Int J Public Health (2009) 54:361–362
DOI 10.1007/s00038-009-0065-3

SPEAKERS CORNER - HEALTH IN A TROUBLED REGION

Commentary: Mosaic Arab world, health and development

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Published online: 10 September 2009
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I have read with great interest the commentary by Maziak (2009) which has generated the commentary below. Arab states, located in North Africa and West Asia, are not all the same. They vary so much: historically (pharaonic, phoenician, ashurian, etc.), geopolitically (Gulf, Maghreb, Egypt, others), socially (conservative, liberal, mixed), economically (oil-rich, resource-rich, moderate, and poor), culturally (traditional, modern, mixtures), healthcare providers/systems (public, private, charity organizations, mixed) and with respect to human resources in health (richest being Egypt, Saudi Arabia and others). They cannot be dealt with as if they are one group of homogenous states. Generalization, with respect to demographic features, socio-economic or health indicators may result in over-simplification of an already complex situation, and may be misleading. Although there have been important advances in healthcare delivery and health manpower with respect to primary health care (especially in Gulf States and Egypt) and tertiary care (as in Lebanon, Gulf States), yet much still has to be done to achieve Health for All, a goal Alma-Ata Declaration set forth more than 30 years ago (Alma Ata 1978).

Health indicators in the Arab world show stark differences between individual countries. But, aggregate figures provide only a narrow perspective. They do not show variation according to socioeconomic group, sex, education, or political affiliation. The scarcity of databases available to collect such detailed data reflects the fact that inadequate political support exists for rigorous intersectoral research of relevance for health in the region. National development agendas and public policies are focused on economic development. Funding for health tends largely to be directed at providing curative medical services designed to emulate Western health systems (Makhoul and El-Barbir 2006). Arab countries have made substantial progress since the 1950s in reducing infant and child mortality, improving life expectancy, and increasing access to health care. Public health challenges include high maternal mortality, malnutrition, wide disparities between rural and urban areas and different countries, emphasis on curative rather than preventive care (in some nations), relatively weak public health institutions, variable quality of health care, lack of capacity in policy making, and unresponsive and inequitable health systems (Jabbour 2003).

Women health should particularly receive attention when discussing health in the Arab World. Available data largely comes from international yearbooks, regional data bases, and small scale field studies (Zurayk et al. 1997). While some countries condone early marriage (as in Egypt, Gulf nations) with related high fertility rates and reproductive morbidity, others (mostly Lebanon and Maghreb nations) have delayed marriage and declining fertility. The socio-cultural context is found particularly relevant to pregnancy and childbirth, seen as natural processes by women, to experiences of menopause, and to reported cases of domestic violence (Zurayk et al. 1997).

A recent report (Boutayeb and Serghini 2006) has subdivided Arab nations into three groups, according to health and development indicators. The first group of countries (Low Health & Development or LHD) offers a multitude of opportunities of improvement in each component implied in the human development index (health, education, standard of living). In particular, this group which represents

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20% of the Arab population has unacceptable levels of maternal and child mortality. Concretely, however, improvement of health indicators is conditioned by economic and political constraints (low income, military conflicts, and drought). On the opposite side, the second group of rich countries (High Health & Development or HHD), especially in the Gulf, has few possibilities of improvement, notably in terms of infant and maternal mortality, but with very limited impact of the whole region since this group represents only 3% of the Arab population. Moreover, the gain will be somehow offset by the burden of injuries and non-communicable diseases which are exponentially increasing in the rich gulf countries (Alwan 1997; Boutayeb and Boutayeb 2005; WHO 2003). A high potential of improvement is offered by the third group (Middle Health & Development or MHD). Indeed, in this group representing 2/3 of the Arab population (including Egypt), human development level is lower than income level and many indicators can be improved. The quasi-totality of countries have high maternal and infant mortality levels contrasting with their economic development. Many countries have unacceptable low percentages of deliveries attended by skilled personnel and/or percentages of pregnant women receiving prenatal care. It has to be also emphasized that recent social conflicts have negatively/seriously affected/reversed prior accomplishments in health system development and healthcare delivery systems, as witnessed in nations with deep long-standing socio-political conflicts, as in Palestine, Iraq, Sudan and Somalia.

Only when a strong political commitment to the public's health is coupled with full cooperation of private sector and grass-roots organizations, we can expect improvement of health and development indicators across the Arab world. There are good prospects that this will happen once the social conflicts are either resolved or at least reduced.

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