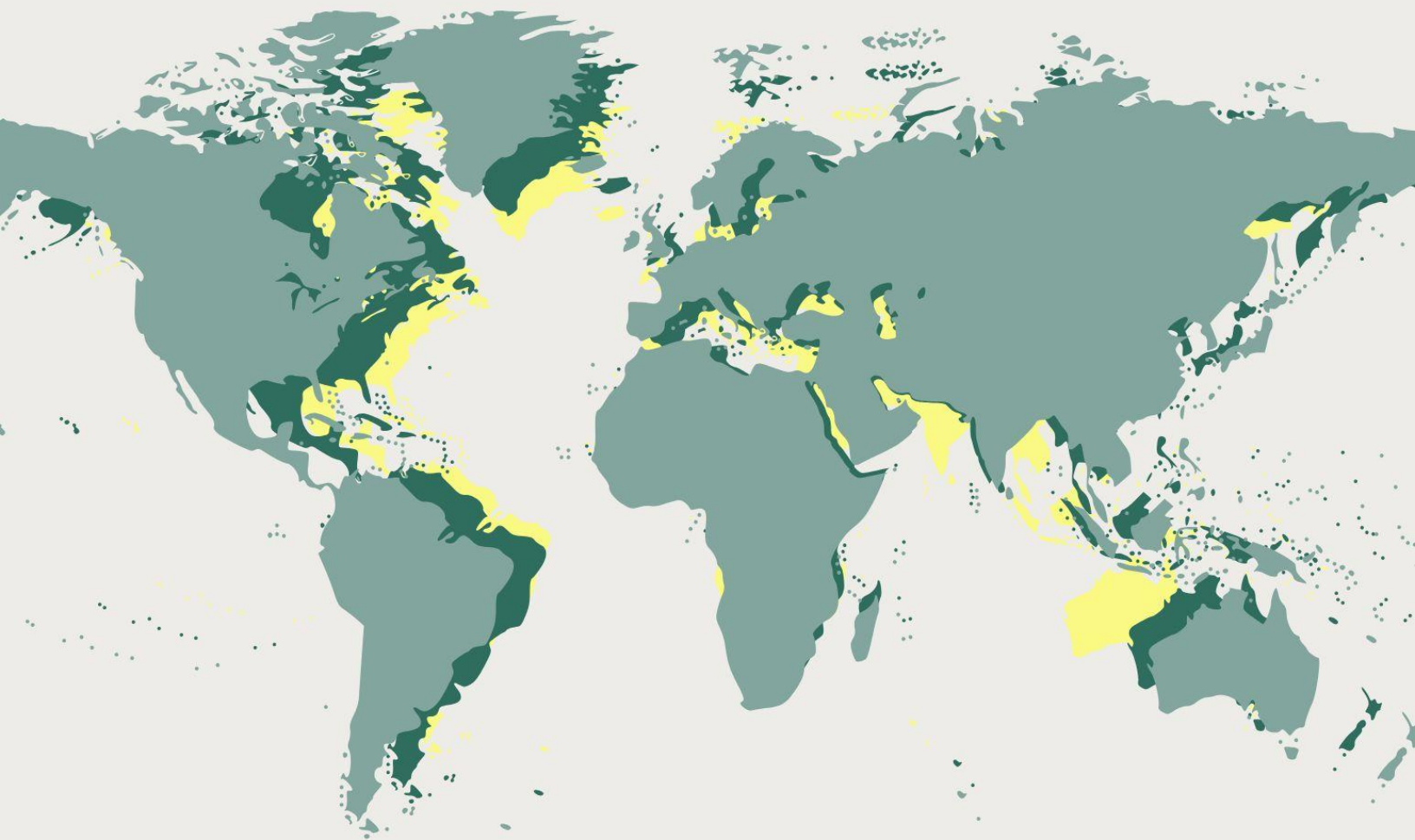


REGIONAL GUIDE EMRO REGION



2025 AMWHO INTERNATIONAL CONFERENCE

Bridging Health and Healthcare Disparities between Low, Middle, and High-Income Countries to Achieve Universal Health Coverage

Introduction

The World Health Organization's (WHO) Eastern Mediterranean Region (EMRO) consists of 21 member states spanning the Middle East with country offices in 17 of the countries.¹ The Eastern Mediterranean region is vastly diverse in terms of culture, socioeconomic standing, etc. Currently, EMRO's official languages are Arabic, French, and English. However, the region encapsulates various other languages such as Farsi, Urdu, Dari, Pashto, and Somali, which are vital in implementing and communicating health policy in the region.¹ Overall, the region must consider various cultural and political contexts to achieve the equitable health policies outlined by WHO.



The region has a long history of humanitarian crises across various member states. These conflicts, natural disasters, and political instability have exacerbated healthcare coverage and access issues.¹ Millions of people have been displaced, leading to weakened health systems.² Nearly $\frac{2}{3}$ of the countries in EMRO are directly or indirectly impacted by conflicts in the region, greatly contributing to increased poverty levels, lowered life expectancy of the region's population, and greater vulnerability to vaccine-preventable diseases.² By the end of 2018, the global number of people in need of aid due to conflict, natural disasters, or political instability was 80 million, and 46% (37 million) of those 80 million people were from the Eastern Mediterranean region.² Moreover, within the year there were major endemic outbreaks in 12 of the region's countries.² These numbers underscore the disproportionate severity of humanitarian crises in the region and these challenges further emphasize the need for strong and comprehensive targeted policies that address the impact of such issues.

The Universal Health Coverage (UHC) service coverage index can be used to analyze the implications of conflict and disaster on healthcare systems in the region as it measures the proportion of the population without quality access to healthcare.² The Eastern Mediterranean region has an index of 64 out of 100, which is below the global average of 68 out of 100.² A serious contributor to this low index is a major healthcare worker shortage, with many countries struggling to meet the minimum staffing threshold.² Additionally, healthcare workers face the threat of attack during humanitarian and political conflicts occurring in the region, further reducing the number of healthcare personnel.² Moreover, the region suffers from inadequate access to medical technology and essential medicines. Mechanisms and policies in the public and private sectors lack the capacity for effective delivery and oversight of medical supplies, and many low-income sectors completely lack access to medical devices and products.² The low UHC service coverage index can also be explained by the low investment in healthcare by the region.² While the region consists of nearly 9% of the global population, it accounts for 2% of global health expenditure.² This continues to exacerbate the issue of poverty in the region as individuals are paying more for medical services out-of-pocket.² All in all, the prevalence of crises and disasters in the eastern Mediterranean continues to amplify issues such as poverty and security that contribute to poor healthcare coverage and access. While the region has taken initiatives such as UHC priority benefits packages and strengthening delivery of services through the primary health care system, EMRO and WHO acknowledge the further efforts needed to achieve UHC.²

Subtheme 2: Disparities in Access to Quality Healthcare

Healthcare systems in the Eastern Mediterranean (EMRO) Region have faced various struggles and obstacles over the past years. These include conflict and disaster, population growth, high unemployment rates, scarcity of water resources, and socioeconomic gaps.¹³ These factors have reduced the quality and access to proper healthcare in the region. Moreover, wealthier countries in the region do not necessarily have better health outcomes. Some high-income countries, such as Oman, have shown similar health outcomes to those of Egypt and Morocco, which are lower-middle-income countries.¹⁴ This indicates that disparities in healthcare quality and access are not based on economic factors alone, but require the consideration of implementation of services.¹⁴ Moreover it is also important to note internal divides within countries that contribute to barriers to healthcare access. Rural-urban divides, discrimination on the basis of religion, gender, race, etc, and health literacy disparities all contribute to unequal healthcare coverage in the region's countries.¹⁵

CASE STUDY 1: RESTRICTED ACCESS TO OBSTETRIC CARE AND MATERNAL HEALTH SERVICES IN SUDAN

With an ongoing military conflict in Sudan, millions have lacked access to quality health care. This is especially true for pregnant women in Sudan. Sudan's maternal mortality rate is one of the highest in the world with an estimate of 295 deaths per 100,000 live births, and it is reported that 86.6% have received limited or no access to healthcare.¹⁵ The continued conflict in Sudan has only exacerbated this issue, leading to the destruction of medical facilities, a shortage of medical supplies and services, and fleeing medical staff.¹⁶ The United Nations Cooperation Framework report for 2020 reported that only 19% of births in Sudan were attended to by professional medical staff.¹⁸ It was also reported that only 40% of medical facilities were functional and international organizations provided most delivery services. Moreover, women in conflict settings are more vulnerable to sexual and gender-based violence, which can have detrimental effects on reproductive health.¹⁵ Women in Sudan have been severely impacted by the effects of the conflict on Sudan's healthcare system, therefore, it is crucial to understand the particular challenges in accessing maternal care to cultivate appropriate solutions.

Political conflict and war in Sudan has made obstetric care very difficult to access for women. The destruction of medical facilities and violent attacks on medical personnel have specifically affected the ability of women to access antenatal care, safe deliveries, and postnatal care.¹⁶ This is largely due to women having to travel long distances to receive obstetric care, putting a strain on the resources and health of the woman.¹⁶ Women often opt out of traveling these far distances, and give birth at home without the proper support. This increases the risk of complications such as sepsis, hemorrhage, and obstructed labor.¹⁷ Moreover, newborn health is detrimentally impacted as well. There is a lack of sufficient medical supplies and resources for preterm babies in Sudan.¹⁸ Sudan has seen an increase in preterm babies due to stress, insecurity, and malnutrition of pregnant women, and preterm babies are often at higher risk for complications.¹⁷ This, coupled with poor sanitation in birthing places, has significantly worsened newborn mortality rates.¹⁷ A lack of quality medical resources and supplies such as drugs for maternal and newborn survival can be attributed to dysfunctional vertical supply chain management in South Sudan. In addition to barriers to access and decreased quality of medical services due to violence and a lack of medical supplies, women also face a fear of traveling to receive care, financial constraints, cultural barriers, and a lack of awareness and education regarding services and care available.¹⁶

There are various ways these challenges have been and can be addressed. One promising solution is a potential resource in the mobile health services called mHealth. mHealth has been shown to improve maternal health by providing women with information, education, and support.¹⁶ Moreover, deploying community healthcare workers such as midwives can address the barriers women face in accessing medical personnel in healthcare facilities.¹⁶ The United Nations Sexual and Reproductive Health Agency (UNFPA) has also engaged in initiatives that can be considered when addressing this issue.¹⁹ This includes reproductive education initiatives, strengthening the Maternal Perinatal Death Surveillance and Response (MPDSR) systems, and improving access to maternal and reproductive health commodities such as contraceptives and medicines.¹⁹

CASE STUDY 2: BARRIERS TO ACCESSING MULTIPLE SCLEROSIS THERAPIES IN LEBANON

Multiple sclerosis (MS) is a complicated autoimmune disease that affects the central nervous system by causing a progressive breakdown of the protective covering of the nerve.²⁰ This includes the brain, spinal cord, and optic nerves that control everything we do. According to a cross-sectional study that was conducted between January of 2018 and December of 2018, rates of multiple sclerosis have increased across the Middle East and specifically in Lebanon.²⁰ Data collection was based on age, sex, geographic region of residence, time of diagnosis, and presence of disease-modifying therapies.

What was once considered rare in the Middle East, in 2018, the crude prevalence of multiple sclerosis was 62.91 cases out of 100,000.²¹ In the total frequency of distribution of MS cases in Lebanon in 2018, the frequency of MS amongst a sample size of 2166, demonstrated that 712 or 32.9% of the sample consisted of men and the remaining 1454 or 67.1% consisted of women.²² In terms of distribution amongst ages, participants between the ages of 35 and 44, 27.6% (598 participants out of 2166) made up the largest proportion, and those above the age of 75 made up the smallest proportion at 0.5% (10 participants out of 2166).²¹ Geographically, the MS cases between Mount Lebanon, South Lebanon, Beirut, North Lebanon, and Bekaa, were distributed at 24.7%, 22.5%, 20.4%, 18.9%, and 13.5% respectively.²¹

The collected data from the sources emphasizes the systemic and logistical barriers to accessing multiple sclerosis modifying therapies in Lebanon rooted in the socioeconomic disparities and challenges in healthcare infrastructure. Reliance on government reimbursement systems, minimal private insurance support, and a lack of advanced therapy like cladribine.²² Urban areas have higher access levels to specialized centers but certain rural areas have pronounced delays due to financial and geographic constraints. Addressing the systemic issues that delay treatment initiations is critical to reducing the burden of MS and comprehensive patient care.

Subtheme 4: Prioritization of Mental Health

Displaced populations, lack of basic healthcare, infectious diseases, poor healthcare infrastructure, and economic hardships are just some of the paramount issues that affect those in the EMRO region. More than 21 million people in the region have been forcibly displaced and 5 million people are refugees.² Individuals are constantly battling the effects of loss and trauma. All of these effects multiply the impact of mental health conditions such as “mental disorders and psychosocial disabilities” that are associated with distress and at times self-harm.² Globally, those with mental health disorders that are severe die 10 to 20 years earlier than the average population.² There is still a large gap between mental health and the necessary provisions in mental health. Those who experience psychological and physiological distress stretch the demand and access to health infrastructures. Limited mental health specialists, imbalances in psychotropic medicine, and other barriers have prevented the necessary delivery of mental health services and support.

CASE STUDY 1: ACCESS TO SYRIAN MENTAL HEALTH SERVICES

Since 2011, Syria has faced a civil war that has displaced millions of people and impacted many still living in the country.⁴ The effects of such warfare have been devastating for Syria’s healthcare system as there has been a severe lack of food, water, and medical resources. This strain has been especially impactful on the access to mental health resources in Syria. Syria has already faced severe stigmatization of mental health for years, and the war has further exacerbated the issue of access to resources such as psychologists and psychiatrists.⁴

It is important to understand how the war has cultivated and impacted certain mental disorders. In a study conducted by Ameer Kakaje, et al., the Kessler Psychological Distress Scale (K10) was conducted on Syrians to evaluate mental disorders. The scale for the tests is as follows:

- * Scores under 20 are likely to be well.³
- * score 20-24 are likely to have a mild mental disorder.³
- * score 25-29 are likely to have a moderate mental disorder.³
- * score 30 and over are likely to have a severe mental disorder.³

In the study, 80.7% of people in Syria scored above 20 on the K10 test, and around 60% of the population reported symptoms aligned with moderate to severe mental disorders.⁴ Moreover, the study reported PTSD levels with 36.9% of the participants having full PTSD symptoms, 60.8% having two or more positive PTSD symptoms, and only 21% without any PTSD symptoms.⁴ Various factors play a role in these levels, such as constantly moving places, bombings, violence, and lack of social support. Overall, more than half of Syrians need mental health and psychosocial support services, however, these conditions are often unaddressed, trivialized, or ignored.⁵

The conflict in Syria has led to many barriers in seeking and receiving quality healthcare. Those internally displaced in Syria do not have adequate access to address the impacts of war on their mental health.⁵ Moreover, there have been targeted attacks on medical personnel and psychiatric hospitals, which has been a barrier to access to resources.⁵ Moreover, healthcare and mental health efforts have been reduced. Before the conflict, in 2014, Syria began implementing better mental health legislation and a new mental health strategy which included greater funding for hospitals and INGOs targeted at addressing mental health.⁶ However, since the conflict in Syria has been occurring, this legislation has been weakly and partially implemented—only 48% of public hospitals and 48% of private hospitals are fully functional.⁶ Furthermore, the healthcare infrastructure faces a shortage of mental health staff. The WHO reported 1,931 mental health professionals, comprising 0.37 psychiatrists, 1.07 nurses, 1.07 psychologists, and 0.08 social workers, per 100,000 people in the population, and for comparison, in Germany, there are around 2.8 psychiatrists per 10,000 people.⁶ That, in itself, is a drastic disparity.

While there is much work and improvement to be made, there are initiatives and progress currently implemented to help combat some of the issues Syria faces. The WHO office in Damascus trained nearly 725 physicians in family and group counseling, psychological first aid, and support for GBV survivors.⁷ There has also been a shift in the attitude toward psychiatric medication. Psychiatric medication was often viewed as narcotics, further stigmatizing them.⁷ However, training for non-psychiatric doctors in prescribing drugs and training for pharmacy staff on differentiating between psychiatric medication and addictive drugs have greatly changed the attitudes of healthcare professionals and Syrians regarding psychiatric medication.⁷ Moreover, the Syrian Association of Psychiatrists has developed a platform for psychiatrists to conduct interviews or consultations electronically to address the difficulties in being able to meet with medical professionals in person amidst political upheaval.⁸ Despite such initiatives, there is still much progress to be achieved. Taking into account cultural and religious taboos regarding mental health support, and placing mental health crises in a cultural context is crucial in implementing effective policy. It is important to address re-strengthening health infrastructure in Syria as well as education and awareness of Syrians regarding mental health and support resources.

CASE STUDY 2: FACTORS ASSOCIATED WITH INJURIES AND TRAUMA OF SURVIVORS OF GENDER-BASED VIOLENCE IN AFGHANISTAN

According to WHO standards, domestic violence, or 'Intimate Partner Violence', is a "behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors".⁹ This challenge is further illustrated through the IPV stigmatization model, which provides a framework for understanding how domestic violence stigma shapes barriers to seeking help.

Amongst the regions of the world, the Eastern Mediterranean region has a 30% median prevalence of physical abuse⁹. Amongst factors that make people more vulnerable, refugees or asylum seekers were 5.8 times more likely to be victims of intimate partner violence.⁹ In many Eastern Mediterranean countries, these social and community-related risk factors exacerbate the risk of domestic violence.

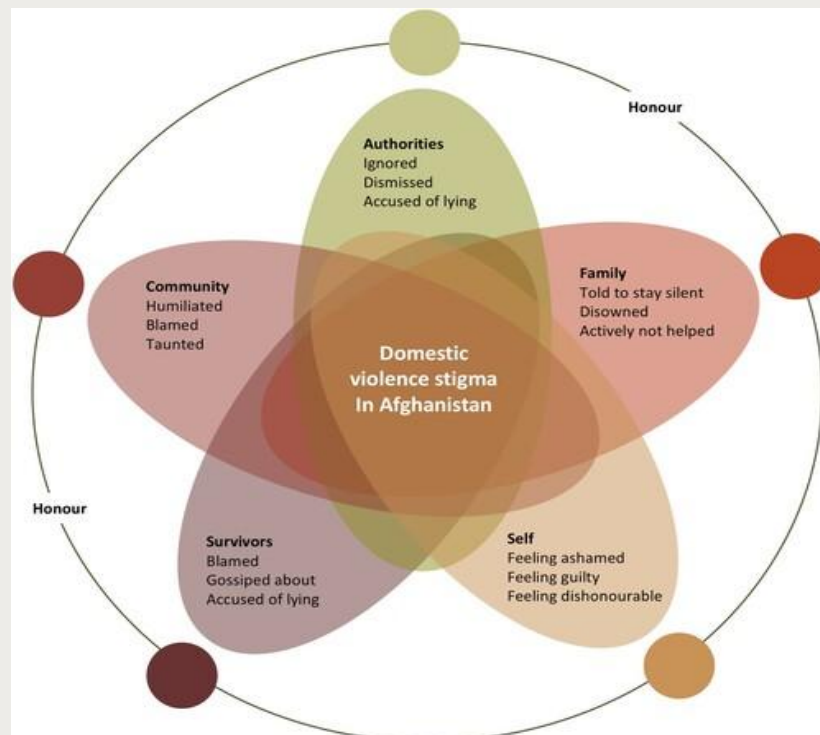
In Afghanistan, domestic violence rates are some of the highest in the world. Around 46% of women report lifetime violence¹⁰. Survivors of domestic violence are also prone to the most environmental stigma in the forms of gossip, blame, and shame.¹⁰ Certain structural elements including government authorities, the predominantly patriarchal format of society, and dismay from the community have been principal in inflaming psychological trauma in Afghanistan.⁹

The Ministry of Public Health of the Islamic Republic of Afghanistan working with the United Nations established a department known as the 'gender department' to regularly track gender-based violence. The data was collected from FPCs (Family Protection Centers) and violence was categorized into 4 different categories: deprivation/neglect, psychological violence, physical violence, and sexual violence.¹¹ The results of these types of violence were then split into injury and trauma. The data collected between November 2013 and October 2019 revealed that:

- Adults have the highest level of trauma among survivors, with children and the elderly being affected in a much smaller proportion.¹¹
- Females experience an overwhelmingly large experience of injury and trauma, revealing disparities relating to gender.¹¹
- Married individuals are most likely to report injuries and trauma, which reveals more about domestic abuse dynamics and marital status.¹¹
- Physical violence has a strong correlation with trauma, potentially connecting psychological tolls of physical abuse.¹¹
- Geographically, northern and western regions show higher trauma reports which could reveal more about cultural and social factors.¹¹

The data reflect that trauma from GBV is present in both physical and mental forms. In Afghanistan, survivors who are predominantly adult women, endure severe long-term psychological impacts even when physical injuries are not visible.¹² Seeking help is frowned upon due to stigma and fear. These factors emphasize the need for mental health prioritization, and addressing both invisible and visible trauma. There is a compelling case for the pervasive impacts of trauma on mental health. Conditions like PTSD, depression, and anxiety are prevalent and they have comprehensive effects on overall well-being, and quality of life, and prevent citizens from being functioning members of society.¹¹

A significant theme in this case is the barrier between effective treatment for trauma-induced mental health conditions, and how limited mental health resources, social stigma, and inadequacies in trained professionals prevent people from receiving proper care. This challenge is further illustrated through the IPV stigmatization model, which provides a framework for understanding how domestic violence stigma shapes barriers to seeking help. The IPV stigmatization model is a framework that allows us to conceptualize domestic violence stigma and how it impacts help-seeking. The model is primarily used in a North American setting, but it tracks findings about women's experiences specifically in Afghanistan.¹¹ The social structures that are used to define the life of a woman, pile together and magnify the overall stigma experience for survivors of domestic abuse.¹² Services based on Western ideas of allowing women to leave abusive relationships and reject stigma to allow the constant perpetuation of violence would be productive in limiting the effects of mental health in Afghanistan. A new system can be implemented to break down these stigmatizing responses and allow survivors to seek help.¹²



Subtheme 5: Unshared Technological Advancements

In the Eastern Mediterranean region, technological advancements have played a vital role in shaping the future of public health. Intricate healthcare challenges, instability in economic systems, and a lack of infrastructure have made adopting new healthcare delivery systems imperative. In the region, 24% of nomenclature systems are used for medical devices, 14% have health technology national policy, and 4.7% have a list of approved reimbursable medical devices.²³ These values demonstrate the hindrances in implementing such technologies caused by a lack of resources, education, and political instability.²³ Ongoing conflicts have generated significant gaps in healthcare systems. Major cases shed light on how technological advancements both drive progress and reveal systematic inequalities within the region's diverse landscape.

CASE STUDY 1: BARRIERS TO CANCER CARE TECHNOLOGY IN IRAQ

Between 1980 and 2017, Iraq has been engaged in successive wars, conflicts, sanctions, and more that have put a strain on healthcare infrastructure in the country.²⁴ The destruction of medical facilities, economic strain reducing health expenditure, and reduced medical staff have left Iraq with high levels of cancer without the proper technology and infrastructure to combat such high levels.²⁴ Iraq is regarded as one of the poorest Arab countries in terms of its imaging services and nuclear medicine.²⁴ Diagnostic and treatment technologies are severely lacking in Iraq due to structural and economic barriers, and these have had long-term negative impacts on cancer rates in Iraq.

Firstly, economic sanctions by the UN on Iraq have blocked technologies. These technologies are blocked due to sanctions. Sanctions placed restrictions on technologies with the potential to be turned into weapons of mass destruction.²⁴ This includes equipment such as linear accelerators and nuclear diagnostic technology. Regarding specific types of technologies, the lack of diagnostic technologies in Iraq has posed a serious threat to citizens. With limited numbers of scanners such as CT and MRI machines, doctors have had to often loosely put together diagnoses with simple X-rays, ultrasounds, and blood tests, which has decreased progress in diagnostic levels in Iraq.²⁵ Moreover, nuclear medicine service is an effective form of cancer diagnosis used in the region, but due to barriers, Iraq's infrastructure for NM is low.²⁶ Currently, the number of SPECT/CT devices, gamma cameras, and PET/CT machines, that are used in NM, is only 0.4 units per 1 million people, and this can be compared to a relatively conflict-free region, Kuwait, with 10.3 units per 1 million people.²⁶ This over-a-decade-long deficit in diagnostic scanners and technologies for cancer has led to a 50% cancer incidence surge in the last decade in Iraq.²⁶

In addition to a lack of diagnostic technologies, Iraq faces insufficiency in its number of therapeutic/radiotherapy technologies. By the end of 2022, the country only had 34 functional linacs for radiotherapy, 9 of which were private.²⁵ This number translates to only 42.5% of the Iraqi population's needs being met (two machines per million population).²⁴ This lack of technology has made radiotherapy hard to access for people as many of them have to travel long distances to access the treatment or wait in long lines.²⁴ Due to these inconveniences, many individuals refuse necessary treatment, especially for older individuals needing geriatric radiotherapy.²⁴ Moreover, in addition to a lack of physical technologies in the region, even if the technology supply was sufficient, there is a shortage of professionals and medical personnel with the training or knowledge to operate these high-level technologies.²⁴

In recent years, Iraq has made efforts and progress to improve cancer diagnosis and care in the region. They began implementing recommendations from a 2021 IAEA-IARC-WHO impACT review which was a comprehensive document outlining ways to improve cancer control in Iraq.²⁷ Iraq has improved coordination between the Iraqi Cancer Board and the Ministry of Health Noncommunicable Disease Unit, adopted a Ministerial decree to better facilitate opioid prescription for terminally ill patients, and has committed itself to creating a national cancer control strategy and plan.²⁷ Despite these actions, more targeted, urgent, and effective long-term measures are needed to be taken in order to improve cancer outcomes in the country. Addressing cancer treatments and outcomes in Iraq requires holistic approaches that address preventative and palliative care, implement effective training for healthcare providers, and account for the psycho-social support needed for patients and families.²⁷

CASE STUDY 2: INNOVATIONS IN E-HEALTH TOOLS IN KUWAIT

At the top of the Persian Gulf, Kuwait is one of the richest countries per capita in the world due to its location and enormous oil reserves.²⁸ With just 4.4 million people in the country, Kuwait is the fourth most obese country in the world, and obesity rates are alarming.²⁸ With a predominantly young population, the looming impacts of disease and complications have increased the focus on public health. The Kuwait Diabetes Epidemiology Program (KDPEP) was a national, population-based study used to study noncommunicable diseases in the country.²⁹ The consisted of four steps which tracked demographic questions, behavioral measurements, physical measurements, and blood biochemistry analysis.²⁹ Specifically, the blood analysis included fasting plasma glucose and glycated hemoglobin measurements, with 4,947 adults completing all steps.²⁹ Data revealed that 21.8% of Kuwaiti adults had diabetes, and there was a strong association between obesity and diabetes as the principal contributing factor to obesity in the country. Elevated body mass index (BMI) and a correlation to the waist-hip ratio were associated with diabetes and prediabetes in the study.²⁹ The study also demonstrated that university education has an inverse relationship with the risk of developing diabetes and said risk is also generally associated with a lower income. This drastic increase in diabetes is over three times other global estimates for adults of 60; outpacing estimated global prevalence across every age group globally.³⁰

The introduction of e-health tools in Kuwait and substantial upgrades to the country's healthcare facilities and infrastructure are underway. In the past year, 80% of the country's healthcare spending comes from public healthcare.²⁹ Aside from the high prevalence of diabetes, another grave issue to public health is the ubiquitous nature of antimicrobial resistance. The leading solution to this issue is the integration of patient health records and better assistance systems. Electronic health systems (EHS) are a systematic approach to managing health information that modernizes healthcare infrastructure and shifts away from outdated paper-based records.³⁰ The article offers a detailed analysis of how the EHS approach relies on a mixed method of quantitative and qualitative interviews.³⁰ Surveys amongst various healthcare professionals such as doctors, nurses, and administrative workers were conducted to estimate the experience and satisfaction involved with EHS. Key findings showed that 70% of facilities included in the survey had some type of implementation of electronic health systems and larger institutions have been leading efforts to implement said programs.²⁹ However, only 45% of the users report that they consistently utilize these resources and attribute a lack of training and prevalent technical challenges as obstacles to successfully implementing EHS.³¹ Data analysis shows a 25% reduction in the time needed to retrieve patient records, even with the limited adoption of EHS, showcasing the possible benefits.³¹ Rural areas continue to lag behind urban locations and the lack of successful implementation limits EHS from transforming Kuwait's healthcare.

This underscores the transformative nature of the electronic health system and the significant strides that have been and are yet to be made. Technological promises and operational challenges have left things incomplete in the journey but the implementation of EHS has demonstrated benefits such as record retrieval times and elevated data accuracy.³¹ However, the issue is uneven integration through facilities and user integration halted due to systemic gaps caused by a divide between rural and urban healthcare centers. The critical question remains as Kuwait embraces new digital health solutions: how could policymakers adopt a more coherent strategy that enhances user training and interoperability? Insight advocates that data-driven approaches will solidify EHS as a sustainable approach to public healthcare in Kuwait.

The EMRO region is grappling with significant healthcare challenges, many of which stem from conflict, economic disparities, displacement, and limited access to medical resources. The struggles faced in different parts of the region—whether it's the mental health crisis in Syria, the widespread gender-based violence in Afghanistan, maternal health barriers in Sudan, or the technological gaps in Iraq—highlight the urgent need for well-designed, targeted policies.³² While initiatives such as Universal Health Coverage, mental health awareness campaigns, and advancements in medical technology have made some progress, critical gaps remain in funding, accessibility, and infrastructure.

Effectively addressing these challenges requires a holistic approach that takes into account the diverse cultural, political, and economic landscapes of the region. Strengthening healthcare systems through international collaboration, increased investment in medical infrastructure, and the expansion of community-based initiatives will be key to ensuring that healthcare is both accessible and sustainable.³³ By encouraging innovation, breaking down social stigma, and focusing on the needs of the most vulnerable populations, EMRO can take meaningful steps toward creating a more equitable healthcare system that improves the well-being of its people.

Conclusion

Equal access to healthcare on a global level is a large scale and comprehensive goal that requires addressing a myriad of issues. The Eastern Mediterranean region, specifically, has experienced political conflict, violence, and natural disasters that have weakened healthcare systems in the region. Addressing these issues requires taking into account socio-cultural factors, internal divides, and economic limitations of the region. However, as divides between low-income and underserved areas of the EMRO region and the rest of the world continue to grow, more individuals will lose access to healthcare services and conflicts in the region will only continue to exacerbate certain health issues. Global leaders must take action into addressing the particular disparities of the EMRO region while taking into account the unique socio-political and economic landscape that shapes healthcare access in these nations.

References

1. Regional Office for the Eastern Mediterranean. (2020). *Health and well-being profile of the Eastern Mediterranean ...* World Health Organization. Regional Office for the Eastern Mediterranean. <https://applications.emro.who.int/docs/9789290223399-eng.pdf>
2. World Health Organization. (n.d.-a). *Addressing the silent impact of war: Who expands mental health care services across Syria*. <https://www.who.int/news/item/26-03-2017-addressing-the-silent-impact-of-war-who-expands-mental-health-care-services-across-syria>
3. USA for UNHCR. "Refugee Statistics." *USA for UNHCR*, 2024, www.unrefugees.org/refugee-facts/statistics/.
4. Kakaje, A., Zohbi, R. A., Aldeen, O. H., Makki, L., Alyoush, A., & Alhaffar, M. B. A. (2021, January 2). *Mental disorder and PTSD in Syria during wartime: A nationwide crisis - BMC psychiatry*. SpringerLink. <https://link.springer.com/article/10.1186/s12888-020-03002-3>
5. World Health Organization. (n.d.-a). *Addressing the silent impact of war: Who expands mental health care services across Syria*. <https://www.who.int/news/item/26-03-2017-addressing-the-silent-impact-of-war-who-expands-mental-health-care-services-across-syria>
6. Cratsley, K., Brooks, M. A., & Mackey, T. K. (2021a, August 3). *Refugee Mental Health, global health policy, and the Syrian crisis*. *Frontiers in public health*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC8369241/>
7. World Health Organization. (n.d.-b). *Mental health*. World Health Organization. <https://www.emro.who.int/syria/priority-areas/mental-health.html>
8. International Review of the Red Cross. (n.d.). *Mental health during the Syrian crisis*. https://international-review.icrc.org/sites/default/files/906_5.pdf
9. World Health Organization. *Intimate Partner Violence*. World Health Organization, <https://apps.who.int/violence-info/intimate-partner-violence/>.
10. Akbari, Maryam, et al. "Intimate Partner Violence and Its Health Impacts in Afghanistan: A Systematic Review." *Global Public Health*, vol. 18, no. 1, 2023, pp. 1–17, <https://doi.org/10.1080/17441692.2023.2212035>.
11. World Health Organization. "Violence Against Women: A Priority Health Issue." *The Lancet*, vol. 359, no. 9313, 2002, pp. 1232–1237, [https://doi.org/10.1016/S0140-6736\(02\)11816-2](https://doi.org/10.1016/S0140-6736(02)11816-2). Accessed 3 Feb. 2025.
12. World Health Organization, Regional Office for the Eastern Mediterranean. "Mental Health in Emergencies." *WHO EMRO*, <https://www.emro.who.int/eha/news/mental-health-in-emergencies.html>.
13. Katoue MC, Cerda AA, García LY, Jakovljevic M. Healthcare system development in the Middle East and North Africa region: Challenges, endeavors and prospective opportunities. *Frontiers in Public Health*. 2022;10(1). doi:<https://doi.org/10.3389/fpubh.2022.1045739>
14. Maryse A, Ayodeji PL, Hadia A, Karam S. *WBI Learning Resources Series Public Health in the Middle East and North Africa MEETING the CHALLENGES of the TWENTY-FIRST CENTURY* Edited By. Accessed November 24, 2024. <https://documents1.worldbank.org/curated/fr/390071468756934950/pdf/291630Public0Health0in0the0Middle0East.pdf>
15. emhj. Access and barriers to health care delivery in Arab countries: a review. World Health Organization - Regional Office for the Eastern Mediterranean. <https://www.emro.who.int/emhj-volume-18-2012/issue-12/09.html>
16. Miskeen E. The impact of the military conflict in Sudan on maternal health: a mixed qualitative and quantitative study. *PeerJ*. 2024;12:e17484. doi:<https://doi.org/10.7717/peerj.17484>
17. Sefiu Olalekan Olaleye, Temitope Folashade Aroyewun, Reem Abdelrahman Osman. Sudan's maternal health needs urgent attention amid armed conflict. *The Lancet*. 2023;402(10405):848-849. doi:[https://doi.org/10.1016/s0140-6736\(23\)01697-5](https://doi.org/10.1016/s0140-6736(23)01697-5)
18. Avigad R. "A Devastating Toll": Sudan's Maternal Health Nightmare. *New Security Beat*. Published 2024. Accessed November 24, 2024. <https://www.newsecuritybeat.org/2024/07/a-devastating-toll-sudans-maternal-health-nightmare/>
19. UNFPA. Maternal Health. UNFPA South Sudan. Published April 27, 2023. <https://southsudan.unfpa.org/en/topics/maternal-health-18>
20. Zeineddine, Maya, et al. "Epidemiology of Multiple Sclerosis in Lebanon: A Rising Prevalence in the Middle East." *Multiple Sclerosis and Related Disorders*, vol. 52, 2021, p. 102963, <https://www.sciencedirect.com/science/article/abs/pii/S2211034821002303>.
21. National Multiple Sclerosis Society. "What Is MS?" *National Multiple Sclerosis Society*, <https://www.nationalmssociety.org/understanding-ms/what-is-ms>.
22. Zeineddine, Maya, et al. "Epidemiology of Multiple Sclerosis in Lebanon: A Rising Prevalence in the Middle East." *Multiple Sclerosis and Related Disorders*, vol. 52, 2021, p. 102963. Elsevier, <https://www.clinicalkey.com/service/content/pdf/watermarked/1-s2.0-S2211034821002303.pdf>.
23. World Health Organization. *Medical Devices: Managing the Mismatch: An Outcome of the Priority Medical Devices Project*. World Health Organization, 2010, https://iris.who.int/bitstream/handle/10665/44407/9789241564045_eng.pdf.
24. Mohsin K, Layth Mula-Hussain, Gilson R. HealthCare Access Barrier (HCAB) framework for the barriers to cancer care during conflicts: perspective from Iraq. *BMJ Oncology*. 2024;3(1):e000252-e000252. doi:<https://doi.org/10.1136/bmjonc-2023-000252>
25. Skelton M, Ahmed Khalid Al-Mash'hadani, Zahi Abdul-Sater, et al. War and oncology: cancer care in five Iraqi provinces impacted by the ISIL conflict. *Frontiers in Oncology*. 2023;13. doi:<https://doi.org/10.3389/fonc.2023.1151242>
26. Al-Ibraheem A, Abdulkadir AS, Mohamedkhair A, et al. Cancer diagnosis in areas of conflict. *Frontiers in Oncology*. 2022;12. doi:<https://doi.org/10.3389/fonc.2022.1087476>
27. Iraq Makes Progress in Improving Cancer Services, Implements impACT Review Recommendation. [iaea.org](http://www.iaea.org). Published March 30, 2023. <https://www.iaea.org/newscenter/news/iraq-makes-progress-in-improving-cancer-services-implements-impact-review-recommendation>
28. "Kuwait Country Profile." *BBC News*, BBC, 18 Dec. 2023, www.bbc.com/news/world-middle-east-14644252.
29. Alkandari, Abdullah, et al. "Adult diabetes and prediabetes prevalence in Kuwait: Data from the cross-sectional kuwait diabetes epidemiology program." *Journal of Clinical Medicine*, vol. 9, no. 11, 25 Oct. 2020, p. 3420, <https://doi.org/10.3390/jcm9113420>.
30. "Why Is the Developed World Obese?" *NBER*, www.nber.org/digest/nov07/why-developed-world-obese. Accessed 25 Nov. 2024.
31. "Healthcare Resource Guide - Kuwait." *International Trade Administration | Trade.Gov*, www.trade.gov/healthcare-resource-guide-kuwait.
32. "Adoption and Challenges of Electronic Health Systems in Kuwait." *Journal of Health Informatics in Developing Countries*, vol. 16, no. 2, 2022, pp. 12–24. <https://www.jhidc.org/index.php/jhidc/article/view/244/273>.
33. Alotaibi, Yasser K., and Frank Federico. "The Impact of Health Information Technology on Patient Safety." *Saudi Medical Journal*, vol. 37, no. 12, 2016, pp. 1350–1355. *PubMed Central (PMC)*, <https://pmc.ncbi.nlm.nih.gov/articles/PMC655123/>.