Analysis and comment

Can action on health achieve political and social reform?

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Public debate about health is rare in Arab countries. But getting the social and political issues underlying health problems onto the agenda could have wider effects on the region's political stagnation

Arab countries face major challenges, including foreign occupations, deficient liberties, poor governance, squandering of resources, economic regression, inequities, and illiteracy.[1] Arab reformists have advocated political, economic, and social change since the late 19th century. However, despite decades of local pressure for change, reforms remain elusive. We consider how action on health can contribute to realising these reforms using examples from Lebanon, Palestine, and Syria.

Health in the public sphere

Despite abundant resources, the populations of most Arab countries endure poverty, inequities, and the burden of communicable and maternal and childhood diseases, rising prevalence of non-communicable diseases, and high rates of injury.[2] Health indicators vary among Arab countries,[3] but they all share common barriers to health.[2 4] The healthcare systems are weak, unaccountable, and poorly governed, shaped by the political structures in which they are embedded.[4] Although the strong social networks support health, other social norms pose challenges. For example, taboos concerning behaviours and lifestyles such as premarital sex and homosexuality, constrain official policies for prevention and control of HIV infection and other sexually transmitted diseases.

Economic liberalisation, which is happening in many Arab countries, presents new health problems. Syria, a signatory to the Framework Convention on Tobacco Control, recently allowed the building of a branch factory of a famous French cigarette maker under the pretext of liberalising trade and creating jobs.

Considering the gravity of the challenges, the lack of public debate on health in Arab countries is remarkable.[5] Even when social and political change is discussed, debate on health is largely limited to curative medicine rather than wider health problems.[2 5] It is tempting to think that competing public priorities, such as struggle for basic necessities or liberation, are the main factors behind absence of health debates, but other factors are also relevant.

The first is political authoritarianism, which discourages public participation and restricts public debate.[6] However, even in Lebanon, with its tradition of individual liberties and press freedom,[7] debate mainly concerns issues of health services and cost rather than rights and policies.

Advocacy march for the rights of disabled people in the Occupied Palestinian Territory

Secondly, health professionals, especially doctors, and their organisations have failed to place health on the public agenda. They have also contributed to medicalising health systems and policy making so that preventive approaches based on rights and social determinants are excluded. Authoritarian and hierarchical health institutions further discourage public engagement.[5]

Thirdly, health is a gendered topic. Although men dominate health policy, management, and medical provision,[8] health is seen as a softer topic of discussion than employment, war, and political reform.[9] Health is thus devalued and depoliticised.

Opportunities for change

Although the lack of public debate on health makes it difficult to promote changes in health services, let alone use it as a tool for wider reform, opportunities do exist. Pressing for debate on health builds democracy and supports public health. Health is everyone's business and thus offers a relatively comfortable entrance into public discussion for ordinary citizens including women, disabled people, and minority groups. Many health issues are easier to discuss publicly than subjects such as family law, custody, and inheritance, where religious doctrine and patriarchal traditions have made more definite pronouncements. Arab governments may not view public engagement in health as politically threatening.

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Health actions that could promote wider reform

- Convene a regional meeting of health activists to establish an advocacy network
- Collect inspiring local examples of action and disseminate findings to the public
- Raise reform at general meetings of health professional organisations and support representatives who pick up the cause
- Create alliances with global movements of similar interest, such as the People's Health Movement (www.phmovement.org) and Global Health Watch (www.ghwatch.org)
- Use the media and internet to make the case to the public
- Identify public figures willing to champion health issues
- Raise funds to support research programmes
- Campaign for serious reforms in health sector institutions

The dizzying pace of change in Arab societies creates opportunities for using health for reform. Globalisation, modernity, and post-colonialism directly affect health. The health effects of socioeconomic policies, foreign investments, and social doctrines mean that health promotion will have to be linked to work on broader issues. Health practitioners promoting prevention of sexually transmitted diseases, for example, act as agents of change without necessarily pursuing a social reform agenda. Commitment to women's health necessitates expanding the focus from prenatal care and family planning to thornier social issues such as discrimination and domestic violence. Similarly, health practice and policies cannot overlook conflicts, military occupations, and destruction of health infrastructure in Lebanon, Palestine and Iraq.

Health as a tool for reform

We describe two experiences that illustrate interactions between health and wider social and political reform. In the late 1970s, Israeli neglect of health in the Occupied Palestinian Territory and the focus of Palestinian institutions on provision of urban health services created large imbalances between urban and rural areas. The disparity, coupled with imperatives of survival and resistance to occupation, led health practitioners to initiate the Palestinian Social Action Movement. By promoting community participation through volunteer work and health committees, the initiative rallied support from different sectors of society and evolved into a genuine grassroots movement. The movement helped overcome problems of access, introduced new concepts and methods in healthcare provision based on equity, community participation, and intersectoral collaboration, and helped build a primary healthcare network.[10] Action was expanded beyond the clinic to include the training and empowerment of (mostly female) community health workers and joint activities with agricultural organisations, women, young people, and disabled people. The movement helped launch the community based rehabilitation network, helping disabled people to organise into a General Union of Disabled Palestinians and to rally support for a law of disability rights, promulgated by the Palestinian Legislative Council in 1999.[11] Although it is difficult to measure the precise effect of these initiatives on health outcomes, their impact on social reform, exemplified through empowerment of women and disabled people, is undeniable.

The second experience is the Reproductive Health Working Group, an interdisciplinary network of over 50 health and social researchers from Arab countries and Turkey.[12] The group advocated a vision of reproductive health based on women's perceptions and priorities. It focused on developing research models to examine issues that receive little local or regional attention, such as reproductive morbidity with emphasis on social determinants.[13] Defining itself as an agent for change from the beginning, the group has had a broad impact. The research broke the "culture of silence," whereby women carry heavy disease burdens silently,[13] and exposed poor medical practice.[14] It has challenged health ministries and regional programmes to prioritise women's health issues and campaigned for doctors and hospitals to adopt women friendly practices and policies. The group is a model for collaboration in a region with limited opportunities for interaction and inadequate space for critical reflection.

Reform dilemmas

Reformist health professionals face challenging political and social issues, such as corruption, patriarchy, secularism, and religious doctrines. Their responses will affect their abilities to achieve the desired reforms. Commenting on development and patriarchy in the Arab world, Joseph argued that although not every development project can work against patriarchal practices, development efforts should not reinforce them.[15] The same argument could be made for health initiatives.

Working with civil health organisations is important in achieving broader reform. However, this is not always straightforward, as shown by Lebanon, where central government is weak and the public health system understaffed and ineffective. The two largest healthcare networks are the Hariri Foundation, founded by the assassinated prime minister Rafic Hariri,[16] and the Islamic Health Society, affiliated with Hezbollah.[17] Each of these organisations has developed a network of primary healthcare centres providing clinical and preventive services to the poor and lower middle classes. Both organisations have used these services to gain support for their political affiliates. Health professionals who disagree with the motivations of either network may find it difficult to engage with them despite the belief that civil participation is essential for social reform.

Syria is in the opposite situation, with dominating state structures and a socialised health system. The government recently introduced important changes, including user fees and private health insurance, without public discussions. Reformist health professionals here must obviously support the development of independent grassroots activities that oversee and monitor state policies, but they also need to engage with state activities. For example, the healthy villages programme, adopted in 1996 by the government as a state-village partnership to improve health and social conditions in underserved villages (currently 560),[18] has not had the desired effect on health determinants, services, and outcomes. The programme has been limited by governmental bureaucracy and dominance by ruling party loyalists. Health professionals can engage more in the programme and push towards making it more transparent, democratic, and, ultimately, more effective.

The way forward

Naturally, health professionals are expected to have a central role in promoting reform through actions to improve health. Such a role is fundamentally different from the roles demanded of health professionals in countries that have undergone political reform, such as South Africa and Eastern European countries[19 20] where the focus has been on monitoring of health effects of democratisation. Although priorities for health actions depend on the country and context, health professionals may consider three broad strategies:

Mobilising health professionals—Acknowledging our current disengagement and historical responsibilities towards the current situation and rallying to the cause of reform are prerequisites to engaging the wider public. This will determine our credibility

Mobilising the public—By engaging the public, civil institutions, opposition politicians, and even government agencies in discussions and projects, health professionals will be able to highlight the social and political determinants of health

Health system actions—We become more effective advocates for reform if we are successful at reforming our hospitals, clinics, and health ministries. Democratising structures, undoing hierarchies, and advancing transparency and accountability in our institutions will contribute to wider reforms.

The box gives some specific actions corresponding to these strategies. These are not meant to be prescriptive but to stimulate debate. Regional collaborations will prove helpful in advancing the cause of reform through drawing on rich perspectives and experiences from different settings. We need wide contributions and research from countries and regions to inform action leading to change.

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Child health and survival in the Eastern Mediterranean region

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Most child deaths in the region are preventable and occur in just a few of the 22 countries in the region. The interventions are not expensive, but governments need to implement them

Over 10 million children aged under 5 years die every year, almost 90% of them in a few countries in sub-Saharan Africa and South Asia.[1–6] Landmark series on child and neonatal survival suggested that this high mortality persists despite low cost solutions being known and that almost 60-70% of these deaths could be prevented by making these interventions widely available.[2 4] To evaluate whether countries have acted on this information, we did an in-depth assessment of child health in the World Health Organization Eastern Mediterranean region. The region comprises 22 predominantly Islamic countries, and health indicators vary widely.

Review methods

We used data from WHO and Unicef to determine child deaths and cause specific mortality.[7 8] We obtained information from the official websites of ministries of health and nationally accredited institutions or research organisations, describing national research priorities for child health, funding for research, and policy. In addition, we reviewed research funding data from the WHO (Eastern Mediterranean

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