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Bedouin in Lebanon: Social discrimination, political exclusion, and compromised health care

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ABSTRACT

Global inequalities in health have long been associated with disparities between rich and poor nations. The middle-income countries of the Levant (Lebanon, Syria and Jordan) have developed models of health care delivery that mirror the often complex make-up of their states. In Lebanon, which is characterized by political clientelism and sectarian structures, access to health care is more contingent on ethnicity and religious affiliation than on poverty. This case study of the Bedouin of the Middle Bekaa Valley of Lebanon is based on interviews with policymakers, health care providers and the Bedouin as part of a study funded by the European Commission between 2006 and 2010. The study explores the importance of considering social discrimination and political exclusion in understanding compromised health care. Three decades after the Declaration of Alma Ata (1978), which declared that an acceptable level of health care for all should be attained by the year 2000, the Bedouin community of Lebanon remains largely invisible to the government and, thus, invisible to national health care policy and practice. They experience significant social discrimination from health practitioners and policymakers alike. Their unfair treatment under the health system is generally disassociated from issues of wealth or poverty; it is manifested in issues of access and use, discrimination, and resistance and agency. Overcoming their political exclusion and recognizing the social discrimination they face are steps that can be taken to protect and promote equal access to basic reproductive and child health care. This case study of the Bedouin in Lebanon is also relevant to the health needs of other marginalized populations in remote and rural areas.

Introduction

This paper examines the extent to which public sector health care in a middle-income country is adequate and accessible for marginalized, rural and formerly nomadic tribal populations. It describes a case study carried out in Lebanon between 2007 and 2010 to determine how and under what constraints the Bedouin accessed health care (Barbir, 2010; Chatty, 2010b; El-Kak, 2010; Mansour, 2010).

Health inequality or health disparities refer to the differences in the quality of health and health care between groups of different racial and ethnic backgrounds, sexual orientations and income levels. After the initial euphoria of the 1978 Alma-Ata conference, when 'health for all' was assumed to be possible by making free health care services available to entire populations, came the realization that severe economic difficulties made free government-provided primary health care unrealistic.

Now, early in the 21st century, there is renewed concern for poverty and equity in health (Leon & Walt, 2001). In her statement in the 1999 World Health Report, the WHO Director-General, Dr. Gro Brundtland, wrote, "First and foremost, there is a need to reduce greatly the burden of excess mortality and morbidity suffered by the poor" (WHO 1999). This was followed by the eight Millennium Development Goals goals, three of which specifically address poverty, child health, and maternal health. The impact of poverty on health outcomes is evident in studies across the world (Kawachi & Kennedy, 1997). Infectious diseases as well as non-communicable diseases have been linked to poverty (Marmot, 2005). Income disparities are also evident in the utilization of health services (Wagstaff, 2002). Non-economic forms of inequality and their links to health have also been investigated, including those related to social capital (Campbell & McLean, 2002) and cultural capital (Khawaja and Mowafi, 2006). Much of the health economics literature does not accept the existence of a causal relationship between income and health, expect possibly through the purchase of health care (Deaton, 2003). Horizontal inequalities in health and skewed access to health care between different ethnic or cultural groups are

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gaining more attention among scholars. Nazroo, Falaschetti, Pierce, and Primatesta (2009) have shown how inequalities exist between ethnic groups in England in terms of their access to hospital and dental care. Yet limited attention has been given to the impact of social discrimination and political exclusion on health and access to health care, particularly in middle- and low-income countries. This merits specific consideration of these factors, specifically on the ways in which ethnic identity and citizenship status – including the lack of citizenship – influence health outcomes and access to health care.

This case study of the Bedouin in the Bekaa Valley of Lebanon examines the impact of social discrimination and political exclusion – through lack of nationality – on health and access to health care. It argues that unequal access to health care, particularly reproductive and child health care, as seen among the rural Bedouin in Lebanon, is less related to issues of income or poverty and is more closely linked to issues of social discrimination, political exclusion and ethnicity. The case study is framed around three general issues:

1. Access to and use of health care facilities
2. The perception and experience of discrimination
3. The resilience and agency of Bedouin in accessing adequate health care

What emerges in this study and what is detailed below is the recognition that the long history of social discrimination and the lack of nationality and a political voice have profoundly impacted how the Bedouin access acceptable health care, particularly reproductive and child health care, in Lebanon.

Map 1. Map of Lebanon and the Bekaa valley.

Case study of the Bedouin of the Bekaa Valley

Background

The term bedouin [*bedu*] is derived from the Arabic word *badia*, the semi-arid and steppe land that covers much of Northern Arabia. The Bekaa Valley is the western-most finger of the *badia*. Numerous Bedouin tribes have moved into and out of the Bekaa Valley during their yearly seasonal migrations (Burckhardt, 1822; Chatty, 1977; Cole, 2003). There are accounts of the Bedouin presence in the Bekaa Valley as early as the 13th century (Oppenheimer, 1939, p. 325) (Map 1).

During the establishment of their League of Nations Mandate over Greater Syria in the early 1920s, the French created the predominantly Christian country of Lebanon primarily by attaching the Bekaa Valley to Mount Lebanon. They began collecting statistical records in 1926 and conducted the first and only census of the population in 1932. Many Bedouin were not registered in this count, either because they happened to be migrating in the *badia* or because they refused to be registered to show their opposition to the French 'colonial' presence. Large swaths of pastoral land in the Bekaa valley were divided and redistributed for agricultural use. The majority of the Bedouin in the Bekaa Valley were not able to purchase land, nor did they have access to education and public health care. By the mid-20th century, many Bedouin found themselves relegated to marginal areas within this rapidly developing area of agricultural production. Some Bedouin diversified and developed multi-resource agro-pastoral economies. The Bedouin who could not afford the investment in agricultural machinery or transportation sought employment in the rapidly diversifying agricultural sector in the Bekaa.

Throughout the region, the governments of the Levant "regarded nomadic pastoralists as anachronisms; throw-backs to a past era" (Chatty 1986, 2006, p. 1) and worked hard to settle them or pushed them to the margins of the state (Chatty, 2006, 2010a). In Lebanon, the Bedouin pastoral sheepherders were largely excluded from the benefits of nationality or citizenship, including joining the civil service or the state's armed forces, access to free education in public schools and national university, and access to hospitalization and the National Social Security Fund (NSSF).

Several categories of nationality apply to the Bedouin and other groups (e.g., the Kurds): full citizenship and two categories of statelessness. The first is 'citizenship under study' (*qayd al dars*), and the second is 'without records' (*maktum al qayd*). The few Bedouin who were registered in the French census of 1932 were granted full citizenship. In 1958, the Lebanese government issued a type of 'amnesty' and permitted the Bedouin without citizenship to register. These individuals were categorized into the 'citizenship under study' or *qayd al dars* group. In 1994, the government granted approximately 10,000 Bedouin with *qayd al dars* documentation full citizenship, the full benefits of which would come into effect after a 10-year waiting period. However, an appeal by a Maronite party has extended the waiting period indefinitely, and the children of the Bedouin with 'citizenship under study' (*qayd al dars*) papers are considered 'stateless without documentation' (*maktum al qayd*). Although there is no census data more recent than 1932, the election rolls for 2009 showing Bedouin voters in the districts of the Bekaa Valley included approximately 15,000 voters. A 'guestimate' of the number of individuals with voting rights (and thus full citizenship) is approximately 40–50,000. Those with *qayd al dars* papers also number approximately 40–50,000, and those with no papers or who are stateless comprise the last third (approximately 50,000) of the Bedouin in the Bekaa Valley. Of a total of approximately 150,000 Bedouin in Lebanon, the majority does not have full citizenship (Chatty, 2010b), and is thus excluded from all government social and health service provisions (Table 1).

By the early 1970s, researchers in Lebanon became interested in understanding the impact of sedentarization on Bedouin society.