

BUILD BACK FAIRER ACHIEVING HEALTH EQUITY IN THE EASTERN MEDITERRANEAN REGION

INTRODUCING THE REPORT OF THE COMMISSION ON SOCIAL DETERMINANTS OF HEALTH IN THE EASTERN MEDITERRANEAN REGION

New report reveals path-breaking insights into the state of health inequities in the Eastern Mediterranean

In-depth analysis carried out for a WHO Commission highlights health inequities in the Region – and what can be done to remedy them.

There are marked inequities in health between countries in every region of the world, but they are particularly dramatic in the Eastern Mediterranean Region.¹ For example, male life expectancy in Somalia is 54 compared with 79 in Kuwait; among women the range is 59 to 82. These inequities in health also exist within countries, related to income, wealth, education, rural or urban location and conditions associated with being a migrant, refugee, or internally displaced person.

Inequities between and within countries that are judged to be avoidable are unfair. These unfair health inequities are shaped by the conditions in which people are born, grow, live, work and age – the social determinants of health – and by political, economic, cultural and environmental influences which are the structural drivers of those conditions. Health systems are necessary for treating illness when it occurs, and universal health coverage is vital. But it is the social determinants of health (SDH) that determine health, and inequities in health, in the first place. In 2005, the WHO Commission on Social Determinants of Health asked: why

treat people if we then send them back to the conditions that made them sick? Now, The Commission on Social Determinants of Health in the Eastern Mediterranean Region has examined the conditions that make people sick and deprive them of the opportunity to lead lives of dignity in the Region.²

The Commission's new report, *Build back fairer*, presents a stark picture of the need for action to improve health in the Region by focusing on the social determinants of health. It is set against the backdrop of pressures caused by the COVID-19 pandemic, and continued problems of conflict, mass movements of people, economic inequity and poverty, environmental challenges and gender inequities. The Commission has brought together a mass of evidence from the Region and provided a comprehensive set of recommendations for stakeholders. International and regional organizations, national and local governments, civil society including faith-based organizations, the health sector, the corporate sector and humanitarian agencies all have a role to play in building back fairer.



The SDH approach has been growing around the world since WHO established the Commission on Social Determinants of Health in 2005. As the WHO Commission declared: social injustice is killing on a grand scale. SDH is part of the same development agenda as WHO's Thirteenth General Programme of Work, which sets three global targets: advancing universal health coverage, addressing health emergencies and promoting healthier populations for a total of three billion people – the “triple billion”. WHO's vision for the Region, *Vision 2030*, sets targets for the Eastern Mediterranean in these three areas, as well as for transforming WHO in the Region to make it fit for business.

National action will be at the heart of efforts to achieve health equity. The SDH approach

requires coordinated work across government policies and departments. Leadership must come from the centre, but the ministry of health in each country needs to champion a whole-of-government approach to make health equity a marker of national progress in all government policies.

It is also important to work as a Region – these issues are regional in scope as well as national. WHO is well placed to provide regional leadership for action on the social determinants of health and health equity, working with other sectors, UN agencies, nongovernmental organizations, civil society, businesses, humanitarian organizations and donors.

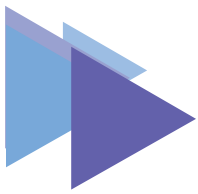
Key steps for establishing health equity

1. Create equity in the conditions for all people to have lives of dignity and good health.
2. To achieve this, focus on the conditions in which people are born, grow, live, work and age and inequities in the structural drivers of these conditions of daily life.
3. All countries, whatever their level of development, should take action guided by the principles: do something, do more, do better.

Here is a summary of the main points and key recommendations of each of the areas covered by the report.

¹ The Eastern Mediterranean Region comprises 22 countries and territories: Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, occupied Palestinian territory, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. To mitigate data gaps, some analysis in the report is based on data from different country/territory groupings.

² The Commissioners are Abdirisak Dalmar, Adel Al Zayani, Anita Zaidi, Assad Hafeez, Bagher Larjani, David Bishai, Hoda Rashad, Iman Nuwayhid, K. Srinath Reddy, Michael Marmot, Rajae El-Aouad, Rowaida Al-Maaitah, Salwa Najjab, Senait Fisseha, and Stephen Gloyd.



HEALTH INEQUITIES

HEALTH INEQUITIES IN THE REGION PERSIST AND IN SOME CASES ARE WIDENING



Photo: © WHO

Available data show that health inequities persist between and within countries in the Eastern Mediterranean Region – and in some cases they are widening. The variation in male life expectancy in the Region is 25 years – that’s half a lifetime lost for those with the lowest life expectancy. Among women the variation in life expectancy is 23 years.

Rates of noncommunicable diseases such as diabetes, cancer and heart disease are high, while many communicable diseases that could be eradicated remain endemic. COVID-19 has highlighted inequities in both communicable and noncommunicable diseases. Within every country of the Region, wealthier groups have lower infant mortality rates.

Data are inadequate; for example, we know the cause of death for only 32% of deaths in the Region, compared with 49% globally. Yet such data – and more detailed data showing social, economic and area differences – are vital for any action to be taken to improve health equity, whether locally, nationally or by international organizations.

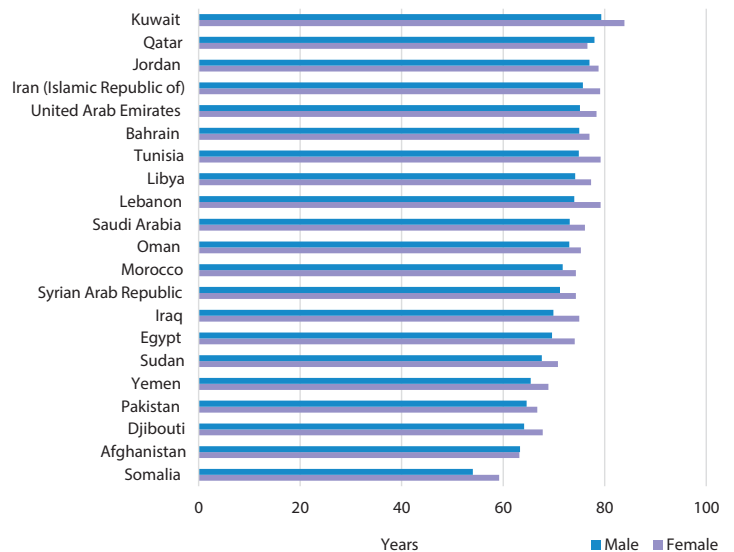
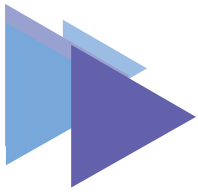


Figure 1 Life expectancy at birth, 2019



KEY RECOMMENDATIONS

1. Develop national social determinants and health equity plans.
2. Establish a monitoring framework and generate data on inequities in social determinants and health.



COVID-19 AND HEALTH INEQUITIES

COVID-19 CONTAINMENT POLICIES ARE DAMAGING THE SOCIAL DETERMINANTS OF HEALTH AND HARMING HEALTH EQUITY

The Eastern Mediterranean has had a relatively low number of deaths from COVID-19, with 125 000 recorded at the start of 2021. But policies to contain the spread of the virus will have long-term impacts on health, especially for those who are already poor and vulnerable.

Extreme poverty had been set to continue falling in the Region in 2020, but with pandemic-related unemployment, reduced working hours and inadequate social support, the World Bank now estimates that the number of people living on less than US\$1.90 per day has risen by between 2.8 and 3.4 million. Food insecurity has increased. Progress in a wide range of areas from girls' education to immunization has also been affected. One ray of hope is that the importance of protecting health has been brought to the fore – for example, the Government of Tunisia has responded with a new law that aims to reduce COVID-19 transmission and deaths by reducing socioeconomic inequalities.

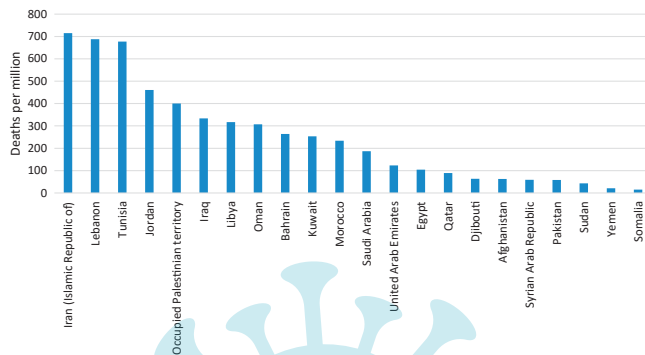


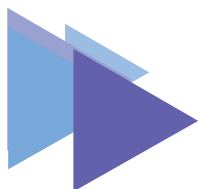
Figure 2 COVID-19 deaths per million in the Region
28 February 2021



Photo: © WHO

KEY RECOMMENDATIONS

1. Reduce inequities in infection and mortality by addressing the underlying causes of inequities and taking steps to minimize inequities in exposure.
2. Mitigate the unequal impacts of containment measures on unemployment, income, hunger and gender equity.
3. Implement equitable vaccination programmes.



CONFLICT AND CONSEQUENCES

CONFLICT AFFECTS MORE THAN HALF THE COUNTRIES IN THE REGION, DEEPLY IMPACTING OPPORTUNITIES FOR HEALTH EQUITY

Most of the world's deaths from war and terrorism occur in the Eastern Mediterranean, with more than 150 000 deaths per year since 2014. In addition to fatalities, conflict also causes high rates of disability, communicable and noncommunicable diseases and poor mental health. It exacerbates existing inequities and adversely affects all aspects of the social determinants of health, including the availability of early years support, education, health services, employment, incomes, social protection systems, shelter, water, sanitation, electricity and basic human rights, and often leads to high levels of migration and the collapse of governance systems.



Photo: © WHO

There have been 150 000+ deaths per year from war and terrorism in the Eastern Mediterranean since 2014 – more than any other region

Conflict is a direct cause of humanitarian crises and the Region hosts the world's largest number of refugees, internally displaced persons (IDPs) and migrants, making the provision of basic services, housing and social protection extremely challenging – a situation now made even worse by the COVID-19 pandemic.

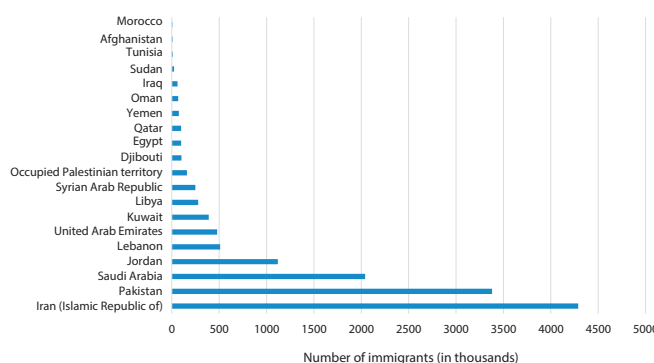
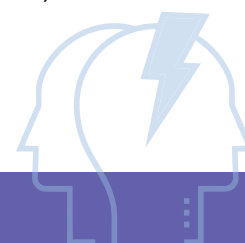
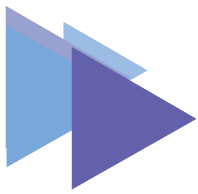


Figure 3 Total number of immigrants by country/territory of destination, 2018



KEY RECOMMENDATIONS

1. Focus humanitarian response to conflict and emergency situations on the social determinants of health, equity in health and dignified lives.
2. Place the health of both migrants and host populations at the forefront of migration policy.
3. Highlight and mitigate the negative impacts of sanctions on health and the social determinants of health.
4. Abide by UN resolutions on the occupied Palestinian territory.



ECONOMIC DRIVERS

HIGH INCOME INEQUITIES REFLECT THE LOW PRIORITY GIVEN TO SOCIAL JUSTICE AND HEALTH EQUITY

The richest 10% of people in the Middle East and North Africa (MENA)³ hold a higher share of all pre-tax national income – 60% – than in any other region, while the lowest 50 percent holds just 10%. And that's not just the resource-rich countries of the Gulf Cooperation Council – even non-GCC countries in the Region have higher income inequities than the United States and Europe. Countries with high income inequities tend to be weak on measures that redistribute wealth, and therefore social determinants of health, and the Region has low personal and business taxes and relatively low government health expenditure. Meanwhile, only 11% of the population of MENA is covered by adequate social protection, with informal and rural workers generally being left out along with IDPs and refugees.

60% of pre-tax national income is held by the richest 10% in MENA – a higher share than in any other region

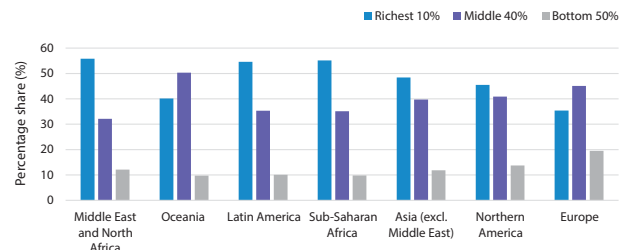


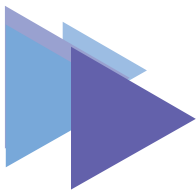
Figure 4 Share of pre-tax national income of the richest 10%, middle 40% and bottom 50% of the population by region, 2019



KEY RECOMMENDATIONS

1. Implement equitable fiscal policy.
2. Increase official development assistance to 0.7% of gross national income for wealthy countries in the Region.
3. Support greater economic inclusion of refugees, migrants and IDPs.
4. Develop measures of national progress which are based on equitable social and economic development.

³ This refers to the MENA region as defined by the World Bank and does not represent exactly the same countries as the WHO Eastern Mediterranean Region.



SOCIETY AND CULTURE

CULTURAL ATTITUDES ARE AFFECTING HEALTH EQUITY



Photo: © WHO

Religious beliefs, gender norms and attitudes towards migrants and refugees are crucial for health equity in the Region. Regular attendance in religious groups is linked with health benefits such as lower blood pressure and better mental health as well as lower alcohol use and smoking, and contributes to community cohesion. Stereotypical cultural and social beliefs about the roles of women and men in society hinder development and limit people's lives and health. Women who are better educated are more likely to be knowledgeable about health care and nutrition, to marry later, to be engaged in the formal labour market and to have higher incomes. Their children are usually healthier.

The United Nations Development Programme's Gender Inequality Index shows that the Eastern Mediterranean Region has one of the highest levels of gender inequality of any region.

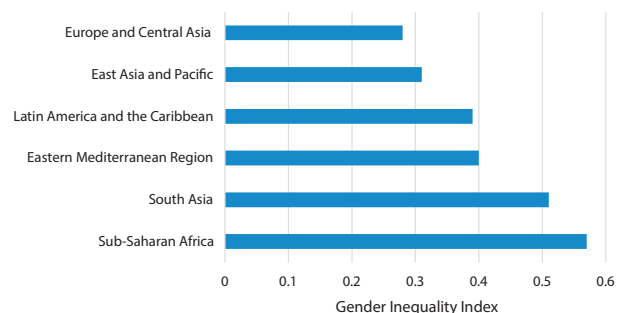


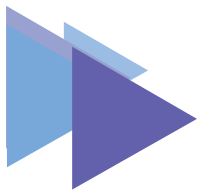
Figure 5 Mean Gender Inequality Index⁴ by region, 2018

Meanwhile, attitudes towards refugees and migrants in the Region are complex, but they are generally not afforded the same services and resources as citizens and there are signs the situation may deteriorate further as a result of the COVID-19 pandemic.

KEY RECOMMENDATIONS

1. Strengthen collaboration with religious leaders and organizations to support health equity.
2. Achieve progress in gender equity.
3. Eliminate discrimination against and exclusion of refugees, migrants and IDPs.

⁴ The Gender Inequality Index (GII) is a composite measure reflecting inequality in achievements between women and men in reproductive health, empowerment and the labor market. The GII ranges from 0 to 1, and the closer the Index is to 1, the higher the inequalities between women and men.



CLIMATE CHANGE AND NATURAL ENVIRONMENT

CLIMATE CHANGE IS ALREADY DAMAGING HEALTH IN THE REGION

The Eastern Mediterranean Region is experiencing the greatest impacts of increases in extreme hot temperatures and decreasing precipitation of any region. This climate change is harming health and health equity, and will continue to worsen health outcomes. The Region is likely to see increases in waterborne diseases, food shortages and mal/undernutrition, and mortality and morbidity during heat waves. There is also increased risk of cardiovascular and respiratory illnesses, pulmonary diseases due to dust storms and heat waves, and the spread of vector-borne diseases including dengue. Almost the entire population of the Middle East is expected to live under water stress by 2050, further undermining health. The World Bank estimates that water-related losses in agriculture, health, income and property will reduce GDP growth rates in the MENA region by 6–14% by 2050.

33 000 more children under 15 in the Region are set to die each year from acute diarrhoeal diseases due to contaminated food or water by 2050



Photo: © WHO

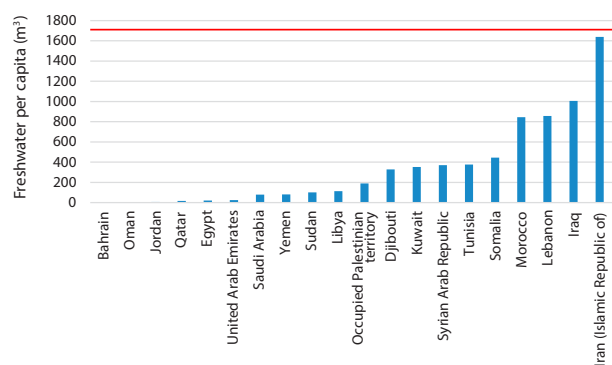


Figure 6 Water resources per capita, 2014, compared with water stress level

The number of people displaced temporarily or permanently by climate change is anticipated to increase as climate change worsens. This will affect incomes and poverty levels and, consequently, health and inequities as housing, environmental services, jobs, education and nutrition are all impacted by displacement.

KEY RECOMMENDATIONS

1. Mitigate and adapt to climate change, increase renewable energy and support health equity in line with the Paris Agreement on Climate Change and the 2030 Agenda for Sustainable Development.
2. Diversify the economy of the Eastern Mediterranean Region away from reliance on fossil fuels.
3. Increase conservation of natural resources and improve water management in the Region.

EARLY YEARS AND EDUCATION

CHALLENGES TO MATERNAL AND CHILD HEALTH AND EQUITABLE EDUCATION REMAIN – AND ARE EXACERBATED BY COVID-19



Maternal and child health in the Region has improved dramatically in recent decades: maternal mortality per 100 000 live births has halved while under-5 mortality per 1000 live births has fallen by 66%.

But levels remain high and the Region has the second highest maternal mortality rate after sub-Saharan Africa, with 70% of maternal deaths in MENA due to preventable causes. Research shows persisting inequities in maternal and child health and early years development in countries of the Region, related to socioeconomic position and refugee or IDP status.

With the COVID-19 pandemic disrupting essential health and nutrition services, WHO and UNICEF have warned that an additional 51 000 children under the age of five could die in the Region by the end of 2020 – nearly 40% more than the pre-COVID figure, reversing progress made in child survival in the Region by nearly two decades. While participation in primary and secondary schooling has improved, there are

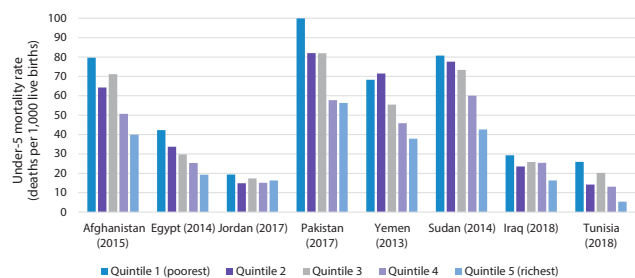


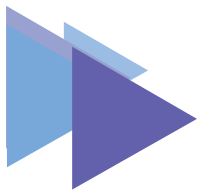
Figure 7 Under-5 mortality rate (deaths per 1000 live births) by wealth quintile in selected countries, 2014–2018

70% of maternal deaths in MENA are due to preventable causes

still gender inequities, especially in rural areas, and access to post-school training, education and employment is particularly limited for young women.

KEY RECOMMENDATIONS

1. Ensure equitable maternal and child health.
2. Ensure that all young people in the Region complete good-quality primary and secondary education and increase equity in access to tertiary education.
3. Build on progress in gender equity in education and increase post-school training and employment of women.



WORKING LIVES

HIGH UNEMPLOYMENT AND POOR WORKING CONDITIONS POSE CHALLENGES TO HEALTH AND WELL-BEING

Employment rates vary widely between countries of the Eastern Mediterranean Region, but overall in 2019 it had the highest unemployment rate (9%) and the highest youth unemployment rate (22.5%) of any region in the world, with all the associated negative health impacts. Many countries have no unemployment benefit system.

There are also high and increasing rates of informal work with multiple risks for poor health including direct risks from working in unregulated and dangerous settings, poverty, and the stress associated with highly irregular income and lack of social protection and savings to ride out economic shocks. Some countries in the Region have relatively high rates of child labour, mainly as a result of conflict and high levels of poverty, with disastrous consequences for long-term health and the ability to thrive throughout life. The high numbers of economic migrants and refugees in the Region are vulnerable to poor working conditions and at risk of harm to their health.

**9% unemployment,
22.5% youth unemployment –
the highest rates of any region in
2019**



KEY RECOMMENDATIONS

1. To improve health equity, reduce unemployment with a focus on young people, women and the long-term unemployed.
3. Improve the quality of work to benefit health equity.
3. Regularize informal employment and eliminate child labour, slavery and trafficking.

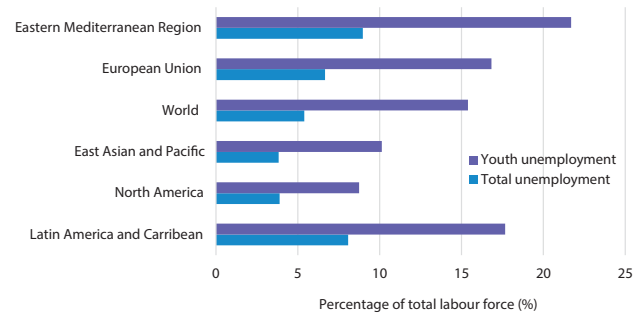


Figure 8 Unemployment, total and youth (15–24 years) as a percentage of total labour force by region (2019)



Photo: © WHO



HEALTHY AGEING

DEMOGRAPHIC SHIFTS AND LACK OF PENSIONS AND CARE SERVICES THREATEN TO LEAVE OLDER PEOPLE UNSUPPORTED



The Eastern Mediterranean Region has a relatively young population by global standards, but the proportion of older people is set to rise significantly over the next 50 years as the birth rate declines and life expectancy increases. The UN projects that by 2050, 15% of the Region's population will be over 60, while the number of older adults with a noncommunicable disease will be 50% higher in 2030 than in 2015. The Region has low levels of social protection, especially pensions, for older people, particularly women and migrants, making it a challenge to protect health in later life. Families have traditionally provided high levels of support to older people but these practices may be unsustainable as the age structure in the Region shifts and given the economic pressures of high unemployment rates.

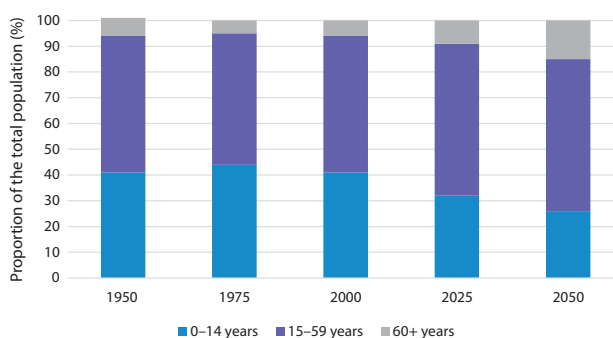


Figure 9 Age structural transition and projected transition in the Region, 1950–2050

There are set to be 50% more older adults with a noncommunicable disease by 2030 than in 2015

KEY RECOMMENDATIONS

1. Expand the provision of publicly funded care for older people.
2. Increase the provision of pensions through government subsidies.
3. Develop national strategies to improve the health and well-being of older people and focus on active ageing.



BUILT ENVIRONMENT

RAPID URBANIZATION IS BOTH A CHALLENGE AND AN OPPORTUNITY



Photo: © WHO

Nearly 70% of people in the Eastern Mediterranean live in towns and cities although there is wide variation between countries – ranging from 100% in Kuwait to 26% in Afghanistan. Rapid urbanization is a challenge even in the wealthiest countries, and many cities in the Region have seen the growth of informal settlements as well as refugee settlements, with all the health problems associated with overcrowded and unsanitary conditions.

70% of the Region's people live in towns and cities

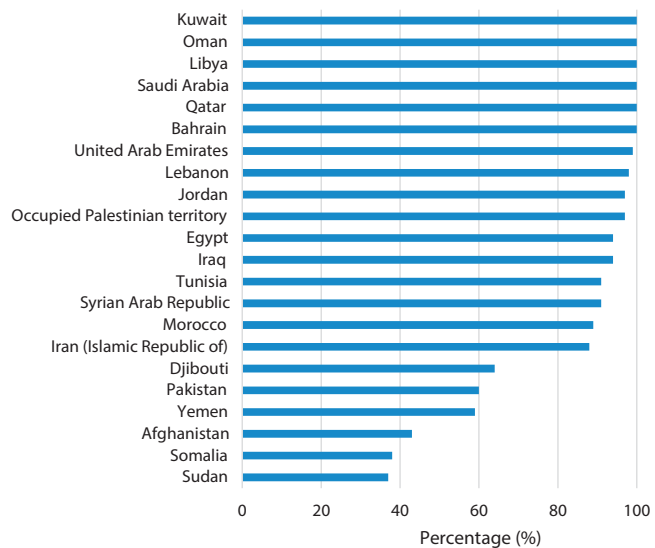


Figure 10 Proportion of population with access to improved sanitation facilities by country, 2017

However, cities can provide better access to services such as electricity and water – in Somalia 70% of those living in urban areas have access to improved water sources, for example, compared with 21% in rural areas. Internet access is increasingly considered an essential service important to health but there is a clear

social class gradient to this, with a higher proportion of the population in the top wealth quintiles having an internet connection.

KEY RECOMMENDATIONS

1. Ensure universal provision of basic services and improve housing quality.
2. Implement sustainable and accessible transport systems.

3. Strengthen regional and national planning mechanisms.

HEALTH SYSTEMS

STRONGER HEALTH SYSTEMS AND EFFORTS TO IMPROVE HEALTH ARE NEEDED

There are huge challenges for the provision of equitable and accessible health care in the Eastern Mediterranean Region, including increasing exposure to health risks, rising health care costs, and acute and chronic emergencies. Universal health coverage (UHC) is one of WHO's top priorities, but the Region is below the global average with wide variations between countries. Improvements in UHC have been uneven with inequities related to gender, education and income. At 5% of GDP, the Region had one of the lowest levels of health spending in the world between 2000 and 2017 – well below the global average of 9.9%, leading to more out-of-pocket expense for individuals. Conflict-affected countries have the weakest health systems, while providing health service coverage for refugees is a significant challenge for many countries with large refugee populations such as Lebanon and Jordan.

Health care systems should focus much more on improving living conditions and strengthening efforts to improve health, as well as treating ill health; building population health systems is central to this. This entails direct work with patients, close collaboration with other sectors, and local, national and international advocacy for the social determinants of health as well as health care.

Average health spending in the Region was just 5% of GDP between 2000 and 2017 – well below the global average of 9.9%

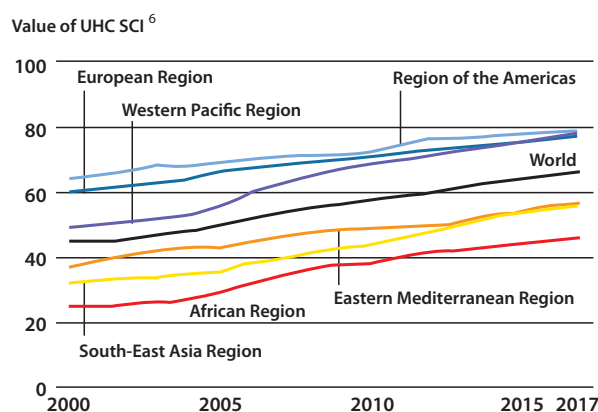
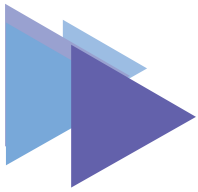


Figure 11 Value of UHC Service Coverage Index by region, 2000–2017

KEY RECOMMENDATIONS

1. Strengthen universal health coverage across the Region and ensure equitable and affordable access to health care.
2. Implement and ensure essential public health functions for each country to achieve universal public health standards.
3. Develop population health systems with a strong focus on equity, prevention and action on the social determinants of health.

⁶ The UHC Service Coverage Index refers to the “coverage of essential health services defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity access, among the general and the most disadvantaged population.” The index is reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage.



GOVERNANCE AND TAKING ACTION TO BUILD BACK FAIRER

HOW TO PUT HEALTH EQUITY AT THE HEART OF GOVERNMENT IN THE EASTERN MEDITERRANEAN REGION



Photo: © UNDP

Underpinning all successful action on health inequities are governance systems that prioritize, support and enable such action. What's needed are national and regional plans on the social determinants of health and health equity, whole-of-government approaches to tackling health inequities, and whole-of-society engagement with SDH, while also ensuring alignment with other pressing priorities such as climate change and economic and social development. Governments need to be advocates for – and architects of – greater equity across the country, despite, and perhaps also because of, the myriad challenges faced in the Region. Recommendations are made for actions to build back fairer involving a range of stakeholders and levers – such as pro-equity tools, better data and research, legal mechanisms and approaches based on human rights and the Sustainable Development Goals (SDGs).

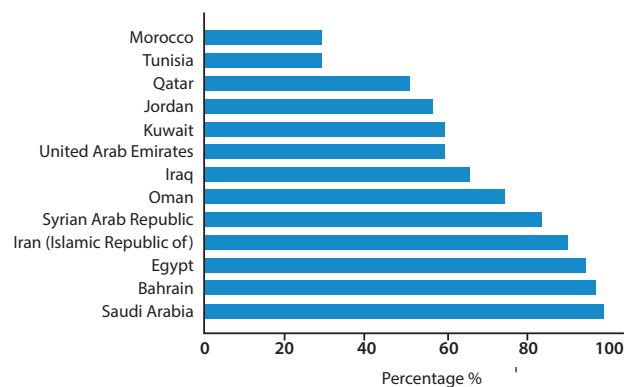


Figure 12 Completeness of cause-of-death registration in countries of the Region, 2009–2017

KEY RECOMMENDATIONS

Principles for governance to build back fairer for health equity

1. Take action on social determinants of health to improve health equity.
2. Put health equity at the heart of government.
3. Do something, do more, do better.
4. Base social action for health equity on the principle of proportionate universalism – spend more on the areas of greatest need to expand social protection.
5. Involve the whole of government in policies and practice to improve health equity.
6. Involve the whole of society in improving health equity.
7. Develop strong accountability for health equity.
8. Align greater action on climate change with health equity.

Key steps for taking action to build back fairer to achieve greater health equity

1. Develop national and transnational plans on the social determinants of health and health equity, for action and implementation.
2. Strengthen the role of civil society and faith-based organizations in action to achieve health equity.
3. Strengthen the contribution of the commercial sector to health equity and stop harmful practices.
4. Support the humanitarian sector to have a strong focus on the social determinants of health.
5. Increase the involvement of the health care sector in the social determinants of health.
6. Develop the role of local government in relation to the social determinants of health.
7. Link action on health equity and social determinants of health with the SDGs.
8. Strengthen human rights approaches in the Region.
9. Develop data and monitoring systems to inform evidence-based action on health equity and greater transparency and accountability.
10. Strengthen legal obligations and regulations to enforce actions to support health equity.
11. Reduce corruption.



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