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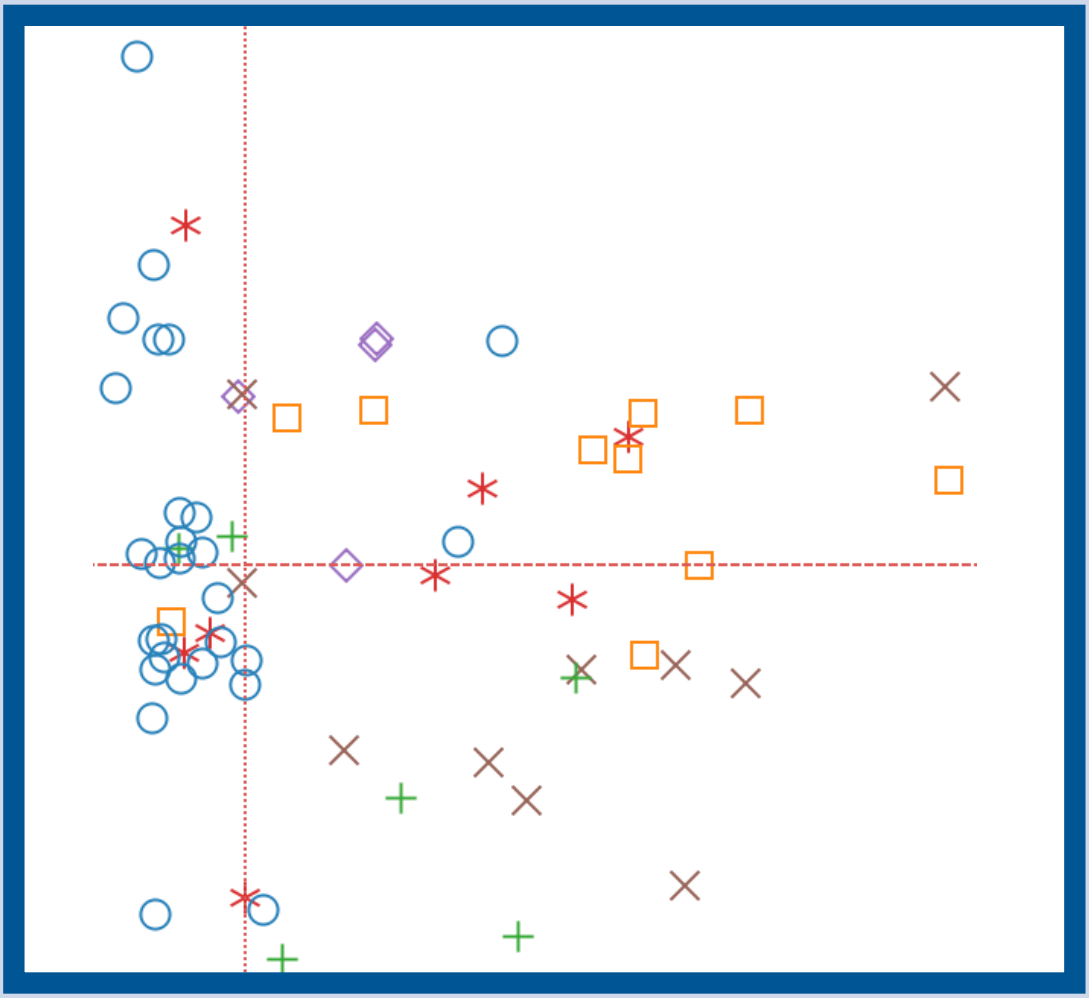
Health inequities in the Eastern Mediterranean Region

Selected country case studies



World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

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Executive summary

This report focuses on the available evidence on inequities in health and inequities in socioeconomic determinants that exist both within and across countries in the WHO Eastern Mediterranean Region. It uses data from the Pan-Arab Project for Child Development (PAPCHILD) and Pan-Arab Project Family Health Survey (PAPFAM). The report aims to assess the extent of health inequality in the Region and identify what contributed to the changing levels of inequalities in the 1990s. The study analyses the role of changing socioeconomic and behavioural characteristics of the population and the changes in health system in contributing to widening or narrowing health inequalities. The analysis is limited to six countries in the Region for which we have data on health outcomes in two points in time (early 1990s and early 2000).

Three main research questions were asked as follows.

1. What is the extent of health inequities within and across the countries in the Region?

A child born in Djibouti is five and a half times more likely not to live until its fifth birthday compared to a child born in the Syrian Arab Republic. Within Yemen, children born to the poorest 20% of households are more than twice as likely to die before their fifth birthday compared to children in the richest 20% of households.

Within countries health inequalities are quite strong. For maternal health-related indicators the inequalities have widened over time in all the countries surveyed except Lebanon. The health status of the poorest has generally improved but the gap between the richest and the poorest has widened with the richest gaining the most from the positive economic performance and investment in health over time.

Coverage of diphtheria-pertussis-tetanus vaccination has improved, and the gap between the richest and the poorest has narrowed over time, except in Yemen, where a major gap still exists, with children from richer backgrounds being twice as likely to be vaccinated than children from poorer backgrounds.

2. What are the major factors contributing to health inequities within countries?

Three main domains were identified: health system factors, socioeconomic factors and behavioural and biological factors.

We analysed in depth the factors that contributed to the inequalities in skilled birth attendance. We were able to perform this analysis of inequalities for Yemen, Syrian Arab Republic, Tunisia and Morocco. We could not run the same analysis for Lebanon or for Djibouti. In Lebanon, this analysis was not done because the analysis of inequalities showed little difference in skilled birth attendance between the rich and the poor. As far as Djibouti is concerned, the PAPFAM data for Djibouti did not contain information on asset ownership, so it was not possible to estimate the wealth index and perform the analysis of decomposition of inequalities.

Results of the analysis indicate that inequities in health system factors contribute between 20% and 33% among the countries considered. In the Syrian Arab Republic and Yemen the contribution of health system factors to the overall inequality in skilled birth attendance were above 30%, whereas in Tunisia and Morocco these proportions were much lower.

Both in Yemen and the Syrian Arab Republic the contribution of behavioural and biological factors to the overall inequalities is minimal (less than 1%), whereas for Tunisia and Morocco around 10% of the inequalities could be attributed to behavioural and biological factors.

The main determinants of inequalities for all the countries studied were the contribution of socioeconomic factors, explaining more than 60% of the inequalities in all countries.

3. What are the major policy implications or actions that countries should consider given the results of the analysis?

The result of the decomposition analysis highlights the contribution to health inequities of factors outside the health sector. This indicates that to lower the inequalities in these selected health outcomes and health system factors effective intersectoral action is needed. Results clearly show that improvement in health can only be achieved through investments in the social and economic sector, via an increase in women's education, reducing poverty and improving well-being across the whole of society with particular focus on the worst off.

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