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Accelerating progress on the 2030 Agenda post-COVID

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Accélérer le progrès vers la réalisation du Programme 2030 post-COVID

المنتدى العربي للتنمية المستدامة

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3 GOOD HEALTH AND WELL-BEING

SDG 3

GOOD HEALTH AND WELL-BEING

Ensure healthy lives and promote well-being for all at all ages

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The Arab region has seen significant improvements in key health indicators over the past decades, including lower maternal and under-five mortality. However, overall, levels of health and well-being remain significantly uneven within and between countries (SDG 10). Health services in the region are fragmented and often supply driven, and access to primary health care and universal health coverage vary widely within and among countries and social groups (SDG 1). Most health systems continue to focus largely on curative health services instead of primary and preventative care, and pay little attention to the social determinants of health. Progress towards achieving universal health coverage has also been challenged in several Arab countries, partly owing to humanitarian crises and political instability (SDG 16).

The COVID-19 pandemic is putting unprecedented pressure on health systems in the region, and various achievements are at risk of being lost. The region as a whole needs to shift to a rights-based and multisectoral approach to human health and well-being, including by consolidating systems and services, enhancing the capacity and numbers of service providers, and addressing the economic, social and environmental dimensions of SDG 3 (SDGs 1, 2, 4 , 6, 8, 11 and 13). Stronger investment in data and analysis and continuity of essential services in times of crisis are also necessary.

Impact of COVID-19 on SDG 3 in the Arab region

There is increased focus on health in several Arab countries, which promises a strategic shift and stronger engagement from other sectors in the approach to health. However, the pandemic has highlighted structural gaps in health systems across the region, as well as opportunities to achieve SDG 3.

Health systems in the region are facing unprecedented stress because of the pandemic, and morbidity and mortality are on the rise. The seriousness of the COVID-19 virus in at least 30 per cent of those infected, and the transmissibility of asymptomatic cases has led to an increase in morbidity and mortality across the region. Health systems' ability to deliver essential health services is dependent on baseline capacity, the burden of disease in the community and the COVID-19 caseload. In several member States the health sector is currently overstretched. In some countries, it is facing near collapse, especially with the increasing number of affected health-care professionals and shortages of intensive care beds, key supplies, equipment and medicines.

Disruptions in the management of non-COVID related illnesses are taking their toll, and will negatively impact the health of populations for decades to come. The reallocation of medical resources towards tackling the pandemic, strict lockdown measures, and fear of contagion at health facilities have negatively affected the supply and demand of essential health services, including sexual and reproductive health services, especially in the initial phase of the crisis. In some countries, immunization campaigns were cancelled or postponed, and access to essential child and maternal health services declined.

A simulation analysis[1] shows that protracted disruption in the supply and demand of primary health care and a deterioration in child nutrition status could result – in the most severe scenarios – in losing 20 years of progress towards reducing childhood mortality in Arab countries, with a potential 40 per cent increase in the number of deaths of children under-five when compared with the pre-COVID scenario.

1 WHO and UNICEF, The potential impact of health care disruption on child mortality in the Middle East and North Africa, 2020.

The health crisis could weaken people's trust in the capacity of the health system to safely meet essential needs, and to control infection risk in health facilities. This further undermines health systems' efforts to engage the public in safety protocols and measures to control infection spread.

The COVID-19 crisis has highlighted the relatively weak capacity of the region to contribute to global efforts to produce a vaccine. The infrastructure for research and development in the region lags behind other regions, which threatens the region's ability to secure vaccines now and in response to future pandemics. While vaccine production in Arab countries such as Egypt and Tunisia exists, it has not been optimized. However the technology for producing vaccines is available in several Arab countries. Some countries, including Egypt and the United Arab Emirates, are reviewing their ability to produce vaccines.

The socioeconomic impact of the crisis will also negatively impact health outcomes. Food security and health and well-being are projected to deteriorate as households are plunged into poverty and economic growth slows. In many Arab countries, out-of-pocket health expenditure can be catastrophic for some households. Moreover, limited fiscal space has meant that resources in a number of Arab countries have been diverted away from other health priorities (such as non-communicable diseases, reproductive health services and mental health) to address the urgent COVID-19 response, leading to more avoidable deaths.

However, the pandemic is also encouraging a whole-of-government approach, and placing the health and well-being of people at the centre of development agendas in the region. Most countries have established high-level national multidisciplinary committees, and have implemented whole-of-government and whole-of-society approaches to oversee the planning and operationalization of the response. This has resulted in increased coordination among line ministries. At the regional level, Arab countries have joined forces to develop a regional health-friendly budgeting strategy, which brings together finance and line ministries to support a more responsive allocation of resources.

Measures taken by Arab Governments

1. **Response plans have been implemented across the region,** which initially focused on contingency plans to establish additional capacity, especially ICU capacity; provide protective equipment for health-care personnel; and ensure the supply of medicine and key diagnostic/treatment. Countries also established testing facilities and sites for treating and isolating cases, developed infection prevention and control policies, and implemented contact tracing and quarantine. Countries also put in place public health and social measures to decrease the infection spread, including imposing travel and movement restrictions, closing borders, schools and non-essential businesses, banning mass gatherings, implementing curfews and partial-to-full lockdowns, and requesting intensive community engagement.

2. **Countries have adopted risk communication and community engagement strategies and plans to tackle the pandemic,** such as the dissemination of timely and credible information to the public, including vulnerable populations. Approximately half of the region's population has been directly targeted with information on how to prevent COVID-19, and how to access essential social services during and after lockdowns. At the regional level, extensive community engagement interventions have been implemented, including collaborations with and empowerment of various stakeholders: religious leaders and communities (Egypt, the Sudan, the Syrian Arab Republic, Yemen); local leaders (Lebanon, the State of Palestine); youth networks (Algeria, Tunisia); women's organizations (Morocco, Yemen); and civil society partners for community mobilization (Djibouti, the Sudan, the Syrian Arab Republic, Yemen). Some countries also witnessed enhanced involvement by national experts and the mobilization of civil society, including professional bodies such as obstetric-gynaecological associations, which have provided guidance on managing pregnancies at risk of COVID-19 and informed the coordination of delivery services.

3. **The region has witnessed a number of innovations to tackle disruptions in medical services.** As part

of the pandemic response, several countries have adopted and integrated essential health service continuity into their COVID19 strategic preparedness and response plans, by providing telemedicine and digital health services to ensure access to preventive measures, diagnostics, treatment, and reproductive, child and maternal health services, and guarantee continued control and management of communicable and non-communicable diseases. For example, polio immunization campaigns continued in the Sudan and Yemen, as did training in interpersonal communication and risk communication for frontline health workers in Iraq to rebuild community trust in accessing health services. In Egypt, measures were taken to assess why patients were not accessing services, and to track the increase in deaths from non-communicable diseases.

4. **A number of countries have devised multi-sectoral approaches, linking social protection measures and essential health and nutrition services,** aimed especially at women and children. This approach contributed to increasing the coverage of immunization services for children in many countries where it had decline during the early months of the pandemic. In Iraq, Morocco, the State of Palestine, the Sudan and Tunisia, ministries of health initiated response plans in coordination with United Nations agencies and civil society organizations, with a focus on linking social protection and health services for food insecure and poor families.

Most at risk of being left behind

A detailed review of the Arab region revealed that SDG 3 targets will not be met by 2030 for the following social groups, whose vulnerability has been amplified by the pandemic.[2]

The poor and uninsured: Out-of-pocket expenditures for health care are high in the region, and many social groups lack access to formal health insurance to defray rising care and medication costs. This particular affects young people, whose unemployment rates are the highest worldwide, and women, who register low formal labour force participation. Many workers are self-employed or involved in the informal sector, including a majority of women workers, and therefore lack health-related benefits. With unemployment increasing as a result of the pandemic, more people across the region are being pushed into poverty, which directly affects their ability to access quality health care.

Arab least developed countries: These nations perform worst on almost all SDG 3 indicators. Their health systems were already at low capacity before the pandemic, with fewer resources and a heavy dependence on aid. They not only face significant challenges in achieving SDG 3 targets by 2030, but also lag behind in the supply chain in terms of the COVID-19 response and in securing vaccines for their populations.

Refugees, internally displaced people and conflict-affected populations: Conflict has undermined health-care access, destroyed health-care facilities, driven an exodus of trained health-care personnel, and caused shortages in medicine and equipment in a number of Arab countries. In addition, large numbers of refugees and internally displaced people are at a higher risk of contracting the virus, and face numerous challenges in accessing care.

Persons with disabilities: Special health-care needs of persons with disabilities – both physical and cognitive – are not adequately addressed in the region. Barriers to health-service access intensify with intersecting inequalities, such as persons with disabilities

Many Arab countries lack systematic forecasting for key needs, such as reproductive health needs. Routine data collection may have resumed in some countries, such as Morocco and Oman, but these efforts do not necessarily focus on sexual and reproductive health (SRH). Availability of routine SRH data was given less priority or stopped completely in some countries, such as the State of Palestine and Tunisia, or was reduced to local levels, such as in Iraq.

In Iraq and Morocco, most SRH services did not suffer disruptions, but were adapted to integrate protection measures, such as the use of PPE, infection control procedures, and handwashing with soap. Some countries scaled down SRH services to prioritize life-saving measures at centralized facilities. In Morocco and Oman, adaptations included national and regional level coordination, where clients could use dedicated helplines and seek appropriate care at dedicated times.

2 ESCWA, Arab Sustainable Development Report, 2020.

in rural, refugee or other marginalized communities, which are all exacerbated by the pandemic.

Non-national residents and migrants: A number of Arab countries extended health-care services to migrants in the context of the pandemic, though not always comprehensively. There is a need to ensure that this inclusion is extended beyond providing access to health services during pandemics, by translating a rights-based approach and SDG3 targets into more inclusive policies.

Adolescents: Compared with adolescents globally, those in the region have higher rates of transport injuries, cardiovascular and metabolic conditions, and mental health problems. Yet health-care providers are not always trained to meet the health needs of this group.

Women and girls: Of all the SDG 3 indicators, only six have sufficient gender-disaggregated data for the region, reflecting the lack of attention to gender considerations in health. Maternal mortality remains high, and female genital mutilation continues to affect millions of girls and women. Gender-based violence remains pervasive, with an estimated 37 per cent of ever-partnered women in some Arab countries experiencing physical and/or sexual intimate partner violence at some point in their lives. Lockdown measures have placed women at a higher risk of intimate partner violence, a trend observed both globally and regionally. Furthermore, women represent 70 per cent of the health and social sector workforce globally, with similar trends observed in the region. Special attention should be given to how their work environment may expose them to discrimination, and to their sexual and reproductive health and psychosocial needs as frontline health workers.

Policy recommendations for ensuring an inclusive recovery and achieving SDG 3 by 2030

The Arab Sustainable Development Report 2020 identifies the following recommendations to accelerate the achievement of SDG 3 in the region and support action on other SDGs. These recommendations also facilitate the COVID-19 recovery, and enhance resilience to future shocks and crises.[3]

- Expand evidence-based health services and health coverage, and enhance affordability
- Improve health-care quality and restore communities' trust in health systems
- Ringfence budgets to ensure the continuity of essential health services, including at the primary health care level
- Intervene upstream to address the social determinants of health
- Invest in better monitoring, data and analysis of health and health-care services
- Strengthen regional and country-level capacities to guarantee emergency preparedness and responses to all hazards, and the continuity of essential services

3 For a comprehensive analysis of these recommendations, see ESCWA, Arab Sustainable Development Report, 2020.

Key facts on SDG 3

	ARAB REGION	WORLD
Coverage of essential health services, index (0 to 100)		
	**63** UHC index in 2017 **+1% since 2015**	**66** UHC index in 2017 **+1% since 2015**
Mortality rate, under 5 years per 1,000 live births		
	♀ **32** under-five deaths per 1,000 female births in 2018 ♂ **37** under-five deaths per 1,000 male births in 2018 **-3% since 2000**	♀ **36** under-five deaths per 1,000 female births in 2018 ♂ **41** under-five deaths per 1,000 male births in 2018 **-4% since 2000**
Maternal mortality ratio per 100,000 live births		
	**149** maternal deaths per 100,000 live births in 2017 **-3% since 2000**	**211** maternal deaths per 100,000 live births in 2017 **-3% since 2000**
Proportion of women of reproductive age who have their need for family planning satisfied with modern methods		
	**63%** of women aged 15-49 years had their need satisfied with modern methods in 2019 **+1% since 2000**	**76%** of women aged 15-49 years had their need satisfied with modern methods in 2019 **0% since 2000**
Adolescent ages 15-19 birth rate per 1,000 women		
	**47** births per 1,000 women aged 15-19 in 2015-2020 **-1% since 2000**	**43** births per 1,000 women aged 15-19 in 2015-2020 **-1% since 2000**
Proportion of births attended by skilled health personnel		
	**90%** of births were attended by skilled health personnel in 2014-2019 **+1 since 2000**	**81%** of births were attended by skilled health personnel in 2014-2019 **+2 since 2003**

Source: ESCWA Arab SDG Monitor. http://arabsdgmonitor.unescwa.org. (Figures have been rounded).

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