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STRATEGIC
RESEARCH

EXPERT BRIEF
REGIONAL POLITICS
10 JULY 2020

Public Health Systems in the Arab World: The COVID-19 Conundrum and The Way Forward

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Source: Anadolu Agency

Abstract: The Arab world is made up of countries and communities that share history, language and culture. At the same time, the Arab countries are a heterogeneous group with diverse political and socio-economic contexts that affect health in varying ways. Public health systems in the Arab world are weak and vulnerable to epidemics and outbreaks of disease. The COVID-19 pandemic has affected Arab countries unevenly. The responses of the various states to the pandemic have already had immediate and negative socio-economic consequences. The pandemic has exposed the weaknesses of the public health systems in the Arab world. Evidence for public health is inadequate, and decisions are incoherent and inconsistent. Community engagement has been limited, as have the contributions of non-governmental actors. Public health actors have failed to protect human rights and vulnerable populations. They have also failed to balance the immediate health risks of COVID-19 with the long-term health impacts of the COVID-19 control measures. The COVID-19 pandemic is an opportunity to grasp the necessity and benefits of investing in reliable public health systems in the Arab world.

Introduction:

By the end of June 2020, the COVID-19 pandemic had spread to over 190 countries with over ten million confirmed cases and more than half a million COVID-19 deaths worldwide. All Arab countries have reported confirmed COVID-19 cases. In total, the Arab states have had more than 500,000 confirmed cases of COVID-19, of which around 400,000 have been in Saudi Arabia, Qatar, Kuwait, Oman and the UAE. Incidence and fatality rates vary remarkably across the region. Qatar has had over 1,600 cases per 100,000 residents, while countries like Syria and Yemen have recorded less than five cases per 100,000. On the other hand, Yemen, for example, has a reported fatality ratio of 27% compared to about 7% in Algeria and Sudan, 4% in Iraq, Egypt, Syria and Tunisia, 2% in Lebanon, Libya and Morocco, 0.8% in Saudi Arabia and Jordan, and 0.12% in Qatar.[1]

Arab countries have generally responded to the pandemic by limiting mobility and imposing restrictions on business and gatherings. These measures will undoubtedly have negative socio-economic consequences for their populations – and possibly negative health consequences as well. Health services, on the other hand, are at risk of a sudden collapse, particularly in fragile states and conflict-affected territories. Public health actors and planners have to balance the potential adverse effects of COVID-19 against those of the measures taken to control it. However, they are confronted with fragile systems, corrupt governance, and political indifference to evidence-based public policies.

The Arab World:

The Arab World, as one region and subject of analysis, has only recently been introduced to the public health literature.[2] The term refers to countries that are members of the

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Arab League. Arguably, it also applies to communities of Arab migrants throughout the world. Arab countries and communities share history, language, traditions and culture. However, they have diverse political and socio-economic contexts which impact the health of their populations and shape their health systems in varying ways.[3]

The Arab world is home to over 400 million individuals, more than 60% of them between 15 and 64 years of age. Unemployment rates range from 0.2% to 23%, with an average of around 9.6%. Armed conflicts continue in Syria, Libya and Yemen. Millions of refugees are putting strain on already-overstretched infrastructures in Jordan, Lebanon and Iraq. Political instability has not been uncommon in the past decade. The annual rate of economic growth in the Arab world declined from 6.7% in 2012 to 2.1% in 2018, compared to global growth of 2.6% in 2012 and 3.1% in 2018. Disparities in wealth and economic performance across the region are conspicuous. Qatar, for instance, has one of the highest ratios of GDP per capita in the world, 200 times greater than GDP per capita in Somalia, and about 60 times higher than GDP per capita in Yemen and Sudan.[4] The region has an overall extreme poverty rate of 5%, and economic growth has failed to reduce poverty significantly.[5]

Public Health Systems in the Arab World:

Public health systems refer to complex networks and interrelations of individuals and organizations that are critical in determining conditions for health. They are not limited to traditional health facilities and organizations but also extend to a variety of other sectors and social institutions that play a crucial role in protecting the health of populations and promoting the wellbeing of communities. Public health activities include health monitoring, diagnosis and investigation, information sharing, resource mobilization, policy development, and assurance and evaluation. The capacities of states to respond to pandemics and contain them depend mainly on the maturity and engagement of their public health systems and institutions. Ideally, public health

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experts will lead disease control efforts in the field, guide health services planning during the crisis, and advise on evidence-based governance and public policies.

Public health systems in the Arab world are weak, and funding is insufficient. On average, Arab governments' expenditures on health are about 2.8% of GDP, compared to a global rate of 7.8%. Total spending on health in Arab countries, including non-governmental contributions, is about 5% of GDP. The private sector accounts for around 40% of total health expenditures and individuals' out-of-pocket spending comprises around 30%.[6] The portions of total health expenditures which area spent on preventive and primary care are low. The levels of health expenditures and the ways in which resources are allocated do not match the existing health needs and current epidemiological profiles.[7] Details regarding the specialized public health workforce in the Arab world are scarce, as services delivery professions predominate. Additional challenges include inadequate resources for vulnerable and displaced populations, weak health data for decision making, limited governance of the increasingly influential private sector, and insignificant external financial support.[8]

The Arab world is particularly vulnerable to outbreaks of disease and public health emergencies. The Global Health Security (GHS) Index is a measure of capacity and preparedness that aims to mobilize the necessary financial and political resources to respond to outbreaks. According to the GHS Index results, Arab states are among the least prepared in the world, and rank last in terms of "epidemiology workforce" and "emergency preparedness and planning measures."[9] In addition, information systems and data sharing infrastructures, which are crucial for guiding and informing public policies and public health responses, are insufficient.

The COVID-19 Response and the Role of Public Health:

Starting in late February 2020, Arab states started to impose various COVID-19 containment measures. The needs and situations of the different countries varied, along with their capacities to respond and to cope with potential consequences. The richer countries, unlike those with

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limited resources, have focused on the clinical aspect of the response, and are better prepared in terms of clinical capacities, laboratories and equipment. This discrepancy is apparent in the higher numbers of confirmed cases and the lower fatality rates in the wealthier countries by comparison with those with limited resources and those experiencing conflict. From a public health perspective, the COVID-19 response across the region nonetheless displayed a number of common characteristics, even though there was no regional collaboration or coordination. Measures began gradually. In the early phases, countries suspended the work of educational institutions and prohibited all public and social gatherings. Some states declared national emergencies granting governments absolute authority. Total and partial curfews were imposed. Internal travel between cities and governorates was generally restricted. Air traffic came to a halt. Foreigners were banned from entering countries until further notice. Almost all non-essential businesses were closed, and in some states, these closures extended to all sectors, including governmental institutions. Mandatory isolation measures were imposed on arriving passengers and on individuals diagnosed as suspected cases. Borders crossings operated at minimum capacity to ensure the flow of essential goods.

One consistent feature of the COVID-19 response in the Arab world has been "data fragility" and a lack of reliable information regarding coronavirus cases.[10] Control measures and policies have not been based on actual needs assessments and available data or evidence. This may explain a variety of inconsistent and incoherent policies and actions. There has also been a lack of strategic planning, as most countries were panicked into adopting strict measures without careful consideration. The response has been steered primarily by politicians and economists.[11] Health professionals have not been actively engaged in decision-making at any time during this public health emergency. The few health professionals who have participated in preparedness and planning activities have mostly been clinicians without any formal training or background in public health practice.

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Another primary function of a public health system is to monitor, investigate, and diagnose outbreaks. It is argued that the capacities of states to conduct mass and early testing of COVID-19 lowers fatality rates.[12] However, the focus of Arab responders has been clinical, prioritizing hospital beds and intensive care units over testing, information sharing and evidence-based policy-making. Initially, many countries announced they had sufficient numbers of beds and equipment. Public health capacity has received little attention. Reportedly, only Lebanon, Tunisia, and the occupied Palestinian territories have raised funds for public health investigations. Some Arab countries have seen scattered and incoherent efforts to raise awareness and disinfect public places, while others have controversially infringed the autonomy of individuals by enforcing the use of protective masks and gloves.[13]

A functioning public health system engages a broad range of social organizations. Effective COVID-19 prevention and control require the engagement of non-state actors, particularly in contexts such as the Arab world where they already have an established role in health systems and services delivery.[14] The COVID-19 response, however, is entirely led by governments. So far, engagement with non-state actors has been inconsistent and ambiguous.[15] In Lebanon, for instance, a government decision to engage the private sector has not been followed by a concrete implementation plan.[16] In Jordan, the government has excluded all private hospitals from COVID-19 treatment.[17] The participation of non-state actors should not be limited to clinical treatment. Limited examples from Tunisia, Morocco, and Lebanon underline the potentials of civil society organizations in raising awareness, limiting the transmission of infections and community outreach during the COVID-19 response.[18] Nevertheless, civil society organizations have remained ancillaries to the efforts of governments and have not emerged as meaningful partners in informing and shaping the response.

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The ongoing conflicts in the Arab world are characterized by the fragmentation of healthcare systems and the exploitation of the health needs of populations for political and military gains. In the COVID-19 era, this means that hundreds of thousands of people are at higher risk of coronavirus morbidity and mortality, particularly in territories controlled by non-state groups

era, this means that hundreds of thousands of people are at higher risk of coronavirus morbidity and mortality, particularly in territories controlled by non-state groups. International and regional organizations have failed to respond to these situations, as they have also failed to put truces and ceasefires in place.[19] In Syria, criticism of the UN agencies has resurfaced again and the medical aid necessary to reinforce a fragmented system that lacks the essential capacity to respond to COVID-19 is being politicized, neglected, and restricted.[20] Humanitarian organizations, civil society and local authorities are allegedly competing with one another over limited resources in northern Syria, weakening the health system further.[21] In Yemen, the first case of COVID-19 was confirmed at a time of active fighting, restricted aid, ongoing cholera outbreaks and floods.[22] Despite the existence of a WHO-led coordination body and a governmental COVID-19 response committee, social media had to fill in the void in public health surveillance and tracing.[23]

The COVID-19 Response: Public Health Impact

Initially, all the restrictions imposed in response to COVID-19 are thought to be in the greater public interest. These rigorous and unusual measures are presumed to be necessary to prevent a collapse in healthcare services that could drastically affect the health of the population. The scenes witnessed in Italy and China prompted fear and anxiety around the globe, and the containment measures adopted by Arab countries and other developing nations mimicked the actions taken in China, Europe and the US. In the Arab states, the policies which have been followed are not based on local needs assessments or situational analyses. This is unsurprising in view of the weak information infrastructure. The success of the measures in question is mostly contingent on contextual and external factors, including countries' demographic and age profiles. Younger populations are less likely to benefit from these measures due to the relatively lower risk of COVID-19 mortality and morbidity among younger

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age groups. Deprived communities are not willing to accept additional economic compromises and prefer to risk death from COVID-19 rather than dying of poverty and hunger. It has been argued that social distancing policies have better outcomes in high-income countries than in developing countries. For example, the value generated by equal adherence to social distancing policies is estimated to be 240 times greater for the United States than for countries like Pakistan or Nigeria.[24]

From a public health perspective, the impact of COVID-19 does not depend solely on how far the outbreak is directly controlled and contagion prevented. Public health is determined by a broad range of social factors that include poverty, unemployment, the built environment, social justice, social empowerment and good governance.[25] The COVID-19 measures currently being taken in Arab states have focused on the immediate health risks and have overlooked the possible indirect and long-term impacts of the response itself. Arab countries have started to feel the economic and social costs of their response to the pandemic. For instance, tourism is one sector that has been severely affected by the crisis. It contributes up to 15% of GDP in Egypt, 14% in Jordan, 12% in Tunisia, and 8% in Morocco. This means that governments are staring at considerable losses from a single sector that provides employment and livelihoods to millions of families and households.[26] Similar scenarios may apply to all productive sectors, including healthcare. The pandemic is taking its toll on the global economy, and the fall in oil prices has hit Arab economies hard. The repercussions are not limited to the oil-producing economies alone: many other Arab countries depend on these resource-rich countries for employment opportunities, remittances and even direct development funds. A preliminary analysis suggests that the economic loss caused by the crisis is equivalent to about 3.7% of total output.[27]

The current measures may detract from the quality and availability of healthcare services through supply chain interruptions and by limiting the mobility of both patients and healthcare professionals. There have been frequent reports of avoidable health complications during the crisis due to patients' limited mobility and access to health facilities, laboratories or pharmacies. Meanwhile, economic downturns affect health not only by reducing health

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expenditures – evidence from developing countries suggests that lower healthcare spending is associated with adverse health outcomes[28] – but also indirectly through increased poverty, inequalities and difficulties accessing healthcare.[29]

The current situation also creates opportunities for fraud and corruption, particularly in government agencies and through the exploitation of procurement processes and stimulus packages.[30] Fraud and corruption can take the form of preferential treatment for specific vendors and suppliers that are connected to officials. In a public health emergency, health is an essential sector which has to maintain its operations and which requires procurements that are relatively large and vulnerable to corruption, mainly in the government health sector. Mismanagement of these procurements can result in a massive waste of scarce resources. In this context, public health actors and organizations may be denied essential resources, and may even be held complicit in such wastage. The risk of corruption may also undermine government efforts and reduce public trust and cooperation with government measures. More broadly, corruption is regarded as a root cause of many socio-economic failures, such as inequality and unemployment, which are linked to adverse health outcomes.[31]

Social protection systems in the Arab world are fragmented and inadequate. Many countries do not have protection policies in place. In countries that do have these systems, they have mostly proved inaccessible and dysfunctional.[32] It has been suggested that the current distancing measures will only deepen social inequalities.[33] These measures will hurt disadvantaged populations, which make up the majority of the Arab population[34], disproportionately. Vulnerable populations also include refugees, internally displaced persons and the migrant workers in the wealthy Gulf countries, who work and live in unfavourable conditions. These groups face a higher risk of COVID-19 transmission and morbidity due to their working and living conditions. Millions of refugees in Jordan and Lebanon, for instance, have already suffered disproportionate adverse socio-economic consequences of the COVID-19 response.[35] Generally, citizens are prioritized. Assistance programmes are either suspended or impeded by distancing measures. Inadequate protection and essential services are

constrained further. Funds and donations are redirected toward emerging priorities, mostly overlooking the pre-existing and continuing needs of refugees and the vulnerable. As a result, disparities in health are likely to increase, and health outcomes for the vulnerable will worsen disproportionately.

Health is a human right, and human rights should be at the core of the response to a health emergency response. Public health actors should adhere to ethical principles in their actions, and a response that violates rights should be avoided. This emergency has justified draconian breaches of individuals' rights to autonomy, independence and freedom of expression. Egypt, for example, revoked the credentials of journalists for citing COVID-19 infection projections.[36] In Jordan, the government arrested several activists and has imposed financial penalties on citizens who "cause panic" about the pandemic.[37] This paternalistic approach might be justified as a necessity to achieve a greater good for the public. However, if a greater good is not consistently observed by preserving individuals' dignity and respect, then serious concerns are raised. The crisis is being exploited for political ends. In Iraq and Lebanon, for example, sectarian tensions and political rivalry have been fuelled by the COVID-19 outbreak.[38]

Public Health Systems: The Way Forward

Arab states have adopted neoliberal policies, and health has been commercialized and privatized. The contributions of governments to health spending, and arguably to health governance, have diminished over the years. By nature, public health is a public investment in the collective wellbeing, and is not a profit-generating sector. The domination of the health sector by the private sector has not therefore encouraged investments in public health, which is arguably antagonistic to a profitable private healthcare sector.

The current pandemic has been a complex health emergency that extends beyond the traditional concept of health. The causal pathways for disease and illness are complex. An in-depth understanding of the social determinants of health is crucial when preparing for, responding to and recovering from a pandemic.[39] Poverty and inequality create conditions for the transmission of infectious diseases, and health disparities can further contribute to unequal burdens of morbidity and mortality.[40] Controlling pandemics requires qualified public health systems that are capable of recognizing all the potential risk factors, assessing the impacts of alternative policies, integrating social science disciplines to understand local contexts and anticipating shortfalls in the necessary resources.[41]

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The COVID-19 pandemic has exposed the weaknesses of public health in the Arab world: scarce financial resources, incoherent, thinly-spread workforces, and fragile and inadequate infrastructures. Governments need to increase investments in preventative care and public health. This does not necessarily mean securing additional financial resources; they could simply dedicate higher proportions of their health funding to public health services. Alternatively, the integration of health and social care services may offer access to additional resources and improve the efficiency of services.

Public health professionals are limited in numbers and inconsistent in competence. Clinicians who do not have structured or rigorous training in public health occupy the majority of leadership positions. Besides, practioners have rarely acknowledged public health as their primary function; it is mostly a secondary interest to members of other health-related professions. Then there is the schism between the community medicine training curricula and the public health training offered by academic institutions. The first is mostly limited to medical doctors, while the latter is open to all professionals. There is a need to synchronize the two tracks and ensure that training responds to specific local and regional needs. For instance, in a region beset by long-term conflicts, public health training must address this challenge. Besides, public health is an interdisciplinary field, and the contributions of medical doctors and other health professionals are no more important than the contributions of the political and social sciences. Building public health capacity requires the creation of a professional identity. It is the role and responsibility of professional bodies and societies to establish this identity. However, such bodies, where they exist, are not fulfilling their duties, and need to be activated. Their roles would include advocating for professional priorities, providing strategic guidance, collaborating with local authorities, academic institutions and public health actors, and identifying training needs, competencies and standards.

Public health services thrive in a collaborative and participatory environment, and the burden of rebuilding systems must therefore be a shared and inclusive responsibility of all stakeholders. Civil society, in particular, has a significant role to play in the development of public health. Civil society organizations represent communities and are well-positioned to access the most vulnerable and to reflect actual needs and social complexities. Moreover, they are capable, through outreach and advocacy, of securing external funds and forging cause-specific partnerships with the private sector. Their efforts have been significant, but also fragmented and reactionary, whereas a strategically planned and integrated response would be more efficient in terms of long-term rebuilding. There is also a leadership vacuum and a need for professional authority to devise strategic priorities and orient rebuilding efforts. It is the joint responsibility of academic institutions, professional societies and local authorities to nurture such professional leadership.

Necessary public health infrastructures include capacities for surveillance, information sharing, testing and tracing, and accessible preventative care. Arab countries need to invest in these infrastructures and capacities. Such services should always be monitored by and accountable to the people – particularly those which carry a high risk of human rights violations. The principles of social justice and human rights must be embedded in public health services and systems. The rights to food, privacy, autonomy, physical integrity, education and protection are all integral to health and have an impact on health status. Injustice adversely impacts health; therefore, it is a duty of public health professionals to promote equity and dignity and to be free of discrimination and other human rights violations. States should not exploit public health systems and services to attain objectives other than the wellbeing of their people.

The COVID-19 pandemic presents a conundrum that will never have a straightforward answer. Arab states have navigated their own routes through this pandemic. While some countries have chosen to face the long-term impact of strict control measures, others have decided to ease those measures and battle their ways through a mounting outbreak. Although this has been a public health emergency, public health systems in Arab countries have not risen to the occasion. Perhaps this is an opportunity to grasp the necessity and importance of investing in public health and rebuilding a weak and outdated system. It could also be an opportunity to act in solidarity, acknowledging that health is not constrained by borders, and that the impacts of choices made in adjacent countries extend from one to the other.

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