

report

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Understanding barriers to health care for minorities and indigenous peoples in Egypt, Iraq and Tunisia





A doctor checks the blood pressure of a Yezidi displaced woman, following the coronavirus outbreak, at a medical centre in the Sharya camp in Duhok, Iraq. 7 March 2020. *Credit: Reuters/Ari Jalal*

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Minority Rights Group International

Minority Rights Group International (MRG) is a non-governmental organization (NGO) working to secure the rights of ethnic, religious and linguistic minorities and indigenous peoples worldwide, and to promote cooperation and understanding between communities. Our activities are focused on international advocacy, training, publishing and outreach. We are guided by the needs expressed by our worldwide partner network of organizations, which represent minority and indigenous peoples.

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Introduction

Increasing evidence confirms that minorities and indigenous peoples are among the most marginalized communities in terms of access to social and economic rights, undermining the right to the highest attainable standard of health.¹ In most health care systems, it is acknowledged that minorities and indigenous peoples have experienced poorer health and barriers to accessing certain services. In the Middle East and North Africa (MENA) region, several other obstacles limit our understanding of the experiences of minorities and indigenous peoples in the region: one has been the lack of data and information on access to services and rights by minorities and indigenous peoples. These questions have become increasingly relevant, especially in the light of the pandemic that affected minorities and indigenous peoples most. Moreover, the Covid-19 pandemic exposed the fragility of the health systems in the region and imposed an additional and serious burden on the existing systems. It is therefore evident that there are important knowledge gaps that need to be addressed. The main objective of this study is to provide a nuanced, experiential, emic description of health care accessibility issues among Copts in Egypt, Yazidis in Sinjar, Iraq, and Jews, Amazigh and Black Tunisians in Tunisia. Identifying some of the

barriers they face in accessing health care may help policy makers to make changes in health policy and elsewhere to respond to these communities' needs.

The definition of health care accessibility has varied over the years. The current interpretation of the concept considers the characteristics of users and services.² For the purpose of this project we used the *availability*, *affordability*, *accessibility*, *adequacy* and *appropriateness* framework to assess the health services available to minorities and indigenous peoples in Egypt, Iraq and Tunisia. Availability refers to the existence of services. Affordability refers to the costs associated with health care services. Accessibility includes physical and social accessibility, and access to information on health care. Adequacy refers to the quality of health care available, which includes both services and infrastructure. Appropriateness examines how respectful the services are towards the culture of minorities. Minorities, indigenous peoples and vulnerable groups are at greater risk of being affected by lack of access to the health care services since vulnerability is determined by socioeconomic status, ethnicity and gender. However, little is known about the effect of belonging to a religious minority on access to health.

Overview of the communities in focus

Yezidis in Iraq

Yezidis are a religious minority in Iraq and other countries in the region. Prior to the ISIS advance, Iraq's Yezidis numbered approximately 500,000 and were concentrated in Sinjar, 150 km west of Mosul, with a smaller community in Shaikhan, the Kurdistan foothills east of Mosul, where their most holy shrine of Shaykh Adi is located.³ In June 2014, Mosul fell to ISIS. As a result, the majority of Yezidis were displaced to camps and informal settlements in Iraqi Kurdistan. Yezidis have suffered many atrocities since, as ISIS singled out this religious minority and captured and enslaved Yezidi women. Women and girls who escaped from ISIS captivity, and who faced rape, torture, forced conversion and other serious violations, are deeply traumatized by their ordeals, and their psychological recovery is impeded by the fact that many have family members who are still missing.⁴ In October 2016, a military offensive led by an alliance of the Iraqi security forces and an international coalition was launched to retake the city. The battle of Mosul lasted for more than 250 days and was described as one of the deadliest urban battles since the Second World War, leaving the area utterly destroyed.

Copts in Egypt

Copts are the largest minority in Egypt, with numbers estimated between 4.7 and 7.1 million. They live throughout Egypt but are concentrated in Alexandria, Cairo and the urban areas of Upper Egypt (southern Egypt). Most Copts are working-class farmers and labourers, although there is a Coptic upper class and middle class of business-owners, urban professionals and small landowners.⁵ Copts in Egypt suffer from multiple levels of discrimination in law and in practice which affect their participation in public life and hinder their access to their social and economic rights.⁶

Tunisian Jews of Djerba

Until 1948, an estimated 105,000 Tunisian Jews resided in the country.⁷ The existence of a Jewish community in Tunisia stretches back to the Roman era. The island of Djerba harbours one of the last Jewish neighbourhoods in its town Houmt Souk, in the Hara Kbira and Hara Sghira

neighbourhoods. The number of families living in Hara Sghira has decreased significantly due to migration and gentrification, with only five families remaining. While the right to religious freedom is guaranteed and protected for the Jewish community, the public and political spheres only tolerate their existence rather than framing policies and laws that take them into account. In the 2014 and 2022 Constitutions, Tunisia's President is required to be of the Muslim faith. For certain professions, such as becoming a judge or lawyer, the induction ceremony obliges the candidate to swear on the Qur'an.⁸

Amazigh

Amazigh are indigenous to North Africa. They live in lands stretching across Morocco, Algeria, Tunisia, Libya, Western Sahara, Mauritania, the Canary Islands and parts of Egypt, Mali and Niger. In Tunisia, Amazigh communities were particularly affected by the Arabization of the Bourguiba era, as they have a unique cultural and linguistic identity. The Amazigh of Tataouine, the focus of this report, are dispersed along the villages of Chenini, Douiret (including Ras El Oued and Bir 30), and Guermezza.

Black Tunisians

There is no official estimate for the number of Black Tunisians in Tunisia. The community is thought to represent between 10 and 15 per cent of the total population of Tunisia.⁹ The main Black communities in Tunisia reside in the south in Gabes (Arram, Mareth, El Mdou, Gwanda ...), Kebeili, Medenine (Arram, Tezdaine in Djerba, El Gosba), Tataouine and Remada. The current situation of Black Tunisians cannot be untangled or understood without considering the history of slavery in Tunisia.¹⁰ The categorization of black and white in Tunisia uses the terms *ahrar* (free men or women, light-skinned), *abid* (slave) and *wusfan* (sing. *wusif(a)*, the common term for a dark-skinned person, which refers to servant or maid).¹¹ It is essential to highlight that Black Tunisians constitute a heterogeneous community. While specific communities remained close to their former masters, for example the Ghbonton tribe in Medenine, many communities dispersed and were impacted by rural–urban migration. Thus, the conditions of the former differ from the latter.¹²

Methodology

This report is the result of fieldwork conducted in Egypt, Iraq and Tunisia and coordinated by Minority Rights Group International (MRG). The study is concerned with identifying key barriers to accessing health care services by minorities and indigenous peoples. This is important because emerging evidence confirms that minorities and indigenous peoples are among the most marginalized communities in terms of access to social and economic rights, undermining their right to the highest attainable standard of health. By identifying barriers as well as any good practices which are being implemented in the region, it is hoped that these vulnerable people will gain better access to health care sooner rather than later.

A qualitative approach was used to obtain an understanding of the experiences in accessing health care by Copts in Egypt, Yezidis in Iraq and Jews, Amazigh and Black Tunisians in Tunisia. A desk review was conducted to understand the specific context of the health care systems. Studies published in English, French or Arabic language were included. The review included reports, book chapters, briefs, conference abstracts and theses.

The study included face-to-face in-depth interviews and focus groups with members of the communities and medical professionals. This allowed the collection of up-to-date information on the key elements of access to health care. Desktop research was triangulated through interviews and focus group discussions with relevant stakeholders. The aim was to provide a clearer picture of the multi-dimensional aspects of accessing health services, which can help verify the information obtained from the desk review and provide critical analysis. None of the participants had any prior familiarity with the interviewer before they participated in the study, and they signed an informed consent form. Participation was voluntary, and participants could withdraw from the interview at any time if they chose to do so. The guiding questions of the focus group were designed to explore the perception of members of the community on the availability, affordability, accessibility, adequacy and appropriateness of health services. The interview questions designed for the health professionals included questions on alternative services and suggestions for improving the supply of the services. The coding process and data analysis were conducted using Levesque's conceptual framework for access to health care, which considers provider and patient

factors. In Egypt the fieldwork consisted of a focus group discussion with members of Coptic minority as well as four interviews with health professionals in both Alexandria and Cairo. These health practitioners provided relevant information beyond their own community, identifying broader issues of discrimination. This work took place in September and October 2022. Particular focus was given to approaching women within the pool of participants to explore instances of intersectional discrimination based on religion and gender.

In Iraq, the fieldwork focused on the region of Sinjar in north-west Iraq, where many Yezidis live, who were severely affected by the emergence of ISIS in 2014. The Sunni Arabs in this area were also targeted by this fieldwork as one of the minorities in this region. The fieldwork comprised of two focus groups with minorities in Sinjar and its villages and took place in August and September 2022. This qualitative study was complemented by three individual interviews with medical staff in Nineveh Governorate. The interviews and the focus group discussion were conducted in Arabic.

This research includes primary data from fieldwork in the south of Tunisia and in Tunis, as well as secondary data in the form of a literature review. The process covered members of the Tunisian Black community in Djerba, Gabes and Sfax, the Tunisian Jewish community in Djerba, and the Amazigh community in Tataouine. In Tunisia the researcher collected primary data with the help of MRG North Africa and her professional network of activists and community members. Data collection and other information included fieldwork visits, ethnographic observations, focus group discussions, and interviews with community members, health workers and civil society actors. The research was implemented in areas with a strong presence of Black, Jewish and Amazigh communities. Fieldwork on the island of Djerba, and in Tataouine, Gabes, Sfax and Tunis took place in August and September 2022. Previous fieldwork in Tataouine was conducted in May, June and July 2021. The tools for data collection included focus group discussion guide sheets. The interviews and focus group discussions were conducted in Tunisian Arabic. The presentation of findings used ethnographic storytelling methods that focus on the lived experiences of respondents. Research on minorities and indigenous peoples in this report considers

the interplay of social class, gender and regional inequity to help shape an adequate analysis of the situation in Tunisia.

The Covid-19 pandemic exacerbated the political and social instability of the country. In Tunisia, the pandemic generated a myriad of economic and social harms. Unpaid debts and high levels of corruption have weakened and damaged the public health system. During the pandemic, patients experienced the results: poor service provision and lack of adequate equipment.¹³

During the fieldwork in the southern governorate of Gabes, the full impact of the multi-dimensional economic crisis hitting Tunisia was becoming clearly visible. Supermarkets lacked basic food – sugar, milk, coffee, yoghurt, water, bread, rice and couscous. Primary health care centres in rural areas had no essential drugs available, sometimes for months. These observations apply to more areas than the region of Gabes and the southern governorates where most indigenous and Black communities are concentrated. Along with the other public services, the health care sector is facing a sharp deterioration. In light of the political, economic and food crisis Tunisia faces, the hopes for a life of dignity that erupted in the 2011 revolution seem to be slowly fading.

An overview of health systems in Egypt, Iraq and Tunisia

Egypt

The health system in Egypt is overseen by the Ministry of Health and Population which oversees the public and private sector. Like other health systems in the region, the public sector in Egypt has suffered from historic underfunding – average expenditure on health does not exceed 5.5 per cent of GDP.¹⁴ The Health Insurance Organization (HIO), a quasi-governmental organization, was created under the Ministry of Health and Population to cover cost of health care for employees of the formal sector.¹⁵ However, this scheme is far from achieving a universal coverage as it is estimated that the HIO covers about 50 per cent of the population.¹⁶

According to the World Health Organization (WHO), the highly centralized health system in Egypt faces many challenges, including the high share of out-of-pocket spending on health and the low quality and inadequate provision of public health sector services.¹⁷ In addition, poor workforce strategies and the lack of appropriate incentives for the qualified workforce lead to demotivation, migration and extensive dual practice (public and private healthcare provision).¹⁸

There has been a lot of construction of hospitals in the recent years, but the manpower is low, and immigration is increasing among health professionals.
(Interview with a doctor)

There have been some efforts to address these challenges. For instance, Egypt's commitment to the Sustainable Development Goals (SDGs) has been a driver for change. An important step has been the adoption in 2018 of the Social Health Insurance (SHI) law. The SHI sets out to ensure adequate and sustainable funding for health and to reduce out-of-pocket expenditures.¹⁹ In this way the system will be restructured and will provide coverage for all, making health services affordable for citizens.²⁰ The plan has been expected to benefit more than 45 million Egyptians who have been left out of the current insurance system.²¹ However, it is yet to be implemented.

While providing universal health coverage is an important goal towards achieving health equity, there are still key challenges affecting the Egyptian health sector

that need to be addressed. Social injustice and lack of equity are the major challenges that drive the illness–poverty cycle. The health system in Egypt is still highly centralized resulting in clear disparities in health outcomes.

People living in rural areas of Alexandria are very deprived in comparison to the city, many health units in the villages have a doctor only for once or twice a week.
(Medical professional in Alexandria)

Iraq

Iraq's health care system is damaged because of decades of war and conflict, on a backbone of a long history of international sanctions. Sanctions imposed on Iraq during the Saddam era affected every aspect of the health system. The embargo on many essential medicines has had a huge impact on life expectancy on the people of Iraq. For instance, only one-third of the medicines were available for chemotherapy for the treatment of acute lymphoblastic leukaemia in children.²²

Article 30 of the 2005 Constitution states that:

[t]he State shall guarantee social and health security to Iraqis in cases of old age, sickness, employment disability, homelessness, orphanhood, or unemployment; shall work to protect them from ignorance, fear and poverty, and shall provide them housing and special programs of care and rehabilitation, and this shall be regulated by law.

Article 31 further stipulates that, 'Every citizen has the right to health care.'²³

Even with this official commitment to the right to health in the Constitution, in practice the health system in the country is in crisis. The situation deteriorated after the US-led invasion on Iraq in 2003, which not only enabled the creation of the neoliberal state but also an environment of corruption. Reports from just two years after the invasion revealed high level of corruption, bribery, nepotism and theft in the Iraqi health sector.²⁴

Regardless of the percentage of government spending on the health system, which was about 4.48 per cent of

annual GDP in 2019,²⁵ it would be futile to increase spending unless the issues of corruption and failed governance are addressed. This environment has pushed many qualified doctors and other medical professionals to leave the country. The weakness and under-resourcing of Iraq's public health system has had a deep and widespread negative impact on people's health. Non-communicable diseases, such as cancer, heart disease, diabetes and chronic lung diseases account for 55 per cent of deaths in Iraq.²⁶

In addition, the ongoing political instability and conflict in the country have resulted in severe damage to the country's infrastructure. According to the World Health Organization (WHO), poor public services – electricity and water supply, waste disposal and others – have serious health implications.²⁷ Restoring the delivery of basic social services can serve to enable the return of internally displaced persons (IDPs) to their places of origin and contribute to the overall peace agenda. This should include policies targeting health care, education, water and sanitation (WASH) and – given the unprecedented level of damage and destruction to facilities including housing – rebuilding infrastructure in Iraq.

This is especially important in the area of Sinjar in north-west Iraq where some of the deadliest battles took place. The city of Mosul was declared retaken by the Iraqi authorities in 2017, yet many medical facilities damaged in the fighting have not been fully restored and are not fit for use. In the absence of a functional public health system, Médecins Sans Frontières (MSF) has been one of the main providers of health services in the region, providing mainly emergency services, maternity care and mental health support. In the Covid-19 pandemic, MSF was one of the few actors able to provide intensive care to patients with severe symptoms in the area.

Tunisia

Since its independence, Tunisia has attached great importance to infrastructure, education and health care. The Bourguiba government built a solid network of primary schools and primary health care centres throughout the country. The *madrassa w mostawsef* policy was a crucial reform in post-colonial Tunisia. This policy allowed 90 per cent of the population to live as close as 5 km to the nearest primary health care centre.²⁹ In 1978, Tunisia joined the WHO International Conference on Primary Health Care in Kazakhstan and committed to the Declaration of Alma Ata, a milestone in promoting health for all.³⁰ In the 2014 Constitution, the right to health for everyone is recognized in Article 38, which states:

Health is a right of every human being. The State guarantees preventive and curative health care to every citizen and provides the necessary means to ensure the safety and quality of health services. The State guarantees free health care for people without support and on low income. It guarantees the right to social coverage, as provided by law.

In the Constitution of 2022, Article 43 maintained the same formulation regarding the right to health. Moreover, Tunisia has ratified several international treaties and conventions to protect the right to health. The International Conference on Population and Development (ICPD) marked a milestone in recognizing reproductive health as a priority in national health programmes.³¹ The country's family planning programme ensures free access to contraception, abortion and counselling for all women.³² In a report on the right to health in Tunisia, the Association Tunisienne de Défense du Droit à la Santé (ATDS) examined the obstacles to the right to health in Tunisia. The issues raised included incoherent policies, regional disparities, bad quality of service, financial unaffordability, corruption, and insufficient access to medicines.

According to WHO, out-of-pocket payments on health care still represent a large share of total health expenditure (36.6 per cent), despite the existence of schemes to support poor households.³³ In addition to the unequal distribution of health care providers and accessibility of specialized services in remote areas, the Tunisian health system suffers from high unemployment for newly graduated health professionals and a brain drain towards the private sector and foreign countries.³⁴

For the purposes of this study, the situation of the health system in the areas of Djerba, Gabes and Tataouine, where Jews, Black Tunisians and Amazigh reside, was examined. The island of Djerba has seen significant investments in and attention paid to its tourism sector since the 1960s.³⁵ Yet the stark contrast between the tourist zone and the rest of the island reveals that the investment is paying off for investors more than it is for the island dwellers. The infrastructure remains rudimentary, and access to water and electricity is inconsistent. Another interesting source of economic change in Djerba is the surge of Libyan medical tourism, even more since the civil war in Libya since 2011. Djerba is only 130 km away from the Libyan border crossing at Ras Ajdir. The political situation in Libya has also played a critical role in expanding the private health sector in the south of Tunisia. The island of Djerba attracts thousands of Libyans yearly for health care and tourism.³⁶ Specific neighbourhoods in Houmt Souk,

such as Sidi Zayed, have become a profitable rental paradise, with more Libyans than Tunisians residing in the district close to private clinics. The surge of private clinics is advantageous for the Jewish community in Houmt Souk.

Corruption has led to the decay of the public health sector in favour of the private sector and is embodied in different forms at all levels of governance. Contracts and assignments for building construction activities and buying equipment are some of the main ways in which public resources are squandered. The hospital of Gabes represents such a case:

We are waiting since 2014 for constructions and rebuilding old parts of the hospital. Can you imagine eight years and we have almost nothing significant happening?

(Health care worker, Gabes, August 2022)

But all barriers and obstacles seem to vanish when a patient is from a well-known family or knows someone in a position of power. Favouritism and nepotism in Tunisia

are highly efficient and discriminate against those with no power. A Black woman from Gabes shared: 'It is not a case of Black or white, it's a thing of personal connections. To me, nothing bad ever happened in hospitals, I know who to call.'

The freeze on recruitment of health care workers in the public sector is entering its seventh year. While the government remains silent, Tunisia is losing highly skilled medical doctors and nurses. In his 40 years of health care service in Gabes, one health care worker stated he had never had to sign so many contracts for foreign recruitment for nurses as he does today. The impression all public health care workers are left with is: 'The State withdrew its hands.'³⁷

The situation in places such as Tataouine is described as 'peripheral spaces within a country that is already on the global periphery'. While the coastal areas of Tunisia enjoyed 90 per cent of development investment, the west and south of the country were left out of the equation.³⁸ These disparities are reproduced in the life expectancy of the citizens. While the average life expectancy is 77 years in the coastal governorates of Sfax and Tunis, it is estimated at 70 years for Tataouine. The latter has one of

Availability, accessibility and affordability of health care

Egypt

One of determinants of access to health by communities is the availability of health care resources which include infrastructure, health professionals and medicines, among others. When asked about how easy it is to obtain health care for minorities in Egypt, the field study's participants provided a complex intersectional view on how minorities are affected. One of the main issues raised by the participants is the issue of the centralization of the Egyptian health system. This means health resources are unequally distributed, where major cities benefit from the concentration of these resources while rural and peripheral areas lack even essential care. This imposes an additional barrier to accessing quality health care for many minorities, who mainly live on the outskirts of the main cities in Egypt. This has major implications not only for the health outcomes of minorities but also for the largest part of the Egyptian population since 57 per cent of them live in rural areas.⁴⁰ One interviewee, a medical practitioner based in Cairo, mentioned that 'Minorities such as Nubians, and Amazighs have problems in accessing health care, because there are vast distances to reach health units, and the expansion of governorates such as Aswan and Matrouh.'

When examining the availability of health care, it is crucial also to ask what care is available. In a context like Egypt, the picture for public and the private health provision is highly unequal. In our field study participants were asked specifically about the provision of reproductive care, so as to explore the intersectionality between gender and minority status.

There is also the question of the availability of mental health services, as there is already a crisis in the availability of these services.⁴¹ One of the doctors interviewed said: 'these services are unavailable in most public hospitals, primary health care units do not have mental health services. In addition, there is a crisis in the awareness of doctors on the importance of mental health and ways of dealing with these issues.'

In Egypt, where about a third of population live below the poverty line,⁴² the question of the affordability of health care plays a key role in determining access to health. Minorities experience an intersectional limitation in their access to health, between identity-based

discrimination and economic marginalization. According to the fieldwork, when poverty and marginalization are combined within Egypt's centralized health system, the result is that many minorities are deprived of their right to health. According to one doctor interviewed: 'treatment is at the expense of the state, but it also requires travel several times, and a complex bureaucracy, even when treatment is free, but access to it is accompanied by great hardship'.

This pushes many either to dismiss treatment or to search for alternative services. According to one interviewee, churches in Alexandria have been funding clinics to provide health care to marginalized Christians for a small fee. These services are especially useful for minorities with chronic diseases requiring long-term medications, an expense which can cause families to fall into deeper poverty. However, these services can only provide for basic needs. There are also social networks formed by kinship ties that provide support, especially during recovery from sickness or in cases of death-related expenses: 'Alternative services [are] provided by the church and [through] kinship ties with financially capable people who help, but it is not sufficient,' a doctor said.

The difficulty of affording treatment has pushed minorities to stop seeking care or depends on alternative sources. A doctor said: 'Unfortunately, those who can't afford the treatment seek alternative methods such as [through the] internet, taking medicines from a former patient with similar conditions, resorting to herbs, and [they] get exposed to misinformation which can lead to major problems and complications.'

The fieldwork highlighted the systemic discrimination minorities face when accessing health care. It is entrenched in a larger reality of marginalization in their access to land, housing, employment and education. During the fieldwork medical professionals were asked about discrimination on the individual level and the quality of treatment of minorities. Not all interviewees belonging to a medical profession think that minorities receive unequal care. Some witnessed minorities being exposed to harassment when seeking care. According to a doctor interviewed: 'discrimination in the health system against minorities exists when racism in the society is tolerated'. Another interviewee mentioned that Christian minorities face unfair treatment in the workforce; Christian doctors and medical staff especially face

discrimination and racism in many attitudes and decisions made by their superiors in the workplace.

All participants agreed that women would face difficulties in navigating the health system. They acknowledge that women from minorities will experience double discrimination. In some cases, health complaints made by women are seen as exaggerated or insincere: ‘some doctors find it easier to prescribe painkillers instead of carrying out a full examination for a woman’.

The quality of services available for marginalized groups, minorities and refugees is very bad: ‘if you are from a minority, marginalized peripherally or geographically, refugees, services are very poor, even in the most basic health needs’.

Iraq

Sinjar district and its villages were hugely affected by the conflict when ISIS took control in 2014. Even after the recapture of Mosul, the situation of the people of Sinjar and Mosul is still dire. Health care is one of the many areas of public life that has deteriorated hugely. Participants in the field study in Iraq revealed that the majority of health centres have not reopened since 2014, and the few available centres only have 40 per cent of basic requirements in terms of medicines, tests and vaccines.

As for the main available hospitals, Sinuni hospital and Sinjar General Hospital, both suffer from an acute shortage of doctors and specialists, devices and medicines. According to participants, Sinuni General Hospital – where MSF provides emergency and maternity services – is the only option for health care services. MSF, through its units in the hospital provides a referral system for patients to Mosul and Dohuk hospitals, where patients can receive more specialized or complex medical treatment. In Sinjar general hospital, there are only three specialists available: two paediatricians and an ophthalmologist.

According to a doctor who was interviewed, many medical professionals refuse to serve in the areas where minorities live due to political instability and the lack of security. According to one of the interviewees, a nurse who works in Sinjar General Hospital, Yezidis are one of the most marginalized groups when it comes to access to health. When asked about the reasons for this, he mentioned that ‘because of continuous marginalization, they have no political representation to fight for their rights. There is also the language barrier as many Yezidis are not fluent in Arabic, the language of most health professionals in the hospital.’

The geographical distances they have to travel for health care access is a key challenge for communities in Sinjar: Duhok is about two and a half hours away from

Sinjar and Mosul about two hours. This puts members of the community at risk. One Yezidi participant said:

The available services are primary health services only, as most of the different communities residing in Sinjar are forced to travel for more than two hours to cities such as Mosul and Dohuk to receive surgery. Many cases of deaths were recorded during transporting patients to the city of Mosul or Dohuk as a result of the distance and the lack of ambulances or a specialized medical staff in Sinjar district.

Not to mention the long waiting times in government hospitals, which may reach weeks and months, with the risk of complications developing over time.

Many stressed that the numbers of returnees to the district of Sinjar do not exceed 60 per cent of the total population of the district before the events of 2014. Participants believed that this reduces the government’s interest in investing in the area. According to a nurse who participated in the study: ‘the government response is very weak, and the evidence is the lack of an integrated hospital or health centres in remote villages, and the lack of reconstruction of the health facilities that were destroyed during the last war’.

The people of Sinjar suffered some of the worst atrocities committed by ISIS. The jihadist group singled out Yezidis, killing Yezidi men on the spot and enslaving women and girls. Thousands of people have been displaced. The events of 2014 and the current instability and unrest in the area have had a tremendous impact on the mental health of the population. High incidence of mental health issues has been recorded among minorities, especially Yezidis, in the area. Everyone interviewed in this study agreed on the importance of the mental health services, especially for this district and its villages, as they have been the most psychologically affected by the events of 2014 and the conflict and political instability since. The participants agreed that the Yezidi minority in general, and Yezidi survivors in particular, were most affected. Under ISIS control, they were subjected to extreme physical and psychological violence. Many in the focus group also mentioned that to this day they feel fear, anxiety, anger over injustice and even panic attacks.

Given the high demand for mental health services, the study participants were asked about the availability of such services. Mental health services are very limited in the area. Some pointed to the existence of mental health care in the Sinuni General Hospital, referring to services provided by Médecins Sans Frontières. When approaching this service participants mentioned there is no discrimination on the basis of religion, sect or nationality, and that the reception and the staff are very

welcoming, however mental health medications are not widely available. In addition, the available mental health services lack specialized staff.

Another service mentioned by the focus group participants was support for women suffering from domestic violence. The service is provided by MSF, who reached out to the community and encouraged women to seek support. However, participants from the Yezidi community mentioned that there is a need for more sophisticated care, especially in response to the complex situation of Yezidi women, and especially Yezidi survivors.

When it comes to the question of the affordability of health care, many participants mentioned that the majority struggle to cover the cost of care. Many of the minorities in the area work in agriculture or as casual workers, hired on a daily basis. For those working in agriculture, their occupation has been hit hard because of reduced rainfall as a result of climate change. Many participants mentioned that their income barely covers the expense of their food and drink. When they were asked about the most costly services they needed, they mentioned expenses such as the cost of transportation to hospitals, and minor and major operations in private hospitals – and even in government hospitals. Furthermore, many mentioned the cost of medication for chronic conditions such as diabetes, and heart and kidney conditions, in addition to the costs of diagnostic tests. Because of the high costs, some participants said that they were forced to postpone using services and may have stopped seeking treatment altogether.

Others pointed out they seek the cheapest options they can get. Due to the lack of financial resources, many were forced to reduce their visits to the doctor, especially those with chronic conditions which need regular follow-ups and monitoring.

When asked about discrimination in health facilities, the Yezidi participants mentioned that they do not sense a difference in their treatment in comparison to other communities. Some Arab Sunni participants pointed out that they face racial discrimination in Sinjar and Sinuni General Hospitals, that this discrimination leads to delay in their access to health services and, if they do obtain treatment sometimes they do not receive all the treatment they need.

When asked about the quality of healthcare, participants described it as bad. This also included social and psychological support. Participants believe that the main reason for poor health services is the government's lack of interest in providing hospitals with the necessary equipment, ambulances, adequate medicines and supplies for laboratories and radiology, as well as the deterioration of the political situation in these areas and the ongoing conflicts.

One Yezidi participant mentioned that: 'because we do not have real representation in making decisions affecting our areas, our lives, no one will fight for our rights'.

Tunisia

According to Jewish community members, the Covid-19 vaccination campaign was very accessible, and the community was eager and proud to get their vaccinations in the youth centres of Houmt Souk. Nevertheless, the community generally shared a lack of trust in public hospitals. In a discussion with a Jewish family from Tataouine living in Hara Sghira, it became evident that even with the accessibility of private clinics, the island's infrastructure negatively impacts health care quality. One of the daughters has been denied surgery that she needed urgently.

My daughter has been like this for one and a half months. She is waiting for surgery. One day the electricity is not working, one day it is something else. It is saddening. We don't even bother going to hospitals. We go to clinics and private doctors when we are sick, and then we trust in God. (Jewish man, Houmt Souk, August 2022)

A common observation for Tunisian Jews in Djerba is that they have several different citizenships. The complex shared history with Portugal, Spain, Israel and France, has allowed different families to obtain other citizenships alongside their Tunisian citizenship. It is therefore common to travel abroad for health care. The strong cohesion within the community is also a vital contributor to their well-organized access to treatment and health care. The community is engaged in transnational health care arrangements that provide a safety net beyond the services of the Tunisian state.⁴³ Age, gender and faith determine the arrangements between the families at home and/or in host societies. Certain community members expressed that they favour treatment by a Jewish doctor, especially for women and girls. Therefore, it is more common for Jewish women to travel abroad for medical reasons.

During the fieldwork, a sense of caution was evident, affecting how open people were to discussing issues around discrimination and marginalization in health care access. The relatively peaceful coexistence between Jews and non-Jews in Djerba seems to prevail through an unspoken code of conduct:

We, the Jews here in Djerba and Zarzis, everyone who respects the other is respected. Never do something out of the ordinary. Put religion aside. In the end, you are a Tunisian citizen.
(Jewish man, Houmt Souk, August 2022)

Disentangling the experiences of Jewish Tunisians related to their religious belonging from the experiences associated with generally poor service and access is a difficult task. Specific experiences will remain hidden beneath the surface due to the fear of attracting attention and resentment.

During the fieldwork, it was hard to reach Black Tunisian doctors to address health care access from the service provider's side. The lack of representation of Black Tunisians in higher positions in all the different skilled sectors, despite their making up 10–15 per cent of the population, is a reflection of the ongoing discrimination against them at the social and economic levels. Eventually, the researcher identified Black nurses who were interviewed. In a conversation with a Black Tunisian activist from Gabes, he pointed out that the case of a Black nurse from Sfax attracted attention recently. This was a nursing service manager in a hospital in Sfax, who was verbally attacked by his ambulance driver. When interviewed the victim expressed that the incident was not unexpected, though it was painful and traumatizing. He said:

When Black Tunisians hold higher positions than whites expect, the judgment parameter changes drastically. Accepting a Black as your supervisor, leader, doctor, or lawyer is still unacceptable in white minds. It is often Black Tunisians who reach an advantageous position that get attacked. 'You Blacks will be slaves forever. You will never be masters!' That is what they say then.

(Black nurse, Sfax, August 2022)

A trail of racist rants and harassment on social media followed when the nurse reported the incident to the police. In July 2022, the court ruled that the nurse was a victim of racial discrimination. Black Tunisians are widely left unsupported in the face of the anachronistic viewpoints often expressed in racial slurs, negligence or discomfort felt by white Tunisians in all sectors and services.⁴⁴

The marginalization of Black communities in the south in their access to health care is multidimensional. It has become rare today in most rural primary health care centres to find free medicines for chronic diseases such as hypertension and diabetes. A health care worker in Gabes shared that the Ministry of Health is not in communication with the centres and is not providing an explanation for the lack of medicines. In a discussion with the Black community of Chenini-Gabes, a respondent shared:

I know people who stopped taking drugs. There was a period where we did not have any blood pressure drugs available. The mother of a friend from Chenini is very

poor and usually, they got her drugs from the primary health care centre, but each time they went, it was not available. The woman died, and she did not receive her treatment.

(Black activist, Gabes, August 2022)

Moreover, the primary health care centres that rural communities rely on in the vicinity have limited and unreliable opening hours. With limited mobility and the unavailability of means of transportation, barriers to health access in Tunisia are increasing. A Black health care worker recalled a patient from a rural Black community who came to the hospital in Gabes for an amputation as a complication for his diabetes. He was cursing and insulting the doctors and nurses. When asked why he was addressing his anger to the health care workers, he complained about not finding a doctor or a nurse in the primary health care centre for the last few months. Living in a remote area, he needed to come down from the mountains on his donkey over a difficult track, just to be disappointed every time. The health care worker added:

The working hours are not respected. You find a doctor who is doing two dispensaries per day. So, he works from 9 to 11 and then moves to another dispensary. This happens out of the low number of available doctors. And in between the right to health gets lost.

(Health care worker, Gabes, August 2022)

Another significant barrier to healthcare access is affordability. The issue of costs is of increasing significance, with more and more citizens forced to turn to the private sector where many medical resources and much infrastructure are concentrated. For example 73 per cent of scanners and 79 per cent of cardiac catheterization laboratories are held in private hands.⁴⁵ This means that in the public health sector fewer tests are available and the waiting lists are longer. A Black mother of three from Tezdaine had her third child in a private clinic after experiencing bad treatment giving birth to her first two children in the public hospital:

For private clinics, white and black are the same. You will always get your business done if you know somebody and have your money ready. They don't care, put your money and that's it. If you don't have money in these times, you die. You are held hostage, they keep you until you pay. One time a woman died in a private clinic. Her family did not have money. 11,000 [dinar]. Only when they paid did they release her body.

(Black woman, Tezdaine, August 2022)

The number of regional public hospitals declined 6 per cent between 2010 and 2018, while private health facilities have seen an increase of 28 per cent.⁴⁶ The public sector is deteriorating, and the Ministry of Health is facing an exodus of health care workers abroad or to the private sector. As a result, the Ministry waives the complementary private activities (APC) regulations and allows doctors in the public health system to offer private consultations within the public hospital as well as their private practice.

The patient pays for private consultation because you get an appointment sooner than in the public consultation hours. The ministry approves this to keep the doctors from going to the private sector, where they would make three times as much.

(Black activist, Gabes, August 2022)

Belonging to the nation is seen here as something negotiable. Being Tunisian is strongly tied to the provision of basic needs by the state. Feelings of exclusion are heightened, especially in young family members, concerning the lack of employment. The high unemployment rate of young people is expressed in narratives of suffering, exclusion and resentment against the state. The midwife shares:

I had a great education in the health sector, and instead [of working] I am partly unemployed and receiving a grant from the employment office. The recruitment in the hospital is far away at least 5, 6, 7 years. How can one see the people who left the country, how they are living, then you look at the situation in your country – it is not farfetched that in five years, people will be stealing food from each other.

(Amazigh midwife, Tataouine, July 2021)

During fieldwork in Tataouine, the severity of the Covid-19 pandemic increased sharply. The socioeconomic climate before the pandemic was marked by social unrest – the Kamour movement, starting in 2017 and revived in 2020, was put on hold by the resurgence of Covid-19 in the region. Socioeconomic inequality and exclusion have epidemiological consequences in the form of differential morbidity and mortality rates during the Covid-19 pandemic. The political exclusion of Tataouine was inscribed in the lives of people during the virulent Covid-19 outbreak there. The marginalization of a region in the ‘periphery of the periphery’⁴⁷ was reflected in the absence of identification with Tunisia in the discourses of people there.

Amazigh: A geographic isolation

For Amazigh communities in Tataouine, one of the main limitations to health access is the geographic location of the communities. In the case of the town of Douiret, transportation is a significant issue. Although there is a regional hospital in Tataouine, it has the second lowest number of specialized doctors in Tunisia after Siliana.⁴⁸ An evaluation of the public health system in Tataouine by International Alert classified Tataouine as the most deficient governorate in terms of service provision. Tataouine went into total lockdown from 11 to 31 July 2021, following a day of catastrophic Covid-19 infections and a high death toll (1,700 per 100,000 inhabitants and 11 deaths). One midwife in Douiret was recruited to transport patients to hospitals outside Tataouine: oxygen reservoirs were empty, and two patients died due to the unavailability of oxygen. The regional hospital often struggles, having the minimum required staff, with only three specialized doctors (an orthopaedist, a paediatrician and a surgeon) permanently employed – for 150,000 inhabitants. For emergencies, a gynaecologist is required to travel from Sfax to Tataouine (around 300 km). A midwife, an Amazigh woman working in the hospital of Tataouine, described the situation:

As if it is not enough that we are living in Tunisia, we are living in Tataouine. I am a midwife. In all Tataouine there is no gynaecologist. Imagine a complication that happens during birth. They don't find a doctor, so the mother dies. And sometimes the baby.

(Amazigh midwife, Tataouine, July 2021)

Travelling up to 550 km to Tunis for health care is the norm. When you mention having to go to Tunis, you are often met with a concerned ‘*Inchallah Labes?*’ ‘Is everything fine?’

The precarity brought by the Covid-19 health crisis exacerbated the already weakened infrastructure of the public health system in Tataouine.

Conclusion

The study has shown that minorities in Egypt, Iraq and Tunisia face many barriers in accessing health care services. In all three countries there is very little disaggregated data on health outcomes based on ethnicity, religion and language. To our knowledge this briefing is one of the few qualitative works that focuses on the experience of minorities and indigenous peoples in the Middle East and North Africa in accessing health services. The results of the study can be understood within the framework of intersectionality. The study participants emphasized that access to health care services is shaped by many interacting factors. It is important to interpret the results of this project within a hierarchy of power that positions minorities and indigenous peoples in the MENA region at the bottom of the social order.

In Egypt there is a prevailing official discourse that does not recognize the unique situation of minorities in the first place. This was reflected in the study and the attitudes of participants, especially the interviewed health professionals, which appeared in the sarcastic smiles, facial expressions or hand gestures, and in their answers that the state essentially does not recognize minorities when planning health policies. The study shows how socioeconomic factors affect minorities' access to health care in Egypt. Deep-rooted patterns of discrimination in society create systemic barriers to the conditions needed to live a healthy life, contributing to poorer health outcomes among individuals belonging to minorities. In addition, the highly centralized health system in Egypt plays a major role in the provision or denial of services. In Cairo, health services are more available, while minority communities located outside Cairo are experience greater barriers in accessing health services. These barriers have pushed Copts to use alternative services that can only cover basic needs, such as services provided by churches and wider kinship networks. The study revealed some optimism among health professionals interviewed with regard to the universal plan to cover health care. They believe that, if implemented, it could have an impact on the health outcomes of the most marginalized.

In Iraq, availability, affordability and acceptability of health care services for Nineveh governorate are adversely affected by conflict, siege and military campaigns. In

Sinjar district, health services in the primary care centres are absent, especially in the remote villages where minority groups reside. The political instability and lack of security, coupled with governmental neglect in restoring infrastructure have had a huge impact on the health system in the area. There is great need in almost every aspect of health care, including for health facilities, medicine, equipment and medical staff, who avoid being allocated to the area as a result. While MSF is working to provide essential services in the district, many Yezidis must travel to Mosul or Dohuk hospitals for emergency or specialized services. It is vital that health actors in Iraq understand the impact of conflict on Yezidi communities and other minority groups in the area to draft policy and design appropriate interventions. Many Yezidis work in sectors hit hard by conflict and climate change, resulting in severe hardship. It is important that health actors consider the socio-economic barriers to health care arising from protracted conflict periods, and address these through social protection measures.

Barriers to access to health among Jews, Amazigh and Black Tunisians in Tunisia are multifactorial. They are rooted in a long history of marginalization and exclusion from political decisions. In Tunisia, the model of health governance is highly centralized. This choice is a major contributor to the reduction in public health care functions since the 1990s. The acquisition of equipment and medicine by the Ministry of Health, for example, is not based on actual needs and thus leads to the total lack of equipment in some health facilities while in others it is left unused. This means that areas such as Gabes, Djerba and Tataouine, where minorities are concentrated, suffer from low levels of health infrastructure and resources. The public sector is a common space for corruption and the squandering of resources. There is no actual research on the scope and significance of corruption in the Tunisian health system.

Regional inequities in accessibility to health are reflected in the distribution and availability of health care facilities in Tunisia. University hospitals are concentrated around the coastal area (Sousse, Monastir, Sfax) and Tunis. For people living in the more remote governorates, the distance to the nearest health facilities varies between 206 and 333 km. According to the *Carte Sanitaire* published by the Ministry of Health of Tunisia,

regional health inequities are reinforced by the brain drain of specialist doctors. The increasing shortage of human resources, including medical specialists and health technicians, affects the interior of the country and the south disproportionately.

Recommendations

- Efficient collection of data that is disaggregated to reflect aspects of social identities such as ethnicity, language, religion in addition to gender and age.
- Support the design and implementation of research and studies to explore health inequalities across different communities by public and non-profit institutions in the Middle East and North Africa region.
- Adapting universal health coverage in Iraq and Tunisia and the full implementation of the Social Health Insurance (SHI) law in Egypt that will guarantee access to primary health care to all citizens.
- Decentralization of health systems to ensure fair distribution of health resources that can serve remote and isolated communities in Egypt, Iraq and Tunisia.
- Follow an intersectional approach to health and investment in the infrastructure of basic services especially in historically neglected areas in Egypt, Iraq and Tunisia.
- Facilitate and support medical education and training for members of minority communities and indigenous peoples in Egypt, Iraq and Tunisia.
- Include minority communities and indigenous peoples in health policies' design and accountability processes, including anti-discrimination policies.
- Ensure the availability of accurate and consistent information accessible to all communities.
- Given the trauma of the ISIS occupation and subsequent destruction in Mosul, mental health should be a priority to all communities in Nineveh including Yezidis and appropriate facilities should be established.
- In Iraq, local authorities and their international partners should put a special emphasis on creating the conditions to enable effective reconstruction and the return of displaced population.

Notes

- 1 Chauhan, A., Walton, M., Manias, E. et al., 'The safety of health care for ethnic minority patients: A systematic review', *International Journal for Equity in Health* 19, article 118, 2020. <https://doi.org/10.1186/s12939-020-01223-2>
- 2 Levesque, J.-F., Harris, M.F. and Russell, G., 'Patient-centred access to health care: Conceptualising access at the interface of health systems and populations', *International Journal for Equity in Health* 12, article 18, 2013.
- 3 See: 'Yezidis', in MRG, *World Directory of Minorities and Indigenous Peoples*, updated Nov. 2017, <https://minorityrights.org/minorities/yezidis/>
- 4 Ibid.
- 5 See: 'Egypt', in MRG, *World Directory of Minorities and Indigenous Peoples*, updated June 2019, <https://minorityrights.org/country/egypt/>
- 6 See: MRG, *Justice Denied, Promises Broken: The Situation of Egypt's Minorities Since 2014*, London, MRG, 2019, https://minorityrights.org/wp-content/uploads/2019/01/MRG_Rep_Egypt_EN_Jan19.pdf
- 7 Lagnado, L., 'The last of the Arab Jews: Tunisian Jewish enclave weathers revolt, terror; can it survive girls' education?', *Wall Street Journal*, 13 February 2015, <https://www.wsj.com/articles/insular-jewish-community-of-djerba-tunisia-has-weathered-revolution-and-terrorism-but-can-it-survive-girls-education-1423869146>
- 8 MRG, *Identity and Citizenship in Tunisia: The Situation of Minorities after the 2011 Revolution*, London, MRG, 2018, <https://minorityrights.org/wp-content/uploads/2018/11/MRG-Tunisia-briefing-Final-ENG-Nov-2018.pdf>
- 9 Mrad, D.I., 'Les mobilisations des 'Noirs tunisiens' au lendemain de la révolte de 2011: Entre affirmation d'une identité historique et défense d'une 'cause noire', *Politique africaine*, vol. 140, pp. 61–81, 2015. <https://www.cairn.info/revue-politique-africaine-2015-4-page-61.htm>
- 10 See: Pouessel, S., 'The democratic turn in Tunisia: Civic and political redefinition of canons of cultural diversity', *Nationalism and Ethnic Politics*, vol. 22, no. 1, pp. 50–70, https://www.academia.edu/30177599/_The_Democratic_Turn_in_Tunisia_Civic_and_Political_Redefinition_of_Canons_of_Cultural_Diversity_2016_
- 11 Scaglioni, M., *Becoming the Abid: Lives and Social Origins in Southern Tunisia*, Libro Ledizioni, 2020, p. 26. <https://www.hoepli.it/libro/becoming-the-abid-lives-and-social-origins-in-southern/9788855261975.html>
- 12 Ibid., p. 25.
- 13 Bounouh, A., 'The devastating impact of Covid-19 on the health system in Tunisia', *Moroccan Journal of Public Health*, vol. 2, no. 1, 2021, pp. 22–44.
- 14 Gericke, C.A., Britain, K., Elmahdawy, M and Elisi, G., 'Health system in Egypt', in E. van Ginneken, and R. Busse (eds), *Health Care Systems and Policies: Health Services Research*. https://link.springer.com/referenceworkentry/10.1007/978-1-4614-6419-8_7-1
- 15 Jurjus, A., 'The health system in Egypt: An overview', 2015, https://www.syndicateofhospitals.org.lb/Content/uploads/SyndicateMagazinePdfs/8396_16-21.pdf
- 16 Fasseeh, A., Elezbawy, B., Adly, W. et al., 'Healthcare financing in Egypt: A systematic literature review', *Journal of the Egyptian Public Health Association*, vol. 97, no. 1, pp. ??, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8741917/#:~:text=Health%20insurance%20organization,-The%20HIO%20is&text=Many%20published%20articles%20indicated%20that,to%2055%25%20%5B33%5D>
- 17 WHO, 'Egypt: Health systems profile', 2018, <https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/EGY-Health-System-Profiles-2018.pdf>
- 18 Ibid.
- 19 Universal Health Coverage Partnership, 'Egypt', 2021, <https://extranet.who.int/uhcpartnership/country-profile/egypt>
- 20 WHO, 'Country Cooperation Strategy at a Glance: Egypt', May 2018, https://apps.who.int/iris/bitstream/handle/10665/137164/ccsbrief_egy_en.pdf;jsessionid=241E95F079C608B743E6A66EE332A3F4?sequence=1
- 21 World Bank, '45 million Egyptians to benefit from improvements to the public health system', press release, 27 June 2018, <https://www.worldbank.org/en/news/press-release/2018/06/27/45-million-egyptians-to-benefit-from-improvements-to-the-public-health-system>
- 22 Akunjee, M. and Ali, A., 'Healthcare under sanctions in Iraq: An elective experience', *Medicine, Conflict and Survival*, vol. 18, no. 3: 249–57, <https://pubmed.ncbi.nlm.nih.gov/12201083/>
- 23 Constitute, Iraq's Constitution of 2005, https://www.constituteproject.org/constitution/Iraq_2005.pdf?lang=en
- 24 Al Rubai, Y., 'Iraq: Health service mired in corruption', Institute for War and Peace Reporting, press release, 1 April 2005, <https://reliefweb.int/report/iraq/iraq-health-service-mired-corruption>
- 25 World Bank, 'Current health expenditure (% of GDP) – Iraq', 30 January 2022, <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=IQ>
- 26 Al-Saiedi, A. and Haddad, M., 'Challenges by the Iraqi health sector in responding to Covid-19', Issue brief, Physicians for Human Rights, 6 April 2021, <https://phr.org/our-work/resources/challenges-faced-by-the-iraqi-health-sector-in-responding-to-covid-19/>
- 27 WHO, 'Iraq: Health systems profile', 2018, <https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/IRQ-Health-System-Profiles-2018.pdf>
- 28 MSF, *2020 Annual Report: Iraq*, <https://www.msf.org/sites/default/files/2021-06/Iraq%20annual%20report%20English.pdf>
- 29 Ministère de la Santé, *Carte Sanitaire 2019*, Tunis, 2021, p. 173.
- 30 Abdelaziz, A.B., '40 ans des soins de santé de base en Tunisie d'Alma Ata à Astana. Il est temps de revitaliser la première ligne des soins', *La Tunisie Médicale*, vol. 99, no. 1, 2021, pp. 179–88.
- 31 Amroussia, N., Goicolea, I. and Hernandez, A., 'Reproductive health policy in Tunisia: Women's right to reproductive health and gender empowerment', *Health and Human Rights*, vol. 18, no. 2, 2016, p. 183.
- 32 Selma, H., *L'expérience tunisienne et l'évolution des services de l'avortement et PF depuis 1965: Rencontre sur l'avortement médicamenteux*, Gammarth, Tunisia, Association Tunisienne de Défence du Droit à la Santé (ATDS) Société Tunisienne de Gynécologie Obstétrique, 2011.
- 33 WHO, 'Tunisia: Health systems profile', 2018, <https://rho.emro.who.int/sites/default/files/Profiles-briefs-files/TUN-Health-System-Profiles-2018.pdf>
- 34 Ibid.

- 35 Othmani, W. and Dhafer, N., 'Le tourisme en Tunisie: Menaces anthropiques majeures versus capacité de résilience', *Études caribéennes*, 2, article 2, 2018. <https://doi.org/10.4000/etudescaribeennes.14098>
- 36 Rouland, B. and Jarraya, M., 'From medical tourism to regionalism from the bottom up: Emerging transnational spaces of care between Libya and Tunisia', *Journal of Ethnic and Migration Studies*, vol. 46, no. 20, pp. 4248–63. <https://doi.org/10.1080/1369183X.2019.1597475>
- 37 In Arabic: *Eddawla hazzit yiddha* اهدي تزه ةل و دلا
- 38 Ghanem, D. and Jrad, E., *When the Margins Rise: The Case of Ouargla and Tataouine*. Regional Program for Political Dialogue in the South Mediterranean, Konrad-Adenauer-Stiftung, 2021, <https://www.kas.de/documents/282499/282548/When+the+Margins+Rise+PDF.pdf/4fd7149a-3628-cd68-8462-a1bd5f9bdefa?version=1.0&t=1625672041874>
- 39 Meddeb, H., *Life on the Edge: How Protests in Tataouine Forced Tunis to Back Down*. Paper for the X-Border Local Research Network partnership of the Asia Foundation and the Malcolm H. Kerr Carnegie Middle East Center, <https://carnegieendowment.org/files/Meddeb-Tunisian-inequalities.pdf>
- 40 World Bank, 'Rural population (% of total population), 1960–2021', <https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=EG>
- 41 WHO, 'Egypt: Mental health', <https://www.emro.who.int/egy/programmes/mental-health.html>
- 42 Statista, 'Number of people living below the national poverty line in Egypt from 2018 to 2021', <https://www.statista.com/statistics/1237023/population-under-the-poverty-line-in-egypt/>
- 43 Østergaard-Nielsen, E., 'Mobilising the Moroccans: Policies and perceptions of transnational co-development engagement among Moroccan migrants in Catalonia', *Journal of Ethnic and Migration Studies*, vol. 35, no. 10, 2009, pp. 1623–41, <https://doi.org/10.1080/13691830903165840>.
- 44 Mzioudet, H., 'Breaking the racial taboo: Black Tunisian activism as transitional justice', in S. Robins and P. Gready (eds), *Transitional Justice in Tunisia: Innovations, Continuities, Challenges*, Abingdon, Routledge, 2023, pp. 63–87.
- 45 Ziadia, I., 'La politique de santé en Tunisie: que nous révèlent les chiffres?', 20 July 2022. <https://inkyfada.com/fr/2022/07/20/depenses-publiques-sante-en-tunisie/>
- 46 Ibid.
- 47 Sadiki, L., 'Tunisia's peripheral cities: Marginalization and protest politics in a democratizing country', *Middle East Journal*, vol. 75, no. 1, pp. 77–98. <https://doi.org/10.3751/75.1.14>
- 48 Ministère de la Santé, *Carte Sanitaire 2019*, 2021, p. 173.

working to secure the rights of minorities and indigenous peoples

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Understanding barriers to health care for minorities and indigenous peoples in Egypt, Iraq and Tunisia

Minorities and indigenous peoples are among the most marginalized in terms of access to social and economic rights, and this is especially the case with health care. This report uses the availability, affordability, accessibility, adequacy and appropriateness framework to assess health services available to minority and indigenous communities in Egypt, Iraq and Tunisia.

It combines research with interviews and focus groups with members of the communities and medical professionals to review the three health care systems. Covering the Coptic minority in Egypt; Yazidis in Sinjar in north-west Iraq; and, in Tunisia, the Black community in Djerba, Gabes and Sfax, the Jewish community in Djerba and the Amazigh community in Tatouine, the report identifies barriers to access to health care in a context of public health systems that have been weakened by Covid-19, as well as poor systems of governance and under-resourcing.



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