



Approaching health through human security – a road not taken

Health is essential to human security

Health is widely recognized as a cornerstone of human development because it underpins the gamut of human functioning. But health is also essential to human security, since survival and protection from illness are at the core of any concept of people's wellbeing. Good health enables human choice, freedom, and progress. Poor health—illness, injury, and disability—undermines those essential human capabilities and can trigger potentially catastrophic reversals for individuals, communities and economies. In turn, health is interdependent with other components of human security—political, economic, environmental and nutritional—and is therefore best addressed holistically.

In the last 40 years, Arab countries have made striking progress in forestalling death and extending life, as evidenced by rising life expectancy and falling infant mortality rates. Yet health is by no means assured for all citizens in Arab countries, with women suffering the most from neglect and gender biased traditions. Health systems are often shackled by bureaucratic inefficiency, poor professional capabilities and underfunding; and health risks from new infectious diseases are on the rise. Despite the ample resources available in the Arab region, the past 5 years have seen all its major health indicators stagnate. Moreover, compelling international ideas and approaches in health and human security, which have been adapted in some other regions, have not yet taken hold in most Arab countries.

Health in international public policy

Health is by no means assured for all citizens in Arab countries

This opening section reviews trends in the international discourse on health and security that provide an important perspective on approaches to health in the Arab countries at this time, as discussed subsequently.

Health and human security

Following the end of the Cold War, and with the rise of globalisation, the once-separate

realms of security and development began to converge. Public health soon became a key area of overlap. In this context, two types of discourse on health and security, each with distinct motivations and targets, set their sights on international public policy.

The first type may be termed developmental and is represented by the work of the United Nations, its development funds and programmes, international and regional commissions and the World

Health security is a transnational, multidimensional and people-centered phenomenon that ties development areas and actors together

This strategic discourse aims to “securitize” international health surveillance as protection against biological warfare

Health Organization (WHO). Through the 1990s, in an age of fast travel and frequent movement of peoples and goods, the recognition that health hazards in one country could quickly spill across others began to influence international development policy. This recognition received impetus from the catastrophic trans-border impacts of emerging diseases such as HIV/AIDS, and of re-emerging ones such as cholera, tuberculosis and resistant strains of malaria. A culminating point was the publication of the 1994 Human Development Report (HDR), which gave a new developmental focus to emerging health challenges by positing ‘health security’ as a component of human security.¹

Essentially, the HDR 1994 advocated for the view that health was an individual human right and a public good that should be accessible to all. It was a duty of the state, and in its own interest, to protect this basic right, which represented both an ethical imperative and a condition of its own survival. However, the sources and impacts of contemporary health challenges were too complex and wide to be addressed solely by states. Rather, health security was a transnational, multidimensional and people-centered phenomenon that tied other development areas and actors together.

The Report noted that the main threats to health for most people in the world had become fast-spreading communicable diseases and pandemics, and death and illness linked to poverty, unsafe environments and the displacement of peoples. Securing people’s health rested not only on traditional medical services and health care but also on other factors such as political, economic, nutritional and environmental security, all of which were vulnerable to abrupt reversals or downturns that could disrupt people’s daily lives. Protecting people from these kinds of risks therefore necessitated proactive responses by multiple state and non-state entities, and by individuals and their communities. Because contemporary health threats did not recognize borders, they also required global-local partnerships to help prevent or manage outbreaks of complex diseases and their spillovers.

In 2003, the Commission on Human Security (CHS) released a follow-up report, *Human Security Now*,² which broadened

and updated the 1994 HDR’s analysis. The Commission’s work confirmed that those health threats most relevant to human security were a) global infectious diseases, including pandemics such as HIV/AIDS and Severe Acute Respiratory Syndrome (SARS); b) health crises caused by armed conflicts and humanitarian emergencies; and c) health problems arising from poverty that could destabilize families, communities and even entire states. A human security approach to these threats, all of which carried heavy local and global consequences, depended on two fundamentals: protection and empowerment. Ensuring these fundamentals however transcended traditional approaches based on horizontal relations among governments and called, additionally, for vertical programmes and monitoring systems associating non-state actors.

In effect, the UNDP-CHS discourse re-situated the objectives of both national security and public health within a comprehensive, developmental and people-centered framework that broadened the definition and interdependence of both.

Health and strategic security

The second type of international discourse is much narrower, and may be termed strategic. It originates during this same period in the concerns of Western military and diplomatic establishments over biological weapons and the deliberate use of disease in warfare. Such concerns were renewed by the 1995 sarin gas attack in the Tokyo subway and spread to the general public after the anthrax scare in the United States following the attacks of 9/11, 2001. The aim of this discourse is to “securitize” international health surveillance as protection against possible biological warfare and so-called “bioterrorism”. The major actors, mainly in the West, are associated with efforts to bring biological weapons control into the realm of global public health and to strengthen the Biological and Toxin Weapons Convention (BWC) with a verification protocol.

The two types of discourse have quite different objectives, constituencies and lobbies yet share a common view of health and security as convergent transnational issues. Thus, the two have come to intersect

at certain points, tipping the international health agenda in one or the other direction at different times. Experts agree that the result of this intersection has generally been to broaden policy discourse on public health security—albeit with reservations from developing countries, including from some in the Arab region—to cover threats from both infectious diseases and biological weapons.³

Some analysts note that, as a side-effect, the considerable pressure exerted by the counter-bioterrorism lobby for a strategic interpretation of public health security may have spurred efforts to strengthen intergovernmental health policies. The latter are embodied chiefly in the International Health Regulations (IHR) promulgated and monitored by the WHO.⁴ In place during the first 30 years of WHO operations, these Regulations originally required member states to report outbreaks from a list of six diseases, later reduced in 1981 to three—cholera, malaria and yellow fever. Wide criticism of this small and increasingly irrelevant list in light of new threats ranging from HIV/AIDS and the Ebola virus to avian influenza, together with poor reporting compliance by numerous countries, eventually led WHO to issue new and considerably strengthened IHRs in 2005, which went into force in 2007.

The new Regulations now require a state party to notify WHO of “all events which may constitute a public health emergency of international concern” (article 6.1). These events include any unexpected or unusual public health event regardless of its origin or source (article 7). They also require state parties, as far as is practicable, to inform WHO of public health risks identified outside their territories that may cause disease to spread, as manifested by exported or imported human cases, contaminated goods or vectors that may carry infection (article 9.2).⁵

The requirement to report on “all events which may constitute a public health emergency of international concern” provides new latitude to cover a wide range of threats. However, the fact that reporting still rests on information volunteered by states has left some sceptics unconvinced that the new IHRs speak to the kind of security regime entailed by concepts of global governance.⁶ On

the other hand, the perceptions of some developing countries, including some Arab states, that these Regulations are laced with the national security concerns of the West, and that data shared may not serve their own interests, risks hampering the effective operation of a stronger disease surveillance and prevention system.

Health security in the Arab context

The 2002 Cairo Consultation on Health and Security,⁷ co-sponsored by WHO, UNFPA and UNAIDS, attempted to adapt the international discourse on human security originally promoted by UNDP and the CHS to the regional level. The three-day discussion acknowledged the comprehensive scope and interdependencies of health and human security, agreed that health spanned disciplines, sectors and agencies and reaffirmed that good health was a basic human right. Yet in the end the meeting defined health security somewhat narrowly as “relative liberation from illnesses and infection.” Most health experts find this definition inadequate whether assessed in terms of the recognized dimensions of health, which are more comprehensive, or in terms of positive security dimensions (what should happen) rather than merely negative ones (what should not happen).

The failure in the Arab context to give wide practical effect to a holistic view of health and human security reflects the limited internalisation of these concepts in the Arab countries. A number of factors may account for this:

First: the Arab reform movement has not embraced human security as a paradigm for change and reform or as a basis for action programmes, which are dominated in general by a socio-economic frame of reference. In the health field, this difference in perspective translates into a more limited focus on expanding health services, clinical facilities and other supply-driven aspects of traditional health care, which continue to be emphasized by both governments and civil society.

Second: as a result, in the absence of an alternative paradigm, approaches to security are restricted to the concept of state security for addressing domestic and

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The Arab reform movement has not embraced human security as a paradigm for change and reform

Public health is treated as secondary

Vital recording systems are not available

international dangers. There are very few discussions concerning the non-political and non-state aspects of security; naturally, the same applies to health security and other components of human security. For example, there is virtually no public debate for the major effects of armed conflict in weakening health systems, or for the diversion of resources away from people's basic health to meet urgent health needs related to the conflict in question.

Third: relatively low priority is given to the subject of health itself in budgets and programmes pertaining to development in the Arab countries. Rather, public health is treated as secondary compared to issues such as basic needs, job creation, and economic growth. This makes it impossible for health agencies to deal with the current or potential health challenges that face the region's inhabitants. The multi-sectoral alliances and funding options that a health and human security approach can deliver have rarely been tapped.

Fourth: health receives very little attention in general public discourse. There is, therefore, a glaring inconsistency between the seriousness of certain health problems in the Arab countries on the one hand, and the absence of the subject from discussions engaged in by Arab states on the other.⁸ When discussions of health

issues do take place, they tend to dwell on matters relating to health services, techniques and technologies. When it comes to public health security, there is little understanding that it consists of a set of effective and multidisciplinary activities required to reduce the incidence of acute public health situations that threaten the health of citizens.

Fifth: Arab civil society is generally weakened by political restrictions and exclusion, and does not often participate in matters relating to health. Hence, non-state actors have had very little effect on health systems and health policy development. Instead, the highly influential Arab medical establishment holds sway over the health field. This "expert" dominance within the existing professional hierarchy is further entrenched by non-democratic health system institutions patterned on Arab political institutions. The resulting dearth of public participation poses an obstacle in the face of health- and security-related initiatives.

These factors, together with the weak, and sometimes contested, linkages between discourse on the international and regional levels, have led to the current situation where the Arab health community appears to have either resisted or ignored a human security approach to health in practice.

Box 7-1

Terms in the discourse

Health security

Relative freedom from disease and infection; 2002 Cairo Consultation on Health & Human Security; Protection against illness, disability and avoidable death; Commission on Human Security, 2003.

Public health security

A set of effective and multidisciplinary activities required to reduce the incidence of acute public health situations that threaten the health of citizens; this Report.

Global public health security

The activities required, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of populations living across geographical regions and international boundaries; WHO, 2007.

Health and human security

A human security approach to health entails treating health 'not just the absence of disease, but as a state of complete physical, mental and social well-being'; Commission on Human Security, 2003.

The health situation in the Arab countries

The present report draws health and health system indicators largely from data published by United Nations agencies. However, the accuracy of such data is subject to question in some cases. On some occasions UN agencies, non-governmental organizations (NGOs) and civil society organizations conduct independent statistical studies. For the most part, however, governments themselves are the source of information. In most Arab states, vital recording systems are not available, and when they are, they are seldom reliable. Often, "national" data are not based on national survey studies, nor do they represent all groups in the society. Consequently, generalizations based on such data are of limited value. It

is, moreover, not customary for states to release data which would reveal internal inconsistencies, which puts the usefulness of the data in question, particularly when examining social equity and justice.

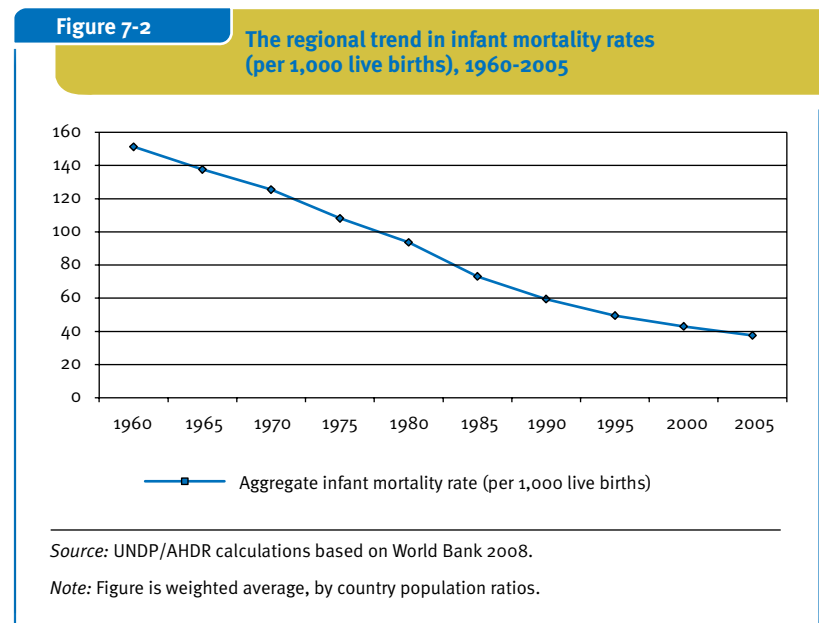
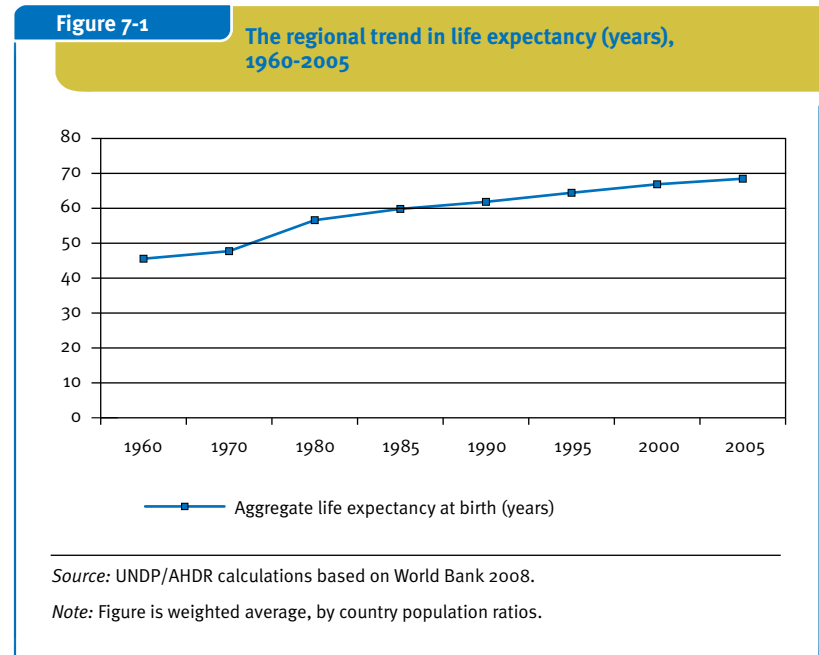
Nonetheless, it may be acknowledged from the outset that the Arab countries have seen great improvements in health over the past several decades, albeit starting with a backlog to overcome. Indeed, between the 1960s and the start of the new millennium, the Arab countries made greater progress in forestalling death and extending life than most developing regions. This can be observed through the 23-year increase in life expectancy and the reduction in infant mortality rates from 152 to 39 per thousand births.

Even so, while aggregate indicators are positive, challenges remain and Arab countries can achieve better health coverage for their citizens in keeping with the wealth available in the countries. A particular continuing challenge is to resolve the noticeable disparities among different Arab states and the injustices to be found within them. In passing, it needs to be recalled that past successes do not rest solely on the sizeable investments made in the quantitative expansion of health systems. They also stem from the major socioeconomic developments that followed the 1970s oil boom, which helped to raise health conditions.⁹

Health indicators¹⁰

Average life expectancy at birth in most Arab countries is about seventy years. Nevertheless, one can observe major disparities in this respect between one sub-region and another. In Djibouti, Iraq, Somalia, and Sudan, for example, average life expectancy is no more than sixty years, whereas in Bahrain, Kuwait, Oman, Qatar, and the United Arab Emirates it exceeds seventy-four years. As in other regions of the world, average life expectancy for women exceeds that for men; except for Qatar and Somalia with a gender gap of 1 and 2 years respectively, the gender difference in life expectancy in the region is between 3 to 5 years.

Disparities among sub-regions are evident on other indicators. For example, the

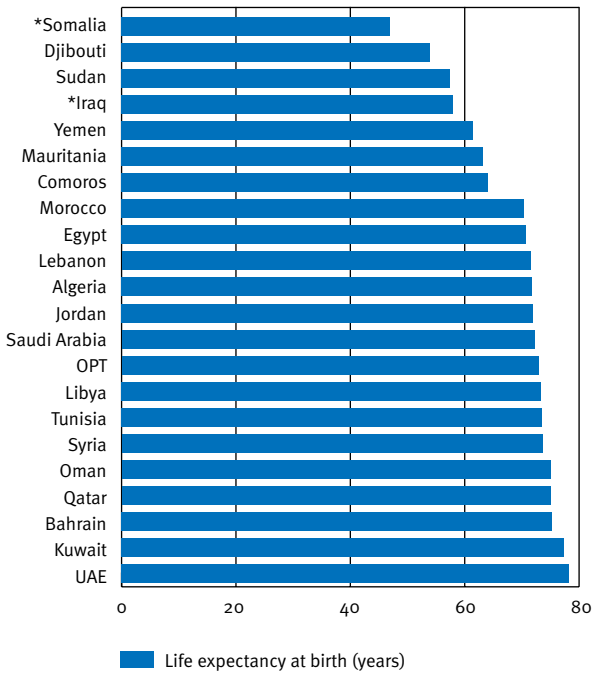


maternal mortality ratio (MMR) ranges from 4 deaths per 100,000 live births in Kuwait to more than 400 per 100,000 births in Djibouti, Mauritania, Somalia Sudan, and Yemen. Infant mortality rates range from fewer than 8 per 1,000 live births in the United Arab Emirates to more than 76 per 1,000 live births in Yemen and Mauritania and eighty-eight in Djibouti.

Progress towards MDG 5, target 6, which aims to reduce by three quarters the maternal mortality ratio by 2015, varies across the region owing to the socioeconomic differences between the

The Arab countries made greater progress in forestalling death and extending life than most developing regions

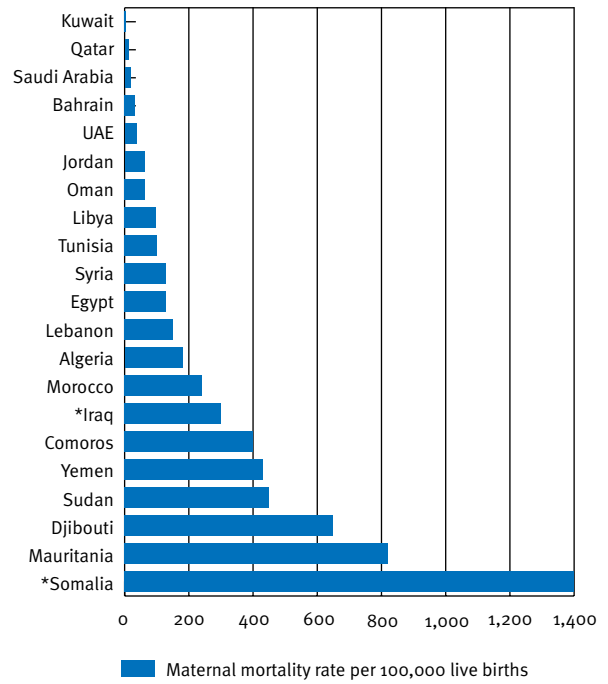
Figure 7-3 Life expectancy at birth, 22 Arab countries, 2005



Source: UNDP 2007.

* Data for Iraq and Somalia are for year 2006, UNICEF 2008.

Figure 7-4 Maternal mortality ratio (deaths per 100 thousand live births), 21 Arab countries, 2005

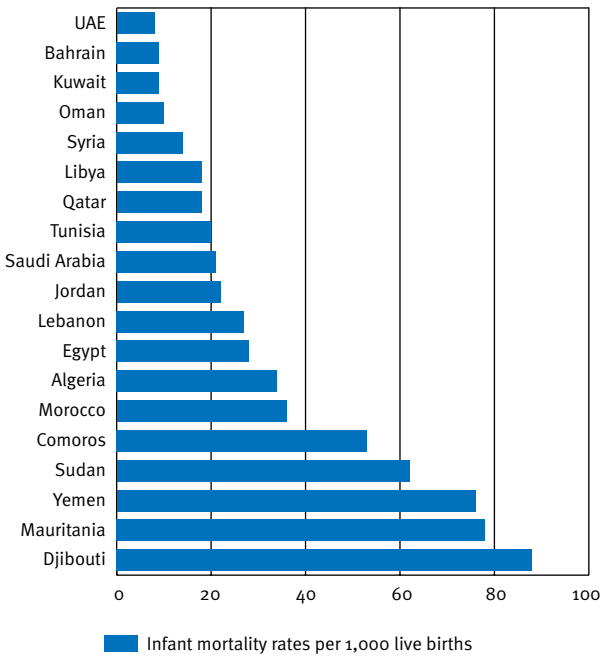


Source: UNDP 2007.

* Data for Iraq and Somalia are for year 2005 from UNICEF, 2008.

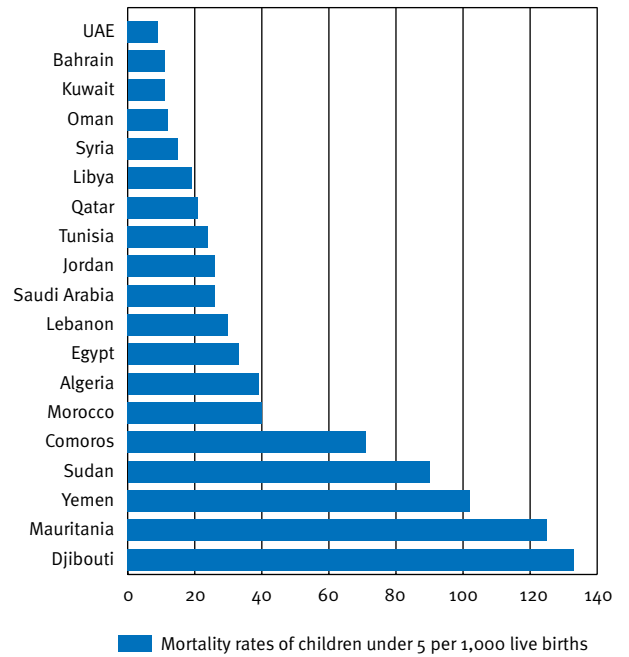
** The above maternal mortality ratios are adjusted based on reviews by UNICEF, WHO and UNFPA to account for well-documented problems of underreporting and misclassifications.

Figure 7-5 Infant mortality rates per 1,000 live births, 19 Arab countries, 2005



Source: UNDP 2007.

Figure 7-6 Mortality rates of children under 5 per 1,000 live births, 19 Arab countries, 2005



Source: UNDP 2007.

sub-regions. Accordingly, while the region as a whole is on track, this is not the case for all of the four sub-regions. In 2000, the MMR was lowest in the GCC countries at about 17 per 100,000 live births, mostly since 98.2 per cent of births in the GCC are supervised by skilled birth attendants. On the other hand, while the MMR in the Arab LDCs dropped by 37.9 per cent to 637.6 per 100,000 live births in 2000, it remains significantly above the developing world average of 450 per 100,000 live births. The average MMR in the Arab LDCs was the highest in the Arab countries; only 44.8 per cent of newborns were delivered by skilled birth attendants in 2000, up by 22 percentage points from 1990. The trends in maternal mortality and births attended by skilled personnel in the Arab LDCs overall are largely influenced by the respective trends in Sudan, which accounts for almost 50 per cent of live births in the sub-region. Slightly less than half of these births are not attended by skilled personnel, and the MMR in Sudan was 509 per 100,000 live births in 2000.

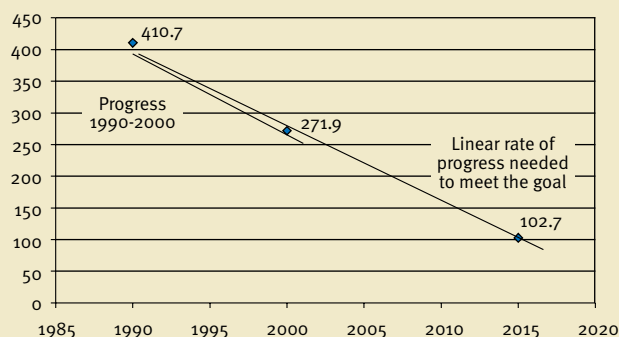
Similarly, mortality rates for under-five children range from less than 20 per 1,000 births in most Gulf States to more than 100 per 1,000 in Djibouti, Mauritania and Yemen. Disparities between rural and urban areas are wide, with the higher rates being found in rural areas.

One noteworthy trend is the spread of under-nutrition in poor states and war-torn countries, a reflection of growing food scarcities. In Somalia, the prevalence of underweight in children under five is 26 per cent and in Sudan and Yemen it stands at more than 40 per cent (most recent data available in the 1996–2005 period). In addition, the incidence of under-nutrition among children in some wealthy states is a further source of concern; for example, the incidence of moderate and severe under-nutrition among children under five comes to 14 per cent in the United Arab Emirates and 10 per cent in Kuwait, which suggests that, despite the ample financial resources of some states, not all of the expected health benefits have accrued.¹¹

WHO statistics indicate that the most important factors accounting for disparity in health levels within Arab countries are income level, place of residence (urban or rural), and mother's educational level.

Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Maternal mortality ratio, Arab region (per 100,000 live births)



Source: UN-ESCWA, *The Millennium Development Goals in the Arab Region 2007: A Youth Lens, an Overview*, 2007.

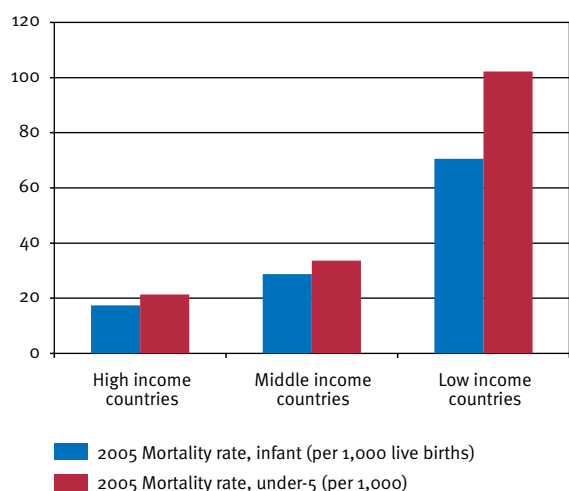
The maternal mortality ratio (MMR) in the Arab countries fell to about 272 per 100,000 live births in 2000, a decrease of almost 34 per cent from its 1990 level. Assuming that the rate of progress achieved between 1990 and 2000 can be maintained, the Arab countries as a whole will meet the goal of reducing the MMR by three quarters by 2015. The considerable decline in maternal mortality is linked to the significant increase in births attended by skilled health personnel. In fact, this ratio rose by over 16 percentage points over the decade. In addition, the reduction in adolescent pregnancy—associated with high risks—has contributed to the overall decline in maternal mortality. Indeed, adolescents aged 15–19 are twice as likely to die during childbirth as are women in their twenties, and those under 15 are five times as likely.

Source: UN-ESCWA 2007a.

Among the most important indicators of the impact of such factors are the likelihood that children will survive beyond age five, the incidence of dwarfism, the chances of childbirth being attended by skilled health professionals, and the availability of vaccinations against measles during the first year of life. The most influential factors in the six Arab states for which such data were available—Egypt, Jordan, Morocco, Sudan, Tunisia, and Yemen—were the level of income and the mother's educational level. In other words, going by some of these WHO indicators, Arab children in families with higher income levels or having mothers with higher educational levels enjoy health care and health levels that are three to four times better than in the cases of children in low-income families and with less-educated mothers.¹²

Disparities between rural and urban areas are wide

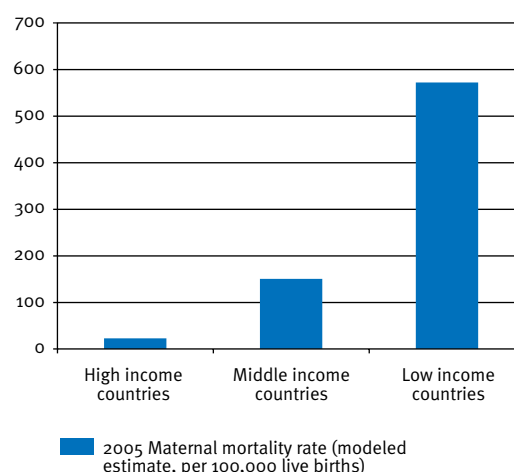
Figure 7-7 Health disparities in the Arab countries, infant and under-5 mortality rates (per 1,000 births), 2005



Source: UNDP/AHDR weighted average calculations based on World Bank 2008.

Note: Categorization based on GDP per capita, PPP (current international \$) with the following thresholds: Low income \$1,100 - \$2,200, Middle income \$3,600 - \$11,000, and High income \$20,000 - \$44,000. Low income countries include: Comoros, Djibouti, Mauritania, Somalia, Sudan, Yemen. Middle income countries include: Algeria, Egypt, Jordan, Lebanon, Libya, Morocco, OPT, Syria, Tunisia. High income countries include: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates.

Figure 7-8 Health disparities in the Arab countries, maternal mortality rates (per 100,000 live births), 2005



Source: UNDP/AHDR weighted average calculations based on World Bank 2008.

Note: Categorization based on GDP per capita, PPP (current international \$) with the following thresholds: Low income \$1,100 - \$2,200, Middle income \$3,600 - \$11,000, and High income \$20,000 - \$44,000. Low income countries include: Comoros, Djibouti, Mauritania, Somalia, Sudan, Yemen. Middle income countries include: Algeria, Egypt, Jordan, Lebanon, Libya, Morocco, OPT, Syria, Tunisia. High income countries include: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates.

Box 7-3 More efforts required to combat malaria and tuberculosis

MDG 6 Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.

While malaria has been almost eliminated in the majority of Arab countries, it remains highly endemic in the Arab LDCs, where on average 3,313 cases per 100,000 were reported in 2005. Djibouti, Somalia, Sudan and Yemen accounted for 98 per cent of notified cases in the region; Sudan alone bore about 76 per cent of the regional burden. Achievement of the MDG target in the sub-region, and in the region as a whole, is therefore heavily dependent on progress in Somalia, Sudan, and Yemen. Furthermore, malaria notification in these countries understates the actual number of cases as surveillance is weak and, in some areas, nonexistent. Lack of adequate health care and laboratory facilities and adverse security conditions are some of the factors hindering progress in survey efforts.

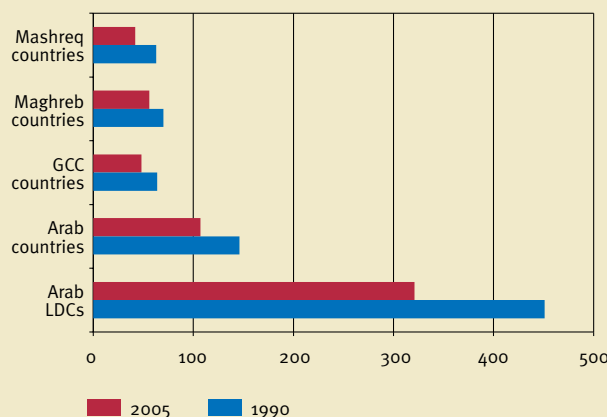
Tuberculosis remains a significant public health problem, and probably the leading cause of communicable disease deaths in adults in the Arab region. It is estimated that in 2005, 240,000 people developed tuberculosis and 43,000 died from it. The Arab LDCs are the countries affected the

Source: UN-ESCWA 2007a.

most, accounting for almost 56 per cent of all new tuberculosis cases in the region.

An estimated 41 per cent of tuberculosis patients do not have access to quality health care.

Tuberculosis prevalence rate (per 100,000)



Source: UN-ESCWA 2007.

At the intra-regional level, on all major health indicators, as national income rises, health levels improve, leading to evident differences among Arab countries.

Changes since 2002

The comparison of health indicators for Arab countries for the years 2003 and 2007 shows that life expectancy increased and child mortality declined. Other health indicators remained static.

- Marked disparities continue between the low-income Arab countries and the medium-income and high-income ones.
- With the exception of a small number of indicators, on average, the performance of medium-income states resembles the performance of high-income states.
- The national and regional data which are available give an inadequate picture of the disparities and inequalities that exist within states. This underscores the importance to policymakers, academics and health practitioners of those national human development reports produced in the Arab countries that consider sub-national variations.

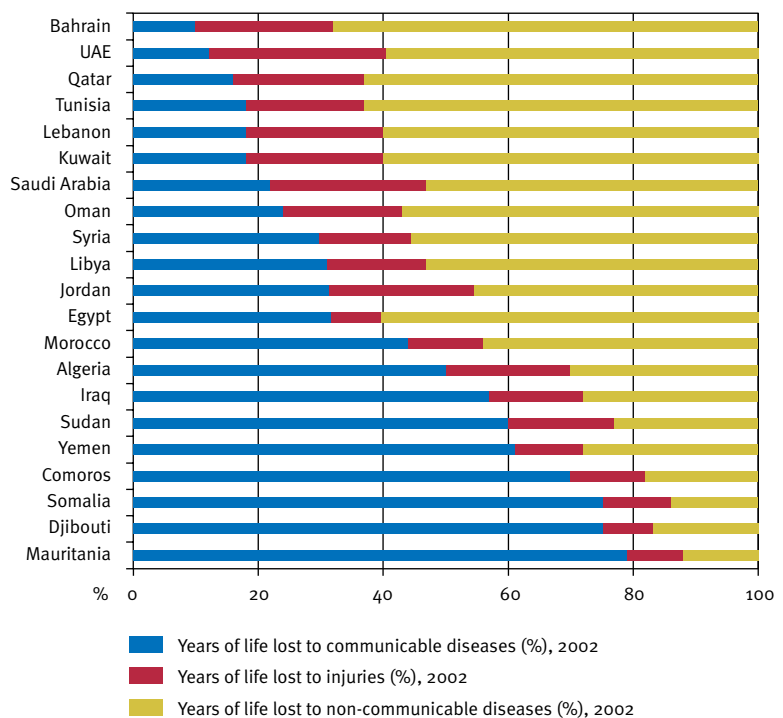
Principal health problems

The effects of violence and communicable diseases continue to be the primary causes of death in war-torn or impoverished countries such as Somalia, Sudan, and Yemen. However, most countries in the Arab region are passing through a phase of epidemic transition with the occurrence of an acute increase in non-communicable diseases, injuries related to traffic accidents, and other types of injuries. The dangers posed by non-communicable diseases such as those caused by smoking, diabetes and hypertension increase with the adoption of modern lifestyles.

Figure 7-9 shows that Arab countries with high mortality rates among both children and adults such as Comoros, Djibouti, Mauritania, and Somalia suffer from a heavy burden of communicable diseases¹³ in comparison with countries in the region with low mortality rates among children and adults.

Figure 7-9

Burden of communicable and non-communicable disease and injuries, 21 Arab countries, 2002



Source: WHO 2008.

Box 7-4

The Hepatitis C virus in Egypt

Hepatitis is a general term meaning inflammation of the liver and can be caused by several mechanisms, including infectious agents. Hepatitis C is caused by infection with the hepatitis C virus (HCV). The virus infects liver cells and can cause severe inflammation of the liver with long-term complications. Of those exposed to HCV, about 40 per cent recover fully, but the remainder, whether they have symptoms or not, become chronic carriers and may develop liver cancer. Hepatitis C virus is usually spread by sharing infected needles with a carrier, from receiving infected blood, and from accidental exposure to infected blood. It is estimated that about 3 per cent of the world's population have HCV. There are about 4 million carriers in Europe alone.

Egypt has a very high prevalence of HCV and a high morbidity and mortality from chronic liver disease. Approximately 20 per cent of Egyptian blood donors are anti-HCV positive. Egypt has higher rates of HCV than neighbouring countries as well as other countries in the world with comparable socioeconomic conditions and hygienic standards for invasive medical, dental, or paramedical procedures.

Source: WHO 2002.

Good public health has a positive impact on development, economic growth and security

Health in areas of conflict

The general effects of violent conflict on human security and public health¹⁴ are a matter of common knowledge. War undermines public health systems, and may lead to the sudden appearance of communicable diseases and diseases linked with malnutrition. Wars are also linked with the onset and exacerbation of various non-communicable diseases, including those that affect the blood vessels and increase the risk of strokes (for example, artery-related diseases in Lebanon increased during the civil war there).¹⁵ They are moreover associated with acute mental health problems such as those observed and recorded in Iraq¹⁶ and the Occupied Palestinian Territory, as discussed further in chapter eight of this report.

Factors that interact with health security

As both the discourse on human security and events themselves suggest, health is profoundly affected by non-health factors. These include deteriorating environmental conditions, foreign occupation, identity-related conflicts, poverty, and unemployment, whose impacts are discussed in other chapters. The question that arises here is: Does the opposite also hold true? Does health have a significant impact on aspects of human security which are not health-related? Given the central and interdependent place assigned to health among components of human security, it is to be expected that improved health should strengthen human security in practice, while at the same time being influenced by its other components. Both relationships may be illustrated as follows:

First: health and income

The rise in the adult mortality rate, particularly in early deaths among breadwinners, can have direct and devastating effects on the family, such as impoverishment and the loss of food security. Such a loss can also have indirect effects on the family by driving groups that sink below the poverty level into contact with segments of society that live by violence, and which

stand ready to exploit their weakness. A rise in the incidence of disease may have the same effects when illness depresses families' income levels.¹⁷ Such effects become particularly obvious in the case of catastrophic health expenses.¹⁸ It is an established fact that when worker productivity is lowered by illness and disability, the effects weaken economic performance, raise health costs for employers and the state and reduce GDP. Conversely, good public health has a positive impact on development and economic growth and, as a further consequence, on security. This, indeed, is the primary driver behind the "investment in health" movement in development circles.¹⁹

Second: knowledge, beliefs, attitudes and behaviours relating to health

People's health behaviour is critically influenced by their health-related knowledge and their attitude towards health and risks. People's behaviour, in its turn, is one of the principal determinants of mortality rates as well as the incidence of disease and disability and their resultant social and economic outcomes. This, in turn, establishes a significant link between behaviour and human security.

Smoking is a particularly telling example of this link. The Arab countries are marked by a high percentage of cigarette smokers; in fact, it has one of the highest smoking rates in the world.²⁰ And although this may apply primarily to smoking rates among men, we find that in some countries such as Lebanon, for example, smoking rates among women are high as well. In addition to cigarettes, many Arab countries suffer from an epidemic of water-pipe smoking. As is well known, smoking contributes in a major way to an increase in mortality rates, the incidence of disease, and dependence on health care services. Consequently, smoking can place an additional economic burden on the family and deplete resources on the social level in general. The negative impact of smoking on development and the economy has become apparent in many developing countries,²¹ and the same is expected to happen in Arab countries as well. Seen from this perspective, smoking in the

People's health behaviour is critically influenced by their health-related knowledge

Arab countries is a threat not only to health but, in addition, to human security and development.

Public attitudes, influenced by tradition, also account for the silence generally surrounding HIV/AIDS in Arab countries, a silence that by inhibiting the spread of knowledge about the disease, contributes to its advance. The final section of this chapter examines this subject as part of a special focus on HIV/AIDS and human security.

Third: cultural practices that impact women's health²²

As suggested above, public health is affected not only by economic conditions, social and political stability and the efficiency and quality of health systems; it is also shaped by the sum total of the prevailing beliefs and values in society, which influence both citizens' attitudes to health and the extent to which they take advantage of modern medical and health facilities and procedures. Certain common beliefs and practices greatly impact women's health security. These are society's entrenched preference for male offspring, which has multiple effects, and the harmful practice of female genital mutilation (FGM). (Chapter 4 cited the latter practice for its grave impacts on women's personal security; this section focuses on its health effects).

Boys before girls

Among poorer Arab families especially, the arrival of a new baby boy is customarily greeted with rejoicing. If the new-born is a girl, the occasion may often be lamented by the family at large, and the mother may find herself the object of her kinsfolk's and neighbours' pity. This reception, which tells the female infant as she enters on life that she is unwelcome, signifies attitudes that may lead to severe parental neglect in early childhood and beyond.

A cultural preference with far-reaching consequences for women's health is the pervasive view that a boy's education is more important than a girl's. The most evident result of this bias is that, in a region where one out of every three people is illiterate, two-thirds of those so deprived are female. In 2005, an estimated 40 per

cent of Arab women could not read or write. Illiteracy undercuts women's health because it effectively blinds women to the fundamental principles of health, hygiene, nutrition and diet, all of which gravely compromises their own wellbeing and that of their families. Moreover, illiteracy and low levels of knowledge perpetuate customs and traditions that are harmful to health and may even be fatal. These include, for example, child bearing at too early or too advanced an age, which poses serious dangers to a woman's health and to that of her children, who risk being born with congenital abnormalities.

Tradition before women's health

As noted in chapter 4, female genital mutilation, the removal or disfigurement of the external female sexual organ, is still too commonly inflicted upon women of reproductive age in the Arab countries. UNFPA estimates rates among this population group at: Djibouti (about 93 per cent), Egypt (95.8 per cent), Mauritania (71.3 per cent), Somalia (about 98 per cent), Sudan (90 per cent) and Yemen (22.6 per cent).²³ FGM is usually carried out between the ages of eight and ten, although some girls undergo it at a later age, especially prior to marriage. The practice originates in misinformed or misleading views about religious teachings, in folklore about promoting female chastity

Public health is affected by the prevailing beliefs and values in society

Certain common beliefs and practices greatly impact women's health security

Box 7-5

A woman's first entrance

"Notwithstanding her condition, whether as a peasant in Algeria, a doctor in Cairo, or a secretary in Beirut, a student in Baghdad, a worker in Syria, the Arab woman shares with her sisters a common fate: a life of renunciation, of captivity, during which she will have to atone for her sin of having been born a woman in a hyper-male society where the ever-present feminine remains synonymous with shame and threat.

To begin with, her birth is already perceived as an occasion for mourning rather than for festivities. She is received in an atmosphere of barely suppressed disappointment. They hoped for a boy. Her coming will bring opprobrium on her mother, a shock to her father: 'Men beget men,' we always say in our culture; 'She has given birth to a girl, he has produced a boy,' they proclaim... What happens on the day when the baby girl leaves her mother's womb is only a foretaste. It is the beginning of a life to be endured as a 'blameful condition' which will be continuously punctuated by steady and heavy repression and intolerance."

Source: Salman 2003.

and in male-centred cultural notions about the requirements for a 'good' marriage. In all cases, the practice is highly injurious to women's health.

Girls are often forced to undergo the operation without anaesthesia; moreover, it is usually performed by unqualified individuals, including midwives, hairdressers, and barbers with licenses to perform circumcisions, using unsterilized instruments in unsanitary environments. Of the numerous potential health complications, some are immediate and others are long-term.

FGM is highly injurious to women's health

Psychological damage: The damage suffered by the young girl from the extreme cruelty of the process leaves lifelong mental scars.²⁴ Neural complications can lead to potentially fatal nervous shock.

Haemorrhagic shock: Such shock results from damage to tissues and blood vessels which results from the ignorance of basic anatomy of those performing the operation. Fatalities among young girls undergoing FGM are considered common, although documented cases are rare since parents and those performing the operation seldom report incidents for fear of the law. In some cases, the haemorrhaging is less severe and is dealt with by treating wounds with crude traditional compounds. Such substances, however, are unsanitary, as are the instruments and hands of those who perform the operation.

Infections: Consequently, young girls are frequently exposed to the tetanus microbe, the HIV virus, and hepatitis B or C. These infections may affect the urinary tract and kidneys, which sometimes leads to cysts, further infections and even renal failure. The uterus and fallopian tubes may also become infected, which can result in the inability to conceive. The slow-healing wound caused by FGM leaves a sensitive legacy of acute physical and psychological complications that crop up later in life, disfiguring marital relations, pregnancy and childbirth.

Health care in the Arab countries continues to suffer from chronic problems

Fourth: health systems management

Numerous recent studies have cast light on the achievements and challenges that face health systems in the Arab countries.²⁵ In the WHO 2000 report on health systems,²⁶ Arab states ranked low based on standards

of good health results, responsiveness to consumers' needs, and equitable funding. There are, in addition, significant and historically based organizational differences among Arab health systems, a fact which makes comparisons among them difficult. Nevertheless, several observations might be made on Arab health systems as a whole,²⁷ the study of which would be helpful given their importance for human security.

1. Narrow conceptions

To most people, the term 'health system' refers simply to the system of health care. Seen from the perspective of human security, however, this definition is insufficient. If we were to adopt a more comprehensive definition of the term 'health system' which included all activities that directly affect health, such as ensuring appropriate nutrition, sufficient basic foodstuffs and access to clean water for citizens, these matters would assume greater importance in health policy formulation. This in turn would produce positive returns in the area of human security. Unfortunately, however, the politics of health in the Arab countries do not accommodate this comprehensive view, nor is it posed for discussion by the public. Instead, the norm is that the arrangements for, and distribution of commodities directly relevant to health, as well as basic matters of nutrition, food and access to safe water, are referred, in an uncoordinated way, to actors not concerned with health, such as ministries of agriculture.

2. Services are inequitable, often inferior and sometimes technology driven

Over the past several decades Arab states have made huge cumulative investments in the health sector, principally in health care services. Yet despite these investments, health care continues to suffer from chronic problems. The following are a number of important observations in this connection:

- Certain basic health care services (which include, for example, free infant health care) continue to be unavailable to many. This is particularly true of marginalized groups in both urban and rural areas.
- Hospitals consume huge amounts of resources in the Arab countries, and

health ministries in the Arab countries spend more than half their budgets on treatment services which depend upon hospitals. In fact, some government and private hospitals in Arab countries have achieved international status. However, there are serious disparities among their performance levels: urban areas enjoy greater support in this connection than do rural areas, and there is no coordination between the public and private sectors.

- A number of Arab governments have attempted to improve the basic health care services offered to the public. However, these attempts are incomplete in most Arab countries and are subordinated to the existing care health system and third-rate hospitals.
- Public sector health care is widely criticised for its low quality and inefficiency, its unresponsiveness to patients' needs, and the frequent referral of patients to the private sector.

The WHO Regional Office has warned of the dangerous effects of such a situation,²⁸ identifying areas of inadequacy in the evaluation of actual needs, in adherence to suitable approaches for contracting and purchase, in appropriate installations, in preventive maintenance, in wise use of resources, and in emphasis on quality. The medical equipment and supplies market in the Arab countries is viewed as a profitable one²⁹ which calls for more profit-based investments. This is important for the health care sector, because it is a recognized fact that the availability of high technology may increase demand. However, the costs of high technology, in addition to the costs of health care, could deplete important resources in the economies of low-income and medium-income Arab countries.

Numerous Arab countries have constructed regional centres to attract patients who wish to obtain high-technology medical services. In view of the fact that the relatively wealthy, even in poor countries, are those most likely to cross national borders in search of health care, 'medical tourism' depletes precious hard currency (dollars) in home countries. For example, in Yemen about 29 per cent of total health expenditure—from private pockets and public funds—is used for treatment abroad. Approximately two out of every three Yemeni Rials spent for health care

are paid by families and households as out-of-pocket payment in cases of illness.³⁰ This in turn places pressure on governments to construct high-tech centres which, for the most part, are built at the expense of health and preventive services.

3. Funding for health is generally inadequate

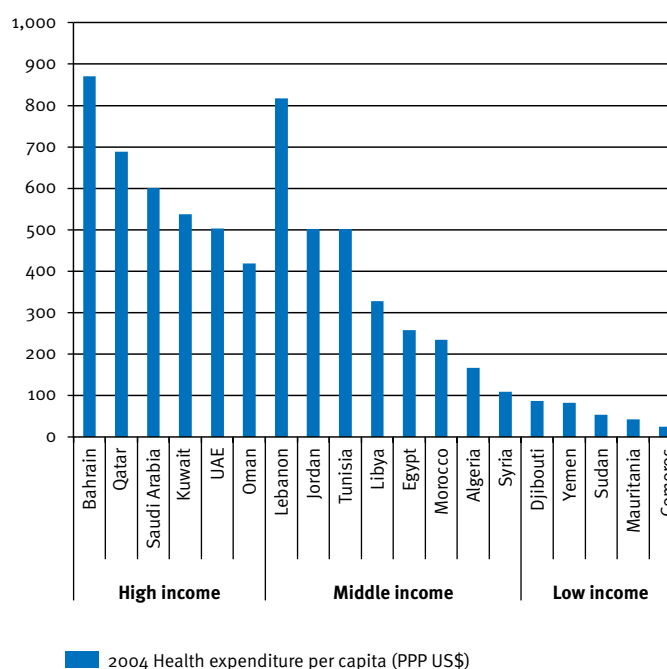
Most of the Arab countries have health expenditures ranging between 2.4 and 6 per cent of their GDP. This percentage is higher in Lebanon and Jordan (12 and 10 per cent respectively), while it is lowest in Qatar and Somalia (2.4 and 2.6 per cent respectively). Actual spending on health, which ranges from \$25 per capita (in PPP terms) all the way to \$871 per capita, reflects clear intra-regional disparities. Current arrangements for health care funding also have a major impact on human security. For, with the exception of the wealthy Arab Gulf states, relatively paltry amounts are directed to the health sector in most Arab states. In many low- and medium-income states—where private expenditures on health come to between 20-72 per cent of total health expenditures—governments spend very

'Medical tourism' depletes precious hard currency

Relatively paltry amounts are directed to the health sector

Figure 7-10

Disparities in health expenditures in Arab countries, 2004



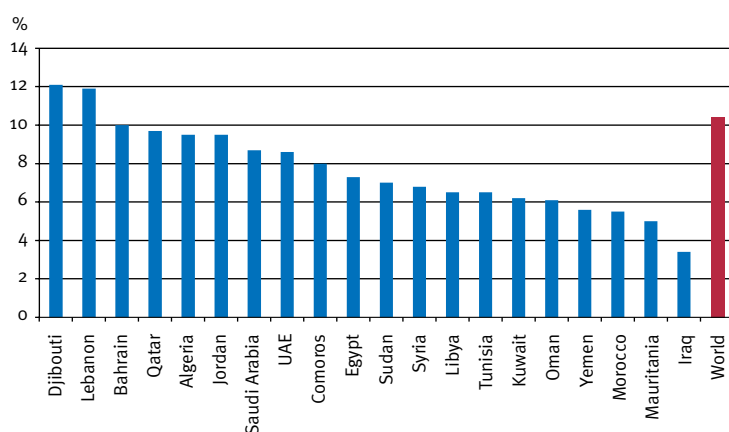
Source: UNDP 2007.

Health costs are rising

little on health. A distinguished exception is the case of Djibouti and Lebanon, where public spending on health, as a percentage of total government expenditure, exceeds the world average. In terms of absolute levels of funding, oil-rich countries invest vast sums, which however do not translate into equitable health coverage for all their peoples.

Figure 7-11

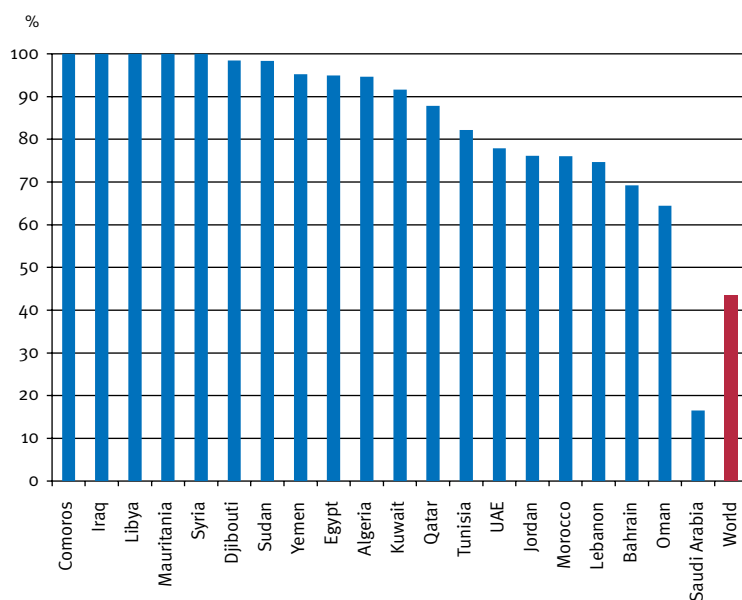
Share of public health expenditure in total government spending (%), 20 Arab countries, 2005



Source: World Bank 2008.

Figure 7-12

Out-of-pocket health expenditure as a share of private health expenditure (%), 20 Arab countries, 2005



Source: World Bank 2008.

*Note: Out-of-pocket health expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of health status of individuals or population groups. It is part of private health expenditure.

Private sector expenditures on health do not take up the slack in total spending. Employee health insurance programmes, the principle vehicle for the private funding of health services in advanced nations, provide only meagre benefits, a fact which leaves significant health-related expenses to be borne by Arab citizens and their families.³¹ As illustrated in Figure 7-12, in 19 out of 20 Arab countries studied, out-of-pocket health expenditures are very high by comparison with those in other regions of the world. This has a major impact on low-income families, since a serious or costly illness suffered by the family's breadwinner can plunge the family into poverty. Even families in medium-income states are vulnerable because their purchasing power is limited. Health costs are rising with the widespread adoption of market policies in this sector, which do not take into account income levels among different groups.

4. Public health systems are under-resourced and perform below expectations

Health systems in Arab countries are sometimes flawed by poor public health capabilities. Several features point to this: the weak performance of many public health institutions, the unsuitability of the current structure for raising public awareness of health issues, the dearth of specialized professionals in public health, and the relatively slight weight of public health in decision making on the governmental level. This situation is reflected, in turn, in negative popular perceptions of the performance of the public health sector. The poor capabilities of the public health sector render it ill-equipped to handle the range of functions required to provide public health security.

5. The chain of command in health systems is often obstructive

The chain of command in Arab health system institutions consists of an inefficient, bureaucratic hierarchy with political objectives that are often at odds with public health. Senior officials with influence and interests outside the hospital or clinic will have influence within it as well. The management of these institutions is often driven by unresponsive, uninformed and sometimes obsolete guidelines, standards, and reporting systems. Incentives in such

systems work against innovation, risk taking, and improved efficiency. Moreover, their top-down systems of control may prevent health institutions from adapting to, and moving towards the popular participation and empowerment needed to achieve human security goals.

6. Key health determinants are blind spots in the system

Current Arab health systems do not place sufficient emphasis on the important indirect determinants of health recognized by human development practitioners, such as the quality and coverage of education, women's empowerment, and social and economic justice. Neither do they evince the mindset required to address key factors such as gender, social class, identity and ethnicity, all of which have obvious effects on human security.

7. Health professionals and support personnel are unequally distributed

With the exception of the most impoverished Arab countries such as Somalia, Sudan, and Yemen (where there are fewer than fifty physicians per 100,000 members of the population), most Arab countries have acceptable numbers of doctors relative to the sizes of their populations, although most of the doctors in the Arab Gulf countries are expatriates. Nevertheless, doctors are not distributed equitably within their countries, as most of them are concentrated in urban areas. The numbers of public health practitioners, dentists, nurses, and medical assistants are however woefully inadequate and their distribution among urban versus rural areas and between hospitals and basic centres is highly inequitable. Arab countries suffers a high rate of 'brain drain,' particularly among health professionals within the region, either from low-income and medium-income states to high-income, oil-rich Gulf States, or to countries in North America and Western Europe.

A health threat that concerns all – HIV/AIDS³²

According to the WHO, HIV prevalence in the Arab region is lower than that for many other diseases, including malaria, liver failure, and respiratory diseases. The number of those in the Arab countries

Box 7-6

Ensuring public health security – the basic functions of a working system

- Surveillance and analysis of the health situation
- Drawing up and enforcing health regulations
- Monitoring, controlling and studying dangers and sources of harm that impact public health
- Evaluating access to necessary health services and ensuring such access in practice
- Improving health and public awareness of health issues
- Developing and training specialized health personnel
- Encouraging community participation and empowering citizens to obtain health services
- Guaranteeing the quality of health services
- Establishing policies and building institutional skills in planning, managing and coordinating the health sector
- Conducting research to find creative solutions to public health problems, and implementing such initiatives
- Minimizing the health-related impacts of emergencies and disasters

Source: The Report team.

living with tuberculosis, for example, is 400 times greater than those living with HIV/AIDS.³³ Indeed, the incidence of HIV in the Arab countries may be the lowest among developing country regions. Nevertheless, all fires start with a spark, and there is no reason to be complacent about this destructive virus whose advance can only be reversed through much greater public awareness, and through scientific methods of prevention. There are, moreover, other good reasons for taking seriously the nature of the illness and the particular features of its emergence in the Arab countries.

A stubborn, proximate and misunderstood danger

AIDS, the acquired immunodeficiency syndrome, is a fatal disease caused by HIV, the human immunodeficiency virus. HIV destroys the body's ability to fight off infection and disease, which can ultimately lead to death. Currently, antiretroviral drugs are available that slow down replication of the virus and can greatly enhance quality of life, but they do not eliminate infection. By the end of 2006, the cumulative number of people infected with the HIV virus since its discovery in 1981 came to approximately 65 million, and AIDS-related deaths around the world had reached a total of approximately

Doctors are not distributed equitably within the Arab countries

Arab countries suffer a high rate of 'brain drain' among health professionals

32 million—more than any other disease in the history of humankind.³⁴

The danger is not far from Arab countries. According to UNAIDS, more than 31,600 adults and children died from AIDS in 2007, in the Arab countries (80 per cent of which deaths occurred in Sudan). One needs to note, as well, the relative rise in the number of new infections. Between 2001 and 2007, there were 90,500 estimated new cases of HIV infections in the Arab countries of which 50,000 in Sudan alone.

The destructive power of HIV lies not solely in its potency as a virus, but also with the social stigma that comes with it. Those living with the virus are sometimes deprived of their fundamental human rights: they may be dismissed from their jobs and denied training and promotion, their children may be deprived of valuable opportunities, doctors may refuse to treat them, and they may be slandered and mistreated.

Moreover, people living with HIV may not be aware of their state until long after infection has occurred. In such cases, the virus can remain in the body undetected for a long time. Those who suspect that they have been infected often do not seek the necessary tests out of shame or fear of being stigmatized or discriminated against. Those who know their condition may yet refrain from informing those closest to them, including their partners, which exposes the latter to infection as well.

Those living with the HIV virus are sometimes deprived of their fundamental human rights

In this culture of secrecy, HIV continues to spread. Meanwhile, few programmes are designed or carried out to reach key populations at risk including intravenous drug users, sex workers or men who have sex with men. When it is appreciated that the risk factors are also linked with poverty, displacement, refugee status, permanent or temporary migration, and women's rights, it becomes clear that HIV/AIDS is a serious and broad-based challenge to human security. Facing the threat is only possible through a multi-sector, multi-tiered development policy which addresses the underlying roots of the virus's spread and which, as such, goes beyond simple health awareness in the traditional sense.

Reappraising the numbers

According to WHO and UNAIDS estimates,³⁵ in 2007, the number of those living with HIV in Arab countries was 435,000, 73.5 per cent of whom were in Sudan. An important observation in this context is that the estimated numbers of those living with HIV/AIDS in the Maghreb (particularly Algeria, Morocco, and Tunisia) are far higher than those in the Mashreq (which includes Egypt, Jordan, and Syria). This may be related to the fact that voluntary testing and counselling centres and other surveillance methods are far greater in the Maghreb and altogether more effective than their counterparts in the Mashreq, which may thus underestimate numbers in the latter subregion.

For example, UNAIDS estimated that in 2007 the number of people living with HIV/AIDS in Bahrain, Jordan, and Kuwait was less than 1,000 in each. These relatively low rates stand in contrast to the estimated numbers of infected people in 2007 in Djibouti (16,000), Morocco (21,000), Algeria (21,000) and Somalia (24,000). In the case of Sudan, the estimated number is altogether higher and reaches 320,000.

Epidemiologists classify epidemics either as 'generalized' (having affected more than 1 per cent of the total population), and 'intensified' (having affected more than 5 per cent in some groups of the population and in certain areas). In

Table 7-1 Estimated number of people living with HIV, 12 Arab countries, 2007

State	Estimate 2007	[low–high estimate]
Jordan	< 1,000	[< 2,000]
Bahrain	< 1,000	[< 2,000]
Kuwait	< 1,000	[< 2,000]
Lebanon	3,000	[1,700-7,200]
Tunisia	3,700	[2,700-5,400]
Egypt	9,200	[7,200-13,000]
Mauritania	14,000	[8,300-26,000]
Djibouti	16,000	[12,000-19,000]
Morocco	21,000	[15,000-31,000]
Algeria	21,000	[11,000-43,000]
Somalia	24,000	[13,000-45,000]
Sudan	320,000	[220,000-440,000]

Source: UNAIDS and WHO 2008.

2007, Arab countries in which the epidemic has reached the 'generalized' phase are the Sudan (1.4 per cent) and Djibouti (3.1 per cent).³⁶ Most of the epidemics are concentrated among particular at-risk populations, including sex workers and their clients, drug injectors, men who have sex with men,³⁷ prisoners, and girls who marry before the age of 18 years, particularly those who marry men who are much older than themselves.³⁸

A significant observation about Sudan concerns the relatively high percentage of HIV-positive women. Compared to a world average of 48 per cent in 2007, 53 per cent of adults living with HIV in Sudan were women. This percentage stood at 30.4 in the other Arab countries, for the same year,³⁹ which is comparable to the situation in Western Europe. There are indications that as much as 80 per cent of female infections in Arab countries occur within the bonds of marriage. For example, in Saudi Arabia, research indicated that most women infected with HIV were married and had acquired the virus from their husbands.⁴⁰

A rising rate of female infections may reflect Arab women's weak negotiating power in domestic contexts. For reasons at once economic, cultural, and social, women are unable to demand that their husbands be tested for HIV/AIDS or use a condom when they suspect that they have been exposed to HIV. This is the main point of intersection between the role of regressive attitudes and beliefs in promoting practices harmful to women's health in general, as discussed earlier, and their specific impact on women's vulnerability to HIV/AIDS.

Another striking fact is that the percentage of HIV-positive persons in the Arab countries receiving either triple combination therapy or antiretroviral drugs is very low—indeed, the Arab region is the one world region that takes the least advantage of these medical advances. In 2006, only 5 per cent of those needing treatment in the Arab countries had access to such treatment, as compared with 75 per cent in Latin America. Even in Sub-Saharan Africa, a lower-income region than the Arab region and one with an HIV-positive population of approximately 25 million, we find that 23 per cent of those who need treatment obtain it.⁴¹ What makes this

Table 7-2

Comparative rates of access to HIV/AIDS treatment in low and middle-income countries, December 2003 – June 2006

Countries	Percentage with access
All	24 %
Latin America/Caribbean	75 %
Sub-Saharan Africa	23 %
East/South-East Asia	16 %
Europe/Central Asia	13 %
North Africa/Middle East	5 %

Source: UNAIDS and WHO 2006.

situation extraordinary is that HIV/AIDS treatment is now available free of charge in most Arab countries.

Means of HIV transmission in Arab countries

In the Arab region, HIV/AIDS is mainly transmitted through unprotected sexual intercourse with a member of the opposite sex. Indeed, this means of transmission accounts for 67 per cent of known cases in the Arab region, ranging from 90 per cent in Saudi Arabia, to 83 per cent in Morocco to 64 per cent in Egypt.⁴² In this context, it is worth noting again that a significant number of women who contract HIV are exposed to it within the context of marital relations. The second most common means of transmission is through the utilization by drug users of contaminated injecting equipment. At the regional level, this accounts for 6 per cent of all known transmissions.⁴³ In contrast, known cases in which the virus is transmitted via unprotected sexual contact between two men do not constitute a high percentage in any Arab country; however UNAIDS/WHO suggest that this factor may be under-estimated. HIV transmission from mother to child represents the next most frequent cause of infection. In terms of HIV transmission through contaminated blood or medical instruments, while this mode accounted for an average of 12 per cent of all cases in 2000, the rate fell to 3 per cent in 2005.⁴⁴ The low rate of infection via this particular mode of transmission may reflect growing mastery of sterilization methods—which are comparatively easy to adopt for the HIV virus—as well as more careful examination of blood stocks and blood derivative.

A rising rate of female infections may reflect Arab women's weak negotiating power in domestic contexts

The Arab region is the one world region that takes the least advantage of HIV-related medical advances

Preventing health problems is more effective and less costly than dealing with them after they land

The way forward: health as a prerequisite for human security

As this chapter illustrates, health is characterized by a number of unique features which make it an ideal entry point for the discussion and treatment of topics relating to human security. Health is fundamental for the achievement of social stability and economic growth. It is a key requirement for the achievement of human and national security—as the nation-wide impact of HIV/AIDS in some countries makes clear—because health cuts across many other components of human security. Accordingly, effective health intervention requires cooperation among a variety of specializations, sectors, partners and agencies. Moreover, because health has internationally recognized value, it may help in building broad alliances that go beyond national, cultural, and ethnic boundaries. Such alliances can, in their turn, create opportunities to reinforce the broader scope of human security.

Health system priorities in the Arab countries

It is generally recognized that preventing security problems is far more effective and less costly than dealing with them after they land. Moreover, given the importance of prevention in health-related interventions, it may represent an ideal point of departure for discussions of human security. Prevention may offer health policy makers and professionals the optimal way to introduce and conduct approaches to higher health levels among more citizens in the Arab countries. In the areas of both health and human security, people are the fundamental beneficiaries and agents of change. Hence, the most effective health programmes are those which invest individuals and societies with a sense of ownership. The same proposition applies to human security interventions, which confirms the importance of health as a prerequisite of human security.

Moreover, the emphasis on health as a human right is among the most important and central priorities for intervention in the areas of health and security. The constitutions of numerous Arab countries explicitly provide for the right to health. It

is time to activate this right by focusing on the social, economic, and cultural determinants of health, and to reform health systems by placing special importance on disparities in access, affordability and quality among citizens. Emphasis should also be placed on priorities consistent with areas specified by WHO/EMRO as summarized below:

- Developing health ministries' administrative capacities
- Allocating equitable and appropriate health system funding
- Providing balanced human health resources
- Enabling all people to obtain basic health services
- Increasing ways of providing, obtaining and using data
- Identifying reasonably priced interventions which target central health problems
- Developing health reinforcement programmes
- Supporting societal initiatives
- Protecting and preserving health in times of emergency and disaster
- Analyzing non-health factors influencing health determinants such as globalization, poverty, gender, and the environment, and applying the lessons

Most health system reforms thus far have focused on the technical aspects of reform, policy making, service delivery, and national health considerations. Customarily, health reform proposals affirm that their aim is to improve the balance between cost, effectiveness, and equity. In reality, however, health professionals in the Arab countries have noted that the first two factors (cost and effectiveness) have received more attention than the third factor (equity). Moreover, the writers of this report believe that equity and equality are the areas in which health interventions need to be made if their aim is to reinforce human security. Those who gain most from such an approach are underprivileged groups such as the poor and those who support them, particularly young children and the elderly, as well as vulnerable and excluded social groups, such as refugees, migrant workers, those with specialized needs, minorities, and women.

There is much to be gained from broadening public health alliances to include

Equity and equality are the areas in which health interventions need to be made if their aim is to reinforce human security

civil society organizations and members of the public who receive services. It would also repay countries to adopt decision-making systems in which health workers themselves take part, and to give priority to public health while strengthening cooperation and complementarity in the areas of medical service provision both between the Arab state and medical institutions, and among such institutions themselves.

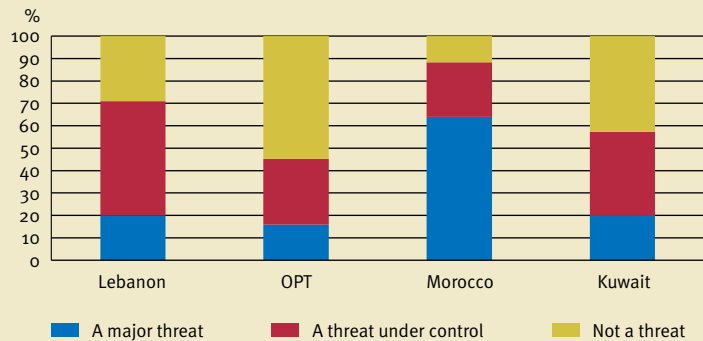
Participation should also be a byword in efforts to combat cultural practices damaging to women's health. Solidarity and cooperation among government institutions, civil society organizations, clerics, the media, and women's organizations offer a way for Arab countries to begin lifting the crushing backlog of ignorance, folklore and gender bias responsible for such anachronisms. Education at all levels has an instrumental role in spreading awareness of the seriousness of these practices, while the authority of the state and the letter of the law must be summoned to ban practices harmful to women's and young children's health and to punish those who encourage or engage in them.

Similarly, national strategies for addressing HIV/AIDS have to look beyond its health-related aspects alone. The disease has a cultural, social, and economic context.

Many past attitudes towards HIV/AIDS will have to be abandoned. Failing to give the challenge the priority it demands, denying its existence and muffling public discussion about it, attributing its prevalence to foreigners alone, and exploiting public fears to further increase the suffering of victims through discriminatory practices, have all worsened the situation in Arab countries. The new norm should start by interpreting the challenge as a growing threat to individual and collective human security in the Arab countries. It should enjoin public compassion and knowledge, supported by a strong public education drive. It should enshrine voluntary testing, counselling and free treatment for those living with HIV/AIDS as a top priority.

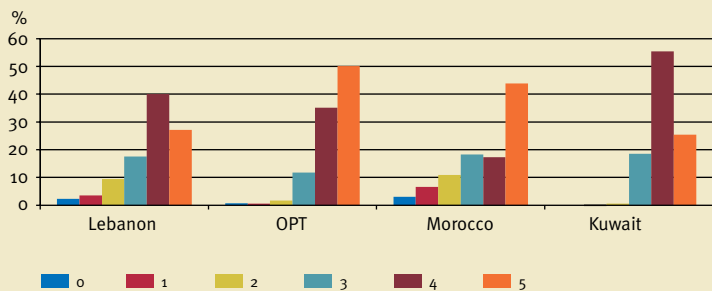
How great a threat is HIV/AIDS in the country?

The only country where the majority of survey respondents thought HIV/AIDS is a serious threat (about 60 per cent) was Morocco. In the OPT, by contrast, a similar percentage believed that HIV/AIDS poses no threat whatsoever. With the exception of Morocco, about 20 per cent of respondents in the other countries acknowledged that HIV/AIDS is a major threat. Half of those surveyed in Lebanon considered that the disease is a threat under control, while the Kuwaitis were evenly divided among those who thought it posed no threat at all and those who believed it to be under control.



How many modes of transmission does HIV/AIDS have?

Interestingly, while most Palestinians believe that the virus poses no threat, they are the most knowledgeable about how it is transmitted. Half of the Palestinians surveyed were able to identify correctly five modes of transmission; 35 per cent were able to identify four. By contrast, the percentage of those familiar with five modes of transmission was 44 per cent in Morocco, 27 per cent in Lebanon, and 25 per cent in Kuwait. The percentage of those who could name four means of transmission was highest in Kuwait, followed by Lebanon. An empirical observation to be drawn from this admittedly small sample is that the link between public knowledge about how HIV/AIDS is transmitted and low rates of infection is real.



Endnotes

- ¹ UNDP 1994.
- ² Commission on Human Security 2003 (in Arabic).
- ³ Fidler 2003.
- ⁴ Kelle 2007.
- ⁵ WHO 2005 (in Arabic).
- ⁶ Kelle 2007.
- ⁷ Gutlove 2002.
- ⁸ Fu'ad and Jabbour 2004 (in Arabic).
- ⁹ Tabutin and Schoumaker 2005.
- ¹⁰ Unless indicated otherwise, the data cited in this part are from the UNDP Human Development Report 2007/2008. Some figures may differ from those cited in other sources, such as the World Health Organization/Eastern Mediterranean Regional Office (WHO/EMRO) report. These differences, however, are not significant.
- ¹¹ UNICEF 2007.
- ¹² WHO 2007.
- ¹³ According to the World Health Organization, communicable diseases or infectious diseases are those caused by pathogenic micro-organisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. Zoonotic diseases are infectious diseases of animals that can cause disease when transmitted to humans. Cholera, Hepatitis B and C, Malaria and Tuberculosis are examples of communicable diseases. [http://www.who.int/topics/infectious_diseases/en/].
- ¹⁴ Iqbal 2006.
- ¹⁵ Sibai and Alam 1991.
- ¹⁶ Al-Jawadi and Shatha 2007.
- ¹⁷ It should be stressed here that the effects of such a situation are important not only in the case of a male breadwinner's early death or illness but, in addition, in the cases of women who, though they may not necessarily be economically active, nevertheless provide priceless services for their families which serve to reinforce their security and well-being.
- ¹⁸ Catastrophic health expenses are defined as those which equal or exceed 40 percent of the family's available income.
- ¹⁹ This movement has been criticized by members of civil society and health activists for promoting the view that health is a commodity rather than a human right.
- ²⁰ WHO 2003.
- ²¹ WHO 2005a.
- ²² Lafteya ElSabae, in Arabic, background paper for the report.
- ²³ WHO 2008a.
- ²⁴ WHO 2008a.
- ²⁵ WHO 2004.
- ²⁶ Abdullatif 2006.
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- ²⁸ WHO 2000 (in Arabic).
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