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On approaching health in the Arab world

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There is a sentence that I still remember from one of my French geography textbooks in high-school: "Asia does not exist, has never existed, has never wanted to exist." Arguably, the first two clauses of this statement can be applied to the Arab world. While we Arabs have wanted to exist as a single nation—this is what twentieth-century pan-Arabism amounts to—we have never succeeded in doing so, our efforts having mostly spawned authoritarian regimes. Furthermore, only some us, mostly urban elites in Cairo, Damascus and Baghdad, appear to have wanted this unity. Maziak (2009) draws a list of health problems plaguing our part of the world and rightly bemoans the lack of democratic practices and adequate social and institutional responses to these problems. He points astutely to some underlying dynamics—women's inferior social status as a cause of honour crimes and poor physical and mental health; authoritarian structures of government leading to flawed data collection with detrimental effects on health monitoring and so on. However, his diagnosis could have gone further had it not been based on a less convincing premise, one that Maziak himself has brought to the fore:

"Understanding the complexity of generalizing to such a vast and diverse region, there is a striking sense of unity and destiny among Arabs, and an ironic commonality of problems facing them nowadays."

I see no evidence of such a sense of unity. Rather, what is ironic is the lack of commonality in health problems, despite the shared language and culture. There is no escaping the fact that Yemen, Saudi Arabia, the United Arab Emirates, Lebanon, Iraq, Palestine and Libya—to pick a few countries almost randomly—appear to have very different health problems, which partly reflect the vast differences in their respective social, historical and geographical settings. A central determinant of Palestinian and South Lebanese health over the last few decades has been Israeli occupations and military incursions (Batniji et al. 2009; Giacaman et al. 2009). Women in Saudi Arabia are constrained by patriarchal structures which are deeply entrenched, give rise to severe restrictions on freedom and can easily turn into abuse (Human Rights Watch 2008), while youth in Lebanon are subject to relentless tobacco advertising (Saade et al. 2008) and high levels of traffic-related trauma (Gerbaka et al. 1999). Islamist and secular political organizations have moved to fill in a gap in the provision of primary health care in countries where the state is relatively weak but not in others (Jabbour et al. 2007). Wars in Iraq, Sudan and Somalia over the last decade have led to the death and injury of hundreds of thousands of civilians. Occupational injury and violence appear to be significant health problems for foreign workers in the Arab Gulf, Lebanon and Jordan, although peer-reviewed research on this topic remains scarce (UNDP 2005). Palestinian refugees in some Arab countries suffer from systematic institutional and legal discrimination with significant health implications. Cairo, a megalopolis of over 15 millions, may have more in common with Sao Paolo, Casablanca or Calcutta, than Sanaa, Ryadh or Baghdad. Indeed, many health and socio-economic indicators at the end of the Arab Development Report 2005 do reflect this wide variability (UNDP 2005). The premise of 'commonality of problems' alas blights Maziak's otherwise powerful and brave article.

Many health dynamics are probably shared by a large number of Arab countries, without being mere reflections of broader globalization trends relevant to Asia, Africa and

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South America as well—structures of economic dependence in the Arab Gulf, North Africa and the Mashreq and their impacts on the health sectors; the emergence of 'health tourism' with effects on the health sectors at both the demand and supply ends; cultural and religious dimensions of attitudes to reproductive health; authoritarian government and patriarchal practices shared by a large number of Arab societies in what amounts to a 'symbiotic relationship between state authority and patriarchy' (UNDP 2005). Do these dynamics justify addressing the health problems of the Arab world through the analytical prism of a common framework? Possibly but not evidently.

The Arab world does of course exist: we share our experience of language, a powerful historical frame of reference and, to a lesser extent, a sense of values, common culture and perhaps, as Maziak writes, common destiny. However, the question that we ought to ask is which dynamics, be they specific to the Arab world or not, are most useful in helping us understand and better address health problems in a particular Arab country or city? Recognizing the diversity of health problems is not only imperative for health practitioners but may also help pointing the way towards the democratic, pluralistic and more realistic Arab union that many of us still hope for.

Therein also lies the answer to Maziak's pessimism: we are part of the Arab World and part of the world at large and we have a wide range of positive experiences to learn from and replicate, as Iman Nuwayhid shows in his response to the same article. Maziak's pessimism is understandable (even if the 'domino-like breakdown', 'looming demographic bomb' and 'imminent avalanche' predicted in the article are less convincing): this pessimism stems no doubt from his long experience in researching health in the Arab world and his genuine concern about the health of his fellow Arabs. However, our job as scientists, researchers and practitioners is to avoid succumbing to exasperation and help steer our societies towards better and more equitable well-being.

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