Global Health Policies and International Cooperation in the Middle East and North Africa (MENA)

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ABSTRACT

The core belief behind global health is that “disease knows no borders” and thus, in order to eliminate health risks, we should focus on the scope of their problems and not their location. However, some countries, such as those located in the Middle East and North Africa, which are dealing with economic and political instability as well as conflict, have to face greater health challenges than others. These states tend to depend more on international cooperation and global health policies to eliminate the growing health challenges in their region. This paper seeks to examine the general health status, health risks as well as some global and regional health initiatives implemented in the MENA region, aiming to respond to the multitude of health issues affecting these countries.

Keywords: Covid-19, Global Health Initiatives, Health Challenges, MENA Region.

I. INTRODUCTION

It is undeniably true that we now live in a globalized world. Contemporary globalization has been affecting every aspect of human life in the modern world. Therefore, the sector of health could not have been an exception to the rapid changes wrought by this phenomenon. The growing importance of non-state actors and international organizations such as agencies, global-scale foundations, etc., has definitely influenced public health to its core. The term that seems to be emerging nowadays is “global health”. According to Brodit and Radwan (2018, p. 150), “Global health is created with the main goal to improve health worldwide, reduce disparities, and protect against global threats that disregard national borders. Good health for all populations is an international goal”. Global health pictures the world as a net of interconnectedness where disease knows no borders. The word “global” in “global health” alludes to the magnitude of the issues, not where they are situated. Thus, domestic health inequities as well as international problems can be the focus of global health (Koplan et al., 2009). Due to the phenomenon of globalization in the contemporary world, there has been an increase in new frameworks for international cooperation to counter emerging global health threats. The emerging importance of globalization in the health sector has led to the expansion of global interest in the formation of new international initiatives to protect and enhance the health status of poorer states that have benefited from globalized to a lesser extent. Therefore, it seems that the need for international cooperation to protect and promote domestic health in every part of the world is rapidly growing as the concept of global health is expanding. Hence, in the 21st century, there is more frequent use of international instruments that serve the purpose of improving world health.

Intergovernmental associations and other health-related actors are becoming more and more prevalent according to current trends and, as a consequence, health diplomacy is on the rise. In recent years, the number of private sector players in global health has quickly increased, evolving and expanding rapidly (Batakis et al., 2020). A wide range of non-governmental organizations (NGOs), foundations, and funding organizations, including pharmaceutical firms that have a significant impact on global health policy, started to spread worldwide forming health collaborations and global health policies in order to address global health risks (Sidiropoulos et al., 2021). The United Nations (UN) has been actively involved in promoting and protecting global health since its founding in 1945. A remarkable moment of the UN’s involvement in health diplomacy was in 2015 when UN member states accepted the ambitious Sustainable Development Goals (SDGs), a set of 17 global objectives for economic and social advancement. Among these goals was one (SDG3) that aims to achieve Universal Health Coverage (UHC) by 2030 and eliminate the AIDS, malaria, and tuberculosis epidemics, as well as provide better access to safe, effective, and affordable treatment (WHO, 2018).

According to WHO’s definition, UHC is achieved when:
"all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (WHO, n.d.a).

The World Health Organization (WHO) is leading this initiative within the UN system. For instance, the global health crisis that occurred in 2009, after the outbreak of the pandemic influenza A (H1N1), resulted in the World Health Organization (WHO) developing a new "global framework" on fair access to influenza protection (Sidiropoulos et al., 2022). What is more, WHO’s leading role in combating global pandemics of the 21st century such as Ebola and Covid-19 cannot be overlooked. The WHO is working with specialists, scientists, epidemiologists, and other experts, on the ground in 150 different nations and is considered to be one of the main actors in the rise of modern health diplomacy. In other words, ensuring health protection has become a global issue and international organizations are now one of the leading actors in forming global health policies in order to eliminate diseases as well as provide all people in the world access to a healthy life.

Unfortunately, some areas face greater health challenges than others due to various factors such as the economy, political instability, domestic turmoil, the significant differentiability of cultures, etc., one of these areas being the Middle East and North Africa region (MENA). Twenty Middle Eastern and North African countries directly from Morocco (in North Africa) to Iran, constitute the MENA area (in South Asia). The MENA region is considered to be of great geopolitical significance and, because many of the countries in the region are resource-rich, the performance of each of the region's 20 economies mostly relies on how susceptible it is to changes in the price of oil. However, the countries deal with a number of domestic issues, including a lack of employment opportunities for women and young people, low levels of public trust, inadequate returns on investments made in human capital, and weak economies (World Bank, n.d.a).

The issues described above, are reflected in the fact the extreme poverty is increasing in the MENA region since 2011 (Karamouzian & Madani, 2020). These severe conditions, as expected, place a heavy burden on population health outcomes and national health systems. As noted by Alami (2017), MENA health systems are far from providing the services required to promote inclusive development and growth. Countries in the MENA region face a high number of health challenges, but at the same time they acquire a reduced capability to combat them. In an effort to improve health outcomes in the MENA region, different states have to overcome different sets of risks, including war and its repercussions. Furthermore, the lack of records makes it harder to formulate health policies and provide services as well as results in a lack of epidemiological data on the primary health issues affecting these people. The global health crisis, which started in 2020 with the Covid-19 pandemic, has definitely challenged the Middle East and North African countries to a great extent, further worsening the health status of the region. In this regard, we can safely state that global health policies that take place in the MENA region are quite complex and need to be examined very carefully in order to be understood.

This paper seeks to examine the health challenges and the global health initiatives that aim to combat them, that take place in the MENA region. Although there is high academic interest on disease-specific research in the region, a review of the various efforts and policies implemented by the international community is not available in the recent literature. In this light, this paper seeks to pull together said efforts and policies, in order to offer a more holistic view of the current situation. More specifically, the paper provides some information regarding the health status of the region, using health indicators extracted from the World Health Organization and the World Bank databases. Global health initiatives that are implemented in the MENA region are analyzed briefly as well as several regional and global responses to the COVID-19 pandemic and its impact in the region. Lastly, a general conclusion about global health policies and international cooperation in the Middle East and North Africa is extracted.

II. THE MENA REGION AND THE IMPACT OF CONFLICT

The health of the most vulnerable population, women and children, has been negatively impacted by the MENA region's protracted conflicts for a long time. Disease outbreaks have been happening across the MENA area, especially in the conflict-affected nations. Continuing public health issues in this region include cholera outbreaks in Yemen and outbreaks of the wild polio virus in Syria. The right to health of the population is seriously threatened by the deterioration of the health systems in the region's war-torn nations (UNICEF, n.d.a). The chronic instability caused by the effects of war in the MENA region exacerbates the already problematic health status of the region (Saleh and Fouad, 2022). More precisely, the MENA region frequently experiences emergencies such as lengthy hostilities, large-scale population displacements, and political and economic instability. In fact, there were protracted conflicts affecting 85% of the population of the region in 15 of the 22 Arab League member states as of 2010 (Saleh et al., 2022).
Nine of these nations are still listed by the World Bank as having fragile and conflict-affected circumstances ten years later (FCAS) (World Bank, 2022a). The catastrophic impact of conflict in the MENA region is reflected in the poor government funding of the national health systems, the fragility of health services, the brain drain of skilled practitioners, doctors, the limited access to education and the lack of health personnel in general. Particularly among the countries in that region, Low-to-Middle-Income Countries (LMICs) frequently experience larger negative effects and health difficulties due to their lower resources compared to Higher-Income Countries (HICs) in the area (Naal et al., 2020). According to the World Bank income categories, the LMICs of the MENA region are: Algeria, Egypt, Iran, Morocco, West Bank and Gaza, Syria, Tunisia, and Yemen (World Bank, n.d.b). Unfortunately, most of those countries are in turmoil, with Syria, Iraq, Libya, and Yemen being in civil war, causing enormous harm to infrastructure and human lives, as well as population displacement. The largest refugee crisis since World War II has resulted from 15 million people fleeing their homes, many of whom have gone to unstable or impoverished nations, including Jordan, Lebanon, and Tunisia (World Bank, n.d.c). The repercussions in the sector of health are severe in the LMICs as the limited economic resources and domestic conflicts are heightening the already increased health risks in the MENA region. Exposure to armed conflict is associated with increases in infectious and communicable diseases due to displacement. Furthermore, heart problems and leukemia in infants seem to be more common in areas where people are exposed to war-related environmental effects, e.g., Kuwait and Iraq (Saleh et al., 2022). Mental health is also deeply affected when it comes to populations living in turmoil in the Middle East and North Africa. According to a study conducted by the World Health Organization (WHO), “1 in 5 individuals in post-conflict settings has depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, or schizophrenia, with 1 in 10 people having moderate or severe mental disorder” (Saleh et al., 2022). Conflicts occurring in many countries resulted in a lack of funding for health workforce development to meet health and conflict-related requirements as well as a significant outflow of skilled health workers, further straining limited resources. After Southeast Asia and Sub-Saharan Africa, the MENA area faces one of the highest disease loads despite having the third lowest density of physicians and nurses (Naal et al., 2020).

### III. Health Status of the MENA Region

According to data extracted from the databases of the World Bank and WHO, since 1990, the region's general health has greatly improved, as seen by decreases in under-5 death rates, maternal mortality ratios, and other health indices. The region has made progress in the last 30 years in reducing premature death and disability from the majority of maternal, infant, nutritional, and communicable causes. In 1990, the average life expectancy at birth in the region was 66 years, with Yemen having a mean life expectancy of 57 years old. In 2020, the average life expectancy at birth in the region was 74 years, ranging from 66 years in Yemen to 83 years in Israel. As expected, the LMICs tend to have lower life expectancy figures than the HICs of the region as they acquire better innovations in health care. According to the World Bank, over a period of 30 years (1990-2020) mean life expectancy in the region increased by 8 years while life survival to age 65 in the female population increased by 13 percentage points (1990: 72% - 2020: 85%).

Based on the data extracted from UNICEF’s official site, from 1990 to 2015, the maternal mortality ratio (MMR) in the MENA region decreased by 50% (from 220 to 110 maternal deaths per 100,000 live births); In the Middle East and North Africa region, under-5 mortality rates (U5MR) decreased by 59% from 1990 to 2015 (from 71 to 29 deaths per 1,000 live births). Neonatal mortality rate (NMR) trends have been similar to MMR and U5MR (a 49% drop from 1990 to 2015), and the present NMR in the MENA region is roughly 15 fatalities per 1,000 live births (UNICEF, n.d.a). These regional accomplishments, meanwhile, mask differences and between individual countries in the region. For instance, according to World Bank estimates, Kuwait had an infant mortality rate of 10 per 1000 live births, whereas Yemen had a rate of 46 (Mate et al., 2017). Moreover, the rate of disability-adjusted life years (DALYs) has significantly dropped since 1990 in all countries of the MENA region, as observed in Fig. 1, with the exception of Syria, which experienced increases after 2011 due to the uprisings and the Syrian war. Disability-adjusted life years (DALYs), as regards for a disease or health condition, are the total of years lost due to early death. Furthermore, maternal and neonatal disorders account for 7,78% of DALYs in the Middle East and North Africa, down from 16.8% in 1990, when it was the main cause of all disability-adjusted life years in the MENA region. Respiratory infections and tuberculosis as a cause of mortality in MENA has dropped as well from 10,23% of total DALYs in 1990 to 3,7% in 2019, while other infectious diseases now represent only 1,44% of total DALYs, an important drop compared to 7,1% in 1990 (Fig. 2). There seems to be an increase in the percentage of non-communicable diseases (NCDs) of total DALYs in the Middle East and North Africa region. As can be observed in Fig. 3, NCDs accounted for 73,2% of all (DALYs) in the area in 2019, a significant rise compared to 45,31% in 1990.
Fig. 1. Rates of disability-adjusted life years (DALYs) from all causes per 100,000 people for all countries in the MENA region (Institute for Health Metrics and Evaluation, 2022a).

Fig. 2. Percent of total DALYs, comparison between 1990 and 2000, in North Africa and Middle East, all causes, both sexes (Institute for Health Metrics and Evaluation, 2022b).
Since 1990, the main factors contributing to maternal mortality in MENA have hardly changed. The main causes of maternal death continue to be difficulties associated to pregnancy and delivery, such as hemorrhage (20%), hypertensive disorders (15%), maternal sepsis and other infections (10%), obstructed labor (10%), and abortive outcomes (13%). Together, these avoidable factors are responsible for over 70% of all maternal fatalities in MENA. Although the proportion of infant fatalities owing to diarrhea and pneumonia has decreased since 2000, these preventable causes continue to account for the majority of post-neonatal mortality in the area (Asbu et al., 2017). In certain lower-middle-income nations in the Middle East and North Africa, such as Iraq, and Yemen, considerable burdens of communicable, neonatal, nutritional, and maternal causes continue despite progress. In addition, the rising incidence of non-communicable diseases in most countries is a symptom that dietary and lifestyle trends are deteriorating people's health.

Unfortunately, the health system constitutes a small part of the economies of most countries in the region, and the improvement of the health sector is definitely not at the top of the agenda of the MENA governments. In 2012, the share of total expenditure on health in the region was 5%, which is much lower than the global average of 8.6% (Asbu et al., 2017). Thus, all-cost government spending as a share in 2018 represented only 3.23% of the gross domestic product (GDP), representing a small drop in comparison with two years prior. However, total government spending for health has increased significantly since 1995, as pictured at the image below, as the number was four times higher in 2018. We can observe that the total government spending for healthcare in the MENA region is slowly and very gradually increasing until 2016 and remains the same until 2018, showing no further improvements in government spending for health.

Moreover, we can’t overlook the amount of out-of-pocket spending on healthcare, which is quite high and seems to be increasing through the years, by the inhabitants of the MENA region. According to the Institute of Health Metrics and Evaluation, out of pocket spending refers to “payments made by individuals for health maintenance, restoration, or enhancement at or after the time of health care delivery, including health insurance copayments or payments devoted to deductibles” (IHME, n.d.). Out-of-pocket spending in the MENA region has increased from 32 billion US dollars in 1995 to 68 billion dollars in 2018, a large amount considering that the total government spending on health care that year (2018) was only 130 billion US dollars, as pictured in Fig. 4.

We should also take into account that the MENA region is mostly comprised by low-to middle income countries, which most likely can’t afford to access the appropriate healthcare services. This proves the deficiencies of the health systems in the MENA region and given that the pandemic highlighted the vital role of social protection in sustainable growth (Emmanouil-Kalos & Prokakis, 2021), external help to combat the increasing health risks is essential.
IV. GLOBAL HEALTH INITIATIVES IN THE MENA REGION

In an attempt to respond to the variety and multitude of health risks in the MENA region, conflict-affected countries, especially the LMICs, have to deal with the lack of information and data as well as the insufficient human and material resources to cover the needs of impacted populations. Therefore, material and financial aid from international and regional organizations becomes necessary to cope with the health challenges affecting these populations. Given the fact that health policy is not considered to be a priority in the national agendas of the countries located in the MENA region, international organizations often play a key role in combating health risks through the implementation of global health initiatives. In this section of the paper, we are going to refer briefly to some of these initiatives conducted in the MENA region.

The American University of Beirut’s (AUBGlobal) Health Institute (GHI) launched the Academy section in 2017 with the ultimate goal of enhancing technical and leadership capacity in global health in the MENA region and other global south countries with a focus on gender equity (Saleh et al., 2022). This division developed contextualized training programs in global health for populations in the MENA region, which were mostly suffering from limited access to continued health-related education/training/career progression opportunities, limited equity between genders in health-related education and training; and health workforce shortages.

A. Mobile University of Health (MUH)

Given the huge impact of conflicts and turmoil in the region, there is a massive displacement of populations, creating a large number of refugees and, therefore, a loss of opportunities in education and professional training, especially in the more vulnerable part of the population, women. In this regard, the following initiative focuses on gender equity by training female community health workers. The Mobile University for Health (MUH) project uses blended learning techniques to improve the professional health abilities of the refugee and host populations. The result will be a skilled healthcare workforce with accredited training from the American University of Beirut, supporting the targeted areas (Global Health Institute, n.d.a.). This program's overarching objective is to provide community health workers in Lebanon with the abilities and information required to meet the fundamental healthcare requirements of their communities. According to the official site of the Global Health Institute of AUB, the full execution of the MUH includes developing and delivering four certificates: Woman’s Health Certificate (WHC), Non-Communicable Diseases Certificate (NCDC), Mental Health and Psychological Support Certificate (MHPSC), and Infection Prevention and Control Certificate (IPCC) through mobile classrooms in the communities hosting refugees in Lebanon as a first stage, and supporting the qualified graduates to lead awareness activities in their communities as a second stage.
The overall MUH educational experience and additional training will help underserved cohorts develop the skills they need to take on significant roles in reconstructing the health system in their country after a conflict and to land necessary employment in the healthcare industry once they graduate. According to data extracted from the assessment conducted by the evaluation of the capacity building program (eCAP), which aims to evaluate these initiatives, over the course of three years, the MUH trained 113 women from vulnerable groups who were then sent out to help their communities.

B. The Centre for Research and Education in the Ecology of War (CREEW)

Through health-related research and capacity building, the Centre for Research and Education in the Ecology of War (CREEW) was founded with the goal of enhancing humanitarian practice in war settings (Global Health Institute, n.d.b). CREEW was founded to fill the gap in health research in the deeply troubled and complex MENA region, where governments tend to adopt short-term solutions instead of producing long-term health policies in times of crisis. This particular curriculum is made to appropriately prepare medical professionals, such as doctors and researchers, to conduct research more effectively in the context of warfare. A mentored fellowship program, one of the main initiatives of CREEW, attempts to mitigate the negative consequences of the lack of research and data in conflict-affected areas. The purpose of creating the CREEW fellowship is to give frontline health professionals working in conflict zones the tools they need to carry out research on the connection between health and war. The results of the research will help to shape the way humanitarian work is done, particularly in areas where there is conflict.

The program used a methodology that combined field-based research with online mentoring, in-person seminars in Lebanon, and online courses. Five frontline health workers from the MENA region's five conflict-affected nations -Sudan, Syria, occupied Palestine, Iraq, and Yemen- participated in the initiative.

C. Non-Governmental Organizations Initiative (NGOI)

Another initiative of the American University of Beirut is the Non-Governmental Organizations initiative (NGOI) with the mission to enhance the well-being and quality of life of communities in the MENA region by developing and empowering the NGO sector (Global Health Institute, n.d.c). Given the continuous political instability and wars in the MENA region, NGOs lack the necessary resources to cover the health needs of the populations in the region. The NGOI program seeks to address this problem by offering ongoing educational opportunities that can strengthen the NGO sector and, as a result, enhance the standard of living and health of communities. In Lebanon and the MENA region, NGOI offers a variety of services to local and foreign NGOs, such as organizational certification, a digital knowledge resource center, a self-assessment platform, a performance improvement service, and a convening platform that promotes communication and engagement among partner organizations and NGOs. Additionally, NGOI provides seminars, webinars, courses, certificates, and diplomas to NGO workers, as well as training and capacity-building opportunities through these media. These learning modalities include in-person, online, synchronous, and asynchronous. Until today, five in-person courses have been offered to 131 students from various NGOs during 2019 and 2020, while four synchronous courses were created in 2021 and delivered to more than 250 students. 92 students are registered in one or more of the asynchronous courses, which are offered in English and Arabic (Saleh et al., 2022).

D. Humanitarian Leadership Diploma (HLD)

Lastly, the GHI of AUB established the Humanitarian Leadership Diploma (HLD), which focuses on health workers in the humanitarian sector, in response to the development of humanitarian organizations in the MENA region and the growing reliance on them for emergency response services. Through GHI's online learning platform, Global Health Learning and Development (GHLAD), eight asynchronous online courses are offered as part of this program. The students might opt to finish a single course or the diploma (eight courses). The students will receive an online certificate after finishing each course, and an online diploma after finishing all eight courses (Global Health Institute, n.d.d). The total duration of the program is one year and so far, 81 students have enrolled in one or more of the HLD courses from more than 10 different countries.

E. The UN Multi-Country Joint Program

One of the actions taken by the UN in the MENA region is the launching of the UN Multi-Country Joint Program in 2019. Before and during the various stages of migration, the program aims to promote the health, well-being, and protection of individuals and communities in Algeria, Egypt, Libya, Morocco, Tunisia, Iraq, Jordan, Lebanon, and Sudan, nine countries in the MENA region (UN, 2019). The Un Multi-Country Joint Program focuses on the challenges that mixed migration poses for women and youth, who are particularly vulnerable to these issues because of a lack of migrant-sensitive health services, particularly adequate sexual and reproductive health (SRH), mental health care, and psycho-social support, as well as absent or insufficient protection mechanisms and legal frameworks, gender-based violence (GBV), human trafficking, and migrant smuggling.
This program is basically based on building a platform that can be used to create national coordination mechanisms in order to improve migration governance in the MENA countries. The four-year program (2020-2024) is in line with the Global Compact for Safe, Orderly, and Regular Migration's comprehensive migration governance framework as well as the goals of the 2030 Agenda for Sustainable Development (GCM).

F. ISGlobal’s Project to Improve the Health of Migrant Populations in North Africa and the Middle East

In early 2022, a new project by ISGlobal to enhance data collection and surveillance of the health of migratory populations residing in North Africa and the Middle East was awarded by Mobility–Global Medicine and Health Research. This project is founded by four European foundations and aims to resolve the lack of health data in the MENA region by facilitating the monitoring of key indices of the health of the migrant population in six North African nations (Algeria, Egypt, Libya, Morocco, Sudan, and Tunisia), as well as Yemen, using an innovative digital tool called the Migrant Health Country Profile tool (MHCP-1), (ISGlobal, 2022). The goal of the project is to examine the relationship between immigration indicators and various diseases (tuberculosis, HIV-AIDS, viral hepatitis, non-communicable diseases, malaria, neglected tropical diseases, vaccine-preventable diseases, and COVID-19). Additionally, this tool will be utilized to achieve some improvement in the collection of data on health inequalities among the migrant populations in the MENA region, as well as to create public health policies that are aligned with the new information and do not reflect these inequalities. In the context of improving research capacity in Middle Eastern and North African countries. The National School of Public Health (ENSP) in Morocco, the National Board for Family and Population at the Tunisian Ministry of Health, the Institute of Infection and Immunity at St. George’s University of London in the United Kingdom, and the Blue Nile National Institute for Communicable Diseases in Sudan have formed an international consortium under the auspices of ISGlobal. The consortium, known as Migrant Health, coordinates research activities in addition to that. The Migrant Health MENA Working Group's objectives include developing a research network on migration and health and assisting up-and-coming researchers in the field by providing funding to six PhD candidates and two postdoctoral fellows.

V. THE COVID-19 PANDEMIC IN THE MENA REGION

The already politically and economically troubled areas of the Middle East and North Africa were put under further strain by the worldwide pandemic. The evident lack of openness and underreporting of coronavirus (COVID-19) infections undoubtedly worsened the situation in the region. This made it difficult for governments to respond promptly and halt the disease's rapid spread. The Middle East and North Africa (MENA) area saw an increase in cases shortly after the Covid-19 pandemic broke out, with Iran first emerging as the worst-affected nation since its infection rates, up until the end of May 2020, were among the highest globally, right behind China and Italy (Statista, 2022). Iran had the most confirmed coronavirus (COVID-19) cases overall in the Eastern Mediterranean as of July 11, 2022, with almost 7.2 million cases (Statista, 2022). Very high rates of coronavirus cases were also reported across Saudi Arabia and Egypt. The ongoing conflicts in the region are creating even heavier burdens for the populations, which are exposed to great risks, having to face a war and a global pandemic at the same time. This is the case for Libya, Syria, and Yemen, which are still experiencing turmoil in their territories, with Libya having reported over 6 thousand deaths due to the Covid-19 pandemic according to recent data from Statista (Statista, 2022). Furthermore, it is vital to mention the increased number of vulnerable populations in the region, partly because of the conflicts, such as immigrants, refugees, migrant workers and Palestinians, especially in Gaza strip and West Bank, which are more heavily impacted by the virus. Thus, despite the fact that the overall impact of the pandemic appears to be below the global average in terms of both the number of cases and deaths, the MENA region has been severely impacted by Covid-19 and, like the rest of the world, has also been impacted by the socioeconomic impact of the pandemic (Altunışık, 2021). The economies and societies of the Middle East and North Africa were severely impacted by the coronavirus pandemic. The majority of the countries on the Arabian Peninsula rely primarily on income from oil. Consequently, the rapid decline in global oil demand brought on by the coronavirus outbreak significantly harmed the economies of the Gulf. According to the MENA Crisis Tracker of the World Bank, in comparison to the counterfactual case of no crisis, estimated macroeconomic losses as a result of the pandemic have increased steadily since March 2020, reaching 6.2% of MENA's 2019 GDP for 2021 as of January 9th, 2022. The largest anticipated GDP losses are expected to occur in Lebanon, with a projected cumulative loss in 2021 equivalent to 10.8% of its 2019 GDP. Comparing the current state of poverty to a hypothetical one without the crisis, the economic losses have made it worse (World Bank, 2022b).

Responses by most countries in the MENA region were limited to certain control infections by closures
of schools and mosques, lockdowns, and border controls. However, these measures proved to be non-equally applied to different populations in the regions as well as insufficient and disorganized, and thus, they were unable to prevent the spread of the coronavirus cases. As mentioned above, diseases and pandemics know no borders, and the region's states, as well as international entities, must work closely together to address the immediate threat posed by the unprecedented COVID-19 pandemic.

A. Regional Organizations and COVID-19 in the MENA region

It is universally accepted that international organizations such as the United Nations (UN) and the World Health Organization (WHO) are perceived as the main security providers, especially in economically weaker areas like the MENA region. Although the rise of communicable diseases after 2000 resulted in the forming of various health regulations by global and regional actors, the existing regional organizations in MENA, namely the League of Arab States (LAS), the Gulf Cooperation Council (GCC), the Arab Maghreb Union (AMU) and the Organization of Islamic Cooperation (OIC), did not create their health governance regulations in a proactive manner. Given the “globality” of the threat of a pandemic such as COVID-19, regional organizations ought to provide assistance to their member states which are struggling with serious health risks. Nonetheless, in the case of the MENA region, it seems that regional cooperation was not very effective as there were no pre-existing strategies that would facilitate collective responses during the hard times of the COVID-19 crisis. As noted by Brik (2022), the inability to adequately address the pandemic resulted in the worst economic crisis the region has experienced.

Firstly, the League of Arab States (LAS), despite being made up of 22 primarily Arab-speaking nations and including all states in the region with the exception of Iran, Israel, and Turkey, has been shown to be inefficient in implementing health policy throughout the region. The Arab Strategy on Health and the Environment and its Strategic Action Guide for 2017–2030, which were developed by WHO-EMRO, were adopted at the Dhahran Summit in Saudi Arabia in April 2018 as a result of the WHO's encouragement of LAS to create common health policies at the beginning of the previous decade. Yet, the implementation of such plans remains limited (Altunışık, 2021). In the outbreak of COVID-19, LAS failed to develop a rapid response and instead of holding the scheduled March 2020 summit and providing opportunities for health cooperation, the summit was canceled. Fawcett asserts that the LAS, while making some affirmative comments, served as a venue for discussion of COVID-19 questions. More particularly, the organization met with China and Japan, two powerful nations in Asia, on separate occasions to discuss issues linked to Covid-19. As a result of the COVID epidemic, LAS states and Japan have met at a high level as part of a current UNDP-sponsored project to discuss the UN's Sustainable Development Goals for the Arab world. Early on, LAS organized a conference between China and Arab countries to exchange information and discuss cooperation. Similar to this, the UN Office of Disaster Risk Reduction (UNDRR) has collaborated with Arab countries to host gatherings where they may exchange COVID lessons and discuss risk mitigation strategies (Fawcett, 2021). All in all, even though the Arab League did not promote a collective health policy in the MENA region, it served in the instance of Covid-19, as a beneficial venue for extra-regional countries to interact with the region as a whole.

Contrary to LAS, the Gulf Cooperation Council (GCC), which consists of: Bahrain, the Kingdom of Saudi Arabia (KSA), Kuwait, Oman, Qatar and the UAE, proves to be more active from the first months of the pandemic. Fawcett refers to virtual meetings about health issues and cooperation organized by the GCC, with representatives from each member state's health ministry in attendance. Unfortunately, only two meetings took place due to internal differences between health ministries among member states of the GCC. From July 2020 onwards the official meetings were generally replaced with workshops and expert panels on various topics and, thus, did not result in any materialized collective effort against COVID-19 (Altunışık, 2021).

At the start of the COVID-19 crisis, two promising ideas included the creation of a Gulf crisis room to coordinate activities and a network to get food supplies. Given the dependence of the region on external food supply networks, this was a critical concern (Fawcett, 2021). Furthermore, billion-dollar stimulus packages were introduced by several wealthier Gulf states including KSA, Qatar and UAE in order to facilitate economies in the region which were suffering from the consequences of the pandemic, such as the falling of oil prices. Despite these limited efforts the GCC policy against the pandemic proved to be insufficient as well.

The Arab Maghreb Union (AMU), which comprises the five Arab countries of Northwest Africa (Algeria, Libya, Mauritania, Morocco, Tunisia), has also failed to form any cooperative initiatives against the COVID-19 pandemic. As Altunışık (2021) notes, the AMU’s response was weak and very limited. Online gatherings with city mayors from the member states were organized by the regional organization. Additionally, the Secretariat made an effort to compile and disseminate daily reports on the pandemic's progress in the Maghreb countries. However, these efforts proved ineffective in terms of producing cooperation around health challenges in the region.

Lastly, the Organization of Islamic Cooperation (OIC) (the second largest international organization after
the UN), which crosses various world regions, including MENA unifying the Islamic states, seemed to be more effective than the aforementioned organizations during the pandemic. According to Fawcett 2021, the OIC held a number of online gatherings, including a conference with the rectors of OIC universities to talk about coordinated tactics to combat COVID-19. Moreover, the OIC took the initiative to organize a discussion on how to tackle fake news, which is significant among member states where there is supposedly widespread misinformation and vaccine hesitancy. The Islamic Solidarity Fund of the OIC has also offered support for OIC members, primarily Least Developed Countries or countries in need of humanitarian aid immediately. Further, according to Altunışık (2021), the OIC has frequently supported national policies and state measures against the COVID-19 pandemic, for instance, in the development and testing of regional vaccines, or in the adoption of COVID-compliant practices.

Taking into account the aforementioned initiatives, it becomes evident that most cooperative and regional mechanisms in the MENA region proved to be particularly weak and insufficient in terms of the fight against the pandemic. Responses in the MENA area have mostly relied on the efforts of individual states and their friends abroad due to the lackluster performance of regional action. The most vulnerable nations and regions have relied on international aid programs like the COVAX program.

B. COVAX

The lack of regional cooperation in the deeply divided, with turmoil and inequality, region of the Middle East and North Africa resulted in some countries in the region having better resources and opportunities to combat the pandemic. In this context, the WHO founded the COVAX initiative to eliminate these inequalities among countries in the event of a global pandemic. In fact, according to the head of the World Health Organization, wealthy nations accounted for more than 87% of the more than 700 million doses of coronavirus vaccination provided globally (CNBC, 2021).

The World Health Organization (WHO), the Global Alliance for Vaccines and Immunization (GAVI), and the Coalition for Epidemic Preparedness Innovations (CEPI) have formed a cooperation known as COVAX to collaborate on the fair distribution of COVID-19 vaccines. It guarantees fair and equal access to COVID-19 vaccines provided by UNICEF and comprises 190 countries with a combined population of more than 7 billion people. It aims to ensure fair and equitable access for all countries around the world and to accelerate the development and production of COVID-19 vaccines (WHO, n.d.b). Within COVAX, WHO plays a variety of roles: It offers normative advice on vaccine policy, regulation, safety, funding, distribution, and state readiness and delivery. Furthermore, Glide, with funding and support from the Bill & Melinda Gates Foundation and support from Global Health Strategies (GHS), developed an advocacy initiative aimed at increasing awareness of and support for COVAX in the MENA region. The COVAX initiative, sponsored by the U.S. and the EU among others, has significantly helped the LMICs of the MENA region to control the spread of the COVID-19 pandemic by providing the states with vaccine distribution, syringes, and health equipment, with countries such as Egypt having received 4.389.600 COVAX doses (Data Science Initiative, n.d.).

VI. CONCLUSION

The Middle East and North Africa region is deeply affected by ongoing political and economic instability as well as conflicts and its implications. These factors are aggravating the region’s health status to a great extent, which, despite some improvements in recent years, is carrying the burden of the spread of communicable diseases and other heavy health risks. The situation is even worse in the Low-to-Middle income countries where the lack of financial resources and the massive human displacement put health policies very low on governmental agendas. The scarcity of health data and the absence of common health policies in the MENA region have created a gap in research that global institutions and organizations are trying to fill through global health initiatives. Many of those initiatives are still very new projects that aim to implement health policies or contribute to existing ones by training health personnel and educating people in vulnerable populations. The COVID-19 pandemic saw a rise in global health initiatives as well as some small improvements in regional cooperation in the MENA region in order to help the most negatively impacted countries by the disease. Given the need for symmetrical recovery after the pandemic (Emmanouil-Kalos, 2021), such initiatives should be maintained and expanded in the long-term. Overall, the global health initiatives implemented in the Middle Eastern and North African countries most recently seem to have contributed to the gradual improvement of health indicators in the region. Nonetheless, there is definitely a long way to go regarding eliminating health challenges in the MENA region.


