Advancing universal health coverage in the Middle East and North Africa: The role of research

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Contents

Preface 4
Executive summary 5
Introduction 8
Discussion themes 11
Opportunities 13
Future priorities 15
Conclusions 17
Annex 1: Breakout group summaries 18
Annex 2: Steering committee 22
Annex 3: Attendee list 23

Preface

Universal health coverage (UHC), providing all with access to quality essential health services without risk of financial hardship, is embedded within the Sustainable Development Goals (SDGs). Globally, however, at least half the world's population still lacks full coverage of essential health services.

Countries in the Middle East and North Africa (MENA) region have made commitments to UHC through their support for the SDGs, yet progress towards UHC is highly variable in the region. In December 2020, the UK Academy of Medical Sciences (AMS) and the Egyptian Academy of Scientific Research and Technology organised a joint virtual meeting to discuss progress made towards achieving high-quality UHC in the MENA region and the role that research could play in accelerating progress towards UHC. The meeting was funded by the AMS, through the Global Challenges Research Fund.

The workshop programme was developed by secreteriat of the two Academies and a steering committee chaired by **Professor Maha El-Rabbat**, Cairo University, Egypt, and **Professor Mike English FMedSci**, KEMRI–Wellcome Trust Research Programme, UK/Kenya (Annex 2.) This report provides a summary of the key themes to emerge at the workshop. It reflects the views expressed by participants and does not necessarily represent the views of all participants, all members of the steering committee, the AMS or the Egyptian Academy of Scientific Research and Technology.

Executive summary

Universal health coverage (UHC), the provision of quality essential healthcare services to all without risk of financial impoverishment, is a core element of the Sustainable Development Goals. As such, it is a key objective of all countries, including those in the Middle East and North Africa (MENA) region.

National per capita expenditure on health in the MENA region as a percentage of GDP is generally below global averages. Health systems differ between countries, with varying degrees of involvement of the private sector. In some countries, out-of-pocket expenditure on health is high, placing households at significant risk of financial impoverishment. National expenditure on research is also low by international standards.

In December 2020, a virtual workshop jointly organised by the UK Academy of Medical Sciences and the Egyptian Academy of Scientific Research and Technology sought to assess the current status of UHC in the region and discuss how the regional and global research community could advance the UHC agenda. Through breakout groups and plenary presentations and discussions, participants identified a range of key challenges and opportunities:

Challenges

The need for local, context-specific solutions: The MENA region is highly diverse and includes lower-middle-income, upper-middle-income and high-income countries, as well as several fragile and conflict-affected countries. Significant progress has been made in improving health in the region, although these gains have been unequally distributed across and within countries. In addition, while the burden of infectious disease has been reduced, non-communicable diseases represent an increasingly serious threat to health, and most countries face the double burden of communicable and non-communicable disease. Fragility and conflict have also had significant consequences for health, for example through the disruption of health services, the destruction of healthcare infrastructure, mass displacement internally and externally, and through the short- and long-term consequences of exposure to armed conflict.

Differing conceptions of UHC: There is no regionally-shared vision of how UHC should be implemented; politicians and other decision-makers in the region have differing conceptions of what UHC means in practice, and it is often conflated with financial risk protection.

Limited political support for primary healthcare: Although primary healthcare is recognised as being at the heart of UHC, it is not a high priority in some MENA countries, with resources typically being focused more on secondary and tertiary care.

Lack of national health research strategies: Health research is generally not prioritised and few countries have developed national health research strategies, policies and plans. This leads to weak priority setting for research and a lack of coordinated research programmes to address national priorities.

A lack of technical and financial support for health policy and systems research (HPSR): Very little HPSR is carried out in MENA countries to improve and strengthen service delivery and health system organisation. Limited funding is allocated to HPSR nationally.

Limited academic interest in HPSR: Universities in the region do not prioritise HPSR, and primary healthcare is particularly under-studied. Research interests are typically those of investigators and may not necessarily reflect national health priorities. The translation of findings into policy and practice is rarely considered a high priority.

Limited policymaker-academia interaction: Although there are some examples of close working relationships, in general there remains a significant divide between policymaker and academic communities. Policymakers may not always be aware of recent research findings or the most appropriate evidence to inform decision-making. Channels of communication may not exist to enable researchers to engage with policymakers during priority setting, and evidence may not be presented in ways that policymakers can use.

Data challenges: Data that are relevant to public health and health system functions may be difficult to access, of questionable quality, and inconsistent between countries. Data sharing across national borders can also be challenging.

Opportunities

Regional expertise: Despite these challenges, the region has pockets of excellence in health services, which could provide a foundation for research programmes to improve healthcare delivery and advance the UHC agenda. Examples also exist of strong and productive interactions between academic and policymaker communities. In addition, regional organisations such as the World Health Organisation Regional Office for the Eastern Mediterranean (WHO-EMRO) and the Middle East and North Africa Health Policy Forum have potentially key roles to play in mediating and nurturing regional collaboration. There are also indications of an enthusiasm for enhanced regional collaboration in research.

Workshop participants identified a range of priority areas for future action:

Mobilising political commitment: There is a need to mobilise political support for UHC, primary healthcare and HPSR. This will depend on proactive engagement and communication with decision-makers, and an emphasis on the potential value of HPSR to deliver better health outcomes and other benefits.

Establishing priorities: To ensure that research is focused on areas of greatest potential impact, there is a need to develop regional and national research agendas that reflect regional and national needs, with clearly identified financial resources and infrastructure. Priority setting should be informed by the perspectives of affected communities, and should take into account the needs of different populations (particularly vulnerable, displaced and other disadvantaged populations).

Closing the implementation gap: Policymakers and researchers need to work more closely to address national priority health issues. Policymakers should play a lead role in establishing national health priorities and should contribute to the development of research projects to ensure that studies address policymaker needs.

Research should have a strong focus on health outcomes, particularly those that are progressive, society-oriented and cost-efficient. The research community needs to focus more on practical rather than academic solutions that highlight potential outcomes and consider the feasibility of implementation. In particular, disadvantaged and underserved populations should be identified and the ease of implementation of policies and programmes to target these groups should be considered.

In some countries, good examples exist of close engagement between researchers and policymakers. There are opportunities to build on these good practices, with clear mechanisms established to ensure that HPSR responds to regional and national needs and that an 'evidence to policy' pathway exists so that research data and evidence from research feeds into policy and decision-making. Findings should be communicated appropriately to policymakers, for example through policy briefs and forums for discussion. There is a need to build the capacity of researchers to carry out policy-relevant research and for policymakers to develop and implement evidence-based policymaking. These activities will collectively help to build policymaker demand for research evidence.

Improving data availability and quality: Efforts are needed to improve the availability of data and to facilitate the sharing of data across countries. Standardisation of data collection would facilitate data synthesis and comparisons between countries. Improved health information systems and data platforms are also required.

Building capacity for HPSR: There is a need to strengthen capacity for HPSR in the MENA region, building on existing centres of excellence. More interdisciplinary collaborations are needed, for example with social scientists and health economists. There is also an opportunity to engage humanitarian, relief and other NGOs in research. More international collaborations need to be developed, led from within the region and addressing local priority issues. Additional regional collaborations are also needed, potentially including regional research hubs linked to national centres.

The MENA region faces many health challenges, including the double burden of communicable disease and growing rates of non-communicable disease, and, in several countries, the impacts of civil conflict. Meeting these challenges and delivering quality healthcare to all will require political commitment to universal primary healthcare systems that meet the needs of national populations. Each country is likely to make its own journey to UHC, but there is great potential for countries to learn from one another. Research has the potential to deliver the evidence required for health systems to effectively and efficiently meet the health needs of populations.

Introduction

According to WHO, universal health coverage (UHC) is a means of ensuring that 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.[1] UHC is an integral part of the WHO Constitution agreed in 1948, which declared health a fundamental human right, and of the 'Health for All' agenda set out in the Alma Ata Declaration in 1978.[2] UHC is specifically referred to in Sustainable Development Goal 3 (SDG3)[3] and, by ensuring the health of populations, it also makes a fundamental contribution to the achievement of other SDGs.

In addition, health is one of the pillars of the Science, Technology and Innovation Strategy for Africa 2024 (STISA-2024), which covers countries in North Africa. Developing health systems and governing structures are included under priority 2 of STISA-2024.

The concept of UHC is based on three key dimensions:

- **Equity:** Services should be available to all, regardless of their ability to pay.
- **Quality:** Services should be of the highest possible quality.
- **Financial protection:** Using health services should not place individuals at risk of financial hardship.

Discussions around UHC often focus on access and equity, and the need for healthcare services to be available to all. However, SDG 3.8 also stresses the quality of such services. Increasingly, the research community and policymakers are highlighting the importance of healthcare service quality, reflecting the fact that 60% of deaths from treatable conditions occur among those who actually gained access to care.[4,5] Similarly, a joint report from WHO, the World Bank and the Organisation for Economic Co-operation and Development (OECD) has argued for the importance of care quality from health, economic and social justice perspectives.[6] The OECD report also highlighted the role of research in empowering governments, health systems, healthcare workers, patients and citizens.

1. WHO. Universal health coverage (UHC). https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
2. WHO (2018). Declaration of Alma Alta. Geneva: WHO. Available at: https://www.who.int/publications/almaata_declaration_en.pdf
3. United Nations. Sustainable Development Goals: Goal 3: Ensure healthy lives and promote well-being for all at all ages. https://www.un.org/sustainabledevelopment/health/
4. Kruk ME, *et al*. (2018). *High-quality health systems in the Sustainable Development Goals era: time for a revolution*. Lancet Glob Health **6(11)**:e1196–e1252. doi: 10.1016/S2214-109X(18)30386-3.
5. Kruk ME, Pate M (2020). *The Lancet Global Health Commission on High Quality Health Systems 1 year on: progress on a global imperative*. Lancet Glob Health **8(1)**:e30-e32. doi: 10.1016/S2214-109X(19)30485-1.
6. WHO, World Bank, OECD (2018). Delivering quality health services: A global imperative. Washington DC: World Bank. Available at: https://www.worldbank.org/en/topic/universalhealthcoverage/publication/delivering-quality-health-services-a-global-imperative-for-universal-health-coverage

Over the past two decades, countries in the Middle East and North Africa (MENA)* (see box 1) have made significant progress in areas such as reducing child mortality, improving maternal health and tackling some infectious diseases. However, the region faces a growing challenge from non-communicable diseases (NCDs). In nearly all MENA countries, NCDs and injuries account for more than three-quarters of disability-adjusted life years, while the prevalence of key NCD risk factors is higher than global averages.[7] Adult obesity is a major problem in multiple countries, while around 25% of the population is affected by high blood pressure.[9] In parts of the region, women are at particularly high risk of NCDs.[10]

Box 1:

MENA countries

Algeria, Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Syria, Tunisia, United Arab Emirates and Yemen; there is no universally agreed list of MENA countries, and some classifications include additional countries.

WHO Eastern Mediterranean Region

Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates and Yemen.

There are indications that health is not sufficiently prioritised. In most MENA countries, total health expenditure per capita is lower than global averages for countries in similar income categories.[7] In addition, the growth rate of total health expenditure per capita has not matched increasing GDP per capita. In most countries, out-of-pocket expenditure on healthcare is high, particularly in middle-income countries in the region, with a high risk that households are pushed into poverty as a result of paying for healthcare. With an increasing burden of disease due to chronic illnesses, many countries in the region are poorly equipped to meet the new challenges of ageing populations and infections such as HIV/AIDS.

However, MENA countries are highly diverse, spanning high-, lower-middle- and upper-middle-income countries and with populations ranging from less than 2 million to more than 80 million. Several MENA countries are categorised as fragile, and civil conflict has had a devastating impact on health service infrastructure and led to considerable internal and external displacement. As of 2018, an estimated 37% of the 70.8 million people displaced worldwide originated from the MENA region.[11] Like other areas of the world, the MENA region has been hit hard by COVID-19. The pandemic has absorbed political and health system attention, and presented major challenges to underdeveloped health systems. Again, countries have varied significantly in their ability to respond rapidly and efficiently to COVID-19, with fragile states in particular often struggling to coordinate effective responses. Notably, COVID-19 has highlighted the importance of investment in strengthening primary healthcare and in some countries encouraged new investment in public health, the health workforce and health systems.[12]

7. Asbu EZ, Masri MD, Kaissi A (2017). *Health status and health systems financing in the MENA region: roadmap to universal health coverage.* Glob Health Res Policy **2**:25. doi: 10.1186/s41256-017-0044-9.
8. https://www.statista.com/statistics/1173180/mena-adult-obesity-by-country/
9. Musaiger AO, Al-Hazzaa HM (2012). *Prevalence and risk factors associated with nutrition-related noncommunicable diseases in the Eastern Mediterranean region.* Int J Gen Med **5**:199–217. doi:10.2147/IJGM.S29663
10. Alshaikh MK, *et al.* (2017). *The ticking time bomb in lifestyle-related diseases among women in the Gulf Cooperation Council countries; review of systematic reviews.* BMC Public Health **17(1)**:536. doi: 10.1186/s12889-017-4331-7.
11. UNHCR (2019). Global Trends: Forced displacement in 2018. https://www.unhcr.org/5d08d7ee7.pdf Accessed June 19, 2020.
12. OECD. COVID-19 crisis response in MENA countries. http://www.oecd.org/coronavirus/policy-responses/covid-19-crisis-response-in-mena-countries-4b366396/

As for health research, the MENA region is under-represented in terms of outputs in global scientific literature. Despite accounting for 5% of the world's population, the WHO's Eastern Mediterranean Region (EMR) produced only 1.6% of the world's scientific papers between 2004 and 2013.[13] Across science as a whole, scientific outputs have been increasing across the MENA region in past decades, but much more slowly than in other countries, and some MENA countries have seen a decline in outputs.[14] The MENA region has published much less than 1% of all publications on COVID-19.

These trends are mirrored in figures for national investment in research and development (R&D). In most high-income countries, this is typically in the range of 2–4% of GDP, whereas the average for the MENA region is 0.5%.[15] The lack of a strong commitment to research in the region is one factor underpinning a major brain drain, with more than half of all students studying abroad not returning to the region. EMR countries account for 31% of the brain drain from developing countries, half of those who leave being medically qualified; 34% of physicians working in the UK are from EMR countries.

In December 2020, the UK Academy of Medical Sciences (AMS) and the Egyptian Academy of Scientific Research and Technology organised a joint virtual meeting to discuss progress made towards achieving high-quality UHC in the MENA region and the role that research could play in accelerating progress towards UHC. Through plenary presentations and breakout groups, participants discussed barriers and obstacles to progress and priority areas for future action. Breakout groups explored three key issues – models of care, strengthening the measurement and performance of quality-adjusted UHC packages, and supporting evidence-based knowledge translation for quality UHC (summarised in Annex 1).

13. Tadmouri GO, Mandil A, Rashidian A (2019). *Biomedical and health research geography in the Eastern Mediterranean Region*. East Mediterr Health J **25(10)**:728-743. doi: 10.26719/emhj.19.082.

14. Siddiqi A, *et al.* (2016). *Scientific Wealth in Middle East and North Africa: Productivity, Indigeneity, and Specialty in 1981-2013*. PLoS One **11(11)**:e0164500. doi: 10.1371/journal.pone.0164500.

15. World Bank. Research and development expenditure (as % of GDP). https://data.worldbank.org/indicator/GB.XPD.RSDV.GD.ZS?locations=JO-KW-MA-TN-SA-EG-IQ-AE-DZ-BH-IR-LB-OM-QA-SY-YE

Discussion themes

A range of converging themes emerged from the plenary presentations and breakout group discussions:

The need for local, context-specific solutions: MENA countries **vary significantly** in their healthcare challenges, sociocultural contexts and health system organisations. Under the general principle of UHC, countries need to identify the best models of UHC that fit their unique contexts. This highlights the importance of a **strong local research base** familiar with national health systems and cultural contexts.

For conflict-affected settings, there are concerns that health research is neglected, but also that when research is carried out in such settings it is typically **driven from outside the region** and reflects the norms and interests of researchers in high-income countries. There is a risk that local knowledge and approaches are ignored, to the detriment of the research carried out, a phenomenon known as 'knowledge subjugation'.[16] This further stresses the importance of a strong national research base with a good understanding of local context and able to play a lead role in research studies.

There are also strong arguments in favour of responding to challenges at a regional level. Health outcomes are determined by many factors spanning not just health systems, but also educational, social and other domains. Given similarities in these determinants across the region, research and analysis can often be more efficiently undertaken at a regional level. Furthermore, many health policy issues have a regional character – for example, the procurement of a trained health workforce and pharmaceuticals – and can be tackled comparatively or collectively in order to overcome resistance to change by vested interests, commercial or professional.

Differing conceptions of UHC among politicians: Some speakers felt that there is no commonly agreed vision across the region for how UHC should be implemented. Of the three dimensions of UHC, coverage and financial risk protection are often seen as the core elements of UHC. Less attention is given to considerations of quality. While there is a greater need for financial risk protection in many parts of the region, particularly in conflict-affected settings,[17] this focus can detract from the need to strengthen health systems to improve service quality and to meet the needs of populations.

Limited political support for primary healthcare: As captured by the Alma Ata Declaration in 1978[2] and re-emphasised in the Astana Declaration in 2018, primary healthcare is widely recognised to be the most cost-effective form of healthcare, offering the best return on investment in terms of improved health outcomes. Within many MENA countries, however, when healthcare is considered a priority, it is often secondary and tertiary care that receives greatest attention, such as investment in new hospitals or high-tech medicine. The **critical role of primary healthcare in delivering UHC is not widely appreciated**, leading to a lack of prioritisation and underinvestment.[18,19]

A further complexity is that, in many countries, a range of health services are provided through the **private sector**, with minimal involvement of the public sector. In some countries, the private sector plays the dominant role in health service provision. This has significant implications for coordination of services and monitoring of quality.

Well-informed populations can be effective **advocates for UHC** delivered through primary healthcare services that meet people's needs. However, populations in MENA countries typically have **limited awareness of UHC**, and in some settings have little confidence in publicly provided services. These challenges are typically greater in conflict-affected countries.

16. El Achi N, *et al.* (2020). *Ecology of War, Health Research and Knowledge Subjugation: Insights from the Middle East and North Africa Region.* Ann Glob Health **86(1)**:120. doi: 10.5334/aogh.3015.

17. Mataria A, Hajjeh R, Al-Mandhari A (2020). *Surviving or thriving in the Eastern Mediterranean region: the quest for universal health coverage during conflict*. Lancet **395(10217)**:13-15. doi: 10.1016/S0140-6736(19)33061-2.

18. van Weel C, *et al.* (2018). *Primary healthcare policy implementation in the Eastern Mediterranean region: Experiences of six countries.* Eur J Gen Pract **24(1)**:39-44. doi: 10.1080/13814788.2017.1397624.

19. Nashat N, *et al.* (2020). *Primary care healthcare policy implementation in the Eastern Mediterranean region; experiences of six countries: Part II.* Eur J Gen Pract **26(1)**:1-6. doi: 10.1080/13814788.2019.1640210.

Lack of national health research strategies: Health research is generally not prioritised and few countries have developed national health research strategies, policies and plans. This leads to weak priority setting for research at national, subnational and institutional levels, and a lack of coordinated research programmes to address national health priorities.

A lack of technical and financial support for health policy and systems research (HPSR): There is some evidence of an **appetite among policymakers for research evidence**, when it addresses key questions and has clear policy relevance, and is delivered in a timely and accessible format.[20] Researchers also recognise the need to engage with policymakers but perceive a range of barriers, including limited opportunities for engagement, a lack of interest in findings and politically sensitive findings.[21]

However, participants suggested that research related to primary healthcare and UHC is not currently prioritised across the region. With some exceptions, there is not a widespread culture of using research to inform health policymaking. **Insufficient funding** is allocated for research focused on health system performance and operations. In addition, political appointees may not necessarily have any background in science and medicine, and may not fully appreciate the value of research in informing decision-making.

Rather than from the academic community, policymakers may seek input from **international consultants**, whose work may lack the rigour of academic research. Such consultants may not be so familiar with local contexts, and are likely to have preconceived ideas of policy solutions.

Limited academic interest in HPSR: Some participants felt that, across much of the region, **research in this area is not a high priority in universities**. Where research is carried out, the emphasis is often on high-profile areas of discovery science or medicine, reflecting the need for publication of papers in high-impact journals, which is seen as important for establishing a scientific reputation and academic advancement.

Local health priorities have limited influence on the research carried out within research institutions and the **translation of findings into policy and practice is rarely considered a high priority**.[22] There are few incentives for individual researchers to carry out research into health systems, which is often seen as the domain of junior research staff.

Limited policymaker-academia interaction: Few opportunities currently exist for policymakers and researchers to work together. Academic research is mostly published in scientific literature, with few attempts made to communicate findings to policymakers. Policymakers are often unaware of what research is being carried out or how research evidence could inform policymaking and practice. The lack of interaction also leads to limited policymaker input into prioritisation and the development of research questions to be addressed.

Data challenges: Research depends on access to high-quality data. However, **data may not be made available** if they are considered politically sensitive. Such attitudes are common, as unflattering data may be seen as damaging to a country's reputation, but this is particularly apparent in conflict-affected settings, where data can be exploited for political advantage.

In addition, data may **only be available at an aggregated national level**. This can hide important sub-national variations, particularly relating to health inequities. Again, such information may be considered politically sensitive in some settings.

International comparisons are hampered by **inconsistencies in measurements** between countries and gaps in the range of data collected. It can also be **difficult to share data between countries**, owing to the lack of data-sharing agreements or a failure to implement such agreements effectively.

20. El-Jardali F, *et al.* (2012). *Use of health systems evidence by policymakers in eastern Mediterranean countries: views, practices, and contextual influences*. BMC Health Serv Res **12**:200. doi: 10.1186/1472-6963-12-200.

21. El-Jardali F, *et al.* (2012). *Use of health systems and policy research evidence in the health policymaking in eastern Mediterranean countries: views and practices of researchers*. Implement Sci **7**:2. doi: 10.1186/1748-5908-7-2.

22. El-Jardali F, *et al.* (2018). *Engagement of health research institutions in knowledge translation in the Eastern Mediterranean Region*. East Mediterr Health J **24(7)**:672-679. doi: 10.26719/2018.24.7.672.

Opportunities

Regional expertise: Despite these challenges, it was suggested that **high-quality health research is being carried out** at a number of sites across the region. Expertise exists in numerous MENA countries, although bibliographic analyses suggest it is concentrated in particular countries and institutions.[13] This provides a foundation on which to build more extensive research programmes in primary healthcare and to support progress in UHC. Examples also exist of strong and productive interactions between academic and policymaker communities, as illustrated by the health technology assessment programme in Tunisia (see box 2) and multiple activities undertaken in Lebanon to promote evidence-based policymaking.[23,24,25,26]

Box 2: Development of an HTA programme in Tunisia

The creation of a health technology assessment (HTA) programme in Tunisia illustrates how scientific expertise can be mobilised to support evidence-based health decision-making.

INEAS (Instance Nationale de l'Evaluation et de l'Accréditation en Santé) is a national non-profit authority set up to promote the use of HTAs and cost-effectiveness analyses to support national evidence-based decision-making. It is a member of multiple global HTA bodies and draws upon well-established methodologies for assimilation of evidence.

INEAS responds to requests from the ministry of health or the national health insurance body and follows a systematic process to scope the nature of the issue, collect and analyse data (undertaken by a multidisciplinary group), organise peer review and disseminate findings. All reports are freely accessible on the INEAS website. They are also actively communicated to policymakers, presented at national and international conferences, and published in peer-reviewed journals.

INEAS engages with multiple stakeholders, including industry, to improve understanding of processes and promote dissemination of results. It also facilitates workshops at the national and international level to share evidence and learnings.

Recently, INEAS has been carrying out rapid reviews to answer health policy questions related to COVID-19, including the possible use of chloroquine and hydroxychloroquine as treatment and flu vaccination during the pandemic.

INEAS illustrates how systematic processes can be introduced nationally to inform decision-making on the introduction of new healthcare technologies. As such, it can provide key guidance on the most effective and cost-effective health technologies, forming a critical tool for achieving UHC.

23. Khalife J, *et al.* (2020). *Hospital performance and payment: impact of integrating pay-for-performance on healthcare effectiveness in Lebanon.* Wellcome Open Res **5**:95. doi: 10.12688/wellcomeopenres.15810.2.
24. Yehia F, El Jardali F (2015). *Applying knowledge translation tools to inform policy: the case of mental health in Lebanon.* Health Res Policy Syst **13**:29. doi: 10.1186/s12961-015-0018-7.
25. Fadlallah R, *et al.* (2018). *Barriers and facilitators to implementation, uptake and sustainability of community-based health insurance schemes in low- and middle-income countries: a systematic review.* Int J Equity Health **17(1)**:13. doi: 10.1186/s12939-018-0721-4.
26 El-Jardali F, *et al.* (2019). *Barriers and facilitators to implementation of essential health benefits package within primary health care settings in low-income and middle-income countries: A systematic review.* Int J Health Plann Manage **34(1)**:15-41. doi: 10.1002/hpm.2625.

It was noted that, although research questions are often context-specific, there are more general questions that can be addressed through regional collaborations and comparisons. Furthermore, it is challenging for individual countries to investigate all relevant questions, and regional collaboration can help to avoid duplication and facilitate coordinated responses to priority areas of research. Bodies such as **WHO-EMRO** and the **Middle East and North Africa Health Policy Forum** have potentially key roles to play in encouraging and facilitating regional collaboration.

Box 3: Regional collaboration

A WHO-led project in Central Asia illustrates how countries can collaborate on health, address health emergencies and advance progress towards UHC.

Central Asia encompasses the countries of Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, all of which have been affected by the COVID-19 pandemic. The WHO project sought to adopt a comprehensive integrated approach to build the resilience of health systems to cope with the impact of the pandemic, building on an established health emergencies collaborative platform.

Its tripartite strategy was to support and strengthen national COVID-19 response capacity, including development of the national focal point network capacity; promoting coordination of assessment, resource mobilisation, implementation of responses, and monitoring and evaluation; and advocating with decision-makers and policymakers to adopt or strengthen COVID-19 control policies.

This led to the development and operationalisation of country preparedness and response plans for COVID-19, translating global guidance to the country level and ensuring good cross-sectoral collaboration. Challenges included overburdened health systems and disruptions to health services, limited access to disaggregated data to identify vulnerable populations, and the impact of travel restrictions.

Lessons learned include the importance of political leadership and of technical expertise to guide responses, the value of partnerships established in 'peacetime' for responses during emergencies, the need for timely access to data to guide actions, the value of institutional capacity building, and having a common vision articulated at global, regional and national levels.

Future priorities

The discussions and breakout sessions identified a range of ways in which research could be promoted to accelerate progress towards UHC in the MENA region:

Mobilising political commitment: Participants argued that it was essential **to advocate for increased political and financial support for UHC, primary healthcare and HPSR**. More proactive communication with politicians and health officials was felt to be needed, focusing in particular on the value of research evidence to decision-making. For example, globally 20–40% of healthcare spending is wasted, because of factors such as the use of ineffective medicines or where there is no evidence to support use of particular medicines. Research has the potential to address these issues and ensure more efficient use of healthcare resources.

Media engagement could also be used to highlight key issues and research findings with the potential to change practice for the better, along with the need for a close relationship between academia and the public sector. **Community engagement** can raise awareness of rights to health and drive change from the grassroots up.

Establishing priorities: It was argued that **regional and national research strategies** were required in order to identify priority areas for research, based on clearly identified regional and national needs. These research agendas should draw on relevant past work carried out by WHO and other stakeholders. They should specify the required financial resources and needs for human and technical capacity building, infrastructure development and strengthening of national innovation capabilities. They should also recognise the need for interdisciplinary research and funding of HPSR.

Priority-setting activities need to be carried out collaboratively to gain the perspectives of multiple stakeholders, and to ensure that there is a shared understanding of national and regional priorities among researchers, policymakers and other key stakeholders. Short-, medium- and long-term health system-strengthening priorities should be identified to build resilience in support of UHC. Priority setting needs to be jointly owned to support mobilisation, to provide a foundation for advocacy activities and to ensure that resources are mobilised to address priority issues.

Participants also suggested that these exercises need to pay special attention to the very specific requirements of different groups, particularly vulnerable, displaced and other disadvantaged populations, in conflict-affected countries but also elsewhere.

Closing the implementation gap: Participants identified a critical need to ensure **closer engagement between policymaker and research communities**. The collaborative development of a national research agenda will help to identify priority areas for research and build demand among policymakers for research evidence to inform decision-making. Engaging policymakers in the definition and design of research studies will help to ensure that research meets policymakers' needs and is likely to increase policymakers' commitment to research evidence.

A clear mechanism is needed to ensure that HPSR responds to regional and national needs and that an 'evidence to policy' pathway exists for research data and evidence so that research feeds into policy and decision-making. It was suggested that researchers need to pay more attention to **communicating findings** in ways that are useful to policymakers, for example through the production of policy briefs, rapid responses and discussion sessions, and by highlighting the policy implications of new research. Participants also identified a need to **build the capacity of researchers to carry out policy-relevant research**, as well as the **capacity of policymakers to use research evidence**.

Improving data availability and quality: Participants identified access to timely and high-quality data as critical to research. There is a need to **encourage greater openness** among governments to increase the availability of data, and for more **granular data** to be collected so subnational variations can be explored.

Moreover, no one country can carry out research into all areas of population health and healthcare. **Greater regional collaboration** and sharing of data would allow research into priority questions to be coordinated across countries and would enable countries to learn from one another.

Greater **standardisation of data** across the region would facilitate international comparisons and evidence syntheses. Data-sharing agreements are needed to ensure the timely flow of data across national borders, and the implementation of such agreements needs to be accelerated to overcome barriers to data sharing. Regional bodies such as WHO-EMRO and the Middle East and North Africa Health Policy Forum could play key roles in brokering data-sharing agreements, promoting data harmonisation, and establishing appropriate standards.

Better use of data will also call for improved **health information systems and data platforms**, potentially including regional data hubs. In addition, the development of human capacity in data collection, management and analysis was felt to be essential.

Building capacity for HPSR: Participants noted that further efforts were required to **develop HPSR capacity** in the region, building on the expertise and centres of excellence that already exist. This could be done through regional collaborations and/or global collaborations in which MENA researchers play a lead role and that are focused on regional priority health questions. Within the region, greater international collaboration and networking could also help to build capacity and coordinate research.

It was also suggested that there is a need to **strengthen interdisciplinary research**, including collaborations with researchers working in areas such as the social sciences and health economics. **Cross-sectoral collaborations** are also necessary, recognising the intimate connections between health and multiple other sectors.

Underpinning these activities is a need to strengthen the **commitment of universities to HPSR**, and to research more generally. Greater emphasis on **research training** for medical professionals and other groups engaged in research, such as nurses and other healthcare workers, managers and health economists, was seen to be essential. In fragile and conflict-affected settings, it was suggested that more could be done to engage **humanitarian and relief agencies** in research.

In particular, NGOs have potentially vital roles to play in research. They are typically embedded in communities, and have the potential to support data collection, contribute funding, and aid interpretation of data in ways that reflect the perspectives of different sectors of society. It is vital to identify and engage the relevant highly specialised NGOs in UHC-related research projects.

Conclusions

MENA countries are committed to UHC, which is seen as critical to achieving health-related and other SDGs. For this to become a reality, there needs to be a stronger focus on quality as well as access to care, with primary healthcare systems delivering quality care to all sectors of the population according to their needs.

Each country needs to forge its own path to UHC, based on the nature of its existing health systems, particular context and development needs. Research has a key role to play in mapping out this journey and in identifying the best ways that healthcare resources can be utilised to deliver UHC. This will call for strong and productive relationships between policymaker and research communities in the region.

The MENA region includes several fragile and conflict-affected states where achieving UHC will be a particular challenge. Such countries will need particularly intensive support from the regional and global community to achieve and sustain their UHC goals.

Despite the diversity of the MENA region, there are opportunities to strengthen collaborations between countries, to share learning, and to establish research partnerships to address priority questions and to accelerate progress towards UHC. Stronger links will enable countries to learn from one another, avoid duplicated efforts and create structures that combine excellence across multiple domains of research.

The research community has a potentially important role to play in generating the evidence needed to build more effective health systems, not only helping to improve health outcomes but also accelerating social and economic development.

Annex 1: Breakout group summaries

Breakout group 1 – Models of care

What is the current UHC and quality of care research landscape across the region?

Strategies

- There is an overall lack of research in this area
- Some research has begun as a result of the impact of COVID-19
- Much of the research is led by academic institutions rather than ministries of health and does not shape policy
- Some research-related work led by consultancy firms may lack rigour
- Some emerging collaborative research projects

What does existing research say about the barriers and challenges to achieving quality UHC supported by research?

- Funding – greater investment is needed to raise quality and amount of research
- Perceptions – this area of research is not perceived as a priority – it is often seen as a topic for junior researchers
- Policymakers do not fully understand the importance of research in this area
- Lack of implementation – the results of research are not translated into policy and implemented in clinical care
- Other areas are seen as higher priority so funding is not allocated
- COVID-19 is dominating all priorities currently
- Diversity of populations within regions needs to be taken into consideration, e.g. migrant populations, refugees
- Public and private sectors do not collaborate in research; the same is true for academia and health services
- Low quality of primary data; problems of access to data
- Lack of adequate capacity for research
- Research needs to be valued by policymakers – it can be demoralising for researchers' work to be ignored
- Many senior members of ministries are appointed for their political beliefs rather than expertise
- UHC is not fully understood by healthcare providers
- The overarching challenge of instability in the MENA region

Where, if any, are there current efforts in these areas, and are there research successes or learnings?

- Successes are small and often at village/local level
- Small pilots can offer success that can then be scaled up
- Much of the research focuses on marginalised populations such as undocumented migrants rather than the whole population
- Some emerging collaborations carry promise

Are there mechanisms to address identified challenges and barriers, and advance UHC through research?

- Much research and healthcare provision is fragmented so there are limited mechanisms
- Effective mechanisms are still hampered by the low priority for research in general and the lack of full understanding of UHC

Where are the key priorities for action going forwards to improve integration and contextualisation of evidence-informed policies?

- Endorsement and advocacy of research into UHC at a strategic level, e.g. from WHO, ministries of health, public health associations
- Operational definitions for UHC for both stable and unstable countries within the MENA region
- Agreement of minimum standards for research – ideally led by WHO
- Involve economists in the design of research in order to help integration
- Assess existing health technology to inform research
- Strengthen capacity for research design and implementation
- Creation of regional research groups to address the key skills and competencies required

Mechanisms, priorities and opportunities for action – research questions to address

- What is the impact of humanitarian intervention on healthcare? E.g. NCDs, HIV
- Need to look at research in the 10 unstable countries differently from those that are stable
- How can we bring care to different populations?
- Vulnerability of people impacts their health needs, funding required and healthcare packages – research should be designed around this

Breakout group 2: Strengthening the measurement and performance of quality-adjusted UHC packages

What is the current state of UHC and quality of care research across the region?

- Due to **political instability and conflict**, there is difficulty in setting and achieving long-term goals for research
- Very little research on UHC including **evaluation of quality** of healthcare, as well as on **quality of research**
- **Fragile, Conflict and Violence (FCV) populations** are often moving within countries making research more complex
- **The perception of quality** is not harmonised across different sectors, leading to different implications at field level. There is a lack of quality benchmarks related to humanitarian context
- Policymakers do not always understand, consult and translate **research into policy**

What does existing research say about the barriers and challenges to achieving quality UHC supported by research? What challenges has COVID-19 highlighted for UHC and quality of care research?

- Limited access to **data**
- Limited and no **data sharing** intra- and intersectoral and between countries
- **No standardised** way of presenting, protecting and benchmarking data in spite of WHO guidance
- **COVID-19 has deprioritised** other essential health areas and funding is being diverted predominantly for COVID from the Ministries of Health (MOH) and NGOs
- Humanitarian organisations are not actively involved in **conversations on UHC and quality of research** with disconnection between the MOH and multilateral agencies
- The **perception of quality** is not harmonised across different sectors, leading to different implications at field level
- **Inequality, inequity and lack of social inclusion** in terms of quality care make research difficult
- **Affordability of care** varies across regions; this is exacerbated in regions of conflict and fragile states, and makes planning for care more complex due to changing priorities
- **Perception of research on quality** varies – there is a need for standardisation on measures through a standardised set of research methods
- Quality domains **humanitarian vs development** (perceptions differ in areas of conflict and non-conflict on, e.g. accessibility, coverage; priority is given to saving lives and efficiency)
- **Physical and mental wellbeing of healthcare workers** and researchers within these regions should be considered (e.g. violence, physical safety, infection prevention and control, etc.)

Where, if any, are there current efforts in these areas, and are there research successes or learnings?

- **Situation** impact evaluation of schistosomiasis and soil-transmitted helminth programme, Yemen
- **Action** strong partnership (MOH, academia, community leaders, technical agencies SCI ICL, WHO, donors (World Bank, END Fund)
- **Result** reduction in the prevalence and intensity of infection from 18.2% to 3.6% in 4 years of the programme life

What are the research priorities for quality and safety in FCV settings to better evidence-informed policies across different levels (e.g. system, policy, research and micro level)?

- **Standardisation** of research quality
- **Benchmarking of data** in a localised setting and among countries
- How can **standards be adjusted** to take into account local **variances in populations**, e.g. migrant populations, internally displaced people
- **Investment** on disabilities and mental health research
- Collaboration and the role of the **private sector, CSOs**, academia, parliamentarians and other stakeholders in UHC research
- **Evaluation** of Minimal Service Package, its effectiveness (if it has met the real needs of the population)
- **The role of Primary Health Care (PHC) in the management of crises in FCV**, e.g. COVID-19, centralisation vs decentralisation of care
- **COVID-19 disruption** and its implication on human resources and health workforce
- **Out of pocket (OOP) health expenditures by different population groups during the conflict** - impacts achievement of UHC
- WHO, World Bank have created a momentum on Health System and Dynamic Needs Assessment

How can research on quality and safety in FCV settings support the UHC agenda? Are there mechanisms to address identified challenges and barriers?

- Research can provide a measurement and strengthen data systems to enable prioritisation and endorsement by government ministries
- Research will provide the right platform for the decision-makers
- Research can stress the continuum of care and not only curative measures
- Reduce the gap in terms of accountability, affordability, equity in order to ensure equitable access to healthcare services
- Research needs to address population needs, preferences and expectations and reflect regional differences, e.g. people-centred approach
- Developing systems (resources, commitment etc.) to reduce the intervention gap between policymakers, academia, in a **system approach**. Decision-makers should work as catalysts between different stakeholders
- Create **movement** that advocates for putting research among **care settings** and care settings should know that research would help
- Build on **local research initiatives** and capacities as entry point for UHC focus, evidence generation and utilisation!

Annex 2: Steering committee

Co-chairs:

- Professor Mike English FMedSci, Principal Investigator, KEMRI-Wellcome Trust Research Programme, UK/Kenya
- Professor Dr Maha El Rabbat, Professor of Public Health, Cairo University, Egypt

Members:

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- Dr Elsheikh Badr, Policy Development Expert, National Qualifications Authority, UAE
- Professor Kalipso Chalkidou, Director of Global Health Policy, Center for Global Development; Professor of Practice in Global Health, Imperial College London, UK
- Professor Fadi El-Jardali, Professor of Health Policy and Systems, American University of Beirut, Lebanon
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