

BUILD BACK FAIRER ACHIEVING HEALTH EQUITY IN THE EASTERN MEDITERRANEAN REGION

REPORT OF THE COMMISSION ON SOCIAL DETERMINANTS
OF HEALTH IN THE EASTERN MEDITERRANEAN REGION

EXECUTIVE SUMMARY



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01



THE COMMISSION: AIMS AND APPROACHES

In 2019, Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean, established an independent, expert Commission on Social Determinants of Health in the Eastern Mediterranean Region.¹

The Commission has five objectives.

1. Analyse and present existing data on health inequities and social determinants of health, including conflict, in the Eastern Mediterranean Region context.
2. Document actions being taken by international organizations, governments, nongovernmental organizations, civil society and communities to address these issues.
3. Build knowledge and evidence for action and offer practical, specific recommendations to reduce health inequities.
4. Provide strategic guidance on developing plans for equity, including governance and monitoring systems for health equity.
5. Identify opportunities to build capacity through research and evaluation of health inequities and programmes for action, and establish knowledge networks across the Eastern Mediterranean Region.



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The inequitable impacts of the COVID-19 pandemic required another, additional, objective for the Commission.

6. To describe and make proposals to mitigate the health inequality impacts arising from COVID-19, including infection, mortality and the long term impacts of containment measures.

The report from this Commission contains recommendations for action to create the conditions that will enable all residents of the Region to lead lives of dignity and achieve better health, leading to a fairer distribution of health—greater health equity.

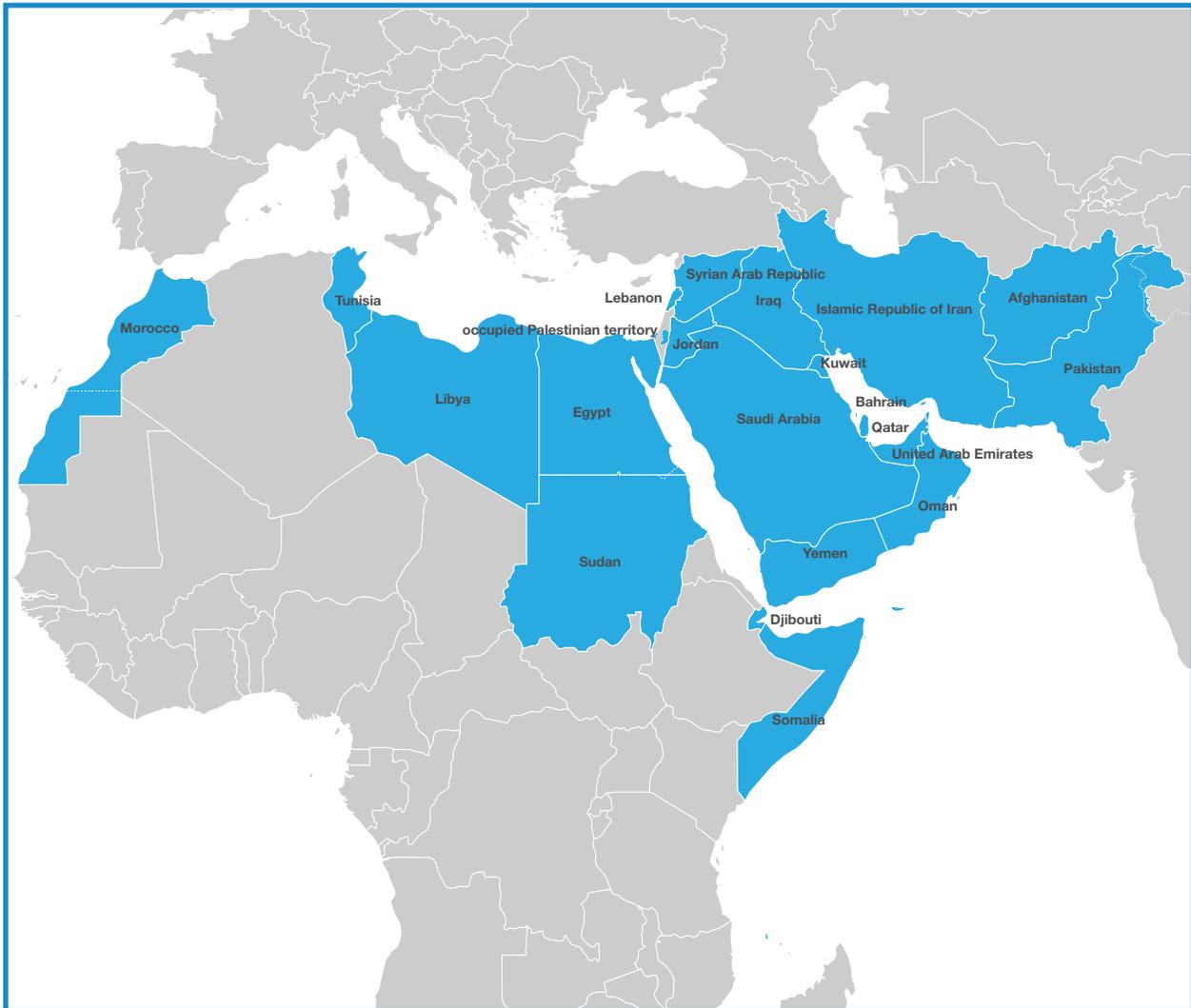
The Eastern Mediterranean Region

The WHO Eastern Mediterranean Region stretches from Morocco in the west to Pakistan in the east and consists of 21 Member States of WHO and the occupied Palestinian territory, including East Jerusalem (1). Specifically, the Eastern Mediterranean Region includes Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, occupied Palestinian territory, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen, as shown in Fig. 1 (1).²

¹ The Commissioners are Abdirisak Dalmar, Adel Al Zayani, Anita Zaidi, Assad Hafeez, Bagher Larjani, David Bishai, Hoda Rashad, Iman Nuwayhid, K. Srinath Reddy, Michael Marmot, Rajae El-Aouad, Rowaida Al-Maaitah, Salwa Najjab, Senait Fisseha, and Stephen Gloyd.

² To mitigate data gaps, some analysis in the report is based on data from different country/territory groupings.

Fig. 1. The Eastern Mediterranean Region



The Region includes countries of enormous contrast – Gulf Cooperation Council (GCC) member countries with among the highest income per person in the world, such as Kuwait, Qatar and United Arab Emirates; and countries that are among the poorest in the world, such as Afghanistan, Djibouti and Yemen. Of the 22 countries and territories in the Region, 10 are designated as fragile and conflict-affected states, and levels of conflict in the Region have increased since 2010. There are enormous differences in health between the countries: among women, life expectancy ranges from 59 in Somalia to 84 in Kuwait; among men it is from 54 to 79 for the same countries.

Social determinants of health approach

Analysis undertaken for this Commission is closely aligned to evidence from around the world about the critical role of social determinants in driving health inequities within and between countries.

Inequities in the conditions in which people are born, grow, live, work and age, and what we label the structural drivers of those conditions – political, economic, cultural and environmental influences – produce inequities in health. Action to improve health

equity must be centred around action on the social determinants of health. We draw on evidence and analysis from previous WHO Commissions, including the 2008 Commission on the Social Determinants of

Health, quoted below, and Commissions in the Region of the Americas and European Region, as well as evidence from national commissions (2, 3, 4).



Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. ... [T]here are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.

.....

Social injustice is killing people on a grand scale.

From: Closing the gap in a generation: health equity through action on the social determinants of health – final report of the Commission on Social Determinants of Health (2008) (3).

Undertaking analyses and making recommendations for widely divergent countries in the Region is complex. Analysis and recommendations must cover interventions to support refugees, reduce high levels of maternal and infant mortality, and secure adequate food and nutrition, while also including proposals to improve health for those living in GCC countries, who have high average life expectancy, but still have socioeconomic inequities in health which require remedy. In this report we frame our recommendations for countries' different levels of development; but whatever the level of development and health care in a country, health is still related to the conditions of daily life and the structural drivers of those conditions – the social determinants of health.

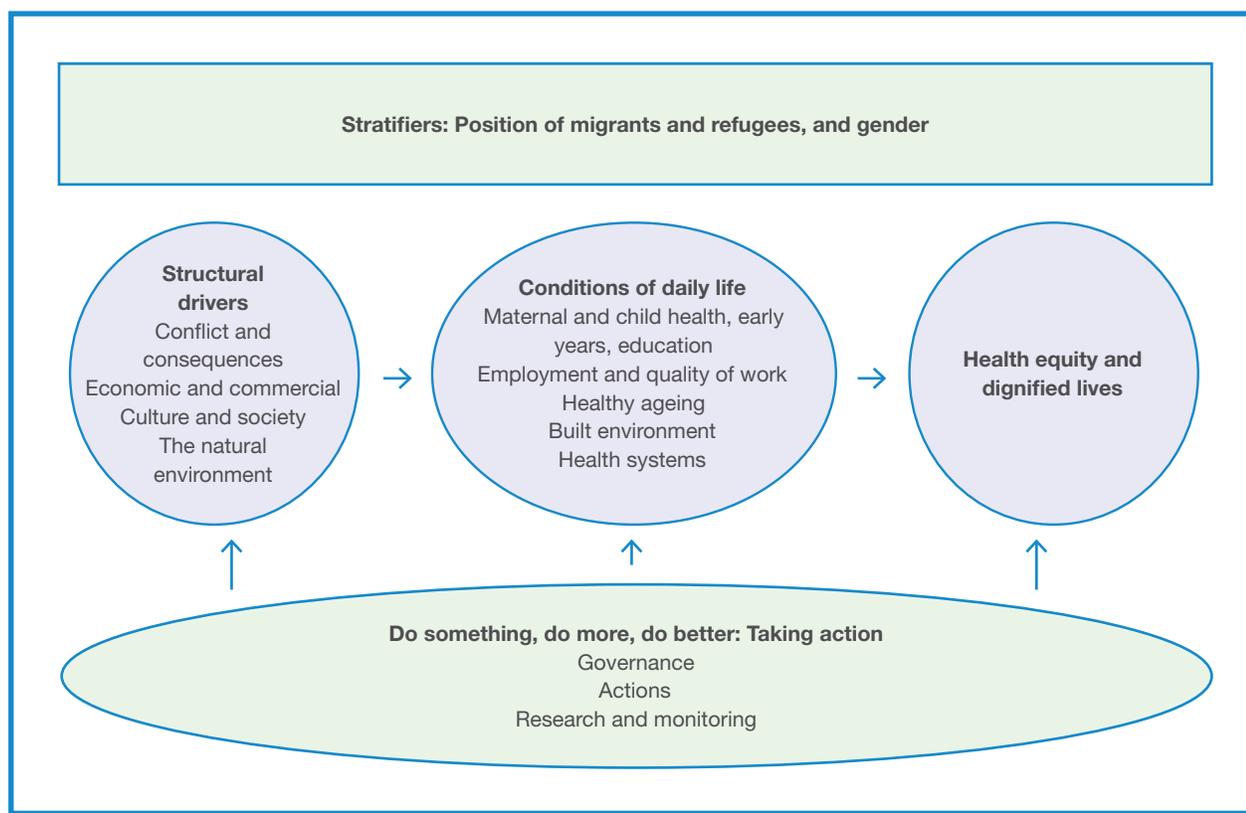
Universal health coverage is of vital importance, and health systems are necessary for treating illness when it occurs, but it is the social determinants of health that produce health and inequities in health in the first place. The WHO Commission on Social Determinants of Health in 2008 asked: “why treat people and send them back to the conditions that made them sick?” It is the conditions that make people sick and deprive them of the opportunity to lead lives of dignity that are the focus of this Commission for the Eastern Mediterranean Region.

While the evidence for the Eastern Mediterranean Region is aligned with analyses from other regions

there are specific structural drivers in the Region, which differ from those in other regions. For the Eastern Mediterranean Region, high levels of conflict and the associated migration, sanctions and occupation affect health across the Region. Gender inequity is present in all regions, but is particularly deep and persistent in this Region, affecting key social determinants of health and development prospects for all countries. Strong religious beliefs and the influence of religious leadership is also a marked feature of the Region, which can be harnessed to support greater equity in health and the social determinants of health. Climate change and environmental degradation are also vital issues for the Region, and the consequences are already being felt in increased temperatures, drought and land degradation, while measures to mitigate and adapt to climate change will greatly affect oil-producing countries and economies across the Region. Faster reductions in greenhouse gas emissions are essential and they can be tailored to be supportive to health equity and economic growth.

The approach developed for the Commission is summarized in Fig. 2. The framework illustrates the conceptual approach, represents potential points of intervention, and provides the structure of the report. In each of these areas, recommendations for action are made for a range of stakeholders and for countries and territories at different levels of development.

Fig. 2. Framework for the social determinants of health in the Eastern Mediterranean Region



COVID-19 and inequities

The need for a focus on social justice and equity to Build Back Fairer is imperative.

The publication of this report comes at a critical time, as the possibility of reducing levels of COVID-19 infection and mortality are beginning to be realized, but globally, the social and economic impacts have worsened prospects for health equity.

Do something, do more, do better

A central theme of the Commission is “Do something, do more, do better”, which fits with the different levels of development among countries in the Region and relates to the necessary actions needed to reduce inequities within countries.

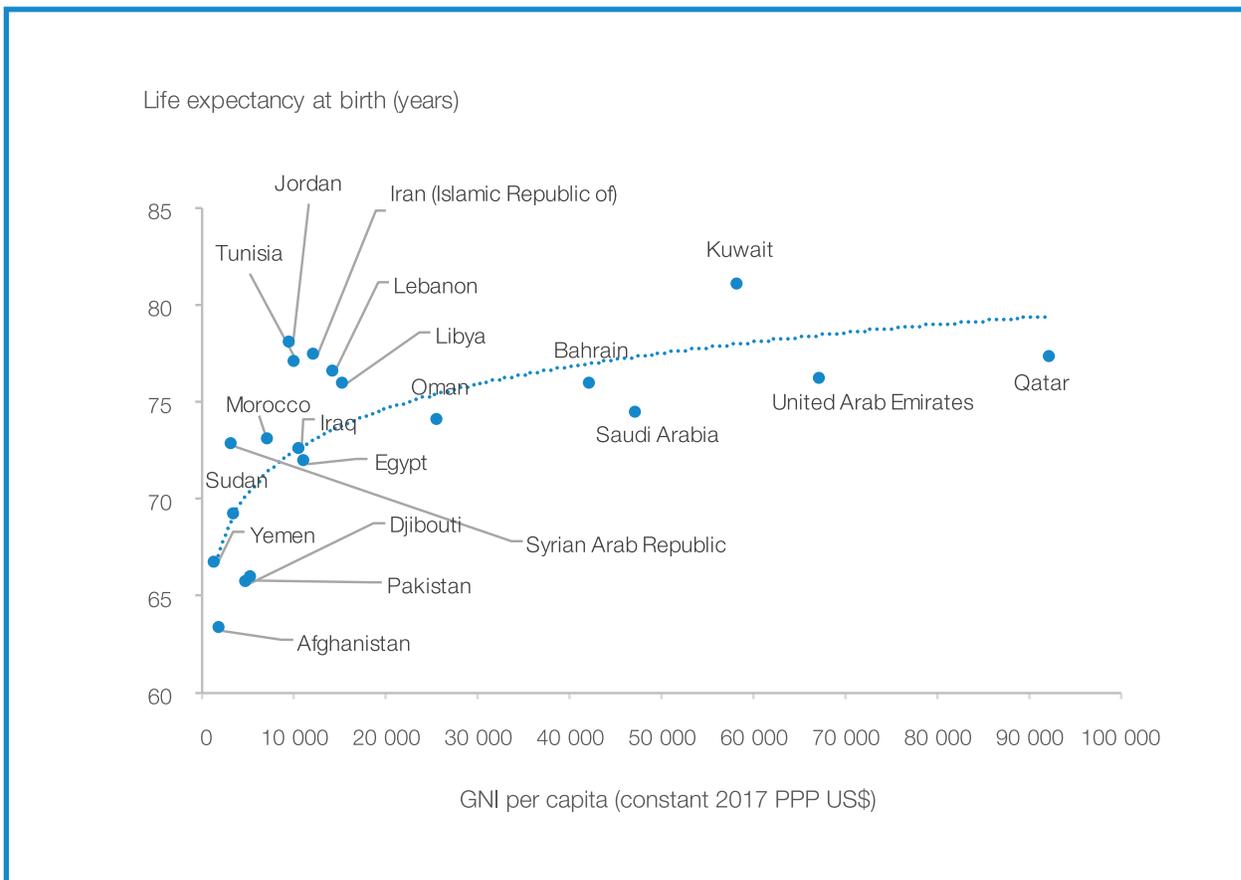
Income is related to health in a way that is informative, as shown in Fig. 3. There are three key insights from this graph.

First, at low levels of national income there is a steep relation with life expectancy: small differences in national income are associated with large differences in life expectancy. If Afghanistan had the national income of Egypt, its life expectancy might be closer to that of Egypt.

Second, there is scatter around the line: at a given level of national income, some countries have better health, and longer life expectancy, than others. Islamic Republic of Iran has about the same national income per person as Egypt but has longer life expectancy.

Third, above a gross national income (GNI) of about US\$ 20 000 per person, adjusting for purchasing power, there is only a shallow relation between national income and life expectancy. Oman has nearly the same life expectancy as Saudi Arabia but lower GNI per capita and Kuwait has lower GNI per capita than Qatar and United Arab Emirates but considerably higher life expectancy.

Fig. 3. Life expectancy at birth by gross national income (GNI) per capita (constant 2017 PPP US\$) in the Eastern Mediterranean Region, 2019



Note: No GNI per capita data for Somalia or life expectancy data for occupied Palestinian territory.
 Source: UNDP (2020) (5) and WHO (2020) (6).

A clear conclusion from this curve is that at low levels of national income, a rise in income offers the opportunity for national actions that would lead to better health. But once a level of income – around US\$ 20 000 per capita – is reached, there is more than income that is driving health levels of countries. Social conditions, affected by policies, are likely to be a reason why for a given level of income some countries have better health than others. It is precisely a key aim of this report to explore what those social conditions are, and what can be done to address them.

Given the capacity of countries with very different levels of development and income to improve health equity through policies, it is appropriate for this Commission to recommend the following framework for country level action – to improve health equity within as well as between countries.

- **Do something.** For countries in the Region at low levels of human development, some action on development, including growth of national income, would make a difference to health.
- **Do more.** Several countries and territories outperform their GNI relative to other countries – Jordan, Lebanon, occupied Palestinian territory, Syrian Arab Republic, Tunisia – and more action here would lead to improvement.
- **Do better.** Countries where levels of health and education do not match their economic success can invest in the kinds of social conditions that would lead to greater opportunities for a dignified life for all and greater health equity.

Data and evidence on inequities in the social determinants of health

Throughout the Report we note that there are substantial gaps in data and evidence on health inequities and the social determinants of health. Without such data, there is a lack of understanding about the extent of inequity and about the impacts of policies and interventions. Issues around social justice and inequity can be overlooked if not regularly reported on, and, as a result, the public and even governments are likely to remain unaware of the profound and unfair differences in life expectancy and health within countries. Establishing effective data monitoring systems and regular reporting on inequities in health and its social determinants is vitally important to understanding what progress has been made in reducing health inequities in every country and holding governments to account for inequitable outcomes.

Given the limitations in data availability, one of our most important sets of recommendations relates to the development of effective national data systems for reporting on health inequities and for regular monitoring. We also set out priorities for research in all the areas covered in this Report, which is essential for understanding and taking action on the social determinants of health.

Recommendations for action on health equity in the Eastern Mediterranean Region

While there are profound challenges and hugely inequitable health impacts in every country in the Region, there is significant potential for action. The Commission makes overarching recommendations

and recommendations by sector for WHO, other international organizations, national governments, ministries of health, local government, civil society and faith-based organizations, as well as recommendations for research funders and institutions.

Putting health equity at the heart of policy action is an essential step for all these recommendations. It requires a commitment to make health equity central in decision-making and the overarching ambition for governments in meeting the needs of citizens. The guiding principle of governments should be to foster social, economic and environmental progress such that health improves and health equity is advanced. Wide inequities in health and in the social determinants of health, mean that a government is not fulfilling its obligations to all its citizens.

Build back fairer

Our commitment to build back fairer, the title of this report, reflects the Commission's judgement that, as countries emerge from the COVID-19 crisis, it is not desirable to attempt to reconstruct the status quo that existed before the pandemic. Rather, this is a moment to work towards more socially just societies. In an alternative world where there had been no pandemic there would still have been great need for evidence-based policies to reduce inequities in health within and between countries. In half the countries of the Region, the "back" of build back fairer could apply to recovery from conflict, or the related challenges of mass movement of people. Whether recovering from the pandemic, from conflict, or looming economic and environmental crises, there is a great need to use the best evidence, in a spirit of social justice, to create fairer, healthier societies.



Summary

1. Create equity in the conditions for all people to have lives of dignity and good health.
2. To achieve this, focus on the conditions in which people are born, grow, live, work and age and inequities in the structural drivers of these conditions of daily life.
3. All countries, whatever their level of development, should take action guided by the principles "do something, do more, do better".

02



HEALTH INEQUITIES IN THE REGION



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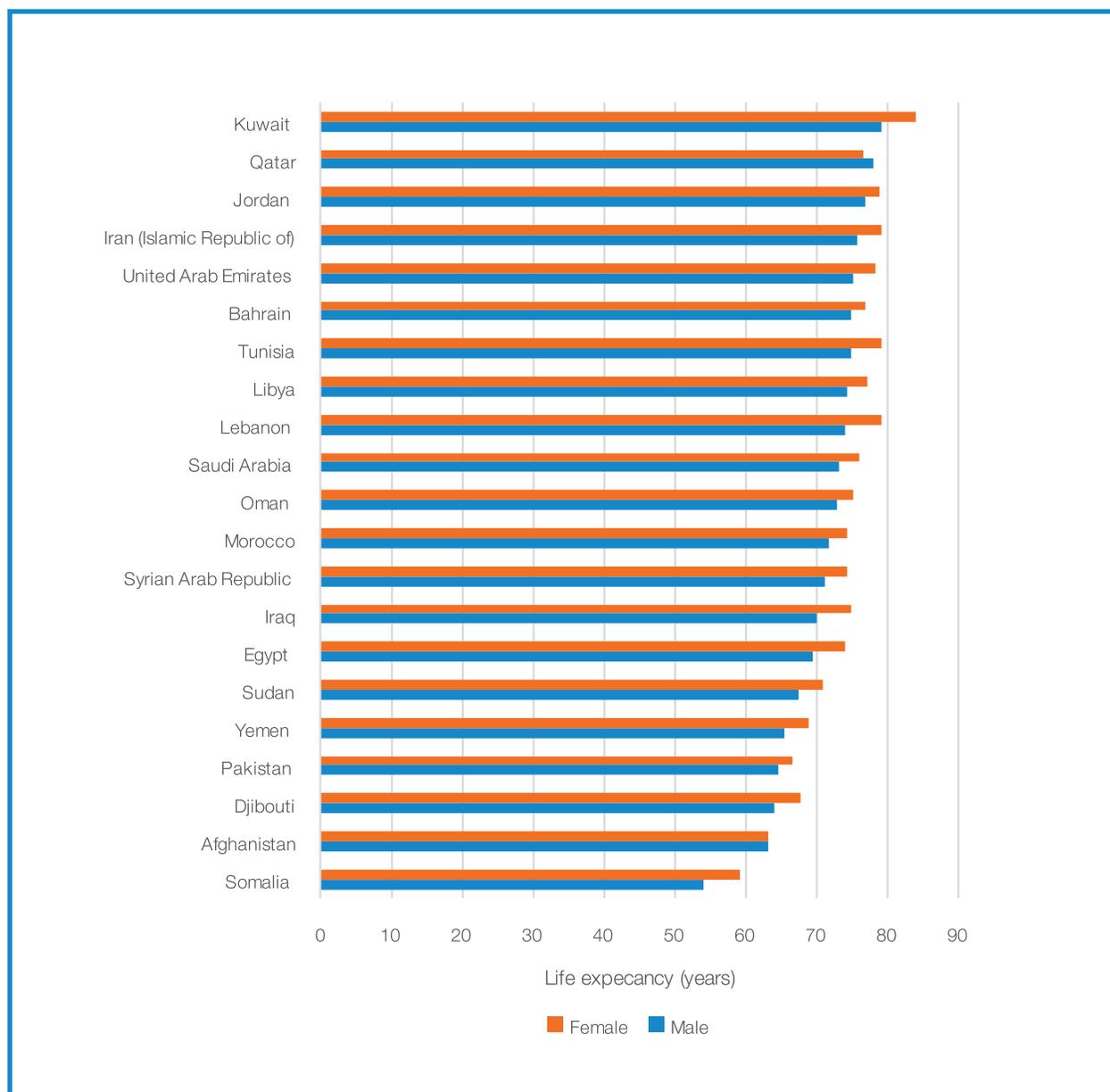
Progress in health in the Region

There have been marked improvements in mortality and morbidity in the Eastern Mediterranean Region over the last 30 years. Premature death and disability caused by communicable, maternal, neonatal and nutritional diseases have been reduced by three quarters since 1990 (7). However, deaths from conflict are rising in many countries of the Region, and obesity, undernutrition and food insecurity continue to pose significant challenges. Food security is being further impacted by COVID-19 containment measures as well as by the effects of conflict and climate change and land degradation. Despite overall improvements in many health outcomes, health inequities between and within countries persist – and in some cases are

widening. The lack of data to assess and monitor within-country inequities in the Region remains a considerable issue and needs to be addressed.

Overall life expectancy in the Region improved by an average of 4 years between 2000 and 2019, from just over 68 years to just over 72 years. Some countries, mainly those with low life expectancies, experienced rapid changes over this period, including Afghanistan, Djibouti, Islamic Republic of Iran, Pakistan, Somalia and Sudan. However, other countries in the Region have experienced slow increases, or even declining life expectancy, as a result of conflict: life expectancy for both men and women has decreased in Libya, Syrian Arab Republic and Yemen since 2010. Average healthy life expectancy in the Region in 2016 was 59.7 years; globally, it was 63.3 years. Fig. 4 shows life expectancy for men and women in countries in the Region.

Fig. 4. Life expectancy in countries in the Eastern Mediterranean Region by sex, 2019



Note: Life expectancy at birth refers to “the average number of years that a newborn could expect to live, if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his birth, for a specific year, in a given country, territory, or geographic area” (8).

Data not available for occupied Palestinian territory.

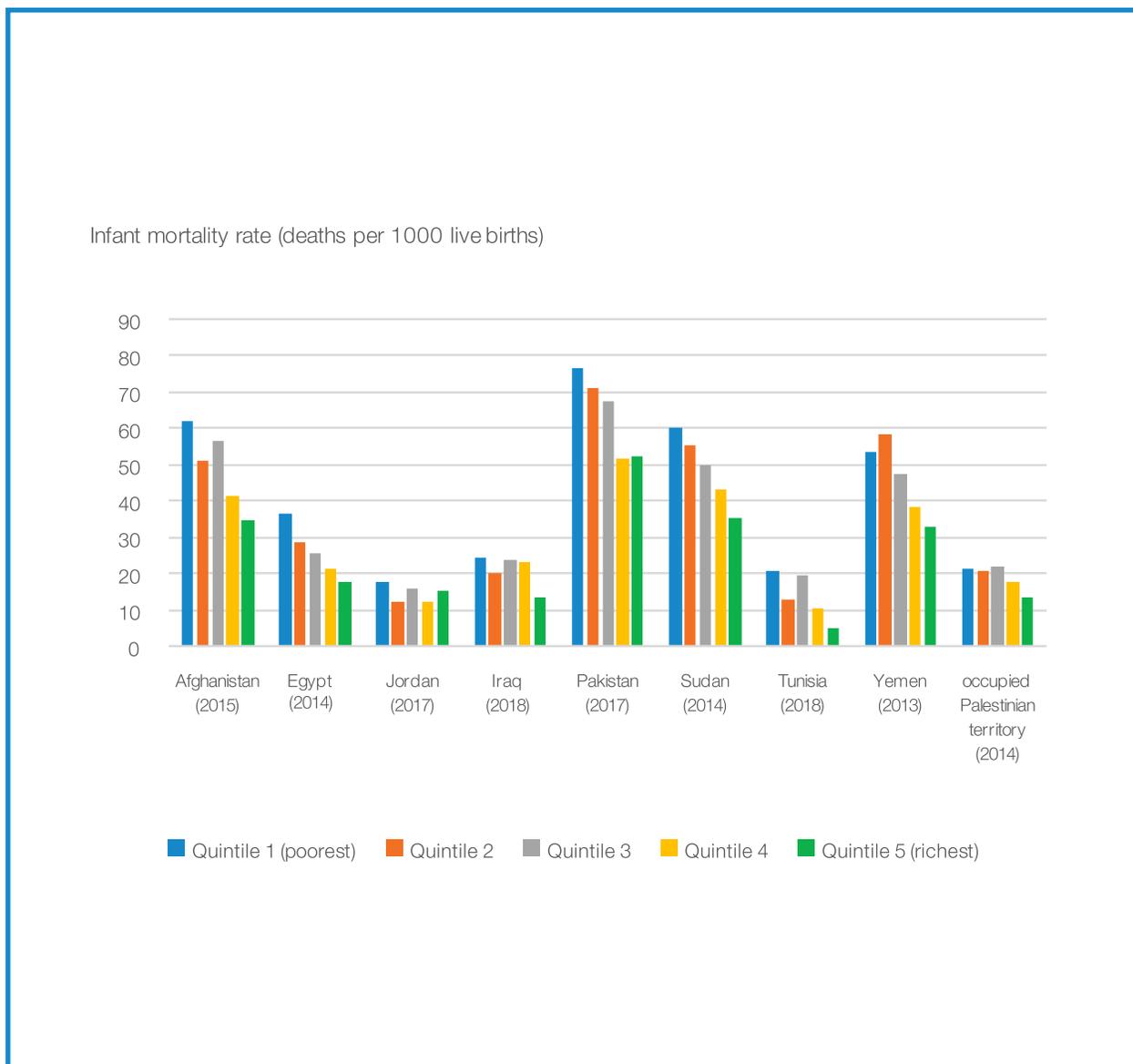
Source: WHO Global Health Observatory data repository (2020) (6).

Inequities in life expectancy and health within countries

For most countries of the Region there are no data available to track social inequities in health in adult life.

In some countries, there are analyses of within-country inequities in infant and child health. Fig. 5 shows inequities in the infant mortality rate related to wealth for countries in the Region with available data. In each country, the wealthiest quintile has the lowest infant mortality rate, except in Jordan and Pakistan.

Fig. 5. Infant mortality rate (per 1000 live births) in selected countries and territories in the Eastern Mediterranean Region by wealth quintile, 2013–2018



Note: Disaggregated data by wealth quintile were not available for Bahrain, Djibouti, Iran (Islamic Republic of), Kuwait, Lebanon, Libya, Oman, Qatar, Saudi Arabia, Syrian Arab Republic and United Arab Emirates. Data for Morocco and Somalia are from more than 10 years ago (from 2003 and 2006, respectively). Source: WHO Global Health Observatory (9) and World Bank (10).

The aim should be to address the whole social gradient in health: to have the health of everyone below the top quintile of wealth to approach that of the best off. There is no biological limit to that aspiration. A further aspiration, for example, could be for the top quintile in Egypt, Iraq and Jordan to have the same low infant mortality as the top quintile in Tunisia.

These health inequities are damaging to the development and progress in all countries in the Region. A report from Jordan indicated that life expectancy inequities in Jordan contributed to a 10.7% reduction in its Human Development Index (11).

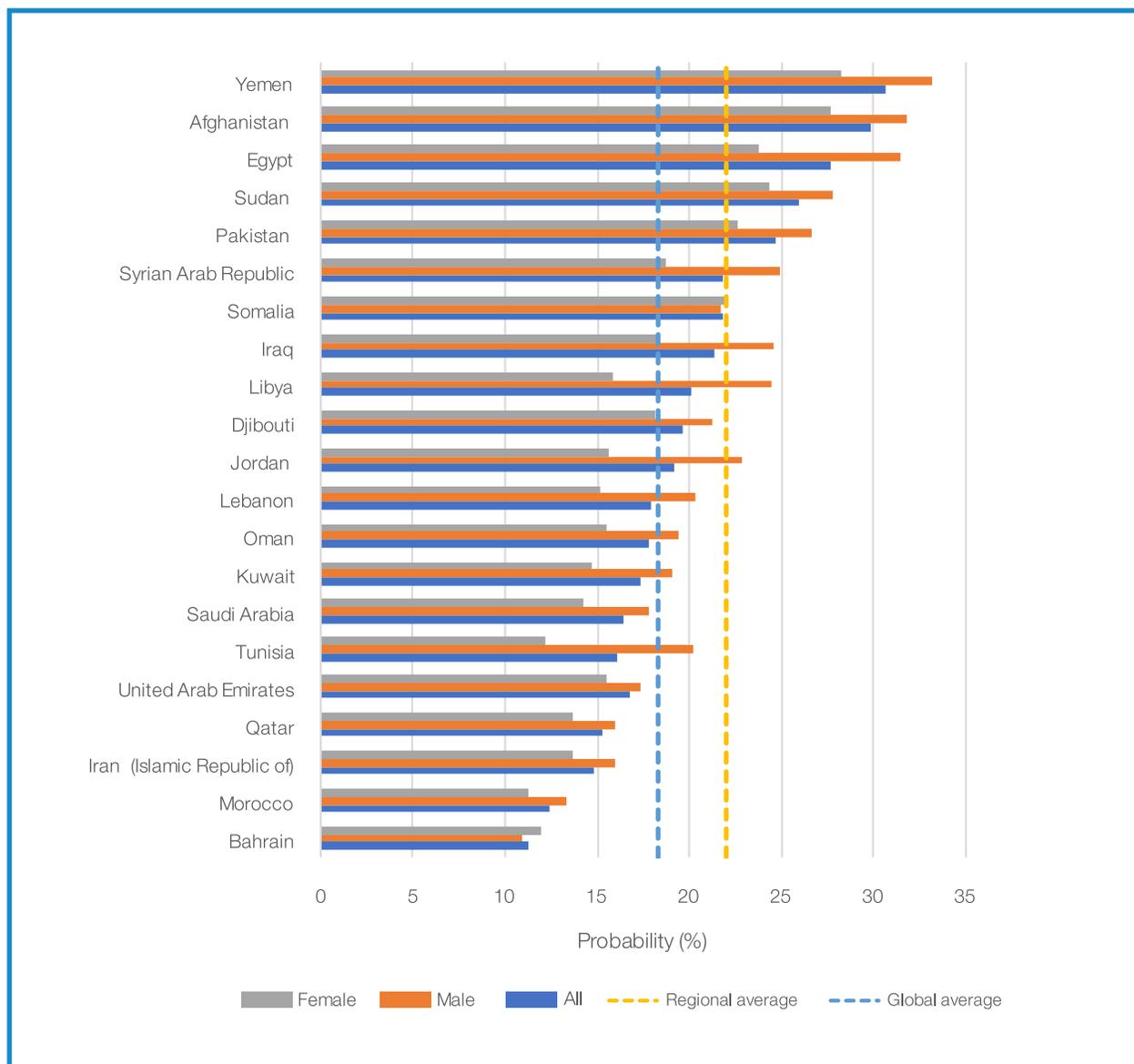
Noncommunicable diseases

Levels of mortality from noncommunicable diseases (NCDs) in the Region are high overall and the average for the Region is higher than the global average.

There are wide differences between countries and nearly half of the countries in the Region have, on average, lower mortality from NCDs than the global average.

In all countries, except in Bahrain and Somalia, women have lower rates of NCDs than men (see Fig 6.).

Fig. 6. Probability (%) of dying between exact ages 30 and 70 from any cardiovascular disease, cancer, diabetes or chronic respiratory disease in countries of the Eastern Mediterranean Region, 2016



Note: Probability of premature death from target NCDs refers to “the percent of 30-year-old people who would die before their 70th birthday from any cardiovascular disease, cancer, diabetes, or chronic respiratory disease, assuming that s/he would experience current mortality rates at every age and s/he would not die from any other cause of death (e.g. injuries or HIV/AIDS)” (12).

Data not available for occupied Palestinian territory.

Source: WHO Global Health Observatory (13).

Many NCDs in the Region, as globally, are the result of poor nutrition and obesity, smoking, lack of physical exercise and exposure to carcinogens, as well as lack of access to appropriate health care. The Commission notes that while many of these health behaviours are the immediate causes of NCDs, the causes of health behaviours, or the causes of the causes of NCDs, relate to the social determinants of health. This means that poorer communities and migrants are more likely to have health behaviours that risk NCDs. Poor nutrition, underweight and stunting are closely related to poverty – not being able to afford sufficient nutritious food. Similarly, obesity is associated with poverty in many countries – purchasing cheap, calorie-dense food and refined sugars and wheat, and not having time or space to exercise. The combination of under- and overnutrition within countries represents a double burden of malnutrition.

Overweight and obesity

There are high and increasing levels of overweight and obesity in the Region and in most countries more than 60% of the population are overweight or obese. Prevalence in Kuwait and Qatar is exceptionally high with more than 70% of the population overweight or obese. In many countries of the Region many people have insufficient activity, particularly women, which contribute to the high prevalence of overweight and obesity and a range of cardiovascular diseases (14).

Food insecurity

There are high levels of stunting and undernutrition in the Region. A 2019 report on food security and nutrition in the Near East and North Africa region¹ indicates that nearly 55 million people in the Arab States (13.2% of the population) are hungry and the situation is particularly worrying in countries affected by conflict and violence (15). The impacts of the COVID-19 pandemic are already increasing levels of hunger and food insecurity in the Region, and action to build back fairer must include alleviating food insecurity and building sustainable food systems.

Smoking

There are high smoking rates among men in some countries in the Region, and in six countries (Bahrain, Egypt, Iraq, Kuwait, Lebanon and Tunisia) rates exceed the global average for males of 32.4%. Smoking rates

for females are lower than the global average, except in Lebanon and Yemen. Efforts to reduce smoking have not been particularly successful overall in the Region and attempts to regulate the marketing of tobacco products have been weak. Tobacco companies have been marketing waterpipe and other tobacco products, such as vapes, particularly to young people, through social media and there are high rates of waterpipe smoking in the Region.

Alcohol

Across the Region, alcohol consumption is low, largely due to religious norms. Consumption is higher for men than women in the Region (16).

Mental health

Political, economic, social and cultural arrangements and inequities, high levels of conflict and fragility, and poverty and hunger, all lead directly to poor and unequal mental health, which is a major component of health inequity.

Across the Region, inequities in critical social determinants of health are likely to result in widespread inequities in mental health that are compounded by lack of access to appropriate therapies and treatments. Rates of mental ill health are likely to be much higher than those recorded, due to low levels of awareness, identification and recording of mental health disorders. Depression and anxiety are the most common diagnoses in the Region, as is the case globally. Both of these types of mental disorder relate to social and economic conditions and are often preventable with improvements to those conditions and with effective therapies and treatments (17, 18).

Communicable diseases

In addition to high rates of NCDs, the Region includes countries with high levels of many communicable diseases, including tuberculosis and respiratory and diarrhoeal diseases. Communicable diseases are highly inequitable and are far more prevalent among poorer, marginalized and excluded communities who live in conditions that support high transmission rates.

¹ The Near East and North Africa (NENA) region for the Food and Agriculture Organization of the United Nations (FAO) includes Algeria, Bahrain, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, West Bank and Gaza Strip, and Yemen.

These conditions include unsafe and insufficient water and sanitation, crowded living and working spaces, and unsafe food production and storage systems. Many treatable and preventable diseases have continuing high prevalence due to lack of access to health care and public health services. Conflict, instability and environmental harms also increase the risk and prevalence of many communicable diseases.

Neglected tropical diseases afflict countries in the Region. Both cutaneous and visceral leishmaniasis are endemic in the Region (19). A significant re-emergence of cutaneous leishmaniasis has occurred in the Syrian Arab Republic due to the impacts of conflict, collapse of the public health system and the exposure of non-immune populations. There have been cholera outbreaks in Yemen and Sudan which are ongoing.

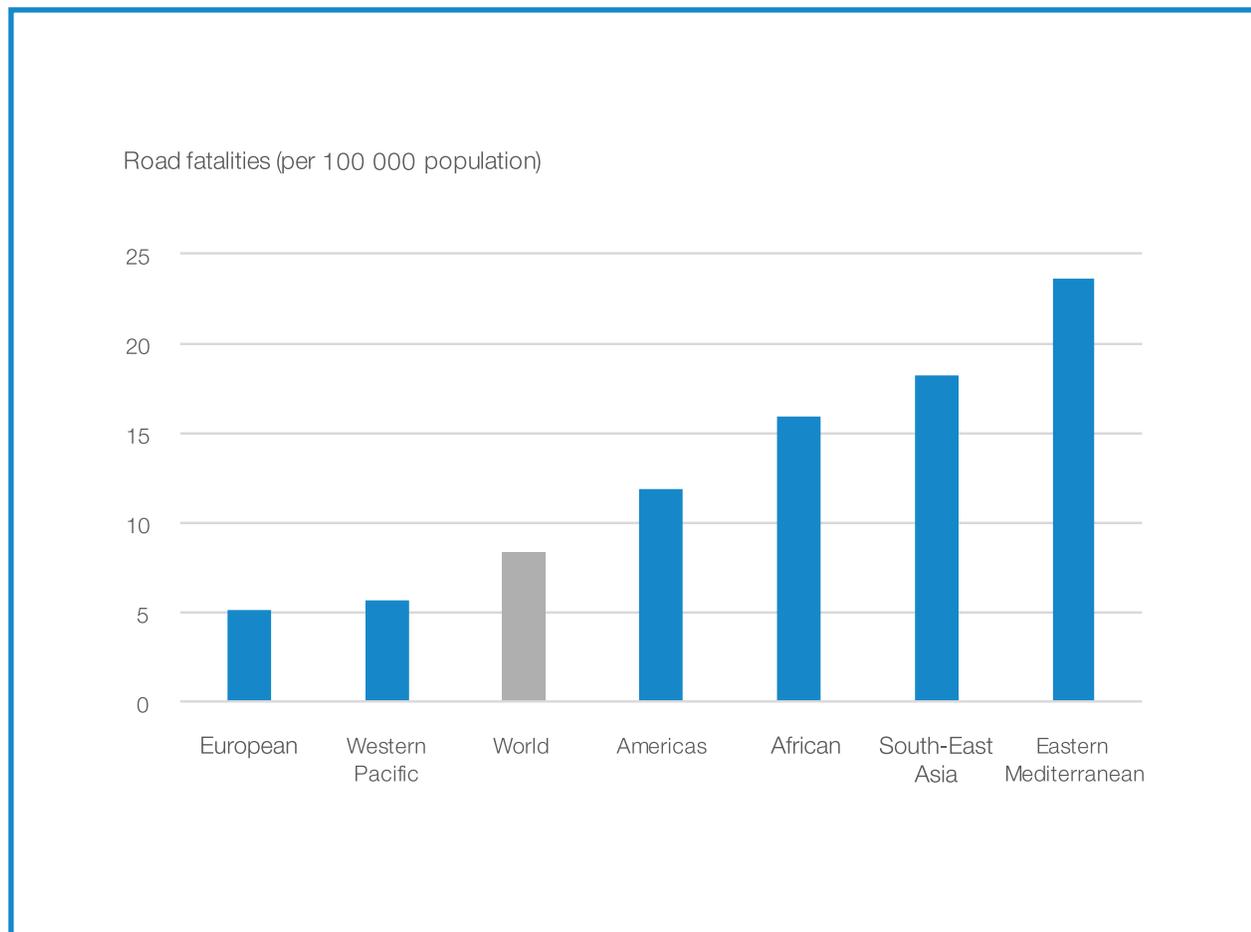
Violence and accidents

Homicide rates are generally low in the Region, with only Afghanistan having rates higher than the global average, and most countries have considerably lower rates. There are, however, high levels of gender-based violence in the Region, overviewed in subsequent sections.

Deaths from road traffic accidents are high in the Region and in high-income countries is the highest by quite some margin compared with other global regions (see Fig. 7).

WHO reports Saudi Arabia has the highest rate of road traffic fatalities in the Region (20).

Fig. 7. Road traffic fatality rates (per 100 000 population) in high-income countries, by WHO region, 2016



Note: "High-income countries" refers to Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates.

Source: WHO (21).

Summary

Good health for those with higher socioeconomic positions in every country provides the marker for what is possible to improve on, in order to “level up” health for the rest of the population.

A lack of data and evidence means that within-country inequities are difficult to identify in some areas, but where evidence on health inequities within countries is available it shows clear socioeconomic inequities in many areas: maternal and child health outcomes and in behaviours which give rise to NCDs and poor

health including undernutrition, obesity and smoking. The rest of the report outlines inequities in the social determinants of health which lead to within-country health inequities.

Our main recommendation in this area is for every country to develop a national social determinants and health equity plan. These plans should outline priorities and implementation for reducing health inequities within each country. Some countries in other regions have developed such plans and implemented strategies. Some are overviewed in the “taking action” chapter. Plans should include analysis of available national data on inequities and a clear plan for action based on the framework of this Commission’s report.

Recommendations

1. Develop national social determinants and health equity plans.

Use the framework of this report to develop a national plan with a monitoring framework.

2. Establish a monitoring framework and generate data on inequities in social determinants and health.

- Develop minimum standards for the data required for equity analysis, including the engagement of transnational organizations that collect or collate data.
- Research funding bodies should create a dedicated budget for generation and global sharing of evidence on social determinants of health and health equity, including research on interventions to enhance health equity.
- Establish different monitoring frameworks for countries at different levels of development.

Do something – Develop and improve coverage of vital registration of births and deaths. Develop mortality and morbidity indicators that can be stratified by sex as well as at least two social markers (e.g. education, income, occupation, ethnicity/race) and at least one geographic marker (e.g. rural/urban). Ensure that a survey such as DHS or MICS is conducted regularly. Obtain data on the health of vulnerable/disadvantaged groups.

Do more – Ensure universal vital registration coverage, including of people in vulnerable situations. Ensure regular, timely reporting of SDG indicators that relate to the conceptual framework set out in this report. Develop regular household surveys covering health, income, living conditions and labour market participation.

Do better – Ensure that SDG indicators relevant to this report and conceptual framework all accord with UN General Assembly Resolution 71/313: high-quality, timely and reliable data disaggregated by sex, age, geography, income, race, ethnicity, migratory status, disability and other characteristics relevant in national contexts. The system should include full monitoring of human rights and those in vulnerable situations.

03



COVID-19 AND INEQUITIES IN THE REGION

The COVID-19 pandemic has exposed and amplified existing social and health inequities and created new dimensions of inequity.

There are clear socioeconomic inequities in risks of infection and mortality from COVID-19 as a result of having to live and work in crowded, insanitary conditions and from being in poor health before infection. Inequitable roll out of vaccines between high- and low-income countries and between high and lower socioeconomic groups and those excluded, will further threaten health equity.

Inequities in infection and mortality from COVID-19

Global evidence shows clear socioeconomic inequities in rates of infection and mortality from COVID-19, which reflect existing social, economic and geographic inequities.

People in poor health, living in poverty or on low incomes, and those living and working in crowded conditions, unable to work from home or working in the health sector, care work and public-facing occupations are all at greater risk of contracting and dying from COVID-19 (22, 23). Underlying health conditions (particularly cardiovascular disease, diabetes and chronic respiratory disease) heighten the risk of severe illness and mortality from COVID-19 (24).



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Access to health care

Access to health care services has declined in the Region during the COVID-19 pandemic.

Disadvantaged geographical areas and social groups are generally served by under-resourced health services. In fragile and conflict-affected states, COVID-19 threatens to overwhelm already weakened health systems (25). In Somalia, physicians stated there were no ventilators and only two intensive care units with a total of 31 beds across the country in April 2020 (26). In Afghanistan, 15% of households stated they were unable to access adequate medical care between April and October 2020, and antenatal care reduced by 21% in 2020 compared to 2019 (27, 28).

Some migrant workers reported being unlikely to seek health care or testing for COVID-19 due to the risk of being quarantined and losing income, and when lockdown measures were lifted, some were still reluctant to visit health care facilities for fear of contracting COVID-19 (29, 30). The pandemic has also caused severe disruption to services for the prevention and treatment of NCDs (31). Temporary stoppages in immunization programmes across the Region have increased the risk of infectious diseases such as measles and poliomyelitis (32, 33).

Poor or lack of access to public health information is a significant barrier to controlling the COVID-19 pandemic (34). Inequities in access to relevant health information include lack of resources, limited access to the internet and language barriers (35).

Access to vaccines

To ensure equitable access, vaccines need to be affordable to low- and middle-income countries and those experiencing humanitarian crises and conflict. In all countries, it is essential that vaccines are available to the most vulnerable populations including refugees and IDPs, who should be fully incorporated into national planning processes (36).

Many countries in the Region will depend on the COVAX Facility for allocations of the COVID-19 vaccine. The allocations are expected to cover 20% of the population by the end of 2021, with no country being able to receive doses for more than 20% of the population until all of the countries in the financing group have been offered the same (37, 38). Recurring outbreaks are likely in countries with low levels of vaccination. It is essential that international assistance for the supply of vaccines and for logistics around distribution are provided to low-income countries.

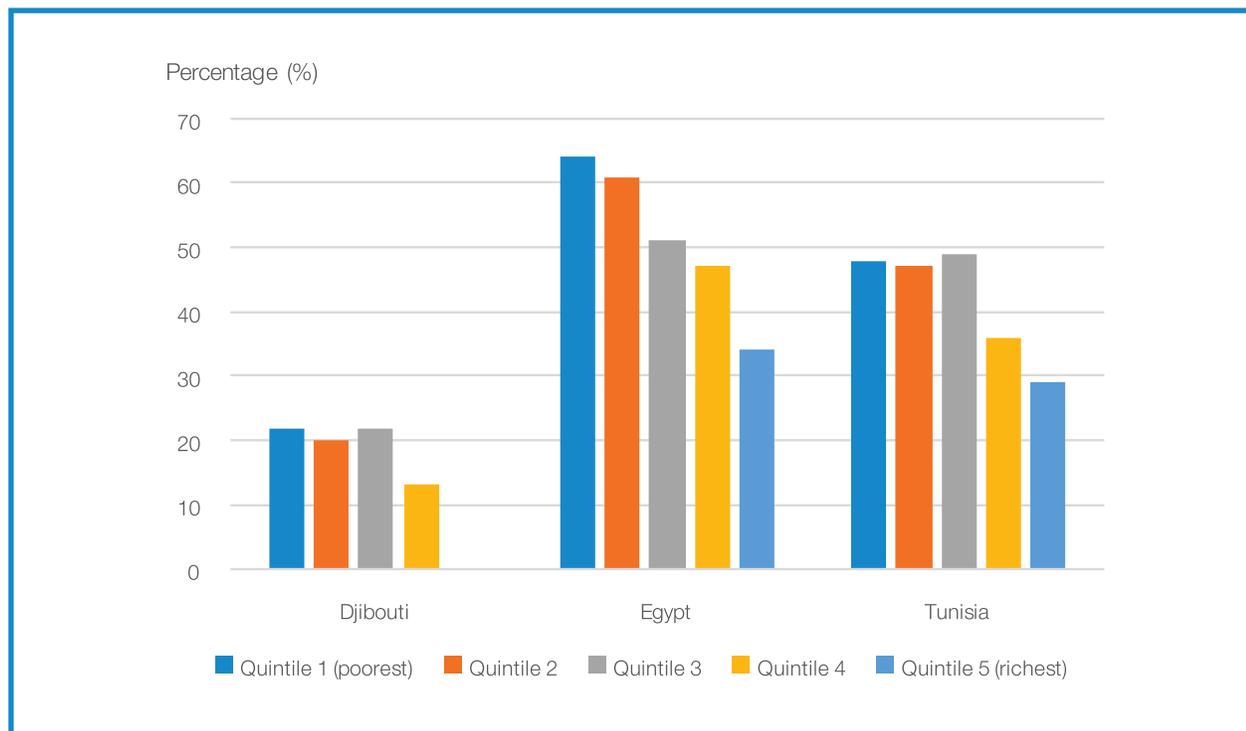
Inequities as a result of measures to contain COVID-19 infection

While the notified number of infections and deaths from COVID-19 are low in the Eastern Mediterranean Region compared with other regions, containment measures are having significant effects on the social determinants of health.

All of the countries in the world have been affected to some extent by economic declines and increasing poverty. In the Eastern Mediterranean Region, even wealthier countries have seen very concerning economic declines. In 2020, GDP was estimated to have decreased by more than 4% across the Region and by 13% in conflict-affected countries (39, 40). It is estimated it could take 10 years to recover to pre-pandemic levels of economic growth (41). Poorer people have been the worst affected.

For countries in the Region where data are available, the impacts of containment measures on employment among lower income workers are severe, putting those already vulnerable to poor health, poverty and unemployment at further risk (Fig. 8).

Fig. 8. Workers who stopped working (%) in selected countries in the Eastern Mediterranean Region, by income quintile, 2020



Source: Arezki et al. (2020) (42).

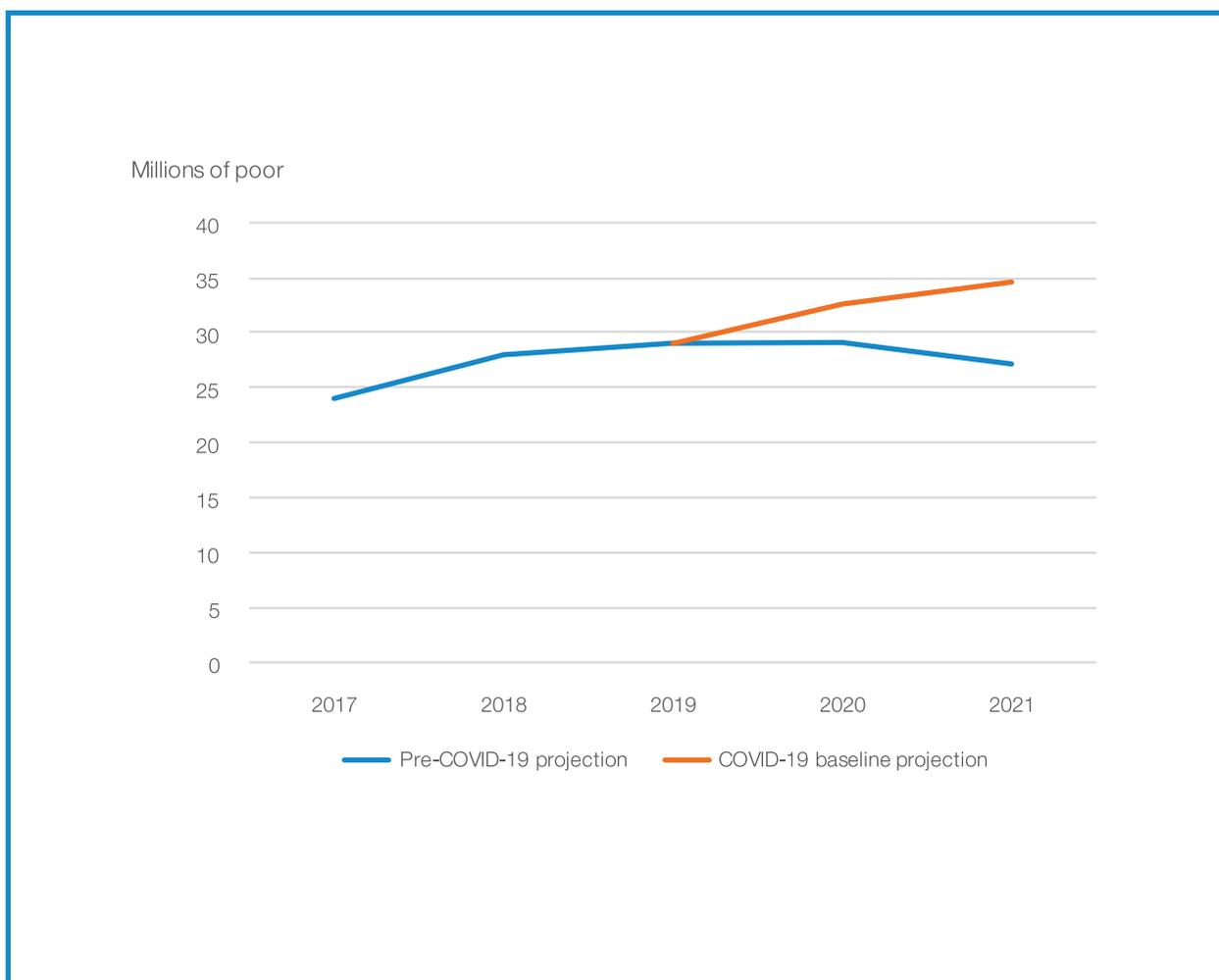
Impacts on income have not been felt equally and those already poor have been worst affected. In Morocco, only 10% of wealthy households report earning no income during containment measures, while 44% of the poorest households reported having no income (42). In Tunisia, 78% of workers in the lowest income quintile received no payment when they were not working; in contrast, 67% of those in the highest income quintile continued to receive either full or partial payment (42).

Reduced household incomes due to the pandemic have had immediate impacts on food security and nutrition. The countries in the Region that were already facing food crises have been the most severely affected.

In a number of countries in the Region, levels of poverty, food insecurity and undernutrition substantially increased during 2020 (43, 44). In Sudan, 9.6 million people were estimated to be food insecure for the period June–September 2020 – a 65% increase compared to the same period the previous year (27).

The World Bank estimates there will be an increase of between 2.8 and 3.4 million people living in extreme poverty (living on less than US\$ 1.90 per day) in the Middle East and North Africa region by the end of 2020, whereas prior to the pandemic the expected forecast was a decrease in extreme poverty, as shown in Fig. 9 (45).

Fig. 9. Forecast of extreme poverty (less than US\$ 1.90 per day) in the Middle East and North Africa, 2017–2021



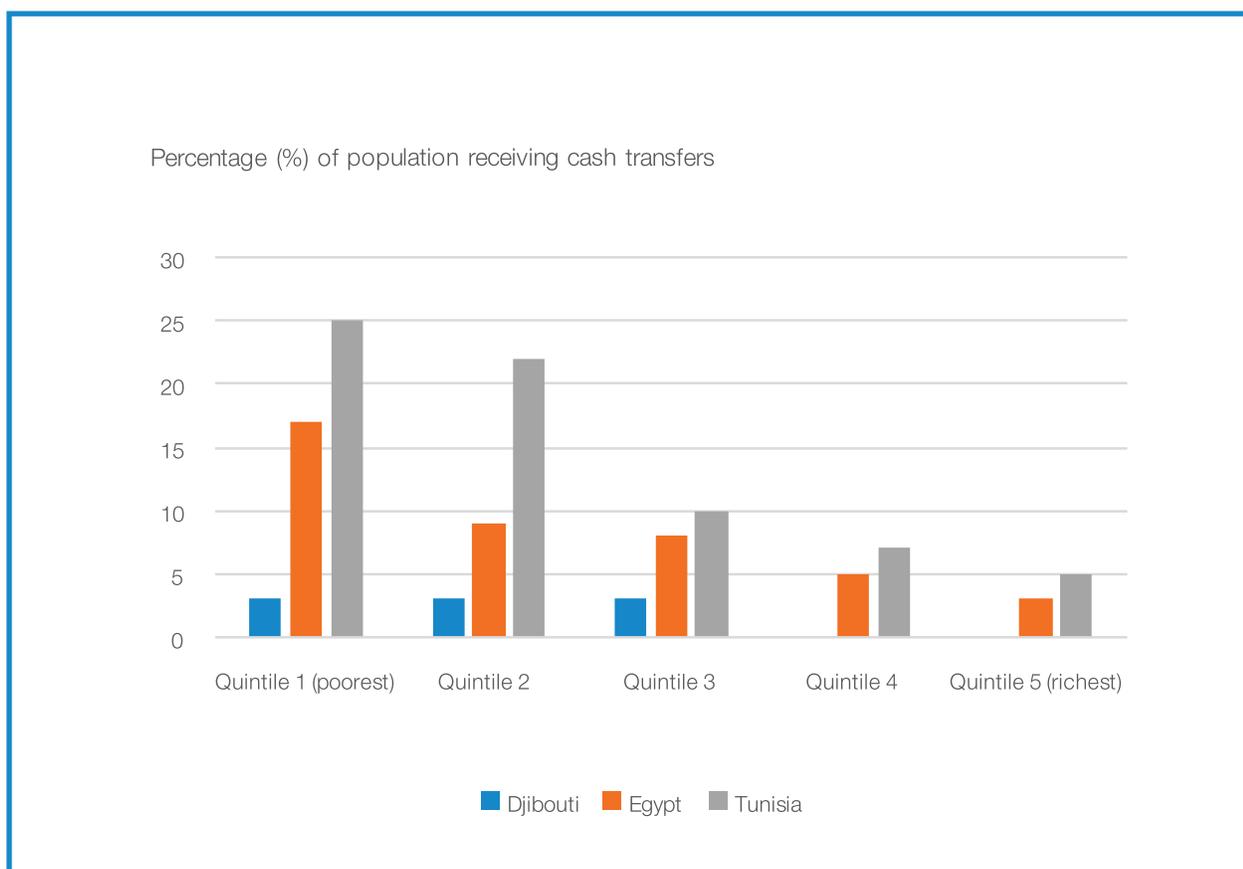
Source: Lakner et al. (2020) (46).

In the Region, there are low levels of social protection to support those who are in poor health, unemployed and with low incomes, and in some countries no social protection at all.

The damaging impacts of containment measures can be catastrophic for people affected without additional support. Various coping strategies for those affected include borrowing money, reducing use of essential

services and reducing food consumption (47). Despite the wide range of social protection support initiated in response to the pandemic in the Region, the World Bank warns that many of the cash transfer programmes implemented in the Region fail to reach the poorest households. Fig. 10 shows only 3% of the poorest households receive cash transfers in Djibouti, while Egypt has slightly higher rates, but still only 17% in the poorest quintile receive cash transfers (42).

Fig. 10. Share of population receiving cash transfers in Djibouti, Egypt and Tunisia, by income quintile, 2020



*Note: Data are from phone survey reports in countries in the Middle East and North Africa region, collected by the World Bank during the first half of 2020. The quintile breakdown is by household assets in Egypt, by income in Djibouti (the top quintile is not covered by the survey), and by consumption in Tunisia.
Source: Arezki et al. (2020) (42).*

Humanitarian agencies in the Region are faced with multiple and increasing humanitarian crises, rising poverty levels and higher demands on humanitarian assistance.

In Afghanistan in 2020, the number of people requiring humanitarian assistance increased to 18.4 million, a

close to 100% growth in one year (48), at the same time, the amount of international funding is declining. In 2019, global international humanitarian assistance fell from US\$ 31.2 billion to US\$ 29.6 billion (49), and in the Region there is expected to be close to a 70% shortfall in funding for UNICEF, the highest shortfall among all UNICEF regions (50).

The COVID-19 pandemic will exacerbate existing educational inequities.

Students who lack easy access to the internet, a mobile phone, a personal computer, or a quiet space to study, will suffer more than learners who have these advantages. In a UNICEF survey, 95% of respondents in countries in the Region stated their children were negatively affected by the consequences of the pandemic. Lack of access to computers or limited internet connections were the main factors preventing students from accessing distance learning (51).

The pandemic is also projected to have significant effects on gender inequities.

Violence against women and girls has increased, girls have less access to online education than boys, and

women have taken on more unpaid household and caring roles during containment measures (52).

Summary

The social and economic impacts of the pandemic and associated containment measures have been hugely damaging in the Region, and will worsen health and health equities, undermine development and stall progress towards the Sustainable Development Goals (SDGs). While these challenges are substantial, the pandemic is also an opportunity to reduce inequities, put social justice at the heart of decision-making and foster a whole-of-society endeavour to improve health and reduce inequities. In short – to build back fairer (53).

Recommendations

1. Reduce inequities in infection and mortality by addressing the underlying causes of inequities and taking steps to minimize inequities in exposure.

- Intensify communication about COVID-19 risks in informal settlements, IDP and refugee camps, rural areas and among migrant workers. Work with communities to develop communication plans and use pharmacies and community workers to disseminate information.
- Urgently ensure sanitation, hygiene, access to clean running water and soap in all IDP and refugee settlements and schools.
- Improve migrant workers' accommodation, reduce crowding, improve ventilation and ensure access to clean running water. Provide free testing and transportation to testing sites for migrant workers.

2. Mitigate the unequal impacts of containment measures on unemployment, income, hunger and gender equity.

- Develop and implement plans to build back fairer based on this report.
- Ensure emergency social protection and nutrition support to include everyone with low incomes in every country (not just those on the very lowest incomes) and provide financial support to quarantined workers.
- Take steps to reduce the increased incidence of mental illness and expand access to mental health services.

3. Implement equitable vaccination programmes.

- Develop equity-driven national vaccine roll-out plans with consideration for risk of exposure.
- Wealthier countries should help secure and fund vaccinations for lower-income countries in the Region and promote cooperation, particularly through mechanisms such as COVAX.
- Prioritize actions to reduce vaccination hesitancy.

04



CONFLICT AND CONSEQUENCES, AND MIGRATION

This section focuses on the impacts of conflict and migration, sanctions and occupation on health equity and the social determinants of health in the Region. We do not explore the complex drivers of conflict, nor how to resolve it – these are beyond the remit of this Commission – but point out the myriad impacts of conflict on health and health equity, and propose that health equity should be a prime consideration in international responses and in peace and reconstruction efforts in the Region.

Focus the humanitarian response to conflict and emergency situations on the social determinants of health, equity in health and dignified lives



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Nearly half of the 22 countries and territories in the Region are currently in an acute or protracted state of emergency. Levels of conflict have increased since 2010, with more than 150 000 deaths annually since 2014.

Life expectancy for both men and women have decreased in Libya, Syrian Arab Republic and Yemen since 2010 as a result of conflict and in 2014 more than half of all deaths in Syrian Arab Republic were attributed to conflict (54). As well as direct harm to health and damage to infrastructure, conflict also leads to widescale migration and high numbers of refugees and IDPs, poor living and working conditions, and highly unstable economic and social contexts – consequences which increase social, economic, gender and health inequities. Table 1 provides a summary of the direct and indirect effects of conflict on health and the social determinants of health.

Table 1. Direct and indirect consequences of conflict on health and the social determinants of health

Conflict consequence	Types of actions	Effects on health and social determinants of health
Direct (battlefield)	Armed conflict <ul style="list-style-type: none"> • Small arms, grenades, artillery, mines, bombs, air attacks • Torture, sexual violence • Kidnapping, assassinations, imprisonment • Besiegement 	Combat deaths and injuries Combat-related illnesses <ul style="list-style-type: none"> • Infectious diseases, cardiovascular and respiratory diseases • Sexual and reproductive health • Mental health, e.g. post-traumatic stress disorder • Malnutrition, anaemia
	Destruction and disruption of: <ul style="list-style-type: none"> • health facilities and systems • schools and education systems • housing • water and sanitation systems • food production and distribution • infrastructure (roads, power, transportation) Economic disruption <ul style="list-style-type: none"> • Destruction of factories, agriculture • Commercial, banking disruption • Exodus of people and their skills (health care workers, teachers, etc.) Resources diverted to conflict <ul style="list-style-type: none"> • Fewer resources for social needs, e.g. health, education, social protection, infrastructure • Reduced subsidies • Reduced capacity of and confidence in the public sector Focus on survival more than healthy behaviours	Inadequate health care access and quality <ul style="list-style-type: none"> • Reduced availability of equipment and supplies • Reduced health care and public health functions Inadequate education access and quality <ul style="list-style-type: none"> • Reduced pre- and general school enrolment • Gender imbalance in schools • Reduced safe and secure shelter Destruction of infrastructure and essential supplies Inadequate housing, electricity and fuel, water and sanitation Increased pollution Increased prices for food, transport, water Unemployment and reduced family income Interrupted safety nets <ul style="list-style-type: none"> • Pensions and support for elders • Poverty reduction programmes (e.g. cash transfers, food support) Reduced personal care <ul style="list-style-type: none"> • Poor diet, lack of exercise, smoking
Indirect		

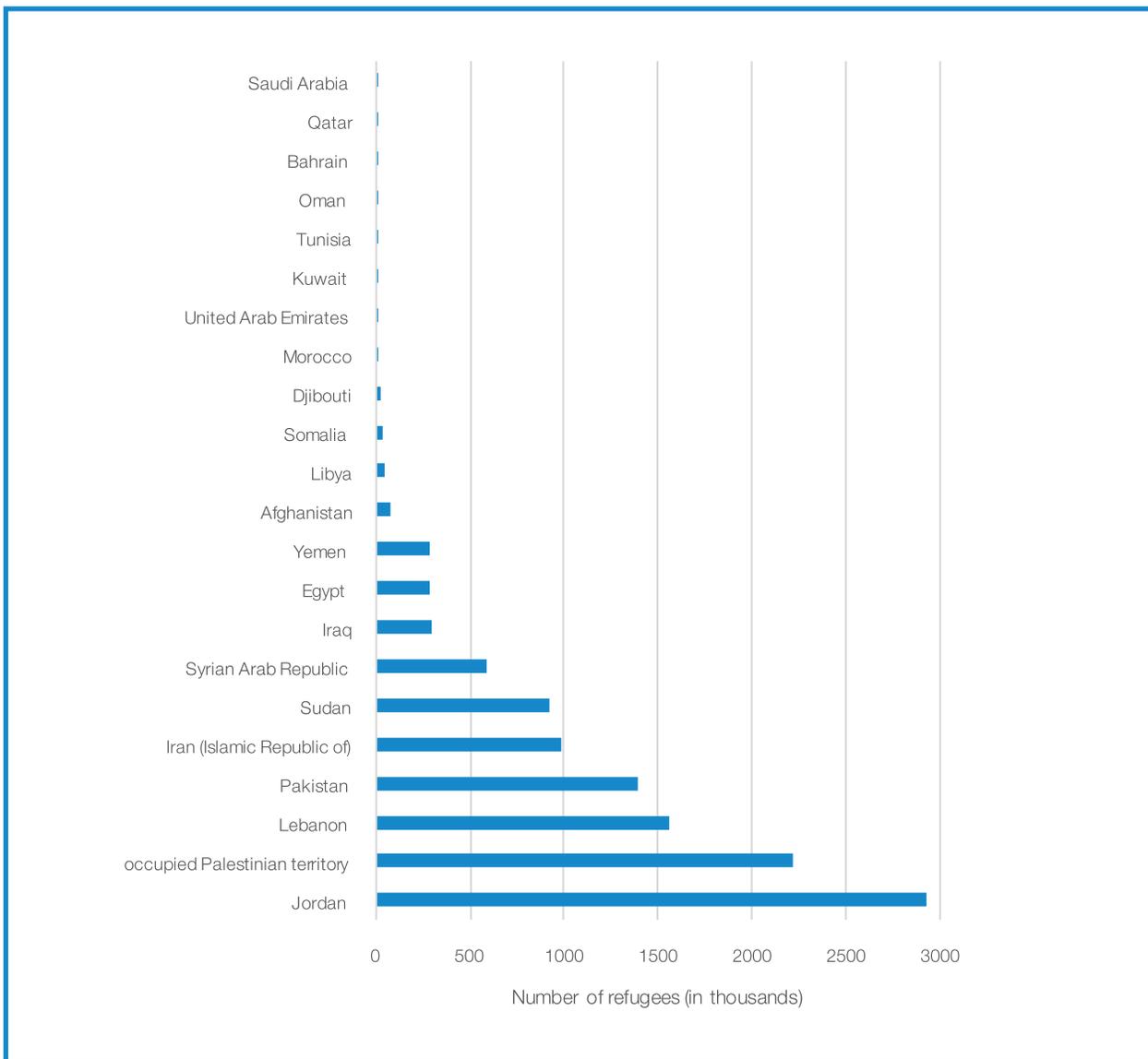
Given increasing levels of conflict in the Region since 2010, it is abundantly clear that health inequity has directly and indirectly increased as a result. There are opportunities to prioritize the social determinants of health in reconstruction and peacebuilding initiatives, in addition to the immediate focus on health care. This Commission recommends that humanitarian agencies and those charged with responding to crises in emergency settings also have a broader remit and a greater role in achieving better long-term outcomes in the social determinants of health.

Place the health of migrants and host populations at the forefront of migration policy

The Region has long been a destination for economic migrants and also hosts the largest number of international refugees and IDPs in the world. Many host countries have seen particularly rapid increases in numbers seeking refuge in recent years as levels of conflict escalate.

Precise numbers are elusive, but by 2019, an estimated nearly 7 million refugees had left Syrian Arab Republic as a result of conflict, and over 6.5 million had been internally displaced (55). Islamic Republic of Iran, Jordan, Lebanon and Pakistan have hosted large numbers of refugees as a result of conflict in neighbouring countries, as shown in Fig. 11.

Fig. 11. Number of refugees (in thousands) by host country or territory in the Eastern Mediterranean Region, 2019



Note: Refugees refers to “the number of people that are recognized as refugees under the 1951 Convention relating to the Status of Refugees and its 1967 Protocol or under the 1969 Organization of African Unity Convention Governing the Specific Aspects of Refugees Problems in Africa; those granted refugee status in accordance with the United Nations High Commissioner for Refugee Statute; those granted humanitarian status or temporary protection by the State in which they find themselves those in refugee like situations; and Palestinian refugees registered with the United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNWRA). Data includes asylum seekers” (56). The estimates are also based on end of year 2017 estimates of refugee populations and refugee-like situations (57).
 Source: UN international migration data (2019) (56).

While countries in the Region have offered refuge to millions of people seeking safety, the resources in host countries are under severe pressure and greater help and international support is required to ensure that they are not further damaged. Legal status in the host country is critically important for the well-being of migrants and often determines their level of access

to health care and other social services (58). In some countries, children with no legal residence do not attend school, and in others, child labour is a common practice to help support refugee and migrant families (59). There have been a range of initiatives to improve conditions for migrants and refugees, but these are not at the scale to have sufficient impact.

Economic migration is directly related to poor outcomes in the social determinants of health in the origin country, including poverty, poor educational standards, unemployment, poor housing and living conditions, lack of access to food and social services, religious persecution, and legal status (60).

Some countries, predominantly GCC countries, attract large numbers of inward economic migrants from countries and territories both within and outside the Region. In some of these countries, migrants make up over three quarters of the total population (61). Many low income migrants suffer poor living and working conditions, and there is evidence of abuse of domestic and construction workers in some GCC countries (62).

Migration policies must be central to the development agenda in the Region and based on the overall vision that migrants and refugees should have the same rights as citizens in accessing health care and education, and to safe and fairly paid employment. Most countries and territories have committed to working towards the SDGs, which indicates a clear justification to demand humanistic migration policies; however, such policies are generally weak at present. It is also important to recognize the positive impacts that migrants' contributions can have on the development of host countries. With well planned integration, migrants can fill key roles in the labour market, and often bring with them special skills useful for the host country's economy.

Highlight and mitigate the negative impact of sanctions on health and the social determinants of health

Imposing sanctions on countries and territories is a tool used largely to leverage political change and contain perceived threats, but such strategies have profound socioeconomic and health impacts on the general population, particularly the most disadvantaged populations.

The health effects of sanctions are rarely assessed or incorporated into policies aimed at coping with and recovering from sanctions. However, sanctions harm health and evidence shows reductions in maternal and child survival rates. Sanctions also lead to disruptions to the medical supply chain leading to medicine and equipment shortages, reductions in health care workforce and reduced funding for health care.

Sanctions also harm the social determinants of health, reduce countries' GDP (63), increase inflation and

unemployment and widen income inequities (64, 65). Food availability is directly and often acutely restricted by sanctions and inflation makes even staple foods unaffordable for large segments of the population. Sanctions also harm education, particularly for low-income households; reductions in government revenues limit funding and children are less likely to attend school due to increases in child labour.

Unlike wars, international humanitarian law has no regulations for sanctions (66). The application of sanctions should incorporate specific cut-off thresholds for unintended consequences on civilians, which trigger the easing or redirecting of sanctions and expanded humanitarian responses when the threshold is reached. This process should include a mandate to monitor, assess and report on the health equity impact of sanctions on the affected populations and whether such thresholds have been crossed.

Abide by United Nations resolutions on the occupied Palestinian territory

Occupation severely impacts health and multiple social determinants of health in the occupied Palestinian territory.

In 2019, the occupied Palestinian territory had a population of 4.98 million, with almost 70% of the nearly 2 million people living in the Gaza Strip registered as refugees (67). For many Palestinians in the occupied Palestinian territory, access to safe water, food, waste removal and housing are limited and in Gaza, in particular, agriculture and fishing have been harmed through embargo, military targeting and pollution from untreated waste. Additionally, there are longstanding restrictions on freedom of movement which have exacerbated the human rights situation and undermined access to health care, education and work (68). Employment opportunities are restricted and many Palestinians live in poverty and engage in dangerous work, and there are high levels of unemployment. There are also low levels of social protection available, although United Nations (UN) organizations and other agencies provide some essential support.

Despite the challenges, there have been many achievements in the occupied Palestinian territory, particularly in provision of education and health care. UNRWA provides social services in the West Bank and Gaza Strip to provide additional relief and assistance to Palestinian refugees. Many civil society and faith-based organizations operate in the occupied Palestinian territory, and ensure access to services and support.



Recommendations

1. Focus humanitarian response to conflict and emergency situations on the social determinants of health, equity in health and dignified lives.

- Ensure that the social determinants of health are addressed, along with emergency health care, by emergency relief, humanitarian and aid agencies.
- In addition to ensuring access to water, sanitation and shelter, prioritize long-term improvements in access to the key social determinants identified in this report.
- Humanitarian agencies should increase action to prevent conflict through improvements in the social determinants of health.

2. Place the health of migrants and host populations at the forefront of migration policy.

- Increase international/external aid for refugees.
- Comply with human rights obligations and the relevant SDGs for everyone, including conflict-affected populations.
- Ensure registration and access to services for migrants and allow refugees to work.

3. Highlight and mitigate the negative impact of sanctions on health and the social determinants of health.

- Improve systematic monitoring and reporting on the impact of sanctions on civilian populations.
- Establish specific cut-off thresholds for consequences for civilians that will trigger easing of sanctions.
- Establish clear exemptions from sanctions as part of international law.

4. Abide by UN resolutions on the occupied Palestinian territory.

- Ensure that human right protections from violence are followed, including the right to health.
- Implement SDG 16: Promote just, peaceful and inclusive societies.
- Focus on social protection and the social determinants of health, as set out in this report.

05



ECONOMIC DRIVERS OF HEALTH INEQUITIES

Having sufficient income to lead a healthy life is a basic tenet of action on the social determinants of health. Even in low-income countries in the Region, there is great scope to reduce poverty, provide effective social protection and public services to those on low incomes, and lessen economic inequities in order to improve health.

Developing measures of progress which capture social, economic and health progress, rather than relying solely on GDP, is an important way to establish health equity at the heart of government.

Implement progressive fiscal policy

Wealth and income inequity is a major feature of the Eastern Mediterranean Region. This is largely a result of political decisions and widespread inequities in wealth and power, which affect the appetite for economic reform. Monetary policy, social protection spending and tax systems should aim to be redistributive, designed to improve the standard of living of communities and populations most at risk of poverty and poor outcomes, and provide sufficient public finances to fund essential services for all.

Many countries in the Region have low levels of economic resources and development, but there is still scope for redistribution of available resources to improve health equity. For countries with abundant resources and wealth – of which there are many in the Region – there is great potential to focus much more on equity and to ensure that health equity is a priority in regional economic policies.



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Income and poverty

Both wealth and income inequity have significant negative impacts on health, and the Region is lagging behind other regions in implementing measures to provide more equitable distributions of economic wealth.

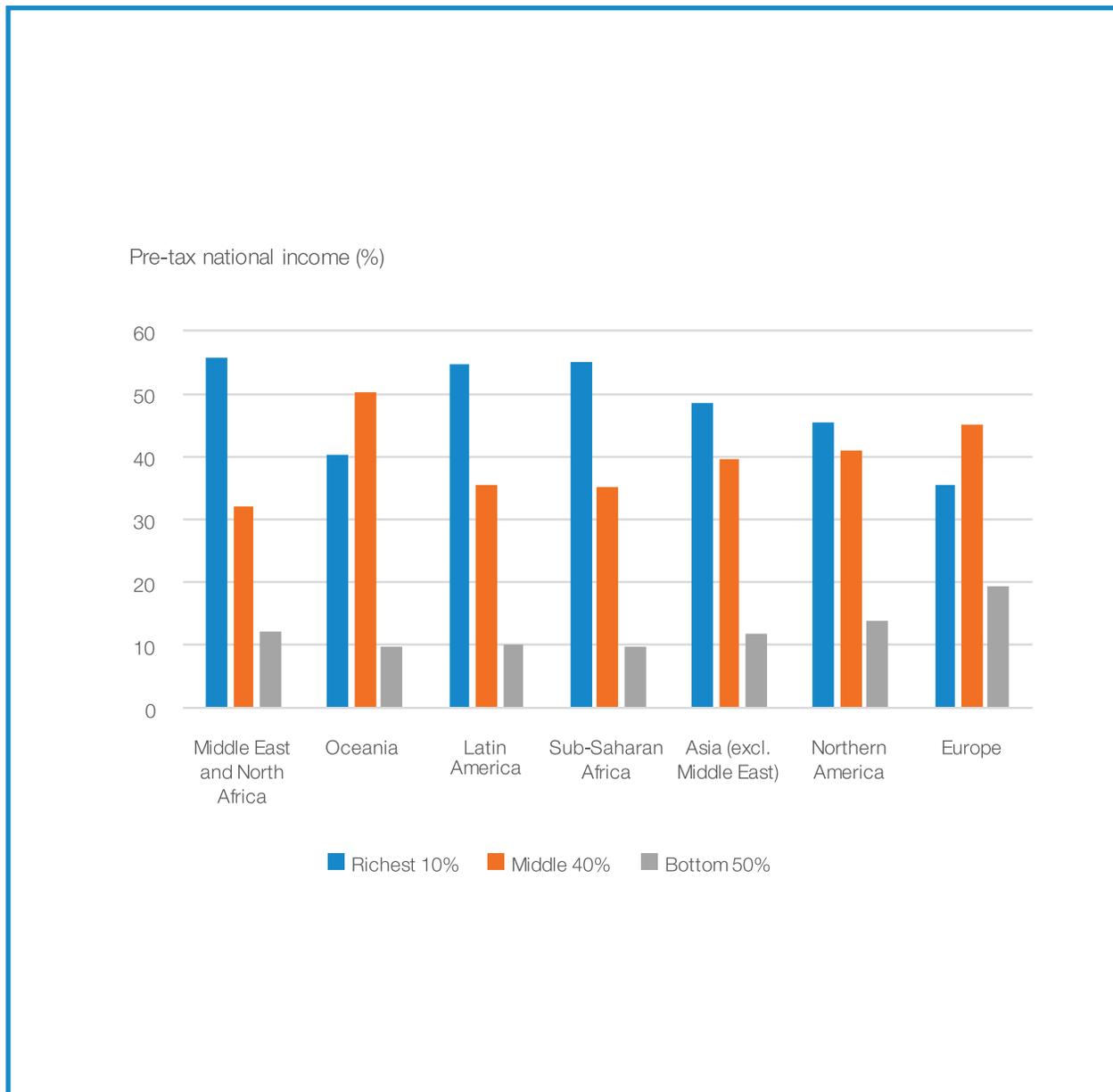
Since 2010, a number of countries in the Region have experienced declines in national income per person. In Djibouti, Egypt, Yemen, and occupied Palestinian territory, levels of poverty (defined as the percentage of the population living on less than US\$ 5.50 per day) increased between 2010 and 2017 (69). The impact of COVID-19 containment measures will depress national incomes still further.

This Commission therefore recommends the development of levels of minimum income for healthy living, appropriate for each country context, to underpin fiscal policies and social protection systems. Nationally-defined minimum income standards for a healthy life would require that social protection and minimum wage policies are pegged to the level sufficient to support a healthy life. Additional services and financial support need to be made available to those who fall below the threshold.

Income inequity

Income inequity is exceptionally high in the Region and has increased, albeit slowly, since 2010. As shown in Fig. 12, income inequities are most pronounced in the Middle East and North Africa, where the richest 10% of the population hold close to 60% of the pre-tax national income while the lowest 50% hold just over 10% (70).

Fig. 12. Percentage of pre-tax national income for richest 10%, middle 40% and bottom 50% of the population, by region, 2019

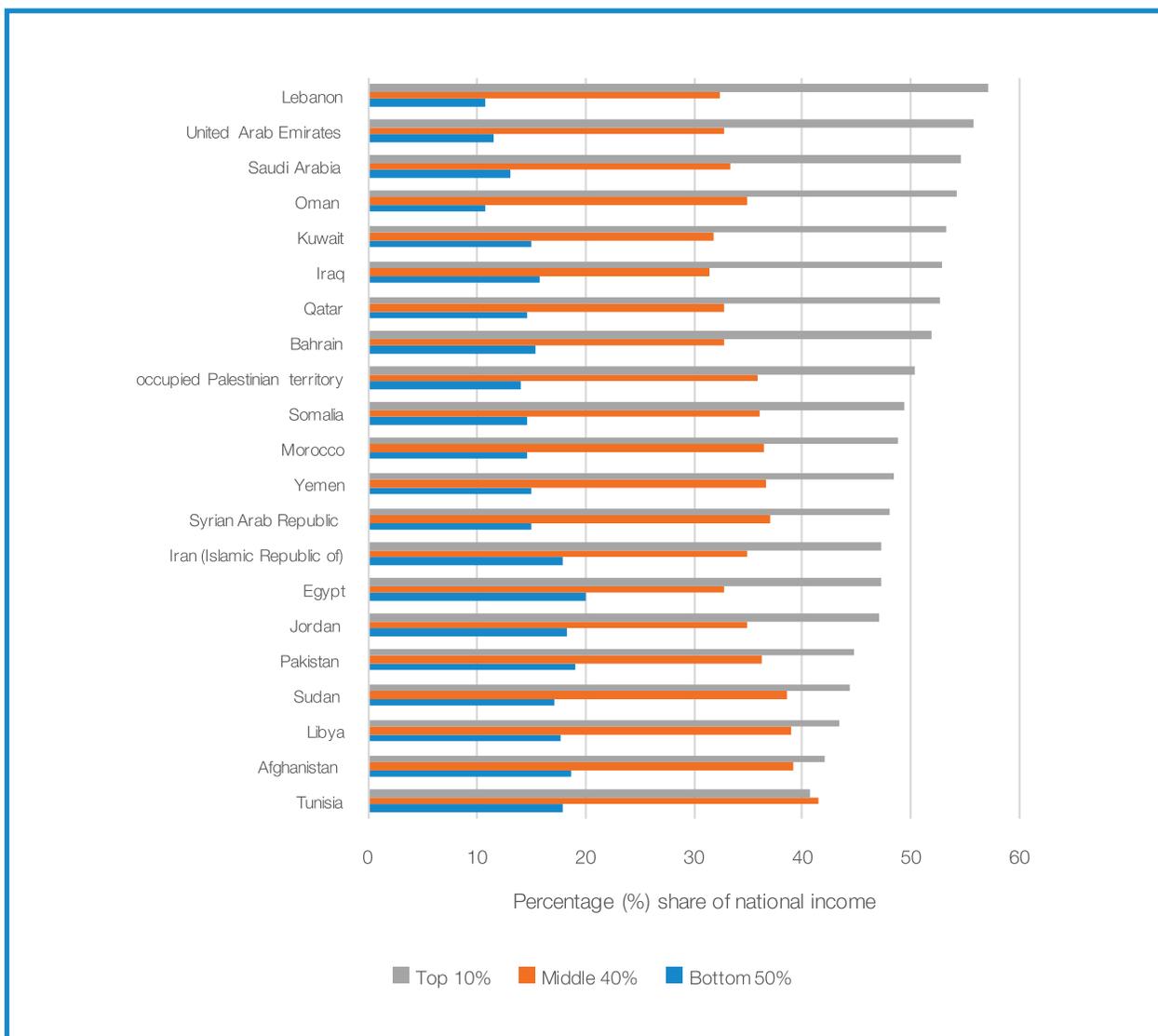


Source: IHE analysis of data from the World Inequality Database (2020) (70).

Based on estimates for countries in the Middle East, the richest 1% held 27% of pre-tax national income in 2016 (71). Even excluding GGC countries, the other countries in the Middle East still have higher income inequities than the United States of America and Europe.

Lebanon has the most unequal distribution of income among the countries of the Eastern Mediterranean Region. Tunisia has the lowest income inequities and is the only country or territory in the Region in 2016 where the middle 40% received a slightly higher proportion of pre-tax national income than the top 10% (Fig. 13).

Fig. 13. Percentage share of pre-tax national income for the richest 10%, middle 40% and bottom 50% of the population in countries and territories in the Eastern Mediterranean Region with comparable data available, 2019



Source: World Inequality Database (2020) (70).

Taxation

Income tax is one of the main ways to redistribute income, while inheritance tax, corporate taxes, social protection and public services help to mitigate the effects of high income inequity. Research shows that tax progressivity is an effective tool to combat income inequity, and countries with relatively high levels of progressive tax are able to reduce inequity as a result (72, 73, 74). OECD countries have reduced levels of inequity, measured by Gini coefficient, by over 25% through increased taxation and have concurrently

reduced poverty rates, including child poverty (75, 76). In the Region, both personal and business taxes are low and there are high rates of tax evasion by individuals and businesses. According to World Bank data, in 2018, average global tax revenue as a percentage of GDP was 14.4% (77), only four countries in the Region have global tax revenue above 14.4%.

Tax evasion (78) is a common problem for many countries in the Region, with groups and companies in the higher income brackets most likely to evade taxes.

In Egypt, an estimated amount equivalent to 7.2% of GDP is lost through tax evasion and in the occupied Palestinian territory and Morocco, half of the eligible tax income is evaded (79, 80). The amount of tax that countries in the Region lose to corporate tax abuse annually is over US\$ 9.3 billion.

Given the high level of income inequity in the Region, and the relatively low levels of taxation coupled with high rates of tax evasion, it is clear the taxation systems are currently insufficient to reduce income and wealth inequity or support greater investment in economic and social development (81). This Commission calls for the introduction and/or expansion of progressive taxation systems in countries of the Region.

Levels of social protection

Adequate social protection is an essential way to improve health, reduce inequities in health and other key social determinants, and enhance overall social cohesion and socioeconomic development (82, 83).

A lack of adequate social protection can leave people susceptible to poverty, destitution and the associated poor health outcomes. Social protection systems are cost-effective, costing countries on average about 1.5% of GDP according to the World Bank (84). The Region has low levels of adequate social protection, the lowest of the World Bank global regions, except South Asia (85).

There are marked differences in the coverage of social protection and labour programmes across countries in the Region, ranging from over 80% population coverage in Iraq to less than 10% in Afghanistan, Sudan and Syrian Arab Republic. Even though overall levels of social protection are low, there are good examples of the way forward from countries in the Region that have introduced social protections, including conditional and non-conditional cash transfer schemes.

The UN has recommended that countries in the Region progressively establish social protection floors (86). This Commission also recommends the urgent progressive implementation of social protection floors by all countries of the Region, with support from WHO, to ensure that they are most beneficial to health equity, with extended coverage for countries which have sufficient resources to achieve higher coverage.

Increase official development assistance to 0.7% of gross national income for wealthy countries in the Region

Official development assistance (ODA) refers to “government aid designed to promote the economic development and welfare of developing countries” and is an important way for wealthier countries to support development and health of less wealthy countries (87). The target outlined by the United Nations is that developed countries should allocate 0.7% of their GNI to ODA (88).

In 2019, none of the wealthier countries in the Region was providing ODA to that level and there had been decreases from 2018. As a result of the COVID-19 crisis, ODA will further decrease, even as lower-income countries’ need for resources increases significantly. For recipient countries in the Middle East and North Africa region, only 10.5% of development assistance for health came from donors within the same region in 2017 (89).

This Commission recommends that all wealthier countries in the Eastern Mediterranean Region increase their ODA to the level of 0.7% of GNI, and that beneficiary countries use these resources to invest in achieving greater health equity through implementation of the recommendations made in this report.

Policies should be directed to the public good

The generation, management and distribution of countries’ economic resources, directed towards the public good, can lead to health benefits, as well as supporting progress on social development; this includes greater regulation of the commercial sector and investment in public services and assets.

This Commission outlines that to reduce health inequities, available public resources should be allocated at sufficient scale and according to level of need and deprivation. The aim is to foster universal public services and interventions which are equitably and proportionately implemented – proportionate universalism.

Government investment in public services

The more countries spend on services such as health care, education, housing and sanitation, the better the population health outcomes. There are huge inequities in government expenditure on public services across countries in the Region. Compared to other regions, the rates of military expenditure are extremely high and considerably outweigh expenditure on health care, which is on average lower in the Eastern Mediterranean Region than globally.

Commercial determinants of health

Poor quality food, tobacco products, air pollution, and unsafe and unhealthy workplace practices proliferate in the Region and affect the health of lower-income households the most, widening health inequities (90). This Commission also views commercial practices which produce unsustainable greenhouse gas emissions and damage to the natural environment as commercial determinants of health.

Measures to influence, regulate and reduce the harmful health impacts of commercial practices and products remain underdeveloped and the capacity and

willingness of governments to tackle the damaging impacts of large corporations remain weak, damaging health and health equity.

Measures of progress

This Commission recommends the development of regional and/or national measures of progress which encapsulate priorities for social development and health in the Region and which take account of levels of inequity. This would be a highly significant step towards reprioritizing well-being and equity for countries and their populations in the Region.

Throughout the report, we highlight the way national policies and programmes can make improvements to social, economic and health outcomes, even in countries with low levels of resources. Despite the significance of other factors in improving health and development, most measures of countries' progress rely on single measures of economic status – usually a country's GDP. Focusing solely on GDP as the main measure for development and progress has inevitably led to a marked focus on increasing GDP, even at the expense of health and, we would add, equity (91).

Recommendations

1. Implement equitable fiscal policy.

- Increase levels of progressive taxation, ensuring efficient collection and reducing tax avoidance.
- Ensure that spending is allocated according to the principle of proportionate universalism – spend more on the areas of greatest need.
- Develop national standards for a minimum income for healthy living as the standard for social protection and minimum wage policies.
- Fund the public sector adequately and regulate to provide equitable and quality services.
- Meet the UN social protection floor.

2. Increase official development assistance to 0.7% of gross national income for wealthy countries in the Region.

- Support lower-income countries to improve health, reduce inequities and achieve the SDGs and human rights.
- Support greater economic inclusion of refugees, migrants and IDPs.

3. Policies should be directed to the public good.

- Develop measures of national progress which are based on equitable social and economic development rather than relying on GDP to measure progress.
- Enact and implement legislation to regulate health-damaging corporate practices and products.

06



CULTURE AND SOCIETY IN THE EASTERN MEDITERRANEAN REGION

Religious beliefs, gender norms and attitudes towards migrants shape the health of all people in the Region. All three of these aspects of culture and society are particularly important in the Eastern Mediterranean Region.

Strengthen collaboration with religious leaders and organizations to support health equity

In the Eastern Mediterranean Region, religion is integral to the identities, behaviours and attitudes that have important effects on people's health and social determinants of health. Religion has the potential to be a powerful ally to the Commission's central themes of health equity, fairness and dignity and religious leaders can be influential contributors to societal endorsement for the agenda and in implementing recommendations.

Global evidence shows that religious practice is associated with good health and faith-based organizations in the Region provide essential services and funding to low-income and excluded communities. However, there are variations in the support for health provided by religious leaders and organizations and there are some damaging beliefs and practices which harm health. While the Report draws attention to the positive role of religious leaders and faith-based organizations, it acknowledges that this is not always the case.



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For those working to improve health and health equity in the Region, strengthening collaboration with religious leaders and organizations can support progress towards the SDGs and greater health equity. To ensure contributions are positive, criteria for partnerships and the scrutiny of religious organizations need to be established. Human rights principles should be mainstreamed in all facets of life, alongside zero tolerance of any violations under the pretext of cultural specificity and misinformed religious interpretations.

Achieve progress in gender equity

Gender is a key social determinant of health for both men and women.

Deep-seated inequities in attitudes towards men and women include expectations about the family roles and domestic tasks that girls and women should perform, what girls and women should aim for in life, and how they should shape their identity. This includes norms about the appropriate age of marriage, numbers of children to have, domestic roles and the appropriate level of education, and affects political and community influence, decision-making and levels of autonomy among women. The Eastern Mediterranean Region has the highest levels of gender inequality measured by the Gender Inequality Index compared with other global regions, although levels vary between countries in the Region.

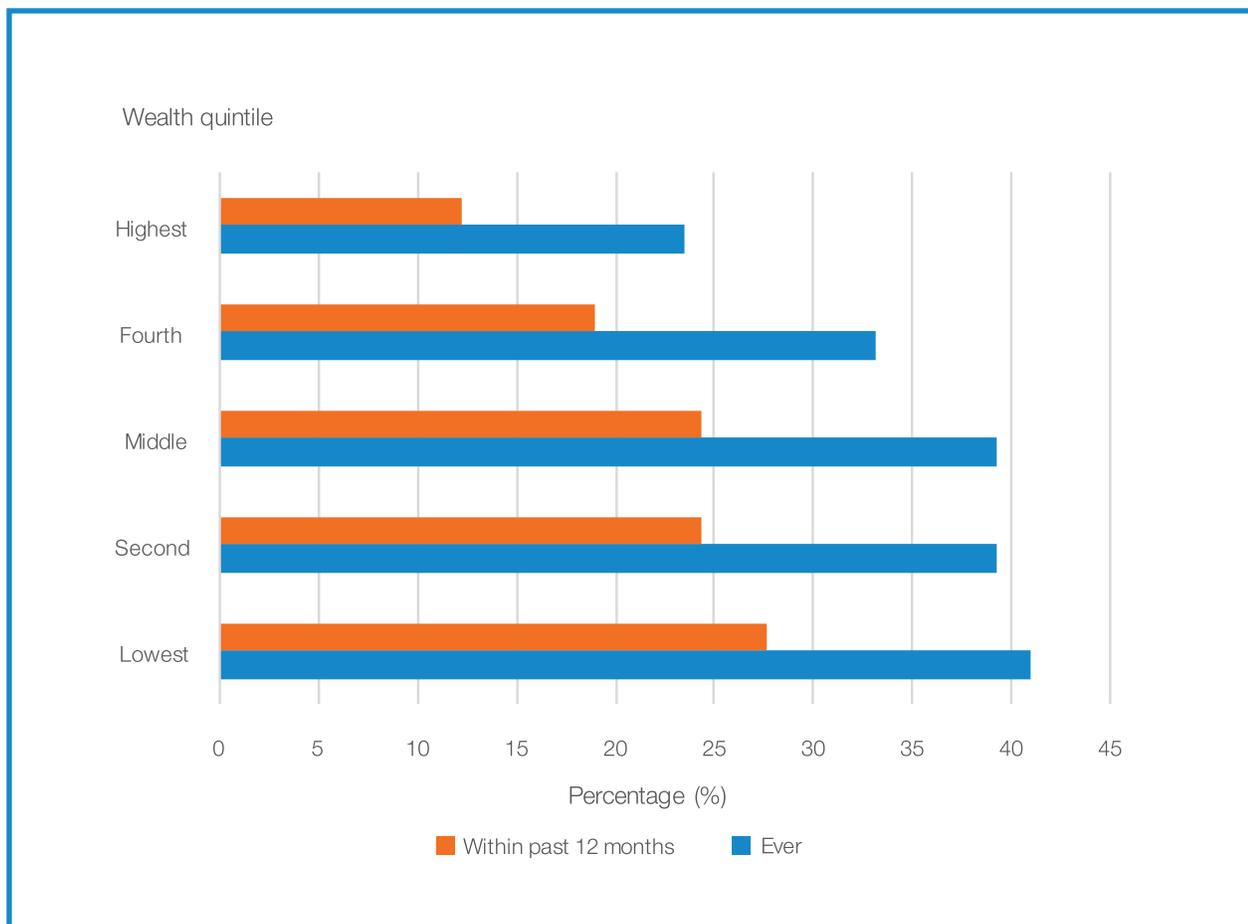
The World Bank has outlined that women who are better educated are more likely to be knowledgeable about health care and nutrition and to marry later and have healthier children (92). An average child gains an extra 0.32 years in school for each additional year of their mother's education (93, 94) and better educated women are more likely to be engaged in the formal labour market and to have higher incomes (92). UNICEF has shown that there is a 0.37 percentage point increase in GDP for every percentage point increase in female education and this can help to support national development (95).

Gender inequities mostly affect and damage girls and women, but boys and men are also negatively impacted by some gender norms and biases. These are reflected, for example, in male risk taking and health-harming behaviours, being expected to be

involved in conflicts and to meet cultural expectations around status and income, and stereotypical masculine identities that can undermine physical and mental health (96).

While gender norms affect everyone in the Region, they are particularly damaging for those with less education and income. Gender inequities intersect with socioeconomic inequities and lead to poorer, less educated women experiencing multiple inequities. Women who are economically insecure are at a disproportionately higher risk of being subject to gender-based violence, less likely to complete primary and secondary education and less likely to have access to employment than more educated women. Survey data from Egypt points to socioeconomic inequities in the likelihood of experiencing intimate partner violence (see Fig. 14).

Fig 14. Percentage of currently married women who have experienced physical, sexual, or psychological violence from most recent husband ever or within the past 12 months by wealth quintile in Egypt, 2005



Source: Analysis by El-Zanaty et al. (2005) as reported by USAID and National Council for Women (97), based on data from the Egypt Demographic and Health Survey 2005.

Gender equity is central to the SDGs and until greater gender equity is achieved, there will be limited progress towards the achievement of the SDGs in the Region.

Efforts to reduce gender inequity need to be made in the legislative and governance realms as well as through programmes to shift societal norms about gender roles. Of the 22 countries and territories in the Region, 19 are State parties to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the exceptions being Islamic Republic of Iran, Somalia and Sudan. Despite being parties to CEDAW, a number of countries in the Region have stated reservations on particular articles of the Convention which impact on its effective implementation (98).

The Region is, however, experiencing some positive developments related to gender equity. These include explicit endorsement of gender equity at the highest level of political leadership, the prioritization of gender equity and women's empowerment in national development agendas, the formulation of strategies and implementation of legislative reforms and actions, and the establishment of "women's councils".

Eliminate discrimination against and exclusion of refugees, migrants and internally displaced persons

The Region hosts and supports vast numbers of refugees and economic migrants, which can strain host countries' resources and levels of social cohesion. There is evidence of hardening attitudes towards migrants in the Region, further undermining their health.

These include a preference for temporary labour for migrants, preferential treatment for national citizens and "attitudes of disdain or even abuse towards those who are 'visibly different'" (99). Migrant workers, particularly low-skilled workers from outside the Region, are even more exposed to negative attitudes, discriminatory practices and racism.

Regional organizations and national governments need to work with the public to shift attitudes towards refugees and migrants through education programmes and supporting closer social contact. Humanitarian organizations, religious leaders and faith-based organizations should be much more involved in efforts to support positive attitudes towards migrants. In addition to efforts to change attitudes, there needs to be enforced legislation to protect migrants from abuse.



Recommendations

1. Strengthen collaboration with religious leaders and organizations to support health equity.

- Use the prominent role of religion to accelerate progress towards SDGs and health equity and uphold human rights.
- Strengthen religious organizations as participants in the ownership of the equity agenda.
- Develop governance arrangements and scrutiny mechanisms for collaborations with faith-based organizations and religious leadership to promote health equity and action on the social determinants of health.

2. Achieve progress in gender equity.

- All countries in the Region should ratify and comply with the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).
- Widen the participation of civil society in gender equity. Support the effective functioning of high-level womens' councils, particularly in monitoring the achievement of gender-related SDG goals and targets and compliance with CEDAW.
- Develop education and religious programmes to reduce gender-based violence and enhance gender equity. Strengthen national legislation to criminalize intimate partner violence including marital rape.

3. Eliminate discrimination against and exclusion of refugees, migrants and internally displaced persons.

- Address social and legal needs of migrants including the protection of human rights, and promote public support for these measures.
- Create a clear path towards legal residence and nationality for migrants and create mechanisms to monitor the implementation of the Global Compact for Safe, Orderly and Regular Migration.
- Increase education programmes to foster greater tolerance and support for refugee and migrant communities, and increase the involvement of faith-based organizations in these programmes.

07



THE NATURAL ENVIRONMENT AND HEALTH EQUITY

All countries are experiencing harm to the natural environment as a result of climate change and damage due to pollution, intensive farming, resource extraction and loss of biodiversity. The greatest health harms as a result of climate change and land degradation tend to fall on the poorest countries and poorest people (100, 101). Aligning health equity and sustainability agendas is essential to mitigate the inequitable harm to health.



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Mitigate and adapt to climate change, increase renewable energy and support health equity in line with the Paris Agreement on Climate Change and the 2030 Agenda for Sustainable Development

The Eastern Mediterranean Region is particularly vulnerable to the effects of climate change and every country and territory in the Region is experiencing increasing number of days with extreme temperatures, reduced precipitation, droughts, desertification and loss of productive agricultural land as a result of it.

Adverse climate change impacts on health in the Region are summarized in Table 2 (102). There is growing evidence that those living in poverty are more likely to be affected by these impacts.

Table 2. Projected impacts of climate change on health and health equity in the Eastern Mediterranean Region

Effects of climate change	Health risks and impacts	Health equity impacts
Increased frequency and intensity of heat waves; increased risk of fires in low rainfall countries; increased number of warm days and nights	Excess heat-related morbidity and mortality; increased incidence of heat exhaustion and heat stroke (dehydration, heat cramps); increased prevalence of circulatory, cardiovascular, respiratory, renal and other NCDs, including mental health disorders; increased premature mortality related to ozone and air pollution produced by fires, particularly during heat waves; increased hospitalizations due to NCDs and mental health disorders.	Increased risk of death, disease and injury to outdoor labourers, including migrant workers and displaced people living in poor temporary housing conditions (without access to cooling or shading devices).
	Greater risk of death, disease and injury due to more intense heat waves and fires.	Greater impacts on poor populations and people working outdoors (e.g. in agriculture, construction), those living in unventilated/ crowded accommodation, and those in poor health.
	Increased risk of respiratory and cardiovascular disease for outdoor workers, the elderly and those without (or with very poor) ventilation or air conditioning.	Reduced incomes due to job losses or reduced productivity.
Changing and increasingly variable precipitation; higher sea surface and freshwater temperatures	Flood damage to water and sanitation infrastructure; contamination of water sources through overflow; lack of water for good hygiene; accelerated microbial growth and increased survival, persistence, transmission and virulence of pathogens; shifting geographical and seasonal distributions of waterborne pathogens and harmful algal blooms.	Increased incidence of diarrhoeal diseases, especially among children; increased incidence of vector-borne diseases, including malaria, dengue and chikungunya; increased incidence of waterborne diseases, including leptospirosis, schistosomiasis and cholera.
	Decreased food production; less access to food due to reduced supply and higher prices; combined effects of undernutrition and infectious diseases; chronic effects of stunting and wasting in children.	Increased rates of malnutrition and undernutrition among households living in poverty and on low incomes.
	Increased risk of foodborne and waterborne diseases.	Increased risk of undernutrition resulting from diminished food production.

Source: Based on (103, 104, 105).

While there are clear direct health equity impacts from climate change, there are also indirect impacts through damage to the social determinants that lead to increased risks of conflict, scarcity of resources and higher prices for food, energy, water and transport, increased poverty and unemployment, and significant increases in numbers of migrants. The World Bank estimates that in the Middle East and North Africa region, climate change could reduce growth rates in GDP by 6–14% by 2050 due to “water-related losses in agriculture, health, income, and property” (106).

The direct harm to health and health equity and the impacts on the social determinants of health can only be permanently reduced by significant declines in greenhouse gas emissions and other climate-harming activities. Currently, the world is not on track to meet the Paris Agreement’s targets, and some countries in the Eastern Mediterranean Region continue to increase emissions. In Gulf Cooperation Council countries, energy consumption is increasing by close to 8% a year, faster than most regions in the world.

Urgent action is needed to accelerate current efforts to achieve lower emissions and meet the targets in the Paris Agreement through clean fuel and technologies, expansion of renewable energy, reduced energy demands and improve energy efficiency (107). In many countries in the Region, there are no or limited plans and strategies to reduce emissions and, with a few notable exceptions, there is a lack of action.

Diversify the economy of the Eastern Mediterranean Region away from reliance on fossil fuels

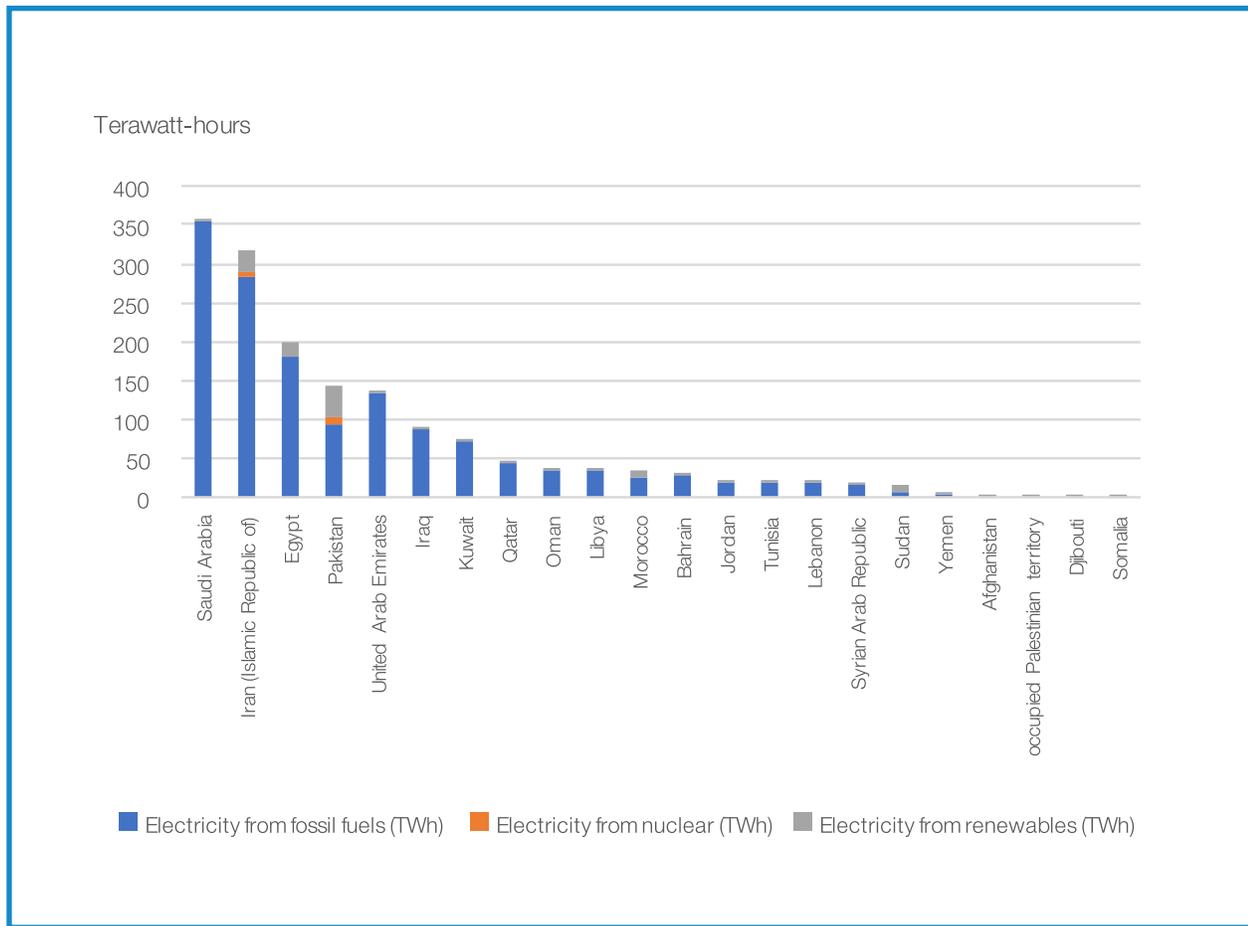
Oil and natural gas production is the main source of income for many countries in the Eastern Mediterranean Region (108). The six Gulf Cooperation Council (GCC) countries’ government revenues are dominated by oil and gas and their economies are the least diversified in the world. In a Region that depends so heavily on fossil fuels, it is a huge challenge to shift to lower carbon economies and diversify energy sources.

Building back fairer from the COVID-19 pandemic requires equitable economic recovery, greater health equity and sustainable environments. Developing green economies is central to these three requirements. Analysis of fiscal recovery packages in G20 countries has concluded that green recovery packages were both environmentally and economically advantageous as green recovery had more multipliers than the “business as usual” model.

Renewable energy

There are enormous opportunities for renewables in the Region, including solar, hydro, tidal and wind, but so far, there have been low levels of investment and development of these assets. Fig. 15 shows that the Region still largely depends on fossil fuels for electricity.

Fig. 15. Electricity production from fossil fuels, nuclear and renewables, 2019 (terawatt-hours)



Source: Our World in Data (2020) (109).

Countries in the Eastern Mediterranean Region have plans to increase both the consumption and production of renewable energy, and Lebanon, Morocco, occupied Palestinian territory, Tunisia and Yemen have committed to use 100% renewables by 2050. However, so far progress is too slow and without much greater investment in renewable energy and reducing energy consumption, the Region stands little chance of protecting health and reducing health inequities.

Reducing energy consumption

Additional efforts need to be in place, including changes in agricultural practices and construction materials and practices, more efficient appliances, more electric vehicles and expanded public transport, alongside increasing renewable energy production.

The Region is experiencing rapid population growth and the population is estimated to increase by 52% by 2050, which will increase energy consumption, even with reduced demand (110). Energy and water subsidies are offered in many countries in the Region, and have been shown to be inequitable, to benefit the highest income groups the most, and to support overconsumption of scarce and polluting resources. This Commission proposes equitably reducing subsidies for both fuel and water.

Increase the conservation of natural resources and improve water management in the Region

Water scarcity and water management

The Eastern Mediterranean Region has among the lowest freshwater resources in the world and they are expected to fall by over 50% by 2050 as a result of climate change and population increases. Water pollution in the Region is increasing and contaminated freshwater and seawater harms health, while lack of access to sufficient freshwater damages both physical and mental health.

There are opportunities for better water conservation in the short term, including decreasing consumption and managing water systems more efficiently. Agriculture

is the largest consumer of water in the Region and reform of agricultural practices is a priority. Sustainable irrigation systems are needed, such as solar powered irrigation, and improvements in using treated wastewater and water supply efficiency.

Land degradation

Climate change, rapid population growth, lack of resource management policies, and overgrazing has increased land degradation in the Eastern Mediterranean Region.

Degradation and desertification lead to reduced agricultural yields and reduced biodiversity, increasing poverty and migration, reducing food supply and harming human health and well-being. Deforestation is also a strong driver of rural poverty. Management of scarce resources and protection of biodiversity must be strengthened across the Region.

Recommendations

- 1. Mitigate and adapt to climate change, increase renewable energy and support health equity in line with the Paris Agreement on climate change and the 2030 Agenda for Sustainable Development.**
 - Recognize climate change as a public health emergency and integrate health and climate policies, making sure ministries of health are involved in climate change policies.
 - Build on the Intergovernmental Panel on Climate Change recommendations, and assess the health equity impacts of adaptation to, and mitigation of, climate change.
 - Introduce and enforce minimum environmental performance standards for appliances and building regulations, and develop sustainable transport systems.
- 2. Diversify the economy of the Eastern Mediterranean Region away from reliance on fossil fuels.**
 - Increase the proportion of energy production and consumption from renewable sources and rapidly decrease fossil fuel production. Reduce fossil fuel subsidies.
 - Rapidly develop the green economy with job opportunities for those on low incomes.
 - Increase Green Climate Fund and other international climate change adaptation funding to reach countries and communities most at risk of poor health from climate- and weather-related disasters.
- 3. Increase the conservation of natural resources and improve water management in the Region.**
 - Build the resilience of regional water resources. Develop regional wastewater recycling strategies and reduce demand for desalinated water.
 - Subsidies to water should be altered to achieve equity and remove incentives for overconsumption.
 - Integrate agriculture and poverty policies to improve food security and protect biodiversity.

08



EQUITY IN MATERNAL AND CHILD HEALTH, THE EARLY YEARS AND EDUCATION

Of all the stages of life, the early years and the period until the end of school are the most critical for health inequities. Experiences in the early years and during childhood lay the foundations for the rest of life and inequities at this stage of life translate into inequities in health throughout life. It is also the period when interventions can be most effective in improving outcomes and reducing inequities yielding lifelong benefits.

Ensure equitable maternal and child health

In the Eastern Mediterranean Region, there has been significant progress in reducing maternal, infant and under-5 mortality. However, socioeconomic inequities in outcomes at this stage of life remain. In order to improve overall outcomes further these inequities must be reduced.



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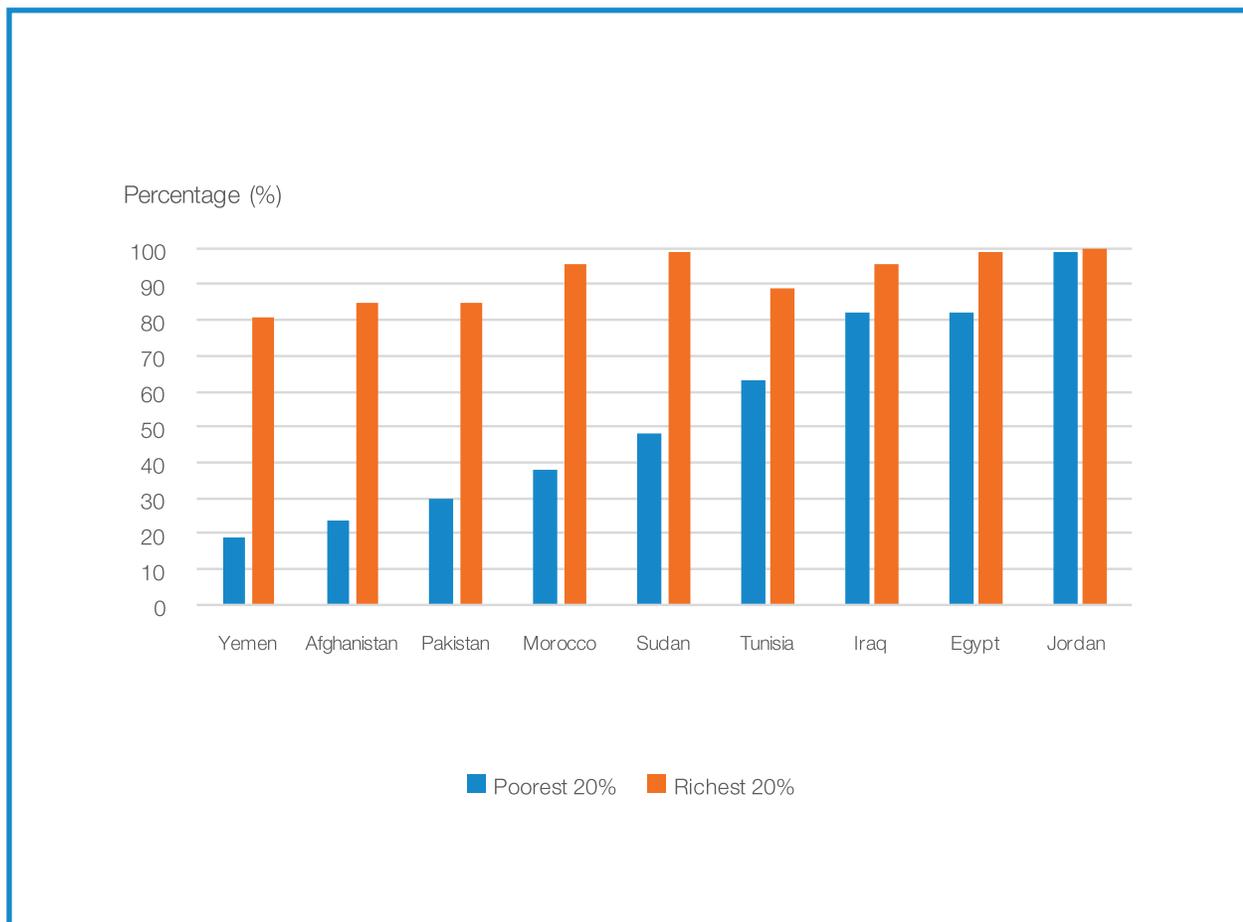
Maternal health

There are clear socioeconomic inequities in maternal mortality within, as well as between countries. These are related to maternal nutrition (which is likely to deteriorate as a result of the COVID-19 pandemic), living conditions, maternal education, household income and access to maternity services. These inequities are cumulative, and poorer and less educated women will experience multiple, simultaneous higher risks.

Remarkably, the maternal mortality ratio halved between 2000 and 2017 in the Region (111). However, nine countries in the Region are yet to meet the SDG target of reducing the ratio to less than 70 per 100 000 live births. Nonetheless, overall the maternal mortality ratio in the Region, 84 deaths per 100 000 live births, is lower than the global average of 211 deaths per 100 000 live births.

Fig. 16. shows inequities by wealth in births attended by skilled health personnel, important for reducing maternal mortality in countries of the Region.

Fig. 16. Percentage of births attended by skilled health personnel (doctor, nurse or midwife) by poorest and richest quintiles in selected countries in the Eastern Mediterranean Region



Source: Demographic and Health Surveys and Multiple Indicator Cluster Surveys, compiled by UNICEF (112).

Child marriage and adolescent fertility

Adolescent motherhood – defined as having children before the age of 19 – is associated with poor health for mothers and babies and it perpetuates social inequities by shortening women’s education and reducing their earnings (113, 114).

In some countries of the Region, the number of girls and women who are married by the age of 15 and 18 is high. In Somalia, 8.4% of girls are married by age 15 and a further 45% by age 18 (115). Gender inequity, low levels of education, poverty, exclusion, marginalization and insecurity, particularly among conflict-affected and displaced communities, contribute to higher rates of adolescent fertility and child marriage in the Region (116). The International Monetary Fund shows that the elimination of child

marriage could increase the per capita growth of low-income countries by over 1% (117). While child marriage had been on the decline in the Region, national and localized conflicts have led to increases (118). There are also concerns that the COVID-19 pandemic will lead to higher numbers of child marriages and higher rates of adolescent fertility.

Some countries have instituted successful programmes to reduce adolescent fertility and child marriage, including concerted activities by health and family planning services, teachers, civil society and faith-based organizations, as well as strengthening legislation on the legal age of marriage. This Commission recommends that the legal age of marriage is increased to 18 and legally enforced, and that cultural and gender norms around child marriage are rapidly shifted.

Access to modern contraception

Lack of access to modern contraception remains an important health equity issue.

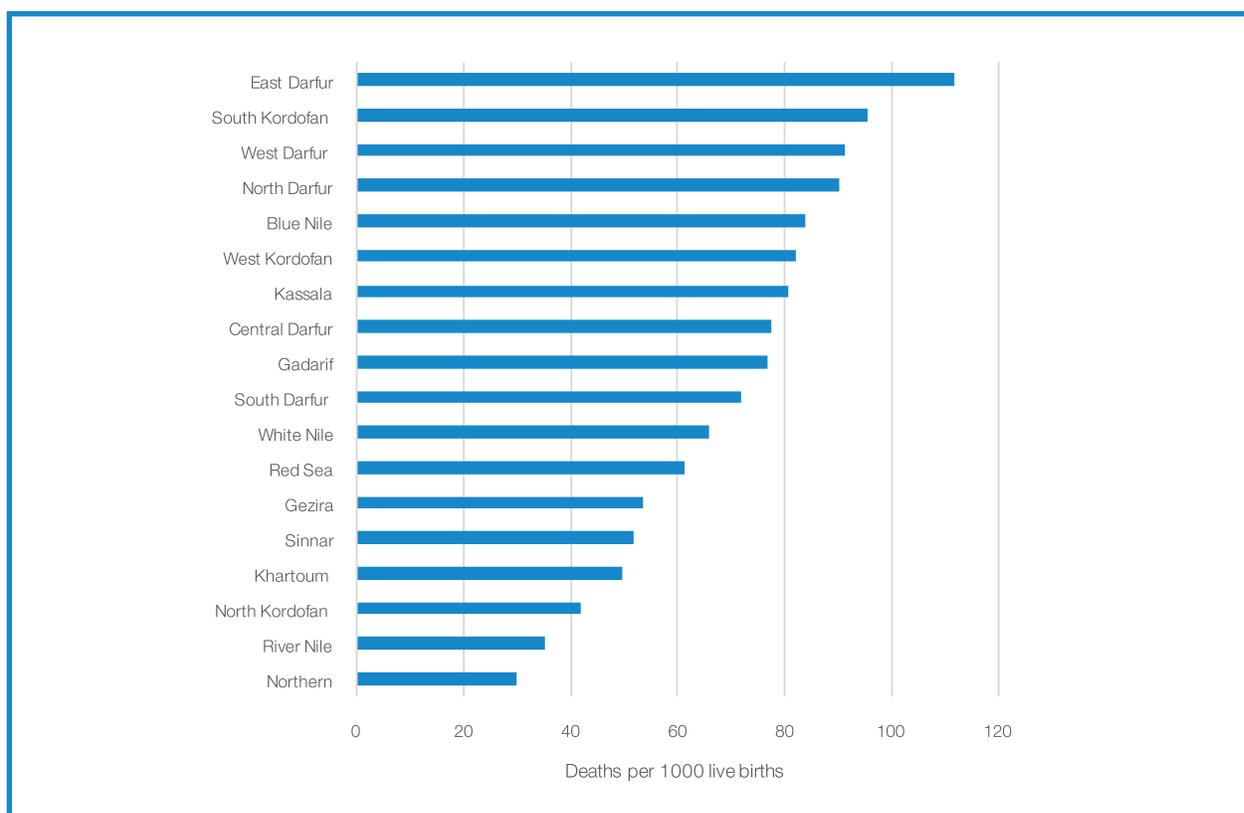
Closely spaced pregnancies and births increase the risk of death and poor health for infants and their mothers and leaving at least 2 years between births can reduce maternal mortality by 30% and child mortality by 10% (119). Some cultural and religious norms in the Region make the use of modern contraceptive methods unappealing or unavailable to women and in all countries and territories in the Region, the percentage of women using modern contraceptive methods is below the global average, except in Egypt. Across the Region, there is much lower access and use of modern contraception for those with lower levels of education and wealth and for those living in rural areas. COVID-19 has further reduced access to sexual and reproductive health services. Programmes led by religious leaders to encourage use of contraception are shown to be particularly effective but are not widespread in many countries and territories.

Child health

Welcome improvements have been made in infant and under-5 mortality, but wide differences within countries persist, related to education, wealth and refugee status.

The most frequent causes of death in children under 5 continue to be infectious diseases – all largely preventable (120, 121). Fig. 17 shows under-5 mortality rates by state in Sudan in 2014, indicating wide inequities by area of residence. Darfur had an under-5 mortality rate of 114 per 1000 live births, while two states had rates lower than 40 per 1000 live births, better than the global average in 2018 (38.8 deaths per 1000 live births). These indicate that inequities in under-5 mortality relate to policies and distribution of resources in key social determinants of health within the country.

Fig. 17. Under-5 mortality (deaths per 1000 live births) by state, Sudan, 2014



Source: Sudan Multiple Indicator Cluster Survey (122).

Nutrition

Lack of adequate nutrition is a leading cause of maternal, infant and under-5 mortality and poor health.

Undernutrition was an underlying cause in 45% of deaths of children under 5 years in 2015 and nearly 20% of babies born in the Region are low birth weight. Undernutrition is associated with lower levels of cognitive development and educational attainment (123). Poor nutrition for mothers increases the rate of anaemia, underweight and stunting in their children.

Rates of stunting and underweight in children under 5 halved between 1990 and 2019 (124), although rates are still high. In 2018, 20.2 million children, or nearly one in four children in the Region, were stunted. The average prevalence of stunting was 10% in the high-income countries of the Region, 23% in middle-income countries and 46% in low-income countries (125), indicating that even the richest countries need to take urgent action to eliminate stunting and improve nutrition.

Exclusive breastfeeding for the first 6 months of a baby's life supports good maternal and child health. In many countries in the Region, the rates of exclusive breastfeeding are very low. This Commission recommends further programmes to increase rates of breastfeeding in all countries, particularly targeted at food-insecure households and those with lower education and wealth. Access to skilled birth assistance and support from family are effective in increasing breastfeeding rates.

Inequities in health service coverage for infants and children

Inequities in maternal and infant health are compounded by lack of access to maternal health services, childhood immunizations and postnatal checks, which are related to maternal education and household wealth in most countries in the Region.

Ensure all young people in the Region complete good-quality primary and secondary education and increase equity in access to tertiary education

Early child development

It is well documented that good-quality early education plays an important role in a child's cognitive, social and emotional development, and is particularly beneficial for more disadvantaged children (126, 127, 128, 129).

In many countries and territories in the Region, enrolment in pre-primary education is low, particularly for more disadvantaged children (see Fig. 18). Given the benefits of early years education for educational attainment, these inequities in participation reinforce and exacerbate existing inequities.

Fig. 18. Enrolment in early care and education by wealth quintile in selected countries and territories in the Eastern Mediterranean Region, 2006–2012



Source: Lu C et al. (2020) and Krafft et al. (2015) (130, 131).

Primary and secondary education

Universal access to good-quality education reduces health inequities. Education is an important equalizer and can help to avoid poverty in adulthood and achieve better living conditions, improved physical and mental health throughout life, and increased life expectancy (132, 133).

Socioeconomic and geographic inequities in access to primary school education and levels of attainment persist in many countries (see Fig. 19), and in secondary school the inequities in participation and attainment become even starker, shown for wealth in Fig. 20.

Fig. 19. Primary school completion rates by wealth quintile in selected countries and territories in the Eastern Mediterranean Region, 2011–2018



Source: Demographic and Health Surveys and Multiple Indicator Cluster Surveys, compiled by UNICEF (134).

Fig. 20. Completion of lower secondary school by wealth quintile in selected countries and territories in the Eastern Mediterranean Region, 2013–2018



Source: Demographic and Health Surveys and Multi Indicator Cluster Surveys, compiled by UNICEF (134).

Reasons for not completing primary and secondary education relate to poverty and conflict; refugee children often do not have access to schools and access to schools is often more difficult in rural areas. The COVID-19 pandemic has increased inequities in participation and attainment still further as children drop out of school to work due to increasing poverty, and many children, particularly girls, are unable to access online schooling during lockdowns.

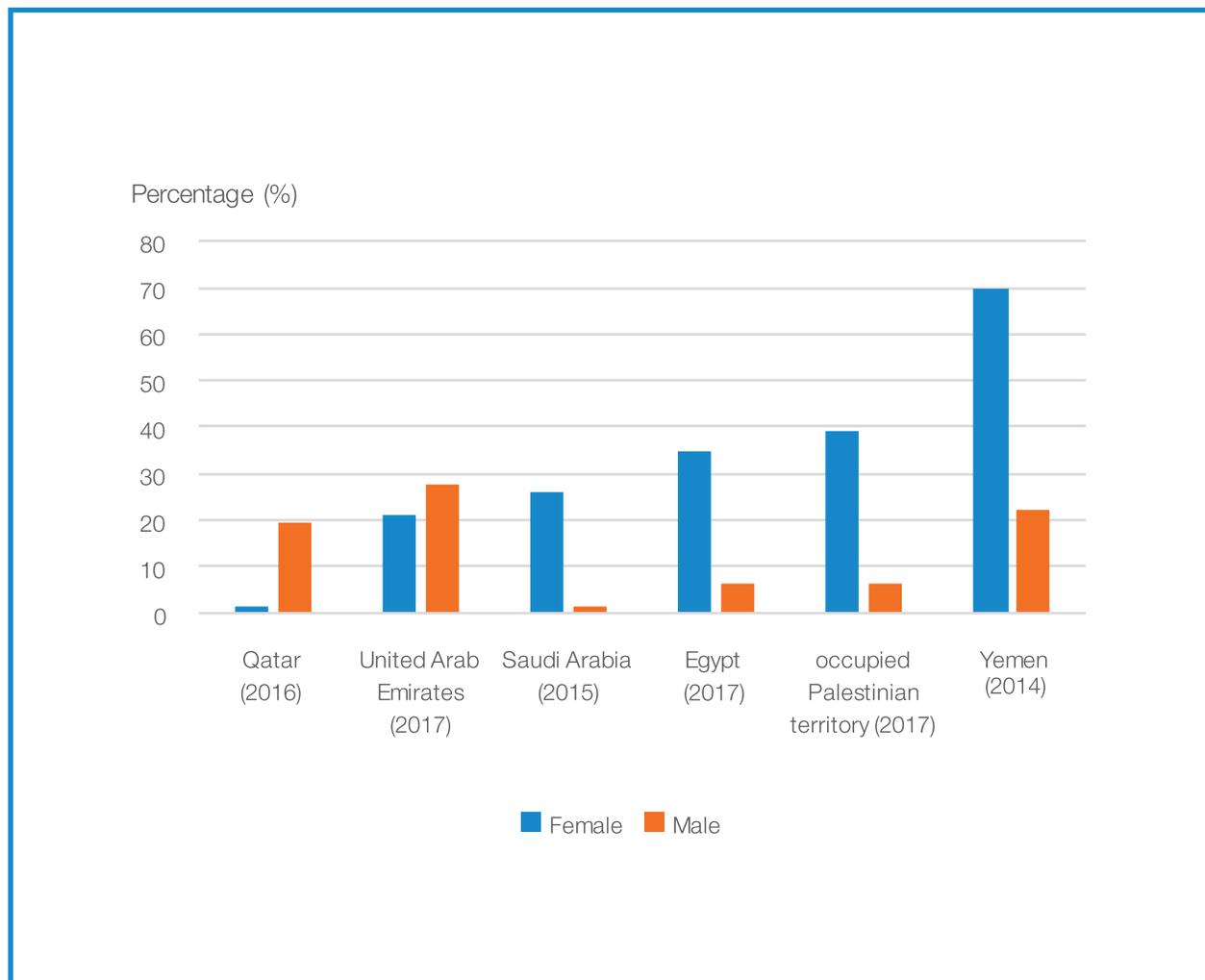
Additional resources must be directed to ensuring all children in the Region complete good quality primary and secondary education. There are challenges, but in many countries, government expenditure on education is low, and resources must be redirected from other spending priorities to invest in children’s and young peoples’ futures.

Build on progress in gender equity in education and increase post-school training and employment of women

Although there has been progress in achieving greater equity between boys and girls participating in education, there are enormous differences in training and employment rates once schooling is complete.

In many countries, young women do not participate in training and employment past school (shown in Fig. 21), with expectations that girls will undertake domestic rather than paid labour. Increasing young women's participation in employment and training after school will reap health and social and economic benefits. Shifting gender norms as well as introducing and enforcing legislation outlawing discrimination are important.

Fig. 21. Young people (15–24 years) outside education, training or employment, by sex, in selected countries and territories in the Eastern Mediterranean Region, 2014–2017



Source: UNESCWA (135).



Recommendations

1. Ensure equitable maternal and child health.

- Expand access to modern contraceptive methods and reduce inequities in access.
- Reduce inequities in access to maternal and post-natal health care.
- Reduce the adolescent fertility rate, increase the legal age of marriage to 18 and apply effective measures to prevent child marriages.
- Increase access to nutrition support for mothers and babies and increase breastfeeding rates in countries and communities with low rates.
- Ensure that all children are registered at birth without financial cost to the household.

2. Ensure all young people in the Region complete good-quality primary and secondary education and increase equity in access to tertiary education.

- Increase primary and secondary school completion to 100% in all countries and focus on the poorest communities and rural areas to reduce numbers of children under 18 who are out of school.
- Increase government expenditure on education as a percentage of total government expenditure.
- Reduce the quality gap between private and state education.

3. Build on progress in gender equity in education and increase post-school training and employment of women.

09



WORKING LIVES AND HEALTH EQUITY

Employment is a critically important determinant of a person's health and well-being and that of their family. Being in "good work" can be defined as having a secure job with good working hours, fair pay, safe working conditions and opportunities for training and progression (136).

Conversely, poor quality work, such as informal and insecure employment, low pay, poor physical or psychological working conditions, unsafe practices and long working hours have adverse impacts on mental and physical health. For parts of the Eastern Mediterranean Region, economic growth has not translated into the creation of decent jobs and reductions in poverty as might have been expected (137, 138). Conflict, political instability and economic disruptions, magnified by the COVID-19 pandemic, have kept the Region's focus away from concerns about employment, pay and quality of work. However, improvements in employment rates, quality of work and pay are essential for health and for social and economic development.



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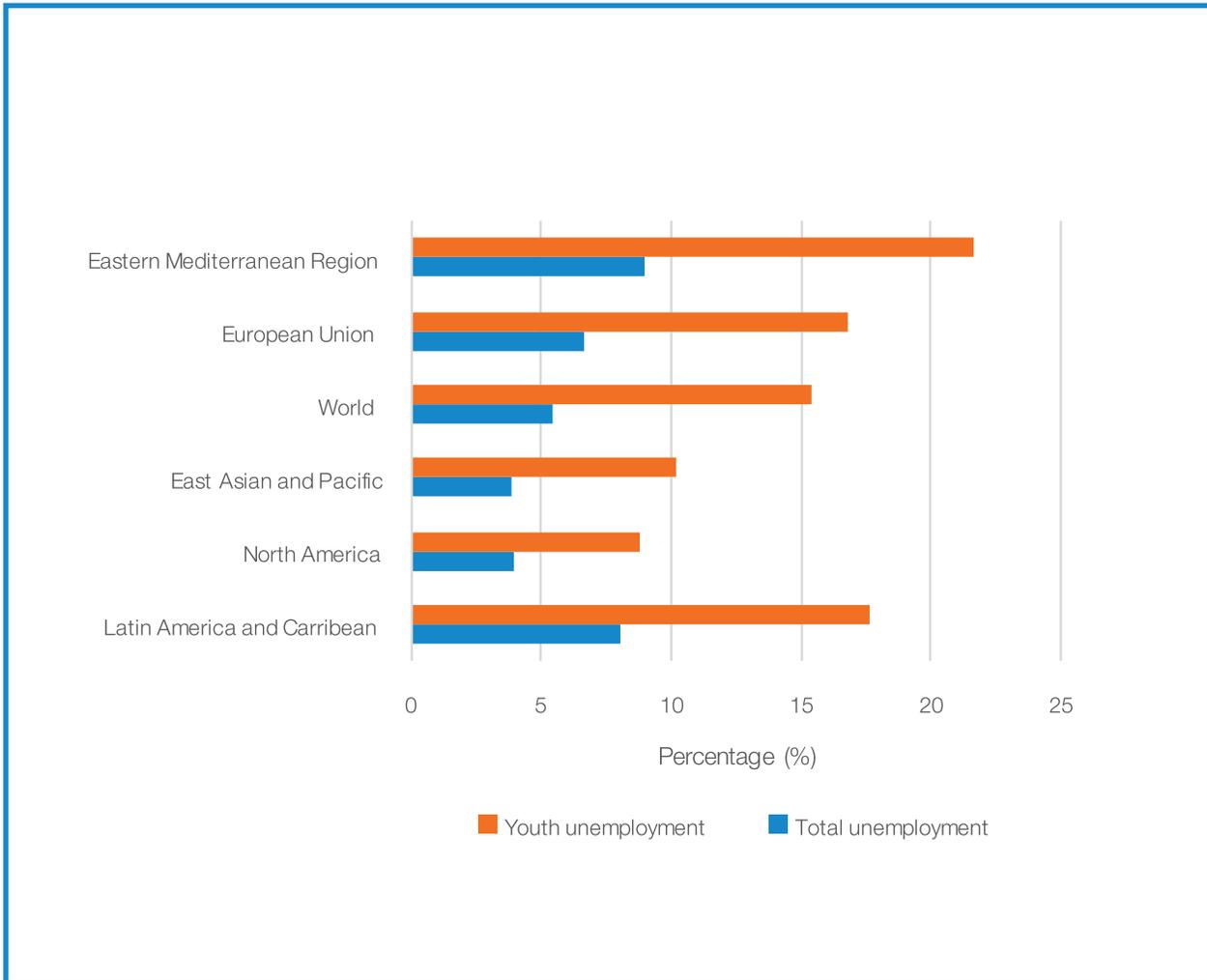
To improve health equity, reduce unemployment with a focus on young people, women and the long-term unemployed

Unemployment results in higher rates of morbidity and mortality and is directly associated with adverse health behaviours such as smoking and drug misuse, increased risks of poverty, food insecurity, loss of housing, and stress, all of which are harmful to physical and mental health (139).

Some countries in the GCC have full employment (over 70%), and attract large numbers of migrants to fill labour shortages. Other countries in the Region, have employment rates below 50%, related to the impacts of conflict, declines in agriculture and public sector employment, low levels of female participation in the labour market and high levels of informal employment.

The Eastern Mediterranean Region has the highest rates of unemployment and youth unemployment compared with other global regions (see Fig. 22) (140). Globally, COVID-19 is increasing unemployment among young people at a faster rate than for other age groups.

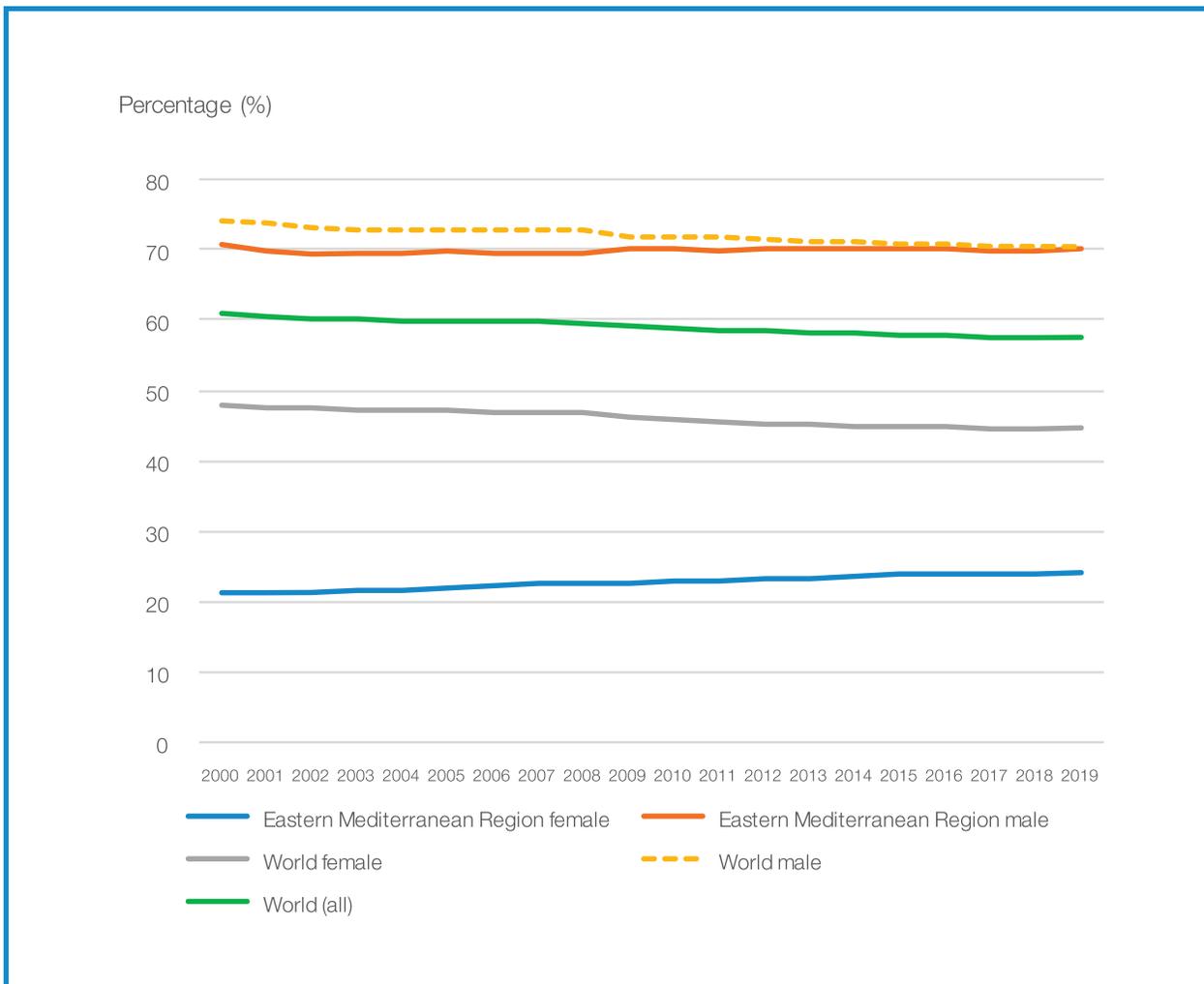
Fig. 22. Unemployment, total and youth (15–24 years) (percentage of total labor force) (modeled ILO estimate) by region, 2019



Note: Unemployment refers to the proportion of the labour force who are without work but are available for work and seeking employment. Youth unemployment refers to the proportion of the labour force aged 15–24 years who are without work but are available for work and seeking employment. Source: World Bank data, ILOSTAT database (2020) (141).

Levels of female employment in the Region are also low. In 2019, the female employment rate in the Region was 24.6%. compared with a global average of 44.3%, as shown in Fig. 23.

Fig. 23. Employment to population ratio, 15+, (%) by gender (modeled ILO estimate) in the Eastern Mediterranean Region, 2000–2019



Note: The employment to population ratio refers to “the proportion of a country’s population that is employed. Employment is defined as persons of working age who, during a short reference period, were engaged in any activity to produce goods or provide services for pay or profit, whether at work during the reference period (i.e. who worked in a job for at least one hour) or not at work due to temporary absence from a job, or to working-time arrangements. Ages 15 and older are generally considered the working-age population” (142).

Source: World Bank data, ILOSTAT database (2020) (142).

For refugees, employment opportunities are often extremely limited and most labour is undertaken to ensure survival. Countries with large numbers of refugees struggle to provide support for refugees and displaced populations who face unemployment, extreme poverty and poor working and employment conditions, which have been compounded by COVID-19 containment measures (143).

There are low levels of unemployment protection measures to offer financial support to those who are unemployed and to support them back into work. This Commission proposes the rapid introduction, or extension, of active labour market programmes to support people, especially young people, into work and the introduction and strengthening of unemployment benefit, to provide some form of protection to those unable to find work. Some countries are actively encouraging female employment and these efforts should be extended.

Improve the quality of work to benefit health equity

Across the Region, the potential positive contributions of employment to health are not being realised and work often damages, rather than supports, good health.

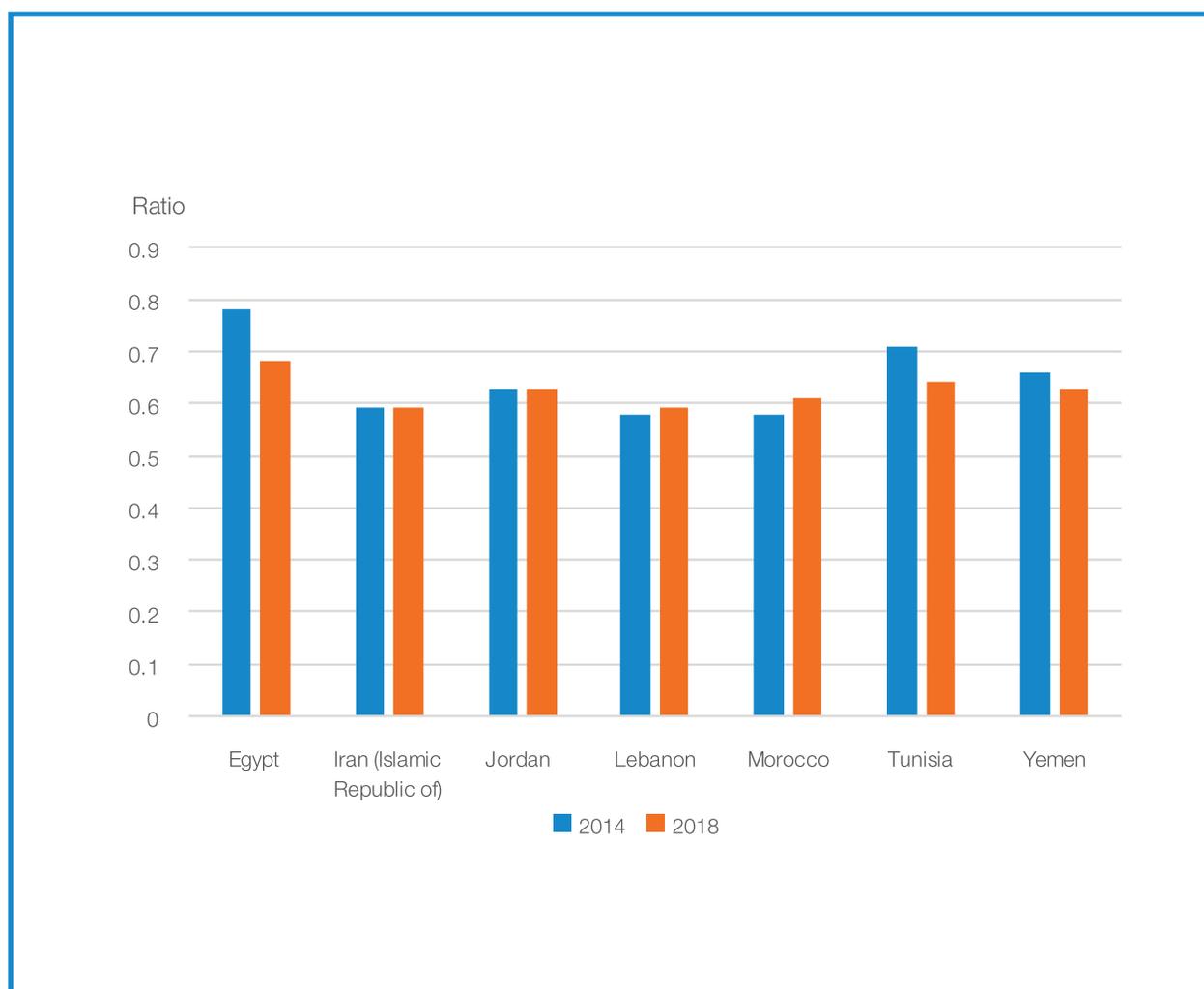
Much of the work available in many countries in the Region is so low paid that it offers little protection from poverty. The Eastern Mediterranean Region has the highest proportion of countries in the world with no minimum wage legislation. Even where national

minimum wage policies are in place, they are not applied to those working in the informal sector and to refugees and economic migrants.

This Commission makes the case that every country should establish a minimum income for healthy living to provide a benchmark to be used as the basis of minimum pay and social protection measures.

Women have lower pay than men across the Region. Fig. 24 shows that for countries with data, none had equal pay between men and women for the same work, and in Egypt, Tunisia and Yemen, the gender pay gap increased between 2014 and 2018.

Fig. 24. Wage equality for similar work (female to male ratio) in selected countries of the Eastern Mediterranean Region, 2014 and 2018



Note: The wage equality for similar work are scored from 0 to 1 scale where 1 stands for equal pay between women and men working in a similar position.

Source: World Economic Forum (144, 145).

Many economic migrants experience poor working conditions (146). Establishing a Region-wide set of labour laws, monitored and enforced by the ILO, specifically related to the safety and well-being of refugees and migrants, would ensure the protection of their human rights, improve health and benefit host countries by expanding the tax base and encouraging economic growth.

The Commission calls for greater advocacy and awareness about the beneficial health impacts of good work, and, conversely, the detrimental health impacts of unemployment. While support for good employment is a vital health and health equity intervention, it is rarely framed as such and the health benefits of employment are not widely understood. For this reason, ministers of health should be involved in labour market programmes and other measures to support employment and good quality work.

Regularize informal employment and eliminate child labour, slavery and trafficking

Informal employment

There are high and increasing rates of informal work in the Region and it comprises, on average, two thirds of all employment in the Region, slightly higher than the global average.

Informal work includes people who usually earn very low wages outside the formal economy, with no guaranteed employment or protections for ill health or unemployment, and who are not subject to national income tax (147, 148). Informal work is higher among young people, the working poor and women, and in fragile and conflict-affected states. The COVID-19 pandemic and associated containment measures have severely impacted informal workers who have found themselves unable to access work and this has left many workers and their families vulnerable to extreme poverty, starvation and homelessness. Informal work, particularly low paid and unsafe work, is highly damaging for health and a major contributor to health inequity across the Region.

Some countries in the Region, including Morocco and Tunisia, have made efforts to regularize informal labour and improve conditions for those working in some of the most precarious and vulnerable situations. This Commission recommends the adoption of ILO recommendations for the transition from the informal to the formal economy.

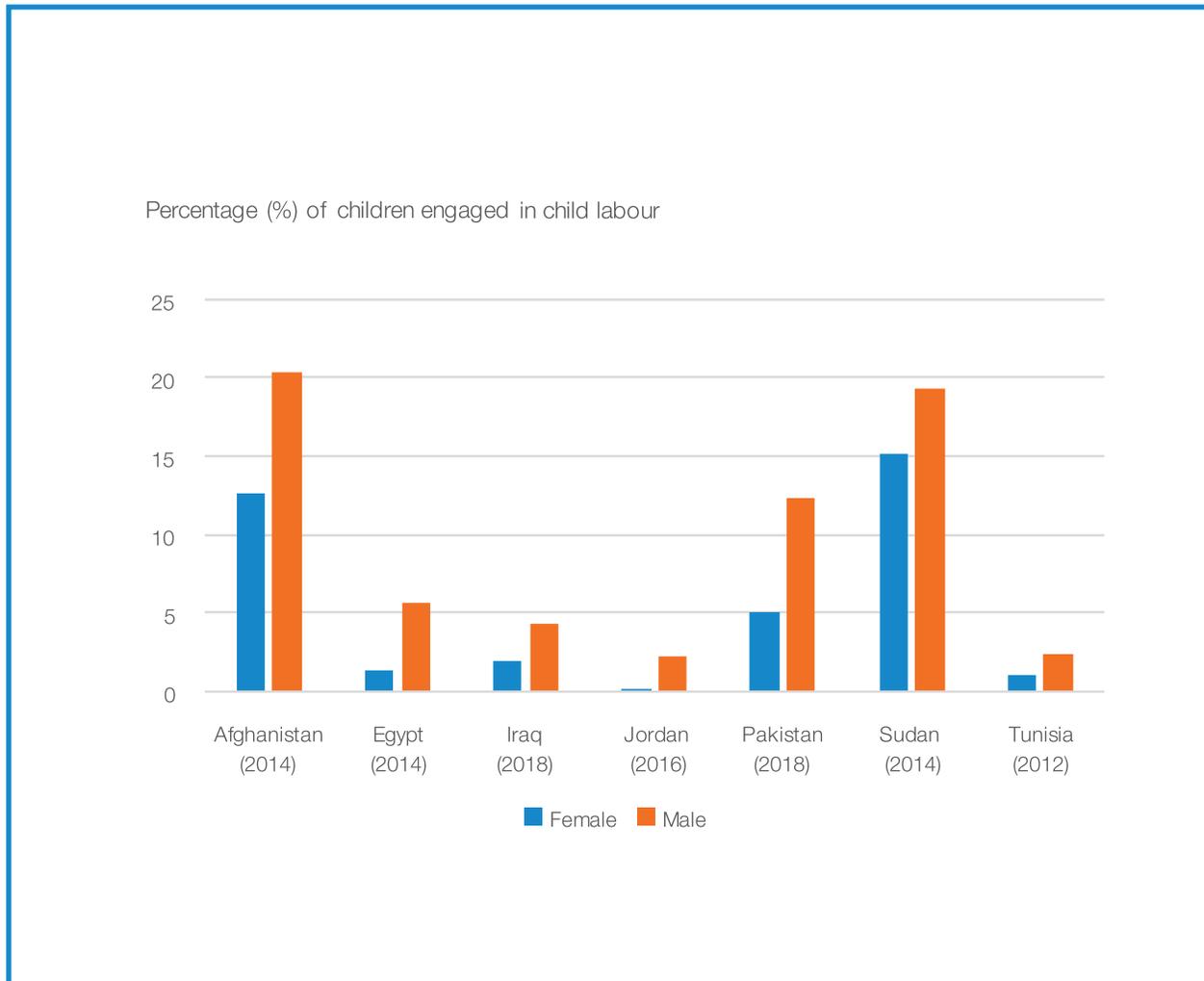
Modern slavery and trafficking

Those who are subject to slavery and trafficking are at high risk of physical injury, violence, serious mental health problems, exposure to infectious diseases and limited access to health care (149, 150). According to available data, the Eastern Mediterranean Region had the second highest estimated prevalence of modern slavery compared to other regions in 2018. The Arab States have a high percentage of forced labour victims who are held in debt, and for women, it is the highest rate in the world.

Child labour

Child labour is defined as “work that deprives children of their childhood, their potential and their dignity and that is harmful to their physical and mental development” (151). Child labour usually involves the loss of education. While accurate figures are hard to establish, countries affected by armed conflict have higher rates of child labour than others and in many countries, the COVID-19 pandemic has increased child labour as a result of poverty and school closures. Some countries in the Region, particularly Afghanistan, Pakistan and Sudan have high levels of child labour, especially for boys, as shown in Fig 25.

Fig 25. Percentage of children (aged 5–17 years) engaged in child labour (economic activities) in selected countries in the Eastern Mediterranean Region



Source: UNICEF (2020) (152).

It is important that legislation to outlaw child labour is enforced and that support is available to enable families to send their children to school by compensating for the loss of income that children earn. Conditional cash transfers have proved effective in other regions (2).



Recommendations

1. To improve health equity, reduce unemployment with a focus on young people, women and the long-term unemployed.

- Introduce quality active labour market programmes with a particular focus on providing formal employment for young people.
- Introduce or strengthen unemployment benefit.
- Conduct strong advocacy to recognize employment and unemployment as key health equity issues.

2. Improve the quality of work to benefit health equity.

- Make fair employment and decent quality work a central part of national policy agendas and development strategies, with strengthened representation of workers. Establish work safety standards, including for migrant workers.
- Introduce minimum wage legislation in all countries in the Region based on assessments of minimum income for healthy living.
- Regulate systems of sponsorship to protect migrant workers from abuse and introduce formal protections for domestic workers

3. Regularize informal employment and eliminate child labour, slavery and trafficking.

- Adopt ILO recommendations for transition from the informal to the formal economy.
- Introduce legislation and enforce the elimination of all child labour, slavery and trafficking.

10



HEALTHY AGEING

While experiences in younger ages affect health in later years, experiences during older age produce additional inequities in health. Income, levels of poverty and social protection, social interaction and access to health and social care for older populations are all drivers of health inequities among older people.

The Eastern Mediterranean Region has a relatively young population, but the proportion of older people is projected to increase over the next 50 years. As the population ages, the political power and voice of older people will increase and expectations for government support will rise, particularly as the working age population is unable to continue offering high levels of support to older people.

Expand the provision of publicly-funded care for older people

High rates of unemployment and poverty, particularly youth unemployment, mean it is increasingly difficult for families to support older family members. In the Region, the majority of families who are expected to financially support and house older family members do not have sufficient resources to do so (153). Without increased state support for older people and provision of care, older peoples health and well-being will deteriorate, creating wider inequities in health (154).

The high levels of family support for older people in the Region are related to the Region's family traditions, gender norms and religious beliefs and the lack of formal care alternatives (155). Many older people



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remain financially supported and intrinsic to family and community life, but the continuation of these practices is unsustainable as the age structure in the Region shifts (153, 154).

In response to these challenging trends, it is vital to expand the provision of publicly-funded care for older people and to increase the role of religious and civil society support, especially for poorer households.

Increase the provision of pensions through government subsidies

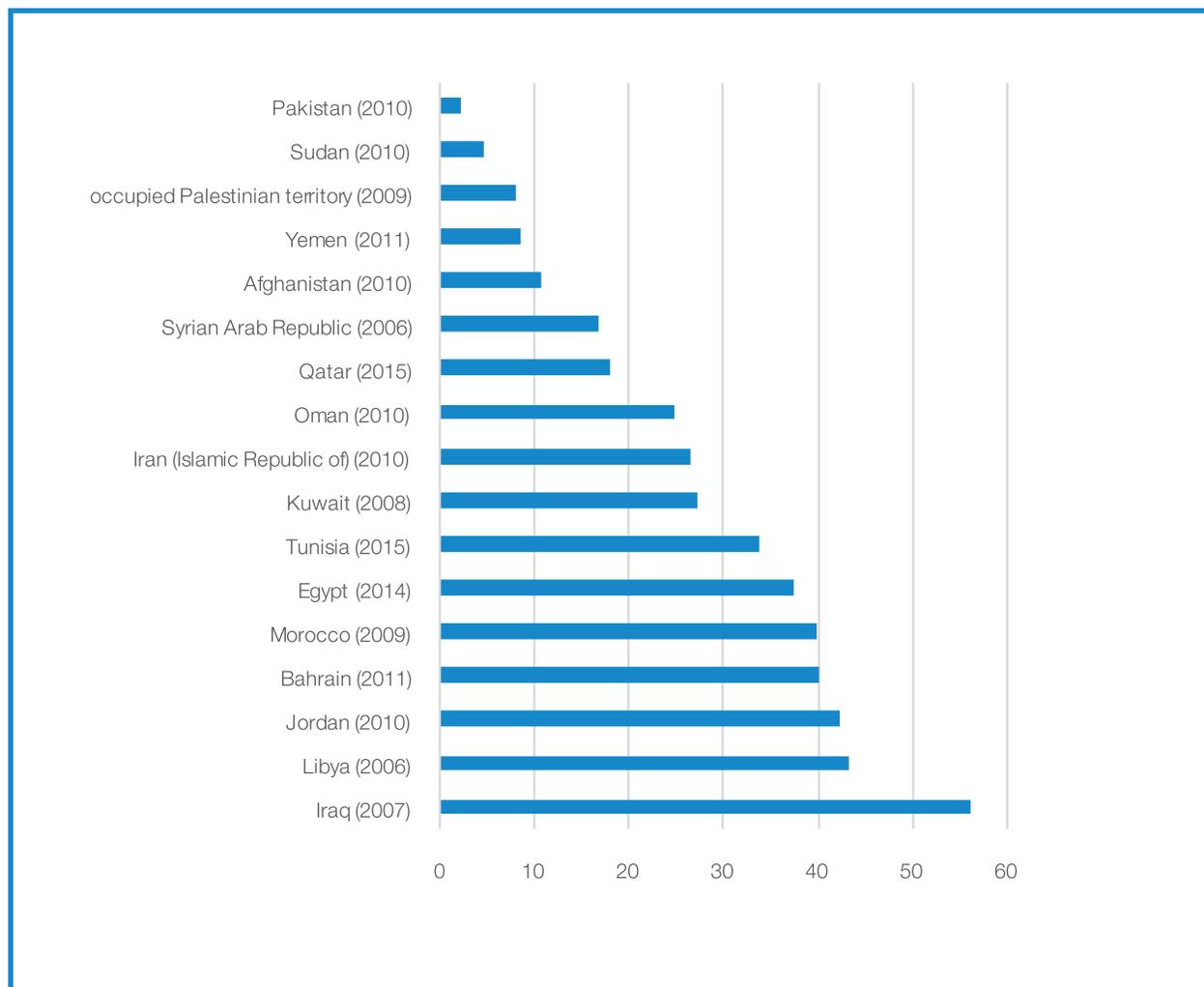
Adequate social protection systems, which include pensions, are essential in reducing the risk of poverty and poor health in older age (156).

Across the Region, there are low levels of expenditure on pensions and other benefits for older people (156), mostly of less than 5% of GDP. In comparison, in OECD countries, public spending on benefits for old-age pensions and survivors' benefits was, on average, 8% of GDP in 2015 (157).

The average percentage of persons above statutory pensionable age receiving a pension in the Eastern Mediterranean Region is 24.2%¹, considerably lower than the world average of over 60% in 2017–2019 (158). Fig. 26, shows the levels of coverage of pensions for eligible people in countries in the Region, ranging from 5% in Sudan to over 50% in Iraq.

¹ Excluding Bahrain, Lebanon, Saudi Arabia, Somalia and United Arab Emirates as data was not available for these countries.

Fig. 26. Proportion of the population above the statutory pension age who receive a pension in some countries and territories of the Eastern Mediterranean Region, 2006–2015



Source: Based on data from the ILO World social protection report (159, 160).

Most pensions in the Region, are contributory and based on employment earlier in life. For people on low incomes, migrant workers, and those who work informally or are unemployed, there are generally no pensions available. Older people mainly rely on their own assets and savings or family support for financial security. For many older people this is insufficient to prevent poverty in later life. Increasing the provision of state subsidies for pensions is fundamental for supporting older peoples' health, reducing the financial burden on younger people, and reducing health inequities.

Develop national strategies to improve the health and well-being of older people and focus on active ageing

Local government, cities and regions, faith-based organizations, and voluntary and community groups, can undertake practical steps to support healthy ageing.

In countries in the Eastern Mediterranean Region, policies to support healthy ageing are absent or piecemeal. Most are geared around health care services. Age-friendly city approaches support cities to develop environments where older people can continue to be healthy, active and socially connected. All cities in the Region should aim to achieve this.

The health system also has a vital role to play in supporting healthy and active ageing through appropriate public health and prevention interventions and through support for physical and cognitive activity. These approaches help to maintain and improve the capacities and health of older people as well as reduce demand on health care and care facilities.

In the Region, abuse towards older people is under-researched, but available studies do indicate that abuse and violence towards older people is at a high level in the Region and has significant impacts on an older person's health and well-being, including physical injury, stress, depression and anxiety.

SDG 3 outlines that “ensuring healthy lives and promoting well-being for all at all ages is essential to sustainable development” (161), and this Commission would add, “to health equity, both at older ages and during earlier life”.



Recommendations

1. Expand the provision of publicly funded care for older people.

- State, religious and civil society organizations should increase support for care and care homes among the poorest people.
- Expand the care workforce and establish career and training opportunities.
- Ensure access to health care including support for good health as well as treatment.

2. Increase the provision of pensions through government subsidies.

- Extend non-contributory pension schemes with a particular focus on women, migrants, informal workers and the unemployed.
- Base non-contributory pension allowances on the minimum income for healthy living standards.

3. Develop national strategies to improve the health and well-being of older people and focus on active ageing.

- Develop programmes and policies to support older people's mental health in the Region and reduce maltreatment within the home.
- All cities in the Region should be age-friendly cities.

11



BUILT ENVIRONMENTS AND HEALTH EQUITY

Ensure universal provision of basic services and improve housing quality

Good quality living environments are central to health, to the capacity for individuals to lead healthy lives and to how communities and nations can support good health.

While there have been improvements in access to essential services in many countries, there are still many communities and people living without any of these and even in many wealthier countries there are socioeconomic inequities in access to such services. This Commission recommends universal provision of basic services and proposes each country develop national standards that are universally applied and cover water and sanitation services, access to electricity, air quality, housing and conditions in refugee and informal settlements.

While the development of basic standards does not ensure the resources and implementation required,



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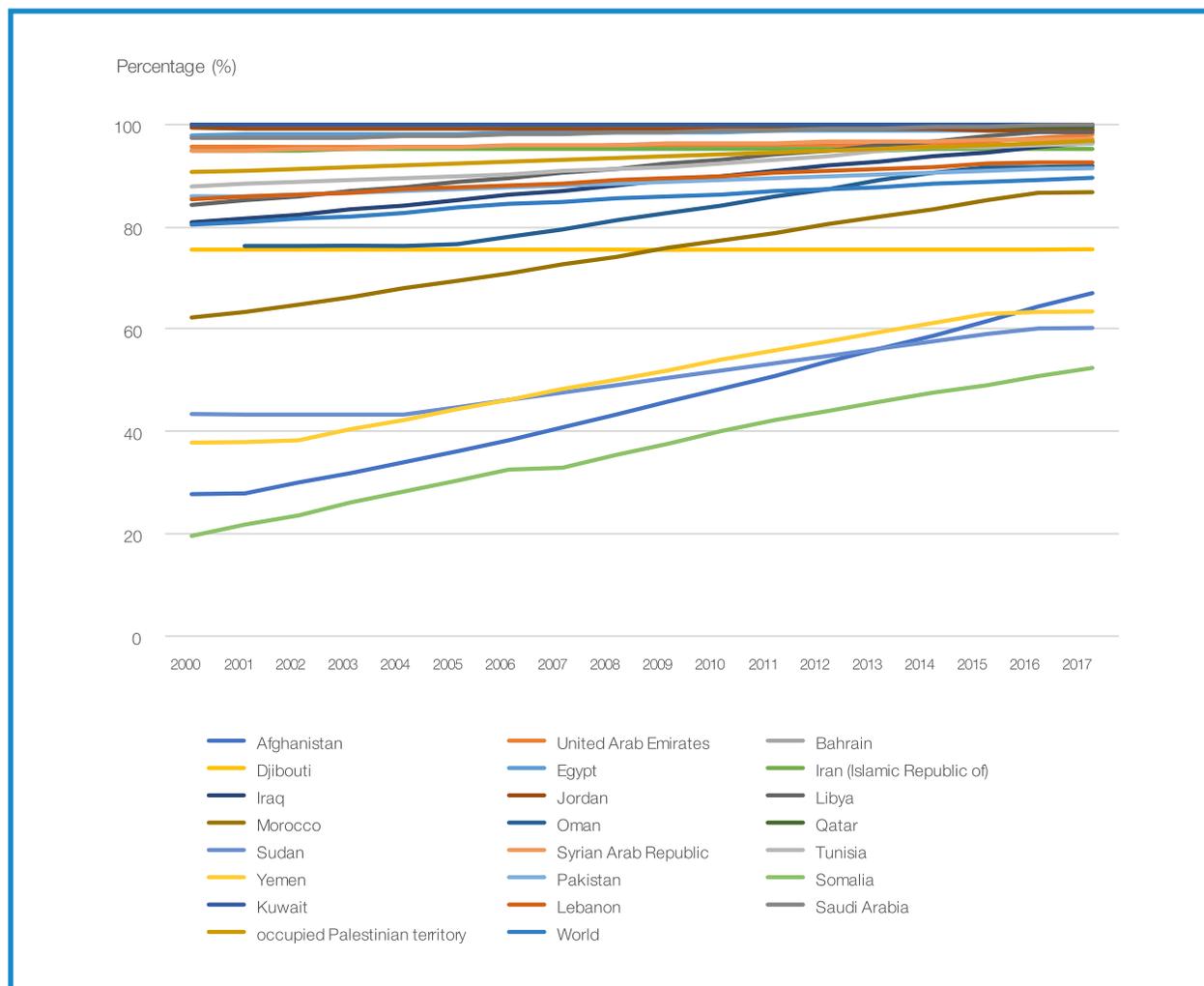
it does provide a template for the planning and delivery of improved living conditions, and strengthens national governments' and international organizations' accountability to deliver. We also recommend basic standards for the quality of informal settlements – which will trigger intervention when they fall.

Access to well-managed water and sanitation

Inadequate water and sanitation services increase exposure to infectious diseases and waterborne diseases (162, 163). The mortality rate attributable to unsafe water, unsafe sanitation and lack of hygiene in 2016 in the Region ranged from < 0.1 per 100 000 in the GCC countries, to 86.6 per 100 000 in Somalia (164, 165, 166).

A number of countries had low levels of access to basic drinking water services between 2000–2017, including Afghanistan, Djibouti, Egypt, Morocco, Somalia, Sudan and Yemen. Most of these countries, with the exception of Djibouti, had made substantial improvements (see Fig. 27).

Fig. 27. Proportion of people using at least basic drinking water services (percentage of population) by country and territory in the Eastern Mediterranean Region, 2000–2017



Note: The percentage of people using at least basic water services includes both people using basic water services as well as those using safely managed water services. Basic drinking water services is defined as “drinking water from an improved source, provided collection time is not more than 30 minutes from a round trip” (167).

Source: The World Bank (167), based on data from the WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene (168).

In the Eastern Mediterranean Region, the majority of refugee camps are unable to provide the recommended minimum of 20 litres of water per day per person and many countries in the Region hosting refugees are already water scarce (169).

There have been improvements in provision of at least basic sanitation services in countries in the Region between 2000–2017, although some countries remain below the world average. In countries where access is not universal, rural populations have much lower access than urban areas. In 2017, 85% of people

in urban areas were using at least basic sanitation services, compared to 64% in rural areas (170).

Access to electricity

Several countries in the Region have particularly low access to electricity, well below the global average of 90%. This is a significant barrier to progress and impacts on development, including in health, education and gender equality (171). SDG 7 includes the commitment to ensuring “access to affordable, reliable, sustainable, and modern energy for all” (172).

Access to the internet

Internet access is increasingly considered an essential service and lack of access can exacerbate and entrench inequities, including in access to health care, education, employment and economic opportunities, as well as to social connections, all of which are important to good health (2, 173).

There have been improvements in access to the internet; however, nearly half the countries in the Region still have rates of access below 50%, and lower still for poorer and rural communities in those countries. Inequities in internet use by gender are also prevalent across the Region (174). According to the International Telecommunication Union, of all regions in the world, the gap in internet use between men and women is largest in the Arab States (174).

Air pollution

Poor air quality is a vital health equity issue in the Region, with 98% of the population exposed to air pollution levels exceeding WHO recommendations. The Region had higher than the global average rates of deaths attributable to ambient and household air pollution in 2016.

Low- and middle-income countries in the Region have higher death rates attributable to air pollution compared to higher-income countries. Women and children are disproportionately impacted by exposure to household air pollution and the adverse effects associated with this. Clean cooking fuels and technologies are essential to reduce household air pollution.

The reduced road traffic during COVID-19 lockdowns has given an indication of the possibility of cities and roads with much lower congestion and pollution. Enforced regulation of transport and industrial emissions and the promotion of electric vehicles are essential components of reducing air pollution, and are also essential climate change measures.

Housing

Access to quality housing is a human right and is also of fundamental importance to good health. In every country in the Region, there are significant inequities in access to affordable and decent-quality housing that impact on health, directly and indirectly.

Unaffordable housing pushes people into poverty and leads to the growth of informal settlements, unhealthy housing conditions and corruption in the housing market. In several countries in the Region, informal settlements are growing rapidly.

Refugees and internally displaced individuals can be particularly exposed to inadequate living conditions as host countries are unable to provide adequate housing and access to essential services to refugee populations (175).

Implement sustainable and accessible transport systems

Public transport systems are generally underdeveloped in the Region and many people are reliant on private vehicles for transport (176). This leads to high levels of car use, traffic congestion, poor air quality and vehicle accidents.

Public transport has been shown to have major public health and health equity benefits, including reduced greenhouse gas emissions, increases in physical activity and greater affordability. Efficient and low-cost public transport is beneficial to economic development, employment for lower-income communities, greater social cohesion and access to services.

Safety on public transport for women appears to be a common concern in the Region. A study by UN Women in 2013 found that, among Egyptian women, 86.5% of survey respondents did not feel safe or secure on public transport (177) and a survey of public transport users in Tunisia found that 89% of women had been subject to harassment (178).

Investing in public transport, encouraging walking and cycling and separating motorized traffic from vulnerable road users, all encourage active transport and reduce transport-related injuries (179). Policies related to investment in public transport have declined since 2013, but there are a number of countries in the Region which have developed urban mobility plans and implemented sustainable transport projects (180).

Strengthen regional and national planning mechanisms

Migration from rural to urban areas usually involves the “pull” of people seeking better opportunities. Other drivers include environmental factors such as endemic water shortages, land degradation and conflict (181). Rural to urban migration can cause significant problems in provision of housing, infrastructure and basic services, but can also stimulate local economies and thriving communities if well managed (182).

National planning strategies and mechanisms and long-term investment can mitigate the health equity risks of increasing urbanization, by ensuring the provision of healthy built environments and infrastructure through sustainable urban development (2). This Commission

therefore recommends strengthened national and regional planning mechanisms, which incorporate the provision of essential services to nationally-defined standards and investment in public transport systems.



Recommendations

1. Ensure universal provision of basic services and improve housing quality.

- Develop and implement standards for universal basic services that cover water and sanitation, housing, transport, electricity and the internet, including in refugee and informal settlements.
- Develop and enforce national plans to reduce air pollution through regulation of manufacturing and resource extraction and transport emissions. Promote the use of electric vehicles.
- Implement and enforce national strategies related to the management of informal settlements and include public recreational spaces, schools, safe and walkable spaces and education and health care services. Prioritize equitable and accessible water, sanitation and hygiene in redesigning informal settlements.

2. Implement sustainable and accessible transport systems.

- Strengthen sustainable and affordable public transport systems including electric buses, trams and rail.
- Improve the safety of public transport, particularly for women and older people.
- Improve road and vehicle safety standards to reduce high levels of vehicle accidents.

3. Strengthen regional and national planning mechanisms.

- Develop national planning strategies for sustainable rural and urban development.
- Establish legislation and mechanisms for formalizing land tenure of inhabitants living in informal settlements.

12



HEALTH SYSTEMS FOR HEALTH EQUITY



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This Commission is focused on the social determinants of health, but health care systems are crucial to greater health equity too.

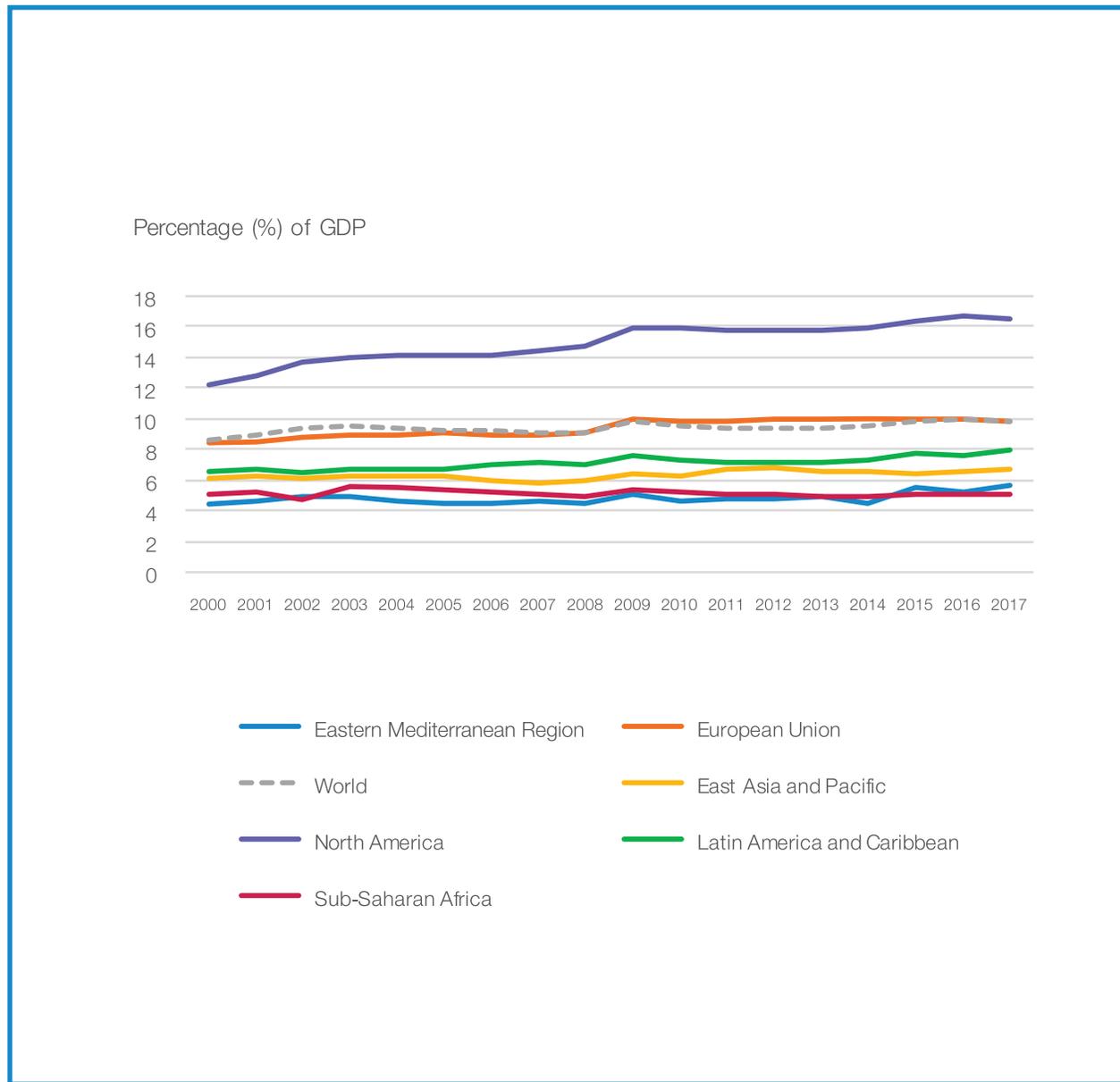
Strengthen universal health coverage across the Region and ensure equitable and affordable access to health care

There are widespread and persistent inequities in health care coverage related to wealth, education and area of residence. Expenditure on essential health care is prohibitive for large parts of the population in most countries in the Region and leads to impoverishment.

There has been a focus on achieving universal health coverage in the Region, and while that has not been achieved, there are signs of progress, although coverage remains low in many countries. Out-of-pocket expenses on health care make up over 70% of total expenditure in Sudan and Yemen and over 50% in Egypt, Morocco and Syrian Arab Republic (183).

The Region is a low investor in health care (184). Fig. 28 shows how the Region had one of the lowest expenditures in the world (as a percentage of GDP) compared to other regions between 2000 and 2017.

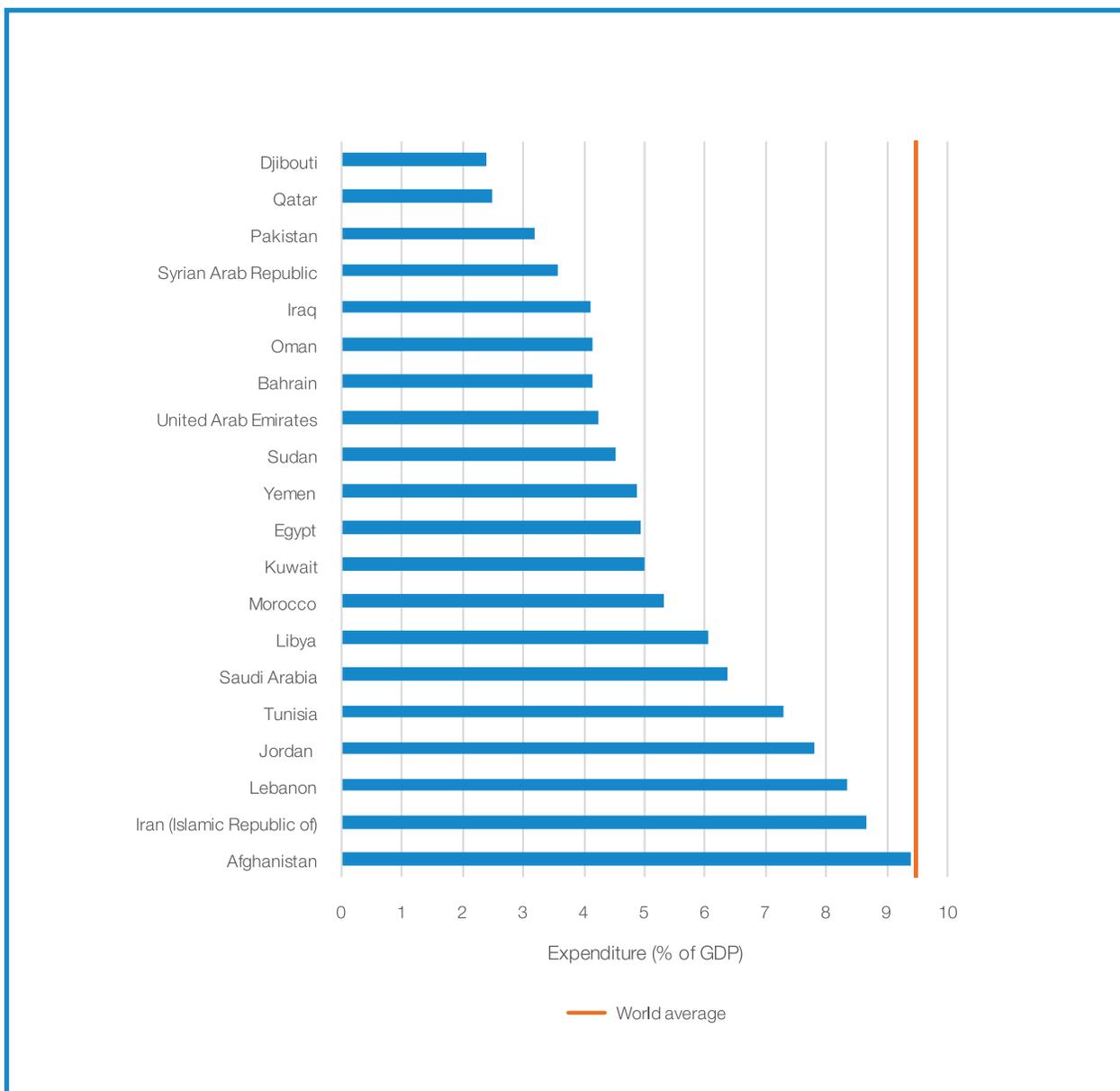
Fig. 28. Expenditure on health care (% of GDP) in selected regions, 2000–2017



Note: Estimates of current health expenditures as a percentage of GDP includes “healthcare goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, IT and stocks of vaccines for emergency or outbreaks” (185). Source: The World Bank based on data from the WHO Global Health Expenditure database (186).

Most countries in the Region invested under 5% of GDP on health care and all countries were below the world average for expenditure on health care in 2018, as shown in Fig. 29.

Fig. 29. Expenditure on health care (% of GDP) in countries of the Region (2018)



Note: Estimates of current health expenditures as a percentage of GDP includes “healthcare goods and services consumed during each year. This indicator does not include capital health expenditures such as buildings, machinery, IT and stocks of vaccines for emergency or outbreaks” (185). Data was not available for Somalia or occupied Palestinian territory. Data for all countries from 2018, with the exception of Yemen, Syrian Arab Republic and Libya, where the data was from 2015, 2012 and 2011, respectively.

Source: The World Bank based on data from the WHO Global Health Expenditure Database (186).

This Commission recommends that the amount of public funding dedicated to health care increases, and includes a greater focus on primary health care, which is currently inadequate. There is even scope to invest further in health care systems in fragile and conflict-affected states and to ensure that coverage

includes migrants and those on the lowest income, currently excluded deliberately or as a result of poverty. The focus on health during the COVID-19 pandemic may help garner the political and public will needed for further spending on achieving universal health coverage.

Implement and ensure essential public health functions for each country to achieve universal public health standards

There are very few countries in the Region who have a national strategy on health promotion and education, with most strategies related to specific diseases (187). In the Region, there are inequities in vaccine coverage and in access to other preventive and public health measures, which undermine equity in health.

Essential public health functions refer to “the indispensable set of actions, under the primary responsibility of the state, that are fundamental for achieving the goal of public health which is to improve, promote and protect, and restore the health of the population through collective action” (188). These functions are important tools to assess public health systems and inequities in access to public health interventions, and are important for developing interventions to strengthen public health (188). In 2013, a WHO initiative was launched to support Member States in assessing their essential public health functions, with the aim of providing evidence-based recommendations for improving public health capacity and performance (188).

Develop population health systems with a strong focus on equity, prevention and action on the social determinants of health

Health care organizations and the health care workforce must be involved in the broad societal endeavour to improve health equity through action on the social determinants of health (189).

In this report, we have identified that acting on the social, economic, cultural, commercial and political determinants of health will support better health and health equity in the Region. In relation to the role of health systems, this means shifting health care towards a population-based health system which works to improve equity in the social determinants of health as well as to treat ill health.

A health system based on prevention and health equity involves:

- A focus on preventing ill health and supporting good health
- A focus on place
- Cross-sector collaborations
- A focus on population health
- Action on the social determinants of health
- Development of proportionate universal approaches (2).

The health care workforce have a vital role to play in supporting population health and reducing health inequities. The World Medical Association has outlined the following six areas which would support the health workforce to support greater action on the social determinants of health (190).

1. Understanding the issue and what to do about it: education and training
2. Building the evidence: monitoring and evaluation of health inequities
3. The clinical setting: work with individuals and communities
4. Health care organizations as employers, managers and commissioners
5. Work in partnership with the health care sector and beyond
6. Health professionals as advocates

Incorporating the social determinants of health into the education and training of health professionals is essential in supporting health professionals to successfully take action on these determinants and to help tackle inequalities (189).



Recommendations

- 1. Strengthen universal health coverage across the Region and ensure equitable and affordable access to health care.**
 - Increase public financing to support equitable access to health care and reduce the likelihood of catastrophic expenditure on health care.
 - Include migrants in universal health coverage.
 - Implement and uphold the right to health, particularly in conflict-affected settings.

- 2. Implement and ensure essential public health functions for each country to achieve universal public health standards.**

- 3. Develop population health systems with a strong focus on equity, prevention and action on the social determinants of health.**
 - Focus health care system interventions on social and economic drivers of health-related behaviours and mental health.
 - Develop whole-system approaches to health which include action to improve living conditions and health education and training programmes.
 - Strengthen partnerships with other sectors, including housing, transport, social protection and education.

13



GOVERNANCE AND TAKING ACTION TO BUILD BACK FAIRER

The overarching principle for governments should be to foster better health and health equity, and to put health equity at the heart of government; and from that, social, economic and environmental progress will come. There is scope for every country in the Region, at very different stages of development, to “do something, do more, do better” to improve equity in health through action on the social determinants of health.

The analysis and recommendations in this report are based on the best available evidence about the challenges in the Region and what is required to meet them to build back fairer. Here, we set out the most appropriate governance arrangements essential for action on the social determinants of health and health equity.



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It is a task for the whole of society – national governments, the commercial sector, civil society, faith-based organizations, international and regional organizations, local government, health care, and much of the workforce. All have levers to improve social and economic conditions for health.

Meeting international obligations, implementing legal mechanisms and human rights approaches, and alignment with the SDGs, are all critical to achieving health equity.

Governance systems and political cultures which prioritize, support and enable such actions underpin successful action on health inequities.

Principles for governance to build back fairer and achieve greater health equity

- Take action on social determinants of health to improve health equity.
- Put health equity at the heart of government.
- Do something, do more, do better.
- Base social action for health equity on the principle of proportionate universalism.
- Involve the whole of government in policies and practice to improve health equity.
- Involve the whole of society in improving health equity.
- Develop strong accountability for health equity.
- Align greater action on climate change with health equity.

In the main report, we outline sector-specific actions for international organizations, WHO, ministries of health, national governments, civil society, local government and research funders. There are other sectors who should be, and in some cases have been, involved in taking forward the actions recommended here.

This Commission's hope is that the agenda we have set out, and the proposals made for action, will also find resonance with other sectors and that they take up the cause and develop their own agendas and implementation plans. Our recommendations, outlined by sector, serve as guides, or inspiration, rather than blueprints.



Taking action to build back fairer and achieve greater health equity

- Develop national and transnational plans for action and implementation.
- Strengthen the role of civil society and faith-based organizations in action to achieve health equity.
- Strengthen the contribution of the commercial sector to health equity and stop harmful practices.
- Support the humanitarian sector to have a strong focus on the social determinants of health.
- Increase the involvement of the health care sector in the social determinants of health.
- Develop the role of local government in relation to the social determinants of health.
- Link action on health equity and the social determinants of health with the SDGs.
- Strengthen human rights approaches in the Region.
- Develop data and monitoring systems to inform evidence-based action on health equity and greater transparency and accountability.
- Strengthen legal obligations and regulations to enforce actions to support health equity.
- Reduce corruption.

Throughout this report we have repeatedly highlighted the lack of data and evidence in the Region which severely limits understanding and action on health inequities. We make recommendations for building data systems capable of monitoring within-country health inequities, and for countries with more resources, we make recommendations for effective data and monitoring systems to support action on

the social determinants of health and health equity. In our recommendations, we include additional urgent areas for research. Research should be seen as an investment in health for the populations of the Region, as without greater understanding and knowledge, the health inequities that damage the people and prospects of the Region will continue.

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