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Rethinking and advancing the movement of resistance, activism, and advocacy in health in four central arenas of the Middle East Region

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Abstract

The Middle East region has a long history of resistance, activism, and advocacy movements in health, most recently as part of the 2011 region-wide Arab Spring. Despite this storied history, however, movements of resistance, activism, and advocacy in health in the region are rarely unpacked, examined, or documented. This historical and contextual analysis aims to examine the long-standing confiscated health rights and subsequent experiences of resistance, activism, and advocacy in health in populations in Palestine, Lebanon, Egypt, and Iraq. Promoting a health equity and health rights-based approach is key to achieving Universal Health Coverage and health-related Sustainable Development Goals, particularly in contexts that experience fragile socioeconomic and humanitarian conditions and political instability such as many countries in the Middle East. Marginalized populations, including Palestinians living under Israeli occupation, Lebanese Lesbian, Gay, Bisexual, and Transgender+ (LGBT) communities, Egyptian women and girls affected by Female Genital Mutilation, and Iraqi refugees and Internally Displaced Persons, have been severely impacted by decades of oppression, conflict, and displacement. These populations have faced various forms of discrimination, neglect, and violence that have hindered their access to quality healthcare and basic health rights. Rather than relying on government efforts, local and international movements to advocate for and protect the

health rights of these populations are key. Innovative approaches, strategic dialogue and collective actions are prerequisites for promoting resistance, activism, and advocacy in health in all country's systems structure. This analysis highlights the important of this social public health issue in the most turbulent region and provides evidence to guide all countries to realize equitable human rights for health for all populations.

KEYWORDS

activism, and advocacy in health, Health equity, health rights, movements, resistance, the Middle East Region

Key Points

- The health rights of marginalized populations in the Middle East, including Palestinians living under occupation, LGBT+ communities, women and girls affected by Female genital mutilation, and Iraqi refugees and IDPs, have been severely impacted by decades of oppression, conflict, and displacement.
- Despite these challenges, there have been efforts by local and international organizations, activists, and movements to advocate for and protect the health rights of these populations.
- Resistance, activism, and advocacy movements should be recognized as local and regional priorities, contributing to realizing health equity and integrating the health rights-based approach into the social and health systems.
- Rethinking and advancing the movement of resistance, activism, and advocacy in health is a necessary step in improving health for marginalized populations, and strategic dialogue between all stakeholders is the first step forward.

INTRODUCTION

Movements of resistance, activism, and advocacy in health encompass a range of dynamic and strategic efforts aimed at addressing and rectifying systemic barriers, injustices, and disparities that impact individuals' access to healthcare and their overall well-being. Such movements involve proactive engagement, mobilization, and collective action to challenge existing norms, policies, and practices that perpetuate health inequities and hinder communities from attaining their rightful health rights. Movements of resistance, activism, and advocacy in health strive to amplify the voices of those who have been historically marginalized or oppressed, empowering them to assert their rights, demand accountability, and drive transformative change within healthcare systems and broader societal structures.

The Middle East region has a long history of resistance, activism, and advocacy in health, particularly in response to political, social, and economic challenges. In many cases, resistance in health is the application of unarmed civilian power using non-violent methods and it is directed at oppressive regimes or policies that prevent people from accessing the healthcare they need.

Despite significant challenges, many people and organizations in the region have worked tirelessly to address issues such as access to healthcare, reproductive rights, and public health crises, advocate for the rights of marginalized communities, and decrease the impact of conflict and displacement on health. For example, during times of political unrest, activists may organize medical relief efforts to help those affected by violence or displacement, resisting their own subjugation while also building community (Bayat, 2002). In recent years, there have been several health-related social movements and initiatives in the Middle East region that have sought to challenge the status quo and advocate for better health outcomes (UN Women, 2021; United Nations, 2023b).

In the complex and dynamic region of the Middle East, the health rights of marginalized populations have long been a pressing issue, shaped by decades of instability, oppression, conflict, and displacement. This analysis examines the experience, challenges, and struggles faced by four specific marginalized groups—Palestinians living under occupation, LGBTQ+ communities in Lebanon, Egyptian women and girls affected by Female genital mutilation (FGM), and Iraqi refugees and IDPs—in their pursuit of equitable, sustainable, and affordable access to quality healthcare and basic health rights.

We selected these four cases because they demonstrate the intersection of multiple different social forces, such as displacement and social norms, with health outcomes. Despite their unique contexts and experiences, these populations share a common thread of facing discrimination, neglect, and violence that have impeded their ability to lead healthy and dignified lives. The analysis also explores the historical and contemporary factors that have contributed to the erosion of their health rights, as well as the local and international efforts that have been undertaken to address these challenges. By shedding light on the struggles and achievements of these marginalized populations, the analysis underscores the urgent need for comprehensive and inclusive approaches to health and human rights and integrating these approaches into the social and health systems in the Middle East.

HEALTH RIGHTS UNDER DECADES OF OPPRESSION IN PALESTINE

The aftermath of World War I precipitated a period of significant change throughout the region deemed the “Middle East” by the powers of the West. The small area between the Mediterranean Sea and the Jordan River, populated mostly by a Palestinian Arab majority and a Jewish minority, became part of the British Mandate. Almost immediately, the British agreed to establish a “national home for the Jewish people” in the territory, against the will of much of the land's native inhabitants, exacerbating a chain of events that eventually led to the establishment of the state of Israel in 1948, displacing hundreds of thousands of Palestinians in a Nakba (“catastrophe” in Arabic) that has, in many ways, persisted to this day—including through neglect and attacks on Palestinian rights to health.

We live in what is often considered a “postcolonial” period, having only just recently emerged from nearly 500 years of both settler colonialism, where settlers claim land and displace local populations as in the United States, Canada, Australia, and South Africa, and forms of extractive colonialism, where colonizers only desire the resources and/or labor of colonized lands and people. At the same time, the U.N. still recognizes 17 non-self-governing territories, most in the Caribbean and the South Pacific, that remain administered by history's most prominent colonizing powers (UN, 2023c). Euphemistically, the definition of these territories highlights those “whose people have not yet attained a full measure of self-government.” Notably, Palestine is not on this list, because of the Palestinian Authority (PA) and its supposed role in self-government.

Yet the state of Israel is the only sovereign entity on the lands known today as the occupied Palestinian territory (made up of the West Bank and Gaza Strip) and Israel, while it continues to seize and reappropriate Palestinian land. Despite Israel's legal obligations as an Occupying Power since 1967, the country's politicians have long made it clear that Palestinian health rights are not a priority. After Israel began its occupation of the West Bank and Gaza, the already weak Palestinian health care system (previously administered by Jordan and Egypt, respectively) was now administered by the Israeli Ministry of Defence, with some supervision from Israeli physicians.

When the PA was established in the mid-1990s, so too were the government ministries meant to eventually take responsibility when a Palestinian state was to be established (meant to be within 5 years of the Oslo agreement). Since then, Palestinian health has primarily been within the purview of the Ministry of Health (MoH). However, the ministry is highly dependent on inconsistent foreign aid and tax income, and due to funding shortfalls as well as Israeli-imposed movement restrictions, public services are insufficient to meet population needs. As a result, the health system also includes the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) for Palestinians and their descendants displaced in 1948, nongovernmental organizations (NGOs) that are both local and international and private facilities, seen as the highest quality but cost-prohibitive for many (United Nations, 2023a).

However, the Palestinian health system continues to operate under the restrictions of military occupation in the West Bank and siege in the Gaza Strip. Aside from restrictions on movement of people and goods that significantly delays, limits, or prevents entry and exit to the occupied territories as well as travel within the West Bank, Palestinians are subject to other forms of repression, discrimination, and violence that make it impossible to achieve a responsive and adequate health system that improves outcomes. Movement restrictions, including a large part-concrete/part-barbed wire fence separation wall enveloping and cutting into the West Bank, hundreds of movement barriers like gates, dirt mounds, and checkpoints within the West Bank, a complete sea, land, and air blockade of the Gaza Strip, and a complex and expensive system of Israeli-issued medical permits required for Palestinians to leave the territories for needed care, have impaired Palestinian health outcomes, despite billions invested by international donors. A growing literature base consistently finds the negative health outcomes created by such restrictions, including in cancer care (Halahleh & Gale, 2018), children's care (Waterston & Nasser, 2017), cardiovascular care (Collier & Kienzler, 2018), mental health (Giacaman et al., 2011), and overall poor health (McNeely et al., 2018). Other Israeli actions like demolitions of Palestinian homes (Marie & Saadadeen, 2021) and forcible home invasions by Israeli military forces (Moss et al., 2021) have also been shown to have detrimental effects on Palestinian health.

While the world systems have nominally prioritized universal health coverage (UHC) as part of adherence to the United Nations health-related Sustainable Development Goals (SDGs), the current reality in Palestine, particularly in Gaza, has revealed the ineffectiveness of asymmetrical systems of power. The UHC, human rights frameworks and conventions, and health-related SDGs remained a wishful promise when they obscure the inequity that has been perpetuated in regions of Palestine.

Health has historically been a space for organizing and resistance in Palestinian communities, including during periods of intensified violence and restrictions, as with the first and second Intifada (uprising). For example, Palestinians formed health committees to push back against the obsolete ideas of the Palestinian medical establishment, decrease Israeli dependence, and bring health services to underserved areas. By 1993, before the signing of the Oslo Accords, health committees were delivering an estimated 60% of primary care services (Hanbali, 2022). However, a significant NGO-ization of Palestinian civil society was brought on by the infusion of funding from the Oslo Accords, where the goals and methods

of Western funders were prioritized over the needs and desires of Palestinian communities (Dana, 2013). Alongside this de-politicization of the health sector, Israel continues its repressive actions to criminalize Palestinian efforts to organize, even around health care. For example, in 2021, Israel raided and shut down the Palestinian Health Work Committees, one of the main providers of services in the West Bank, and also arrested its director, Shatha Odeh, with no warrant, and held her in prison for nearly a year (Addameer, 2021).

Since October 2023, there have been an alarming number of casualties and injured residents in Israel's assault on Gaza, which has been termed a genocide by many global experts. Gaza has now become one of the most uninhabitable locations on Earth. The effects of the ongoing war and siege on Gaza extend beyond the mere loss of land and houses, with irreparable damage to the physical, mental, and social well-being of Palestinians for generations to come. Still, Palestinian health workers have shown significant resistance to their own elimination, continuing to work in hospitals and refusing to abandon patients. More than 400 have been killed in these conditions.

If history is any precedent, there is little likelihood of meaningful political interventions from the international community, with the future especially uncertain after the Hamas attacks in Israel on October 7, 2023, and the subsequent devastating Israeli campaign in Gaza. Instead, they have continued to offer Israel complete impunity despite mounting evidence of Israeli treatment of Palestinians amounting to the crime of apartheid. Thus, it is vital that Palestinians and their allies find ways to re-integrate health into efforts toward liberation and realization of Palestinian health rights. International actors that genuinely wish to support Palestinian health justice should go beyond offering humanitarian support to challenge Israeli policies that limit Palestinian health rights as well as support Palestinian movements and initiatives. Humanitarianism alone will never be sufficient to attain Palestinian rights. Only through the pursuit of both justice and sovereignty can their health rights be truly realized.

A RIGHT-BASED APPROACH TO THE HEALTH OF LGBT+ COMMUNITIES IN LEBANON

A human rights-based approach to health is defined as a commitment by countries to develop rights-compliant, effective, gender transformative, integrated, accountable health systems and implement other public health measures that improve the underlying determinants of health, like access to water and sanitation (WHO, 2023). In Lebanon, and more specifically Beirut, is known as “Gayrut,” or the “gay paradise of the Arab world” (Nagle, 2022; Reid-Smith, 2012), due to its higher levels of sexual tolerance than the rest of the Middle East countries (Healy, 2009). “Lesbian, gay, bisexual, and transgender” LGBT+ individuals are often perceived as challenges to society's stated moral values, religious beliefs, and cultural norms across the region. As a result, Lebanon became a home to numerous state and non-state actors who collaborate to destroy the country's queer spaces and harass LGBT+ individuals and activists (Nagle, 2022). These movements are supported by the Penal Code of Lebanon, Article 534, which states that “any sexual relations that contradict the laws of nature” are punishable by a prison sentence of 1 month to 1 year and a fine of between 200,000 and one million Lebanese pounds (Helem, 2008). On the other side, some activists establish specialized NGOs to promote LGBT+ rights, and some joined more radical movements that engage in intersectional struggles that advocate for anti-imperialism, antiracism, and resistance to sectarianism and patriarchy (Naber & Zaatari, 2014).

Fulfilling the rights of LGBT+ people has become a substantial part of being considered a liberal democracy at the global level (Dandashly, 2022). However, the situation is complex in

countries that have a strong religious identity and where religious groups are active (Ayoub, 2014; Siegel, 2020). In Lebanon, even before the beginning of local LGBT+ activism, there was animosity towards homosexuality based on moral, sociocultural, and religious grounds. Article 534, together with other laws that criminalize sex work, drug use, and trafficking, made LGBT+ people vulnerable, not only within their families but also by the state (Mandour, 2019).

After the Arab Spring, LGBT+ activism in Lebanon has gradually expanded and activists began to gain experience, participate in high-level discussions, and create their own organizations (Dandashly, 2022). One example is the "Lebanese Coalition of LGBTIQ rights" that was formed by LGBT activists in Lebanon, with the first demand raised being protection (Mandour, 2019).

Access to healthcare is a primary LGBT+ right that needs additional advocacy in Lebanon. LGBT+ people receive low-quality care due to stigma, lack of information among healthcare practitioners, and insensitivity to the community's specific needs (Hafeez et al., 2017). They are more likely to be subject to physical or sexual abuse, exposed to sexual transmitted diseases (STDs), and experience mental health problems (Conron et al., 2010; Van Leeuwen et al., 2006).

Public perception of the LGBT community remains a concern (Nasr & Zeidan, 2015). However, with the significant expansion in activism, visibility, health research, and policy, including an upsurge in LGBT rights activism, attitudes toward them are gradually shifting (Farchichi, 2012; Gereige et al., 2018; Ibrahim et al., 2016; Naal et al., 2018; Wagner et al., 2012; Wright et al., 2017). In particular, healthcare providers' attitudes and practices towards LGBT patients have changed and many health providers have shown more of a willingness to respond to their medical needs (Abdessamad & Fattal, 2014; Naal et al., 2020).

Furthermore, considerations for LGBT mental health have been incorporated into the Lebanese Ministry of Public Health's (MoPH) national strategic plan (Ministry Of Public Health, 2015). Mental health providers were less likely than others to consider homosexuality as a mental health illness (Naal et al., 2020). However, despite some shifts in the attitude towards the LGBT communities in Lebanon, they still face discrimination and obstacles in social, legal, and healthcare sectors (Abdessamad & Fattal, 2014), which discourage many of them from seeking medical care (Mayer et al., 2008).

Consequently, the Lebanese Medical Association for Sexual Health (LebMASH) worked to improve LGBT access to healthcare services (Naal et al., 2018). LebMASH created the first directory of LGBT-affirming healthcare providers in Lebanon, known as LebGUIDE. The main aim of LebGUIDE is to enhance the health of LGBT+ individuals by providing equitable and inclusive access to knowledgeable and LGBT-affirming healthcare professionals nationwide, including mental health professionals (Lebmash, 2022). When it was first launched in 2017, LebGUIDE included 50 medical professionals, from a range of medical specializations. The user-friendly and dynamic directory enables LGBT individuals to rate their experiences with the healthcare professionals listed and include any remarks (Naal et al., 2018).

However, prejudice and discrimination may persist as a result of lack of training of health professionals, resulting in low-quality healthcare and poor health outcomes. Training of healthcare providers on the particular needs and challenges of LGBT communities is a must (Hafeez et al., 2017).

A broader grassroots approach to LGBT+ equity in Lebanon should be seen as part of a broader "right-based approach" to help this community overcome barriers to healthcare access and locate health providers who support diversity, equity, and inclusivity of healthcare as a human right.

HEALTH AND SOCIAL MOVEMENTS TO FIGHT FGM AND ITS MEDICALIZATION IN EGYPT

FGM refers to "all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs for nonmedical reasons" (WHO, 2018). FGM is a violation of human rights and although widely criticized, it is still a commonly used practice in many countries throughout the world, especially in Africa and Asia (El-Gibaly et al., 2019).

In Egypt, the prevalence of FGM was 50% in 2008 (A tag-Eldin, 2008). The Egyptian Family Health Survey (EFHS) in 2021 demonstrated that 86% of married women between 15 and 49 years old have experienced FGM (Ministry of Health and Population, 2022). However, the percentage of mothers who plan to circumcise their daughters has reduced to 13% in 2021 (Ministry of Health and Population, 2022) in comparison to 35% in 2014 (Abd-Elhakam et al., 2022; Ministry of Health And Population, 2015b; UNFPA, 2023a).

FGM has received wide international attention, reaching its peak in Egypt after the International Conference on Population and Development (ICPD) in 1993, (Boyle et al., 2002; Van Raemdonck, 2013). Consequently, the "National Task Force against FGM" was established in 1994 with an overarching aim to apply new approaches to protect girls' and women's health-related rights (EL Dawla, 1999). The task force was able to conduct its activities within the framework of international rights activism and development discourse. However, there was difficulty engaging in feminist postcolonial practices due to some political-cultural positions that were part of the "colonizing ideology" (Van Raemdonck, 2013).

FGM is rooted in Egyptian social culture, which in many cases is upheld by religious beliefs, and any movement that has tried to terminate it entirely has failed (El-Gibaly et al., 2019). Therefore, Egyptian activists started discussions with the religious authorities in the country until 2007, when the Azhar Supreme Council for Islamic Research released a statement confirming that FGM has no root in the Islamic Sharia or its provisions (Al-Awa, 2012). That move resulted in a real transformation in women's attitudes towards FGM; however, there remains some resistance to its termination (UNFPA, 2023a).

FGM "medicalization" is a common approach in Egypt, where FGM is carried out by health practitioners, in an effort to lessen its complications while still satisfying cultural demands (Refaat, 2009). The rate of medicalization among girls and young women (≤19 years), increased from 55% in 1995 (Ei-Zanaty et al., 1996) to 74% in 2014 (Ministry of Health And Population, 2015a) even though the practice was made illegal in 2008 (El-Gibaly et al., 2019).

After the task force was dissolved in 1999, the National Council for Childhood and Motherhood (NCCM) served as a fresh venue for anti-FGM activities (Van Raemdonck, 2013). In 2003, the NCCM launched the "FGM Free Village Model" as a country-wide project (Barsoum et al., 2011). The inclusion of the NCCM in the anti-FGM campaign gave access to public media and prominent religious leaders to reinforce significant changes in the legislation at multiple levels in the subsequent years (Van Raemdonck, 2013).

In 2007, MoHP issued a ministerial decree (271) that banned everyone, including health professionals, from performing FGM in health organizations (UNFPA, 2023a). Moreover, FGM was criminalized by a new law approved by the Egyptian Parliament in 2008 which established a custodial sentence between 3 months and 2 years in prison for health practitioners who conduct FGM (UNFPA, 2023a). Under new amendments (Article 242) in 2016, they will face between 5 and 7 years in prison—or up to 15 years if the practice results in death or deformity (National Council for Women, 2020; UN Women, 2023; UNFPA, 2023a).

The National Strategy to combat FGM (2014–2018) was launched by the National Population Council (NPC). The implementation of that strategy was supported by UN

agencies which helped the NPC start a TV campaign called "ENOUGH FGM," widely broadcasted on national TV till the end of 2015 (UNDP, 2023). Moreover, UNFPA developed a training program in 2014 for legal staff to raise awareness on all aspects of FGM and identify gaps in the current legal and administrative arrangements that constraint the implementation of law (UNFPA, 2023a). Another training was provided by UNFPA and MoHP for doctors on how to address FGM prevention and care and in 2017 the 'Doctors Say No to FGM' initiative aiming to stop the medicalization of FGM was also launched (UNDP, 2023).

Since the approval of the law in 2008, the UNFPA-UNICEF Joint Programme to Accelerate the Abandonment of FGM has been working to support law reform, research and data analysis, capacity building for health professionals, and community engagement (UNFPA, 2021). Through the establishment of the National Committee to Eradicate FGM in 2019 (National Council for Women, 2020), a number of national campaigns were launched such as the radio campaign #ProtectHerFromFGM which increased calls to the national child helpline where people could ask questions about FGM, particularly from a religious perspective (UNFPA, 2022).

Early activists (e.g., the task force) have made a significant contribution to shaping the dominant discourse on FGM (Berkovitch & Bradley, 1999; Brennan, 1989; Ramphele, 1988). Robust awareness campaigns regarding the FGM penal code that were launched through collaborative efforts of the UN agencies, the NPC, MoPH, and the Prosecution office resulted in increased law enforcement. Since 2015, Egypt witnessed a new turning point in the fight against FGM with the sentencing of the first doctor to be found guilty of the practice and another six criminal cases were referred to public prosecution in 2016–2017 (UNDP, 2023). However, more investigation is still required since cases of activism, resistance, and health-related mobilization are insufficiently examined in the Arab world, including in Egypt (UNFPA, 2023b).

THE HEALTH OF IRAQI REFUGEES AND IDPS

In the more than 20 years since the United States and its allies invaded Iraq, the recklessness of the decision and the destruction of the war have only become more apparent. Ultimately, the weapons of mass destruction did not exist, the invasion and occupation only planted seeds for further terrorism, and the Iraqi people have suffered the consequences for decades, including the many millions displaced from their homes.

Of course, Iraq had been undergoing humanitarian crises before the 2003 invasion, largely due to economic sanctions placed on the country in 1990 due to the Iraqi invasion of Kuwait and the subsequent Gulf War in 1990–1991, causing widescale poverty and the deterioration of health and education systems. While economic and social conditions were a significant contributor to displacement in that period, the increasing authoritarianism of the Iraqi regime also led to more Iraqis applying for asylum (Chatelard, 2009). Yet the country's displacement crisis was about to get exponentially worse.

Indeed, the US-led invasion in 2003 led to decades of war, conflict, and ongoing political instability. The toll on the Iraqi population was significant, and many fled the country entirely, causing one of the largest displacement crises in the region. An estimated 1 in 25 Iraqis left their homes due to fighting, and many from within the country's professional classes; engineers, lawyers, academics, and artists were among the first to leave the country. The healthcare sector was similarly affected—about half of the country's doctors left shortly after the invasion (Cost of War, 2023). Those working in such sectors often had the resources to leave and attempt to build new lives elsewhere. Several years after the beginning of the war, however, those leaving the country were more likely to be poorer and less educated.

Further, as the waves of migration increased, neighboring Arab governments began to enact stricter migration policies to prevent further migration.

Although many Iraqis have since returned to their homes or resettled outside of the country, it is estimated that today, about 1.2 million Iraqis live as internally displaced persons (IDPs), and almost 70% have been displaced for more than 5 years (UNHCR, 2023). Most live on a combination of informal work, remittances, or aid, yet circumstances vary depending on their pre-existing socioeconomic condition and the policies of their host country. For example, Jordan was hesitant to offer robust health and education services to refugees for fear it would attract more. While Syria was initially more open to Iraqi refugees, it was difficult for refugees to declare formal status in the country, preventing them from working, accessing healthcare, or attending school (Harding & Libal, 2012). Yet even refugees resettled in wealthy countries like the United States faced hardships in accessing health services had a high prevalence of chronic conditions (Taylor et al., 2014), and continued to face high mental health burdens (Slewa-Younan et al., 2015).

For years, unemployment among these populations was high, rendering them largely unable to afford adequate food, shelter, and health care. The housing conditions of many IDPs and refugees are also unsanitary and crowded, and access to clean water was also scarce. Infectious disease spread was common, including in children, and the psychosocial burden among IDPs is also high (Ladek, 2012; Seidi et al., 2023). Not surprisingly, food security was a significant issue for Iraqi refugees, even those that were relatively well-integrated within host communities in countries like Jordan and Syria. In fact, this may in fact limit their ability to know about and access needed services since many are based in camp settings (Doocy et al., 2011).

Despite decades of repression under the regime of Saddam Hussein and then by the militant Islamic State, Iraqis have persisted in mobilization and resistance efforts. Most recently, the Tishreen uprising that began in the fall of 2019 was led primarily by youth, and demanded an end to government corruption, high unemployment, and lack of public services. Political parties were eventually borne out of the protest movement. The message of the movement was simple: "we want a country." For this movement, demanding democracy, service provision, and accountability, this surely included a country that serves all, including IDPs (Halawa, 2021). In 2020, Iraqi doctors themselves planned protests due to lack of jobs and unsafe working conditions (Mahmoud, 2020). Aside from formal protests, Iraqis have been building movements throughout social sectors to meet population needs. Iraqis have developed organizations to help assist IDPs within the country, leveraging use of technology. Once such organizations, for example, proposed creating videos to help prevent the spread of disease in these populations as a way to manage overloaded health facilities in places where IDPs fled, like Kurdistan (Strasser, 2015).

The multiple humanitarian crises experienced by Iraqis in recent decades have taken a significant toll on the country, one with one of the longest histories of recorded civilization in the world. The massive, forced migration crisis expedited by the 2003 invasion led to millions of Iraqis that found themselves out of their home, possibly out of their country, and unclear about the future. While Iraq has yet to achieve the political stability and democracy needed to truly meet its citizen's needs, it is vital that the energy and ambition of the country's people must be cantered in any efforts to rebuild.

GAPS, LESSONS LEARNED, AND THE WAY FORWARD

Despite the different historical and political dimensions of these four disparate communities, tracing the trajectory of the different movements that developed organically as a result of each setting provides helpful lessons about what is successful—and where gaps remain.

This analysis adopts the social movement action framework (SMAF) as a guiding theoretical and practical framework for strengthening the movements of resistance, activism, and advocacy in health in the region. This framework identified elements of social movement action across three key time phases: the earliest phase (preconditions) as the urgent need for change begins to emerge and pressure for change rises; the central phase in which social movement action develops (key characteristics); and the concluding phase in which the impact of social movement action is seen (outcomes) (Grinspun et al., 2022). Generally, this comprehensive farmwork supports the effectiveness of social movements considering micro, meso, and macro levels. The framework elements are also intersected with many social movements, and it focuses on both similar and different recognized social and political issues and factors such as civil rights, democratic movements, and health-related movements. In light of this framework, it is demonstrated that resistance, activism, and advocacy movements should be recognized as local and regional priorities, contributing to realizing health equity and integrating the health rights-based approach into the social and health systems. Advancing the movement of resistance, activism, and advocacy in health is a necessary step in improving health for marginalized populations, and strategic dialogue between all stakeholders is the first step forward. Below highlighted the central social and political issues, priorities, and challenges in each country.

One of the primary barriers in achieving health equity in Palestine is the significant de-politicization within the health and humanitarian spheres, which are heavily dependent on external actors for funding. While many humanitarian agencies and government actors are more than willing to acknowledge poor Palestinian health and well-being outcomes (often coupled with bids for more funding), too often these outcomes are connected to issues secondary to occupation, blockade, and apartheid policies, such as poverty, food, and water insecurity, or stress. While it is true that too many Palestinians are impoverished, food and water insecure, or experiencing severe mental distress, it is insufficient to consider these social determinants of health as existing within a vacuum that does not ultimately consider the root causes of these issues. It is also vital that external actors work to support and build Palestinian institutions rather than creating parallel institutions that do not build capacity in Palestine and are often dependent on funding calls that prefer de-politicized framings that do not engage with the reality. Palestinian civil society has been clear about their needs and the role international actors can play to support them, including, first and foremost, ending the policies of endless impunity for the actions of the state of Israel that flagrantly violate international law and devastate Palestinian lives. International actors can also offer financial and political support for the re-emergence of Palestinian health committees, which re-centre Palestinians and their needs as the primary actors in Palestinian health.

In Iraq, civilians are still suffering the ramifications of decades of sanctions, invasion, and authoritarian leadership. The US-led invasion and occupation, justified as a mechanism of Iraqi liberation, has instead tied the fate of Iraqi life to the whims and donations of foreign powers, especially regarding IDPs. While the Iraqi people have undertaken efforts to overcome these obstacles, greater financial and political support for the plight of IDPs in Iraq and for the Iraqi refugees scattered throughout the Middle East is needed. All efforts should be taken to help those Iraqis who are willing and able to return to their homes do so. For those more permanently displaced, more generous employment, housing, and healthcare policies in host countries are needed to help populations integrate and become productive and thriving members of society. Within Iraq, the protection of IDPs should be a priority for the Iraqi government and humanitarian agencies. The country, still in the midst of attempting to rebuild its institutions, cannot afford to ignore the needs of over 1 million vulnerable people. The calls of Iraqi civil society and youth must be heard to ensure opportunities for growth, reconciliation, and justice.

Although the incidence of FGM in Egypt has decreased during the past 25 years, this success can be reversed by current humanitarian crises such as disease outbreaks, climate change, and displaced populations (i.e., refugees in Egypt). Such situations could threaten the SDG achievement of gender equality and eradication of FGM by 2030. Multisectoral collaboration at the national and local levels, in addition to partnership with relevant NGOs and international organisations, can help advocate for girls' and women rights, "hold the gains" and sustain the success. Community sensitization on human rights, including girls' rights and gender equality, is a must, highlighting that religion does not demand FGM. Training healthcare providers and educating girls and their families on the risks and realities of FGM is also essential. Girls may get closer to realising their rights to health, education, income, and equality as they begin to challenge harmful gender norms and power relations in their communities.

Lebanon is considered more liberal than many other countries in the Middle East, however, equality for LGBT people is yet a sensitive issue. Activists and NGOs are exploring different ways for this vulnerable group to be included in the community and to advocate for their rights including for healthcare. Culturally sensitive intervention strategies that are targeted to LGBT communities in Lebanon are urgently needed to mitigate sexual and mental health risks and address health needs. Training of healthcare providers on the needs and challenges that LGBT people face is essential to overcome stigma and discrimination and promote health equity. Social media, if used and managed at the national level, could be a powerful tool to change societal attitudes towards LGBT communities, and enhance community connectedness and social cohesion.

CONCLUSION

Promoting a health equity and health rights-based approach integrated in the social and health systems must be local and regional priorities in the Middle East. The health rights of marginalized populations in the Middle East, including Palestinians, LGBT+ communities in Lebanon, women and girls in Egypt affected by FGM, and Iraqi refugees and IDPs, have been severely impacted by decades of oppression, conflict, and displacement. These populations have faced various forms of discrimination, neglect, and violence that have hindered their access to quality healthcare and basic health rights. Despite these challenges, there have been efforts by local and international organizations, activists, and other movements to advocate for and protect the health rights of these populations. These efforts have included legal reforms, awareness campaigns, community organizing, and the establishment of support networks and healthcare services. However, much work remains to be done to ensure that these populations can fully realize their health rights and lead healthy and dignified lives.

International actors must prioritize the rights and well-being of these marginalized populations and support their efforts toward justice, equality, and sovereignty. Local and national health population' priorities and needs, and those of disadvantaged communities in particular, should be respected. Building on their experience and understanding of the community, civil society organizations and community associations must play a greater role in planning, decision-making, and intervention. Rethinking and advancing resistance, activism, and advocacy in health is a significant step in moving toward health equity in the Middle East. Strategic dialogue between all stakeholders is the first step forward. Building consolidated alliances that includes an observatory, knowledge and strategy centre, and communication platform are essential to track health equity trends, mobilize efforts and resources, generate evidence, and promote influence and awareness around health equity

and health rights across countries and region. Only through collective action and continued advocacy can the health rights of these and other vulnerable populations be fully realized and upheld.

AUTHOR CONTRIBUTIONS

Mohammed Alkhaldi contributed to the initiation and ideation of work. All authors equally contributed to the formulation and review of the manuscript, and all approved the final manuscript.

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The authors declare no conflict of interest.

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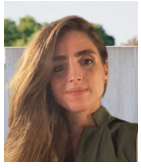

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