Strip and 24 in the West Bank) and 291 ambulances (79 in the Gaza Strip and 212 in the West Bank) have been hit. This is in addition to arbitrary arrests and detainments of health workers. As noted by the United Nations Special Rapporteur on the right to health, "the practice of medicine is under attack. […] The healthcare infrastructure in the Gaza Strip has been completely obliterated".

Moreover, the severe blockade imposed on the Gaza Strip, including, among other aspects, the cutting off of water and limited deliveries of food, water and medical supplies, has increased the risk of outbreaks of infectious diseases. In one week, cases of diarrhoea among children under age 5 increased from 48,000 to 71,000, amounting to around 3,200 new cases per day. Prior to the war, diarrhoea cases in children under 5 were on average 2,000 per month.

Attacks on the health-care system have long-term cumulative impacts at all levels. They reduce access to and use of health services by communities; increase fragmentation and funding instability; cause losses of infrastructure, equipment, medical supplies and personnel; and have negative repercussions on health workers personally and professionally. Underlining the importance of adhering to international humanitarian law in conflict situations is critical. So is the need to support data collection on the impacts of attacks on health-care systems in order to properly inform responses and enhance accountability.

Sources: Hyzam, 2022; UN News, 2024; OHCHR, 2023; University of California Berkley, 2023.

D. Policies to leave no one behind

Inequitable access to health services and staggering variation in the quality of health care available to different groups are clear markers of inequality in the region, with reverberating implications over the life cycles of individuals and communities.

The following is a sample of policies in some Arab countries to reduce disparities in health care and improve health outcomes for all:

- The Health Strategy (2018–2022) of **Jordan** broadened the scope of subsidized civil health insurance to include low-income households (with an income between JD 300 and JD 500), a policy change that aims to enhance health-care accessibility and reduce financial barriers, ultimately striving for greater health equity.

- In 2017, the Parliament of **Morocco** voted to expand national health coverage to include self-employed individuals and independent workers by 2025. This is expected to benefit approximately 11 million individuals, constituting about 30 per cent of the population.

The poor and uninsured (including the unemployed, self-employed individuals and those in the informal sector) face barriers in accessing health services, especially if they are not recipients of insurance or subsidized packages. This results in them shouldering the financial burden of out-of-pocket expenses to access medical care.

- To extend health-care coverage to additional categories of workers in the **United Arab Emirates,** the Department of Health in Abu Dhabi introduced flexible health insurance packages in 2013. These were specifically designed for entrepreneurs and investors, aiming to provide them with health coverage at reduced and competitive costs, with options to upgrade if needed.

Non-national residents and migrant workers often have limited access to fair and affordable health-care services due to their employment status, lack of comprehensive health insurance and exclusion from formal health-care systems. This leads to difficulties in affording essential medications and high health-care expenses that impose substantial financial burdens and increase vulnerability.

◆ **Egypt** is working to advance training and research on geriatrics. The faculty of medicine in Ain Sham University offers a degree programme in geriatric medicine, involving theoretical training, a residency programme and a clinical training course.[69]

◆ **Algeria** and **Jordan** have taken steps to ensure health coverage for older persons. Law No. 10 of 2010 on the protection of older persons in Algeria grants free access to public health care to all persons aged 60 and above. In 2017, Jordan expanded subsidized health insurance coverage under its civil health insurance law to all persons aged 60 and above.[70]

Older persons, especially those living with one or more chronic illnesses, require long-term quality care. This increases the need for geriatric and gerontological education and training for health professionals and para-professionals. Shortages in most Arab countries are evident with a ratio of not more than 1 geriatrician for every 100,000 older persons. The lack of universal health protection hinders the provision of adequate medical care to older persons, negatively affecting their health and well-being.


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◆ In **Egypt,** the Family Development Strategy (2015–2030) includes a dedicated pillar on improving access to family planning and reproductive health. The National Project for the Development of the Egyptian Family (2021–2023) aims to provide free and safe family planning and reproductive health services to women aged 18 to 45, including through the establishment of a family insurance fund to incentivize commitment to family planning. The project also seeks to strengthen penalties for child marriages, child labour and unregistered births.

Additionally, the Supporting Egyptian Women's Health initiative, under "100 Million Healthy Lives", intends to reach 28 million Egyptian women across the country, offering general reproductive health check-ups, early breast cancer detection and screenings for non-communicable diseases.

Women and girls of childbearing age are subject to disproportionate health risks, including maternal mortality, unmet family planning needs and limited access to affordable contraceptives. Unmarried women, particularly in disadvantaged socioeconomic conditions, are at a higher risk of illegal abortions. Furthermore, services for survivors of sexual and gender-based violence, including unintended pregnancies, remain limited.

◆ In the **United Arab Emirates,** the National Policy for Empowering Persons with Disabilities (2017) includes measures to improve health-care access and services, comprising fitness and wellness and physical and socioemotional well-being. The policy adopts an inclusive approach to integrating people with intellectual disabilities to ensure their full access to health-care services.

Persons with disabilities often encounter disparities in accessing equal health care due to physical barriers, discrimination, inaccessible information, high costs and insufficient policy support.

◆ **Egypt** grants refugees and asylum-seekers access to all health services provided in public facilities for free or at low cost, similar to Egyptian citizens.[71]

Refugees and internally displaced persons face multiple barriers to health care, including a lack of awareness of available services and the cost of health consultations, treatment and medications. Formalization and documentation issues also hinder the health-care access of **asylum seekers and irregular migrants,** especially in fragile and conflict contexts.

◆ **Jordan** introduced its National Policy on HIV and AIDS and the World of Work in 2013. This policy prioritizes ensuring that employees living with HIV and AIDS access health care while maintaining the confidentiality and privacy of their HIV status and medical details. This creates an environment where employees can access health care without concerns of stigma or bias. The policy guarantees delivering appropriate medical treatment, care and support to HIV-positive workers, including access to vital services such as antiretroviral therapy.

People with HIV and AIDS are still at risk of stigma and discrimination, a lack of domestic investment in related health services and an absence of adequate information systems.

◆ In **Algeria,** an executive decree initiated an "institutional twinning" programme in 2016, connecting hospitals in the developed northern regions with those in the underdeveloped and remote southern areas of the country. The programme facilitates the sharing of resources, medical expertise and personnel to reduce health-care disparities, enhance health-care access for residents in remote areas and provide health-care services to underserved southern regions.

People living in remote areas have limited access to reliable and quality health care, which increases their vulnerability to adverse health consequences.

◆ In **Palestine,** the 2016 School Health Policy aims to provide comprehensive health services to school-age children and adolescents. This includes regular health check-ups, vaccinations and health education programmes. The policy incorporates mental health support and counselling services within schools to address students' psychological well-being, and promotes parental involvement in students' health, fostering collaboration between schools and families.

Children and adolescents in the region are often at risk of being left behind when it comes to health equity and outcomes due to various factors, including economic disparities, a lack of access to quality health care and limited educational opportunities, especially related to their sexual and reproductive health. All these factors increase their vulnerability.

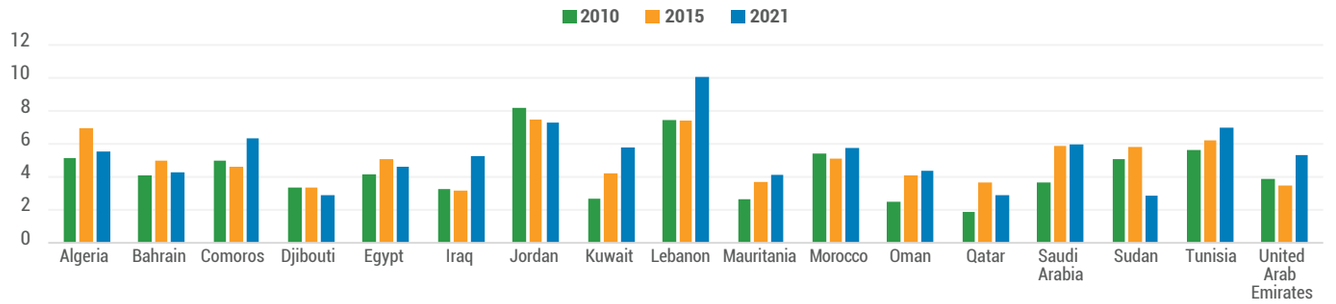
E. The financing landscape

Current health expenditure as a share of GDP in most countries of the Arab region is lower than the global average of 7.3 per cent. Large variations exist among countries, with **Lebanon, Jordan, Tunisia** and the **Comoros** spending 10.1, 7.3, 7 and 6.3 per cent, respectively, in 2021 (figure 3.1). These shares are higher than in other Arab countries, including the Gulf Cooperation Council countries, where spending stood at 6 per cent in **Saudi Arabia,** 5.8 per cent in **Kuwait,** 4.4 per cent in **Oman,** 4.3 per cent in **Bahrain** and 2.9 per cent in **Qatar.** Although there is no recommended level for spending on health, increased and effectively targeted health expenditure by Governments is linked to better health outcomes, especially in developing countries. Low allocations typically indicate that health is not a priority,[72] fiscal space is limited or the population is fairly young.[73]

Increasing public spending on health is essential for progressing towards universal health coverage. This entails expanding domestic government spending on health as a share of total health expenditure and as a share of general government expenditure. Funding through pre-payment and pooling schemes should replace direct out-of-pocket spending borne by households and non-pooled health plans. This shift is referred to as the health financing transition. The further countries progress through this transition, the greater the protective capacity of the health system and the lesser the burden of health spending on the vulnerable.[74]

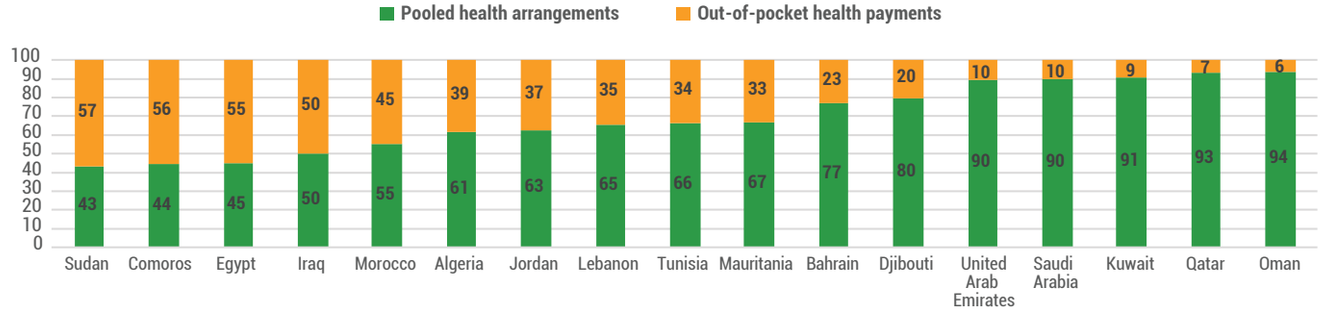
Looking at **health spending by type of finance** for 2021 (figure 3.2), it is clear that the financing mix varies among countries. The proportion of out-of-pocket spending generally tends to increase as income level decreases. Spending on health in high-income countries mostly involves pooled health arrangements, comprising government schemes, compulsory contributory health-care schemes and voluntary health-care schemes.

Figure 3.1
Current health expenditure (Percentage of GDP)



Source: WHO Global Health Observatory, Health Financing Indicators, accessed on 15 December 2023.

Figure 3.2
Health expenditures by financing scheme, 2021 (Percentage)



Source: WHO Global Health Expenditure Database, Data Explorer, Health Expenditure Data – Financing Schemes, accessed on 16 December 2023.

Most countries seem to be advancing through the **health financing transition,** with an increase in the pooled share of health spending for greater financial risk protection, albeit at different paces (table 3.1).[75]

Table 3.1
The health financing transition in selected Arab countries

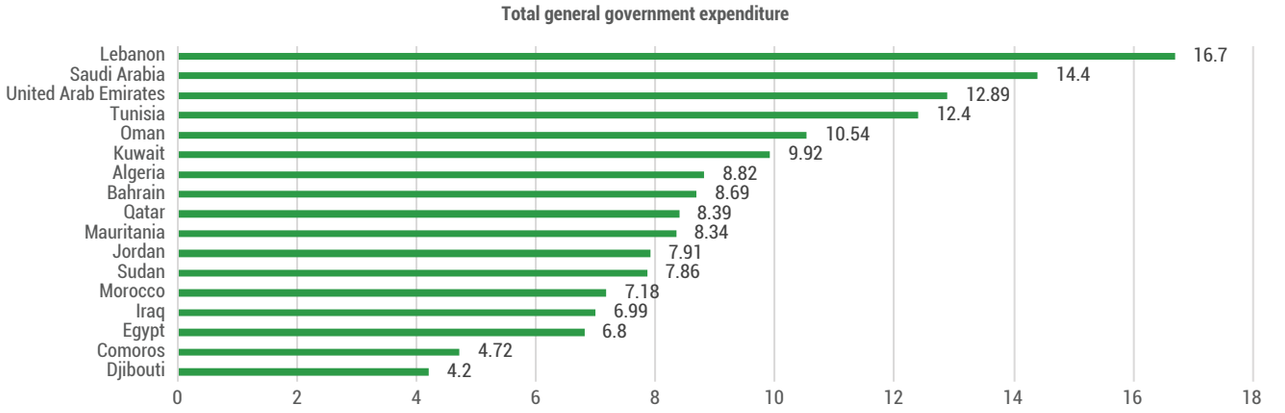
Countries	Health financing transition
Djibouti, Jordan, Kuwait, Lebanon, Mauritania, Oman, Qatar and the **United Arab Emirates**	Fast progress: there is an average annual increase in pooled health expenditures per capita and a decrease in out-of-pocket payments per capita, resulting in a rapid increase in the pooled share of health spending.
Iraq, Morocco and **Saudi Arabia**	Slower progress: the rate of the annual increase in pooled health expenditures per capita is faster than that of out-of-pocket payments per capita, resulting in an increase in the pooled share of health spending, albeit at a slower pace than in the first category.
Algeria, Bahrain and the **Sudan**	No progress: the rate of the annual increase in out-of-pocket payments per capita is faster than that of pooled health expenditures per capita, resulting in a decrease in the pooled share of health expenditure.
Comoros	No progress: the rate of the annual decline in out-of-pocket payments per capita is faster than that of pooled health expenditures per capita.

Source: ESCWA, 2022b.

The **share allocated to domestic government health expenditure** from general government expenditure indicates the priority given to health compared to other public spending. It is expected that this share would increase with higher GDP per capita. This is not the case for several countries, however (figure 3.3). The shares of higher-income Gulf Cooperation Council countries seem to compare with those of middle-income countries.

This could be due to the large contribution of the hydrocarbon sector to the GDP per capita level in Gulf Cooperation Council countries. **Egypt** and **Iraq** appear to have a somewhat lower share than other middle-income countries with similar GDP per capita levels, while **Lebanon** and **Tunisia** have a higher share. By and large, Arab countries do not tend to give high priority to health expenditure compared to other areas of public spending.[76]

Figure 3.3
Domestic general government expenditure as a percentage of general government expenditure, 2021 (Percentage)



Sources: WHO Global Health Observatory, Health Financing Indicators, accessed on 15 December 2023; World Bank World Development Indicators, accessed on 16 December 2023.

Private health insurance is growing in some countries across different economic groupings (table 3.2). Voluntary health insurance spending as a share of current health expenditure is the largest in **Lebanon,** reaching 26 per cent in 2021.

Support from donors and international agencies to the health sector varies (table 3.3). In 2021, **Djibouti,** the **Comoros** and **Mauritania** had the highest shares of support relative to their health expenditure. This has mostly entailed funding for development projects and budget support.[77]

Funding for emergency humanitarian responses has increased since 2011 for countries affected by conflict but is still inadequate to meet basic social and health needs.[78]

The **funding of health services for refugees in countries hosting large refugee populations** remains challenging. Initiatives such as the Global Concessional Financing Facility were launched to narrow the gap in development and humanitarian funding to refugees and host communities in **Jordan** and **Lebanon.**[79] The facility has supported efforts to strengthen health, education and basic service delivery in Jordan, and to improve housing, water and sanitation services in Lebanon since 2016. Jordan and Lebanon received $459.45 million and $95.13 million, respectively, in facility concessional financing from 2016 to 2022, which catalysed concessional loans of $2.73 billion to Jordan and $432.45 million to Lebanon.[80]

Table 3.2
Voluntary health insurance schemes as a percentage of current health expenditure for selected Arab countries

Country	2010	2015	2021
Algeria	1	1	1
Bahrain	8	9	11
Comoros	1	3	3
Djibouti	0	1	1
Egypt	1	8	3
Iraq	0	N/A	0
Jordan	6	16	14
Kuwait	1	1	1
Lebanon	15	19	26
Mauritania	3	1	1
Morocco	1	1	1
Oman	4	3	5
Qatar	7	6	7
Sudan	1	1	3
Tunisia	1	5	5
United Arab Emirates	7	7	3
Yemen	1	1	N/A

Source: WHO Global Health Expenditure Database, Data Explorer, Health Expenditure Data – Financing Schemes, accessed on 17 December 2023.
Note: N/A = not available.

Table 3.3
External health expenditure as a percentage of current health expenditure for selected Arab countries

Country	2021	Country	2021
Algeria	0.6	**Jordan**	8.3
Comoros	25.6	**Lebanon**	10.4
Mauritania	23.8	**Morocco**	3.6
Djibouti	44.9	**Sudan**	10.4
Egypt	0.6	**Tunisia**	2.0
Iraq	0.8		

Source: WHO Global Health Observatory, Health Financing Indicators, accessed on 17 December 2023.
Note: External sources include direct foreign transfers managed by development agencies residing in a country and foreign transfers to governmental agencies.

F. Regional dimensions

Regional collaboration exists in a few SDG 3 areas but could be further strengthened to build resilience during health emergencies.

Examples of existing regional collaboration include the following:

- **In maternal, child and adolescent health, the League of Arab States and the United Nations Population Fund (UNFPA) developed the Multisectoral Arab Strategy for Maternal, Child and Adolescent Health 2019–2030.**[81] It serves as a reference framework for countries to develop policies and take actions to achieve the highest attainable standard of equitable physical and mental health and welfare for every mother, child and adolescent. One pillar of the strategy is to enhance capacity, resilience and preparedness support for mothers, children and adolescents in armed conflicts, wars and natural disasters.
- **A regional strategy to strengthen midwifery and nursing practices**[82] **was developed by the League of Arab States and UNFPA, and endorsed by the Arab Council of Health Ministers in 2022.** The strategy strives to empower midwifes and nurses to deliver a wider set of high-quality sexual and reproductive health services based on community needs, and in line with the principle of leaving no one behind.
- **To prioritize and advance the region's health finance agenda, the League of Arab States, UNFPA and WHO have developed the Regional Health-Friendly Budgeting Strategy**.[83] Launched in 2023, this serves as a comprehensive framework for Arab countries to enhance the financing of health-care needs, ensuring that health services are adequately funded and accessible to all, and ultimately contributing to improved health outcomes and the well-being of people across the region.

Examples of areas that could benefit from strengthened regional collaboration include:

- **A regional emergency preparedness and response programme:** such a programme necessitates a multifaceted approach, starting with strengthening the capacity of health-care systems with investments prioritizing the training of health-care workers, securing essential medical supplies and ensuring the availability of health-care facilities. The establishment of robust coordination mechanisms at both the national and regional levels is important to facilitate effective communication and collaboration among health-care providers, government agencies and international partners. Adequate resource allocation for emergency preparedness and response is also necessary, encompassing funding for research, surveillance and the formation of emergency response teams.

  Building on the COVID-19 pandemic experience, several key strategies could be incorporated in the regional emergency preparedness and response programme. These include ensuring fair and equitable access to vaccines through targeted distribution and vaccination campaigns, and increasing investments in digital health information systems to improve data collection, analysis and sharing, which facilitates disease monitoring and rapid responses. Accelerating regional progress towards digitized health systems could also improve health and medical supply chain management.
- **Cross-regional coordination to address the health and well-being of refugees, migrants and internally displaced people:** comprehensive, cross-regional collaboration is needed. It should extend beyond health-care service delivery to tackle the social determinants of health,[84] and consider individuals traversing migration routes, residing in humanitarian settings and living in host communities. By combining immediate and long-term action plans with technical and financial support, the region can better respond to the evolving needs of displaced populations and enhance overall public health and well-being.

Endnotes

1. Saleh and Fouad, 2022.
2. The four major non-communicable diseases are cardiovascular disease, cancer, diabetes and chronic respiratory disease.
3. See the World Bank data, Out-of-pocket expenditure as percentage of current health expenditure, accessed on 24 January 2024.
4. Several countries in the region have experienced prolonged conflict and political instability since 2011. These have severely disrupted health-care systems and disease surveillance and limited the ability to respond to public health emergencies.
5. WHO, 2023c.
6. Algeria, Bahrain, the Comoros, Egypt, Iraq, Kuwait, Libya (the draft constitution adopted by the Constitution Drafting Assembly of Libya in July 2017), Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Somalia, the State of Palestine, the Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen.
7. Saudi Council of Health Insurance, Laws and Regulations.
8. Migrants mostly depend on individual or employer-sponsored private health insurance schemes.
9. Military personnel are insured by different schemes.
10. See Egypt, third Voluntary National Review 2021.
11. National Programme of Assistance to Needy Families.
12. See Les Comores, Tableau de la situation de l'égalité femme/homme.
13. See L'assurance maladie généralisée bientôt opérationnelle.
14. See Mauritania, Voluntary National Review 2019.
15. Katoue and others, 2022.
16. See Saudi Arabia, Voluntary National Review 2023.
17. See Algeria, Voluntary National Review 2019.
18. World Bank, 2020.
19. Integrated sexual and reproductive health packages should include family planning services, maternal and child health care, medical assistance to survivors of sexual and gender-based violence, post-abortion care, HIV prevention and management, other sexually transmitted infections, reproductive cancers and infertility.
20. WHO, 2020c. Exceptions include Somalia (less than 50 per cent) and Saudi Arabia and Yemen (less than 75 per cent). The 16 policy areas cover: family planning/contraception; sexually transmitted infections; cervical cancer prevention and control; antenatal care; childbirth; postnatal care; pre-term newborns; child health and development (includes seven subcategories); adolescent health and violence against women.
21. UNFPA and MENA Health Policy Forum, 2019.
22. Ibid.
23. Kabakian-Khasholian and others, 2020.
24. UNFPA and MENA Health Policy Forum, 2019.
25. Ibid.
26. UNFPA and MENA Health Policy Forum, 2018.
27. UNFPA and the American University of Beirut, Faculty of Health Sciences, Center for Public Health Practice, 2022.
28. Ibid.
29. According to UNFPA (2022), the region has 78,200 midwives; 130,000 more full-time midwives will be needed by 2030.
30. WHO, 2023a.
31. See the WHO Noncommunicable Diseases Data Portal, accessed on 12 December 2023.
32. See the Comoros, Voluntary National Review 2023.
33. World Bank, 2023.
34. See the United Nations Treaty Collection.
35. WHO, 2023e.
36. See Implementation Database for the WHO Framework Convention on Tobacco Control, Treaty provisions, General and other obligations, Comprehensive multisectoral national tobacco control strategy – C111, accessed on 23 October 2023.
37. WHO, 2023e.
38. No information has been reported for Djibouti, Somalia or the Syrian Arab Republic.
39. The tax rate in Egypt is 74.9 per cent of the retail price.
40. Relevant characteristics comprise: the inclusion of mandated and rotating health warnings on all cigarette packages and retail labelling, indications of the harmful consequences on health from tobacco use that are large, clear and visible and in all principle languages of a country, and pictures or pictograms. See the WHO Noncommunicable Diseases Data Portal, accessed on 12 December 2023.
41. Between July 2020 and June 2022.
42. An effective media campaign involves: (a) implementing the campaign as part of a comprehensive tobacco control programme; (b) forming a deep understanding of the target audience prior to the campaign through research; (c) pre-testing and refining communications materials for the campaign; (d) designing a rigorous media plan and process for purchasing air time and/or placement to ensure effective and efficient reach to the target audience; (e) working with journalists for publicity and coverage of the campaign; (f) evaluating the process after conclusion to assess implementation effectiveness; (g) evaluating outcomes to assess impact; and (h) airing the campaign on television and/or radio for a minimum of three weeks. See the WHO Noncommunicable Diseases Data Portal, accessed on 12 December 2023.

43. See the Ministry of Health Strategy (2020–2024).
44. WHO, 2022a.
45. WHO, UNICEF and UNFPA, 2022.
46. WHO, 2022a.
47. Lebanon, Ministry of Public Health, 2023.
48. WHO, 2022a.
49. See more on health sector transformation in Saudi Arabia under Vision 2030.
50. See Tunisia, Voluntary National Review 2021.
51. WHO, 2023f.
52. Libya, Oman and Somalia did not develop a policy or legislation on mental health. No data are available for the Comoros, Mauritania and the State of Palestine.
53. WHO, 2020b.
54. Only Egypt indicated that it had estimated and allocated human and financial resources for the implementation of its mental health plan launched in 2015. Although Lebanon did not indicate estimates and allocations, it noted that total government expenditure on mental health as a percentage of total government health expenditure was 5 per cent.
55. Lea Zeinoun, 2023.
56. WHO, 2020b.
57. See Algeria, Voluntary National Review 2019.
58. Lebanon, Ministry of Public Health, 2015.
59. Arab Health by Informa Markets, 2020.
60. See the WHO Global Health Expenditure database, accessed on 23 October 2023.
61. WHO, 2023d.
62. Jordan News, 2023.
63. See Le ministère de la Santé lance l'extension du plan stratégique national de prévention et de contrôle de la tuberculose 2021–2023.
64. See Morocco, Voluntary National Review 2020.
65. WHO Global Health Expenditure database, accessed on 23 October 2023.
66. United Nations Libya, Common Country Analysis, 2021.
67. World Bank, 2019.
68. World Bank, 2022.
69. ESCWA, 2018.
70. ESCWA, 2022a.
71. See UNHCR, Health – HELP Egypt.
72. See WHO data on health expenditure, accessed 15 December 2023.
73. ESCWA, 2022b.
74. Ibid.
75. Ibid.
76. Ibid.
77. UNICEF, 2018.
78. Ibid.
79. Ibid.
80. GCFF, 2022.
81. UNFPA and League of Arab States, 2020.
82. UNFPA, WHO and League of Arab States, 2022.
83. Bahrain News Agency, 2023.
84. See the extensive analysis of social determinants affecting the health of migrants globally and in the region as provided in WHO, 2022b.

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