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Keynote Speech by

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to

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COMMUNITY HEALTH: CHALLENGES FOR THE ARAB WORLD

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Ladies and Gentlemen, Colleagues,

It is a privilege for me to be here with you and it is always a great pleasure for me to be in this wonderful country, Oman. I thank ACCESS Community Health and Research Centre and the Ministry of Health of Oman – for inviting me to address the conference.

This conference comes at a time when there are major setbacks in the health status of many Arab communities, a time of crises of unprecedented magnitude and major humanitarian tragedies affecting millions of Arabs, and when we are all being challenged to prove that what connects us is stronger than distance and conflict. Here in this conference, we all have a keen interest in health and the health development of our communities and this is a strong basis on which to cement our societies in this difficult time.

I have been asked to focus in my statement on the challenges in community health. I will try to do that and at the same time propose areas where action is urgently needed.

It is stating the obvious that community health is concerned with the improvement of the health of people within their communities. Nineteen out of the twenty-two countries of the WHO Eastern Mediterranean Region are Arab countries; and currently over half the population of the region is Arab. Without understanding the challenges facing the communities within which the Arab populations live, one cannot identify the way forward in improving their health and fulfilling their aspirations.

The population of the Arab world has grown by about 380% during the past 60 years with an annual median rate of increase of 2.9% – well above that for the world as a whole, which stands at just over 1%. At this rate, the Arab population will reach 600 million by 2050 from the current population of just below 400 million. One of the characteristics of the Arab world, which strikes anyone who lives in it, or who has visited it extensively, is its diversity and heterogeneity, as well as its commonalities. Both attributes bring strength.

Among the commonalities, the Arab population has a fairly high but rapidly declining fertility rate; a declining and mostly low mortality rate – although the poorer countries have shown slower declining rates; and a young age structure with a median age of about 22 years, compared with a world median of 29.6 years in 2015. Finally, several countries have witnessed substantial increase in the working-age population as a result of labour migration.

These commonalities, however, hide a lot of disparities and I cannot speak of community health and its challenges in the Arab world without acknowledging that diversity. Although many countries have made great gains and have built extensive modern networks of health infrastructure with wide deployment of medical technologies, these gains have not been shared across and within countries. In our work in the Region, we opted for grouping the countries into three groups based on several health outcomes and health system performance indicators. This has helped us tailor the support provided to countries. There are Arab countries within each of the three groups.

All Gulf countries have large migrant populations, with three of them having more expatriates than nationals. The United Arab Emirates stands out as having the largest expatriate population at 7.8 million, out of 9.2 million. Most of the non-nationals in these countries are men of working age (15–64 years), distorting the age-sex composition of the country where they reside; for example, 85% of the population of Qatar is of working age. The Arab world today has the largest number of refugees in the world and a very high level of displaced population. The Palestinians and Syrians are the largest group. While struggling to fulfil their basic needs, the extraordinary influx of Syrian refugees into neighbouring countries, including Jordan and Lebanon is placing pressure on both the economic and social spheres in these countries.

Let me now review key challenges to community health in the Arab world. In our work with our Member States, five cross-cutting public health priorities have been identified; and WHO has been working with countries to develop policy options and strategies to address them. Despite the heterogeneity of the region in socioeconomic terms and health indicators, the challenges are shared, to varying degrees by all countries.

One key challenge is that of maternal and child health. Great strides forward have been made in the past 25 years in the health and survival rates of mothers and children. In the Region as a whole, child mortality fell by 46% while maternal mortality fell by 50%, between 1990 and 2013. In the Arab countries, a more important reduction in maternal mortality – exceeding 55% – was achieved while under-five mortality decreased by 45%. But what is striking is that a great deal of more progress could have been attained, given the existing knowledge and experience and the available cost-effective interventions. Indeed, progress towards achievement of Millennium Development Goals 4 and 5, which aimed at specific reductions in child and maternal mortality by end 2015, is in jeopardy for seven Arab countries. During the past three years, we have been working intensively, along with other partners, to support the countries facing the biggest challenges in meeting the goals by developing and starting to implement acceleration plans. These plans are based on evidence-based, cost-effective interventions along the continuum of care and will enable countries to make better progress and get closer to the targets they committed themselves to. However unless political commitment becomes stronger and until gaps in health systems are addressed and adequate funding becomes available, it is unlikely that the targets for reducing child and maternal deaths will be realized in some of these countries. These three impediments will need to be the focus of collective work by countries and the partners in the post-2015 agenda.

The second challenge was identified as the unfinished agenda with regard to communicable diseases with special emphasis on health security. Immunization programmes are confronted by several challenges. More than 1.3 million children did not receive the DPT3 vaccines in 2013. The focus of our work with countries is on vaccine-preventable diseases, including measles and polio, which remains endemic in our region, and on progress towards MDG 6 which relates to HIV, TB and malaria. We also focus on the threat to health security posed by the need to strengthen, across the Region and in all countries, the capacity to detect, assess, prevent and control emerging disease threats. This includes the readiness of countries to implement the International Health Regulations (IHR) which they endorsed at the World Health Assembly in 2005. So far, only seven Arab countries among the States Parties to the IHR in our region have declared that readiness. This particular challenge has been highlighted in the past two years with the emergence of Middle East respiratory syndrome coronavirus (MERS-CoV) within the Region, and the threat to global health posed by the outbreak of Ebola Virus Disease in West Africa and the risk it poses to nearby Arab countries. The role of communities in ensuring that essential vaccines reach those who need them is key to controlling many preventable diseases.

The third challenge is that of noncommunicable diseases (NCDs). NCDs are estimated to account for over 60% of all deaths in the Arab world – ranging from 19% in Somalia to 85% in Lebanon. More people are smoking in the Region than ever before, and they are smoking at younger ages. In particular, waterpipe use is alarming, involving up to 35% of 13-15 year olds in some countries. In addition, as urban life has become dominant, with 57% of the population in Arab countries living in cities, fewer and fewer people are engaging in daily physical exercise. Estimates on physical activity suggest that our region is the least physically active region in the world. More and more are prone to the effects of pollution and poor air quality. The regional intake of fat, salt and sugar increases year on year, and is reflected in extremely high levels of obesity among adults and children, diabetes and hypertension. People are dying too young from NCDs with a seriously negative impact on socioeconomic development. While the overall increase in life expectancy is welcome, the magnitude of premature deaths due to cardiovascular diseases, cancer, diabetes and chronic respiratory diseases is unacceptable. One important message that I must emphasize here is that we know what to do, we have the right vision and a clear road map to address NCDs. We have cost effective interventions which we call "best buys" to reduce risk factors but the commitment to initiate and sustain effective action has so far been weak. Not enough is being done to implement the United Nations political declaration endorsed by the Heads of State and Government at the General Assembly Meeting of 2011. We have translated the recommendations of the political declaration into a regional framework for action which has a practical and realistic set of actions that each country should implement. All countries need to do better in monitoring NCDs and their risk factors. They should do much more in implementing the best buys like the proven tobacco control measures, salt reduction, trans fat elimination and implementing the recommendations on marketing unhealthy foods and beverages for children. Let us also call for serious action on the currently unopposed advertising and marketing of unhealthy foods. The UN General Assembly is meeting again in New York in 2018 to assess the progress countries are making in the four actions areas: governance, surveillance, prevention and health care. The challenge for the region, which has one of the highest rates of NCDs, is to scale up in order to perform better in meeting the global targets.

Two further challenges were identified and both of these have tremendous impact and potential in regard to community health in general, but also in regard to the three challenges I have referred to already. The first of these is health systems strengthening, and the second is emergency and humanitarian preparedness and response.

The main challenge for health systems in the Region concerns the high rates of out-of-pocket payment – in at least five Arab countries the share of out-of-pocket payment is more than half of total health spending, putting individuals and families who seek health care at high risk of financial ruin and impoverishment. In addition, there are inequities in access to health care; a lack of long-term strategic planning for the health workforce; inadequate national capacity in key areas, such as public health and family medicine; inadequate access to essential technologies and medicines, a large, unexploited and unregulated private health sector; and fragmented health information systems. We have been working with Member States to address these gaps and we have already made positive progress in some of them. Let me take health information as an example. Intensive work over the last three years has resulted in the adoption of a practical framework for national health information system which has three key components: monitoring health risks and determinants, tracking health status including mortality and morbidity, and assessing health system performance. Under each components, a list of core indicators have been approved with a total of 64 standardized indicators. The next step for us is to build capacity in generating, analyzing, disseminating and using reliable data for policy making.

Coming back to the theme of community health, the purpose of any health system should be to ensure the best possible care for the community as a whole, whether at the population level or at the village level or at the level of the most vulnerable population groups. Our priority is therefore on the goal of universal health coverage. Universal health coverage means that everyone has access to needed health services without the risk of financial hardship. Together with countries, we agreed on a roadmap and a set of strategies to pursue this goal that take into account the diversity of resources, capacities and priorities among countries, while maintaining the principles of equity and fairness at the heart of the approach. Universal health coverage calls for national solidarity within the community and can only be realized if we accept the values of social equity and justice – something that is integral to the history, culture and values of countries of the Arab world.

The last of our key challenges is to ensure countries are adequately prepared for emergencies, both in terms of advance planning, in order to mitigate poor outcomes, and in terms of ability and capacity to respond. The Arab world is a Region that has not been out of the news headlines for decades, and more often than not, for the worst of reasons: conflict, crisis and manmade disasters. As I said before, the number and magnitude of crises in this region is unprecedented. We have to go back to the Second World War era to see such numbers of affected populations. We now live in a region in which a state of emergency seems almost to have become a way of life. At any one time, we have more than half of the countries in the Eastern Mediterranean Region affected by

crises and emergences. The humanitarian crises in Syria and Iraq are categorized as grade 3, the highest level, and I fear we might expect more. Indeed the health situation in Libya and the one in Yemen are of great concern to WHO and the international community. The situation is intense and consequences are wide and scaring. Conflicts and crises have long term consequences for health. We have seen in this region how public health gains, developed after decades of hard work and investment, are wiped away in just a few months. The side effects of embargoes and economic sanctions deprive patients of vital medicines and services they need for survival. What has allowed our communities to survive this severe situation is the resilience that has developed over time.

Ladies and gentlemen,

Our experience in managing emergencies and the current global experience in managing the Ebola outbreak demonstrate the extent the whole world, including our region, is ill prepared to respond to serious public health emergencies. In particular, public health capacity to detect, adjust and respond to emerging health threats needs to be considerably strengthened in all countries. Let me here highlight two decisions made by the WHO Regional committee during its last session in Tunis, just four months ago: the establishment of the Regional Emergency Solidarity Fund, strengthening of the regional logistics hub, and the development of a network of a network of emergency response experts ready for deployment during crises.

There are many other aspects of community health I could highlight. For example, the lack of provision for mental health care across the countries, and lack of planning for the future as climate change is becoming a creeping reality, and the population ages and health care for the elderly becomes more important. Or the seriousness of the tobacco issue, or road traffic injuries or substance use. Or the environmental and chemical hazards that threaten our future.

Despite the diversity of our priorities, and the distinct strategies needed to address them, they all share the need to be tackled from a community perspective. This will ensure a holistic approach, and will be both more effective and more cost-effective. But, I believe that our success in addressing our priorities will depend, to a great extent, on four key factors: commitment, engagement, capacity and solidarity.

Commitment. Today, I can say with confidence that we know the problems that the Arab communities face, and we know most of the solutions. We also have several of the instruments or tools needed to ensure adequate implementation of the solutions. What is needed is strong political commitment on the side of governments and policy-makers and translation of such commitment into sustained action.

The recent calls for greater democracy in several Arab communities highlight the need for improved governance and enhanced commitment to the values of social justice – at the heart of which is ensuring the goal of universal health coverage. Our communities deserve greater public investment in health – and at the heart of such investment is human capital. We need to stand firm in fulfilling our commitments to maternal and child health and to tackling the increasing burden of noncommunicable diseases, based on the directions provided by global commitments and declarations and regional frameworks.

Second: Engagement. The challenges facing health development in the region require a multisectoral approach. We will not make a significant difference in any of our priorities without meaningful engagement of non-health sectors and adoption of a whole of government approach. Health must be included in all policies. People live in communities, not in sectors. Addressing health issues in isolation from economic, social and environmental development imperatives will not lead to improved population health.

Third: Capacity. It is true that massive gains have been made in most Arab countries in recent decades in provision of curative care, both in the public and private sector. However, this has not been accompanied by similar achievements in promoting and protecting public health and countries are critically lacking in public health capacity. Therefore countries must put in place programmes and incentives to encourage, train and nurture public health professionals and leaders. And to attract the brightest and the best of their young people into public health. If we do not do this, improvements in population health will stall, and you will continue to struggle to meet the targets you set for yourselves. To kick start such a move, we have worked with two countries – - Qatar and Morocco – to assess the public health functions of their ministries of health to analyse strengths and gaps of the public health system and recommend approaches to strengthen capacity and help in planning for the future. We have also recently developed a leadership for health programme targeting middle and senior level public health professionals. Last week, a group of 25 public health professionals completed the first regional WHO Leadership programme in Public Health which was organize over a period of four weeks in both Geneva and Muscat. The course was very well received, but its true success will only become visible in the coming years. And we need to guide more young people into a public health career.

Finally, solidarity. To achieve real gains across the five strategic priority areas I have outlined, we need solidarity between all countries. A health threat on the border of one district, one country or one region will not remain in that one place without coordination, collaboration and mutual support. Health security is the concern of every nation. We could be talking about an outbreak of

infectious diseases such as polio, MERS Co-V, Ebola or cholera, or the pernicious threat posed by advertising and availability of unhealthy or counterfeit products, or the destruction of health infrastructure by conflict or disaster, or any other of the many health threats we face today. Low-income countries of this region and those experiencing crises will require intensive and sustained support from other Arab countries. I take this opportunity to urge greater solidarity between you all, and between the Arab countries, for the sake of the health of all our communities.

I thank you for your attention.