briefing

minority rights group international

Health services for Egyptian Border Communities during the Covid-19 pandemic

Sherif Mohyeldeen

Nubian woman in traditional dress sitting and counting money in front of a traditional Nubian home.
Credit: Dietmar Rauscher.

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About the Author
Sherif Mohyeldeen is a consultant with Minority Rights Group International and a senior analyst on security, development, and culture in the Middle East and North Africa with twelve years of experience of research in Egypt, Lebanon, Tunisia, and the cross border areas with Libya and Sudan. Sherif has worked as a non-resident scholar at Carnegie's Global Think Tank.

Sherif holds a master's degree from Durham University, in addition to a pre-master's and bachelor's degrees in Political Science and International Relations from Cairo University.

Previously, Sherif has worked as director of the research unit at the Adalah Center for Rights and Freedoms and also as a researcher and coordinator of counter-terrorism and human rights at the Egyptian Initiative for Personal Rights (EIPR).

Furthermore, he has worked as a consultant at several international think tanks, NGOs, universities, media, and news agencies. These include Oxfam, the House of Wisdom for Strategic Studies, Yale University, Wits University, and Anadolu Agency. He has also worked as a research fellow with the Project on Middle East Democracy POMED.

Sherif has been awarded the Civil Society Leadership Award from Open Society. He has also been awarded the golden prize of Seif Award for his research on human rights in Egypt. He has also provided consultancy for the Egyptian Prime Minister and the committee for amending the constitution, in addition to UN agencies.

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Health services for Egyptian Border Communities during the Covid-19 pandemic

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Executive summary

This briefing reviews aspects of Egyptian minorities and indigenous peoples' living conditions and the level of health services provided to them by the Egyptian state during the Covid-19 pandemic (2020–22). To that end, the briefing relies on both desk and field research with members of ethnic minorities and indigenous peoples in Egypt. The research process covered Egyptian Nubians, Bedouins and Amazigh.

The most common governmental narrative when it comes to the health services for the borderland areas of the country is that, first, the regime is spending hundreds of millions of Egyptian pounds (EGP) to develop hospitals in these areas and, second, that the government has allowed some civil society initiatives to sent doctors temporarily to the areas where they are most needed. While both assertions are technically true, this briefing sheds light on some limitations of government policy that need to be addressed.

The briefing concludes that, despite a general surge in public spending on health services across Egypt, there are still many shortcomings, and the health services provided require development. This is of particular importance given that in most of the governorates where the three communities are concentrated (Aswan, Sinai and Matrouh), the percentage of the population living below the poverty line is even higher than the national level, which has risen over the last decade to nearly a third of the country's population.

While the dispatch of mobile health clinics as part of both governmental and civil society programmes to the most neglected areas can provide some relief, there is still an urgent need to address the root causes of the health care crisis in these areas. New policies addressing both education and health in those areas can help to resolve the issues most effectively, with more medicine faculties for the local populations in the borderland areas, combined with higher quality training and incentives to work in the border regions.

The briefing closes with a set of recommendations, one of which is to continue to prioritize the border governorates where the communities in question are concentrated within the new comprehensive health insurance system. It is important to focus on capacity-building for the medical personnel there rather than relying principally on the current system, which sends newly graduated doctors to the borderlands on temporary placements. It is also vitally important to incorporate sustainability into plans for the development of health services, and to achieve a more equitable balance in relation to the budget for developing hospital and service facilities, and the current focus on spending on the facades and the exterior architecture alone.

1 Introduction

According to a young doctor who has been working in a government health centre in Upper Egypt during the Covid-19 pandemic, a family came to him in his first week there after leaving Cairo, carrying a 14-year-old girl who was close to death due to the collapse of her respiratory system. As an emergency physician, he tried to resuscitate her with the limited resources available at the centre, but he was unsuccessful and the girl passed away as he treated her, with her family present. He was struck by the fact that if he had the resources that he had back in Cairo, he could have saved her life. Yet, after almost a year of him working there, the gap between Cairo and the marginalized governorates seemed only to be increasing. Every day he wonders, 'How can I give a proper health service to more than 100 patients in less than six hours without basic health resources?'[1]

This observation could apply to more than one area where Egypt's minorities and indigenous peoples are concentrated, be it Sinai, Aswan or Matrouh. For a deeper understanding of the roots of the problem, it is important to note the nature of Egypt's health system and the places where these communities live, including marginalized and border areas, to determine the root causes of this crisis. To begin with, this briefing sheds light on how the 'assignment' (*takleef*) process functions as a lifeline for Egypt's health system, as well as a testing and training laboratory for thousands of newly graduated doctors, through their integration and placement in all of Egypt's government health centres and hospitals. The first section presents a brief overview of the state of the Egyptian health sector looking at three dimensions: doctors, hospitals and medical equipment, and health sector funding.

The second section focuses on the situation of minorities and indigenous peoples during the Covid-19 outbreak. It covers the geographic location of minority groups and demographic statistics in the context of the pandemic, and it shares key findings about the state of health services for these communities in Egyptian border areas. These findings were reached through field research conducted between the last quarter of 2021 and late February 2022.

2 Background on the health system in Egypt

Doctors

The assignment system for doctors is based on the power entrusted to the Minister of Health to assign Egyptian graduates from the different faculties of medicine, pharmacy and dentistry, as well as the graduates of institutes, schools and centres that train nursing personnel, health technicians and other categories of medical assistants, to work in two-year, potentially renewable positions, in government, local administrative units or other public agencies.[2]

For more than 50 years, this system has been the gateway to employment for most Egyptian doctors recently graduated from universities and governmental and Azhari medical institutes (which is part of the historical Azhar Mosque education system that include hundreds of schools and tens of faculties all over Egypt). The system has undergone some modifications during the Covid-19 pandemic. The Ministry of Health has moved to update the system, to make it more compulsory for doctors, to the extent that they are deprived of their right to choose whether to accept or reject their assignment, or even to choose certain specialities and locations. With the crisis Egypt is facing due to the growing shortage of doctors, and with many doctors having emigrated to the Arab Gulf states or Europe (Germany and Britain in particular) for better working conditions and pay, the Ministry of Health has resorted to making it mandatory that doctors accept their assignment. This was met with significant opposition from doctors, especially among the graduating classes of 2020 and 2021, who number more than 16,000. According to the website of the Assignment Department in the Egyptian Ministry of Health, there are 13 waves of assignments each year, involving a total of about 20,000 graduates.

The assignment system typically sees a split in the geographic distribution of doctors, as Egypt's 27 governorates are divided into two groups: central and remote. The second group includes all the governorates studied. These border governorates (Matrouh, North Sinai, South Sinai, Red Sea, Aswan and New Valley)[3] contain areas where various minorities and indigenous peoples are concentrated, such as Nubians, Bedouins and Amazigh, while the central group includes the rest of Egypt's governorates. We will explore the impact of this system on the health services provided to Egyptian minorities and indigenous peoples later in the briefing.

Hospitals and medical equipment

An Egyptian journalist who has covered health services in the wake of Covid-19 made a surprising discovery when comparing Egypt and France's respective readiness to face the pandemic. He found that Egypt has more hospitals and departments specializing in pulmonary medicine than France; intriguingly, most of these hospitals were established during the period of the Muhammad Ali dynasty, some two centuries ago.

This finding suggests two things. While Egypt has long had a well-established health services infrastructure, this needs further development and attention to keep pace with the times. Moreover, the centralization that prevails in many public policy areas in Egypt, including in the provision of health care, makes policy outcomes more inequitable and exclusionary for many marginalized areas far from the centre. As a result, some groups have less access to services, including many of the country's minorities and indigenous peoples, who are concentrated primarily in border areas such as Sinai, Matrouh and Aswan.

Funding of the Egyptian health sector

The consistent challenge with regard to basic social services in Egypt can be summed up as inadequate financial resources, on the one hand, and a rapidly growing population on the other, as Egypt's population increases by an average of 2 million citizens per year. Moreover, finding solutions to the crises afflicting public service providers in Egypt is not always easy, as it involves numerous bureaucratic complications.

One of the major changes in Egypt after the January 2011 revolution was the surge in funding dedicated to the country's budget over the course of a decade, especially the regime of President Abdul Fattah el-Sisi from June 2014 to the present day. The country experienced the injection of tens of billions of dollars in an unprecedented surge. Most of the money, however, came from foreign and domestic borrowing, which doubled the public debt.

A great deal of money was pumped into the post-2011 health care sector. The country's updated Constitution of January 2014 contained a provision on health care spending for the first time, with Article 18 stating: 'The state commits to allocate a percentage of government expenditure that is no less than 3 per cent of Gross Domestic Product to health. The percentage will gradually

increase to reach global rates.' This provision remained unchanged in the most recent constitutional amendment of 23 April 2019. Article 18 also stipulates that the state commits 'to the establishment of a comprehensive health care system for all Egyptians covering all diseases'.[4]

Government spending in general boomed, including spending on the health sector, with the Egyptian government allocating about EGP 23.5 billion (US $1.5 billion) to develop the health infrastructure in six border governorates.[5] Nonetheless, these huge expenditures have yet to be reflected significantly in the quality of health services provided to minorities and indigenous peoples concentrated in those border governorates.

3 The impact of poverty and the Covid-19 pandemic on health access for minorities and indigenous peoples

The situation of marginalized and border areas in Egypt's health care system

The proportion of the population living below the poverty line in the governorates where the three communities in question are concentrated (Aswan, Sinai and Matrouh) is higher than the national rate, which has risen over the last decade to almost a third of the national population. For example, as of 2017/18, nearly half (46.2 per cent) of the population in Aswan Governorate lived below the poverty line, with figures of 50.1 per cent in Matrouh Governorate and 38.4 per cent in North Sinai.[6]

It is worth mentioning that the low population density of the governorates makes the centralization of health services in their main cities a challenge, and remains an obstacle to providing health services to the population at large. According to official statistics, the local population only occupies 1.5 per cent of the total area of Aswan Governorate, 1 per cent of Matrouh Governorate and 7.2 per cent of North Sinai Governorate.[7]

The research for this briefing found that anaemia is widespread among children in the governorates where minorities and indigenous peoples are concentrated. The proportion of children with anaemia in Aswan Governorate is 46.7 per cent of all children in the governorate, rising to 59.3 per cent in Matrouh Governorate – twice the national average, according to government statistics for 2014.[8] There are no such government statistics on children in Sinai in the same period.

In addition, the number of doctors per 10,000 population is 5.8 in Aswan, 17 in Matrouh and 8.9 in North Sinai.[9] This means that although Aswan is the most populous of all the Egyptian border governorates – its population of more than 1.5 million making up more than half the population of the five border governorates combined (Aswan, Matrouh, North Sinai, South Sinai and New Valley) – it has the lowest ratio of doctors to population among the border governorates.

What is more, most doctors in the border regions are recent graduates, posted in accordance with the assignment system, which dictates that recent graduates of faculties of medicine at Egyptian public universities spend two years in public service as doctors in government hospitals and centres throughout the country. According to a doctor on assignment in South Sinai, many recently graduated doctors used to opt for the remote governorates (under the assignment system's division of governorates into central and remote areas, as mentioned earlier) because there is less competition for positions. This enables doctors with middling or weak marks to later specialize in difficult and highly competitive specialities such as surgery or neurology in Cairo after spending a one-year assignment in that speciality in a remote governorate.[10] Such remote governorates, of course, are the ones where the Egyptian communities in question are concentrated.

Based on the above, the additional financial incentives provided by the Ministry of Health for doctors to serve in the 'remote' governorates are meaningless, and the system is not well governed. Without a strong system of follow-up and continuing education, doctors' time on assignment could be paid vacation time, according to one doctor on assignment in South Sinai: 'They pick up a speciality in name only, and that's it.'[11] In addition, millions of Egyptian pounds are being directed to the external appearance of hospitals and government health centres rather than being spent on medical infrastructure and equipment.[12] The disastrous consequences of this situation for minorities and indigenous peoples in the border areas and the health services provided to them are easy to imagine. Given that, unlike in Cairo and some of the major cities in the north of the country, the option of private hospitals is either unavailable or of poor quality, many of the more qualified doctors move to Cairo or abroad to obtain higher salaries.

On the other hand, the historical evolution of Egypt's health system has witnessed remarkable advances as a result of initiatives by doctors who served in areas on the periphery of the country, outside the capital. These doctors saw first-hand the consequences of marginalization and the inferiority of the health services compared with the situation in Cairo. As just one example, the first obstetrics and gynaecology departments in Egypt were established by the Egyptian doctor Naguib Mahfouz. In his early youth, he had witnessed an obstructed labour in Alexandria that led to the death of both mother and child when no obstetrician could be found.[13] He pledged to himself that he would dedicate his life to saving women undergoing difficult labour.

In the footsteps of Mahfouz came Dr Magdi Yacoub, a cardiologist who founded a medical facility in Aswan, the Aswan Heart Centre, as a project of a charitable foundation

named after him and established with the late Nobel laureate Ahmed Zewail and the late ambassador Mohamed Shaker in 2008. It is one of the best hospitals anywhere in Egypt. Its primary aim is 'Offering Free of Charge state-of-the-art medical services to the Egyptian people, particularly the underprivileged and vulnerable age groups.'[14]

Health care access in the border areas during the Covid-19 pandemic

Sinai

The Bedouin of Sinai

Derived from the Arabic word 'bedu', meaning 'inhabitants of the desert', Bedouin are descended from nomadic groups originating from the Arabian Peninsula and Libya. Having inhabited the Sinai region for centuries, they still make up the majority of the population today, with one estimate suggesting that around 70 per cent of the total population of North and South Sinai combined are Bedouin.[15] Their distinct lifestyle continues to be driven by these nomadic traditions.

Long marginalized from the central government and underdeveloped, the region has in recent years struggled with armed groups and an increasingly oppressive counter-insurgency launched by the Egyptian military. Civilians have suffered property destruction, forced displacement and extrajudicial killings, carried out by soldiers as well as militants. In this context, communities have had to contend with a variety of challenges and restrictions on movement, basic services and livelihood access.[16]

In Sinai, many Bedouins have reportedly complained about being victims of state neglect for decades before the pandemic hit the country. Since Egypt regained control over the Sinai peninsula in 1981, governmental plans for development of the region have been repeatedly announced. Yet on the ground, little has been done to support the basic human rights of Sinai's Bedouins.

For instance, according to the national project for developing Sinai, it was announced in 1996 that 'hospital beds are to be increased to 6,000, to meet the needs of [the] growing population, by building 500 hospitals affiliated to the Ministry of Health and Population and 23 private sector hospitals'.[17] Yet, almost 25 years later, according to the most updated annual bulletin of health services statistics, as of 2019 the Sinai peninsula's two governorates (North Sinai and South Sinai) had among the lowest number of hospitals of all the country's 28 governorates: 8 hospitals in North Sinai with a total of 386 beds, and 9 in South Sinai with 1,067 beds[18] – well below what is needed to meet the needs of the growing population in line with the stated aims of the 1996 plans.

In the early days of the first Covid-19 wave in Egypt, starting in mid-March 2020, government hospitals and health centres in South Sinai saw few patients and families coming in. One resident attributed this to a state of panic and fear coinciding with the spread of the epidemic, as well as uncertainty about the exact nature of the disease. News and reports proliferated, including rumours, which affected citizens' willingness to go to hospitals and health centres for fear of infection. Consequently, given the dominant view of hospitals as ideal places for infection to spread, many patients opted for treatment at home rather than going to the doctor.[19]

According to a doctor at Nuweiba Hospital, even before the pandemic people were coming to the hospital at lower rates compared to other Egyptian governorates and cities, with the exception of Cairo which has a population in excess of 10 million people. But as the news of Covid-19 spread, lockdowns and social distancing were implemented across the country, causing people to come to the hospital even less. One doctor described how, while previously they might see ten patients a day, with the onset of the Covid-19 the number fell to two or three patients.[20]

In spite of the vastness of the Sinai peninsula, the distribution of specialized medical staff there is not as extensive as in many governorates of the Nile Valley. Barely any Sinai cities are self-sufficient in terms of medical specialisms. For example, citizens living in Ras Sedr may have to travel dozens of kilometres for an ophthalmology exam at Nuweiba Central Hospital or Sharm International Hospital.

Even after making an inconvenient and expensive trip, citizens may find that many medical specialisms are available in name only, no more than ink on paper, without adequate equipment or experienced, knowledgeable doctors. Most of the local residents and medical personnel interviewed for this briefing agreed that this was the case.

An Egyptian Initiative for Personal Rights report titled *The Right to Health in North Sinai: Challenges and Community Solutions* made a general assessment of the status of advanced health care services (hospitals) in Sinai based on field research. Although services are available, and they are geographically and economically accessible, the main problems are acceptability (the health services provided by hospitals there are limited, and therefore public confidence in them is low) and poor quality (while some services exist, it is difficult for the population to have much confidence in them).[21] Patients are thus forced to travel hundreds of miles to Cairo for treatment, provided they have the financial means to do so and can get past the security and military barriers widely deployed in the region without being subjected to random arrest on the basis of their identity – a frequent occurrence amid the war

declared by the Egyptian state against terrorism in northern and central Sinai.

It is difficult to imagine that there could be a building called a hospital with no surgeon or anaesthesiologist, as is the case in many Sinai hospitals. When emergency cases come in, such as those resulting from car accidents and other accidents, they cannot be dealt with. One doctor in Sinai described how, on the first day of his assignment, there was a road accident, and three patients arrived at the hospital. 'I was shocked at the lack of proper equipment and the inadequate experience. We could only do first aid, and unfortunately the day ended with the three patients having died. If there had been enough equipment, they would have survived.'[22]

The need for surgeons and anaesthesiologists is increasing, especially because many roads in Sinai are in poor condition both on account of the mountain and desert terrain and because of poor road equipment and maintenance. This results in more vehicle accidents on a daily basis with the attendant consequences, whether they involve residents or visitors to Sinai. According to one resident, this problem of inadequate medical capabilities and experience, especially in dealing with vehicle accidents, is 'a problem we have complained of since forever, but without any solution or development!'[23]

Most residents of Sinai interviewed for this briefing were firmly convinced that there is a predominant tendency on the part of the Egyptian state to manage the public sphere for the benefit of the rich only. Therefore, Sinai's best medical equipment is available in Sharm el-Sheikh, and there are some private medical institutions in Dahab – the two most popular tourist cities. Meanwhile, the Bedouins and other residents in the rest of Sinai, as well as migrants there, face medical services that are poor in quality or entirely non-existent. Some doctors who had come from Cairo confirmed this after witnessing the difference between the equipment at the Sharm el-Sheikh hospital and that in Nuweiba, Ras Sedr, Abu Zenima and elsewhere. According to one doctor, Dahab did not originally have a hospital, only a main governmental clinic. But after the Dahab bombings in 2005, when the government became aware of the increased number of deaths after the wounded had to be transferred to Sharm el-Sheikh, more than an hour away, some progress occurred and the Dahab Hospital was established.[24]

The medical crisis affects not only the outcomes of vehicle and other accidents, but extends also to childbirth. When a pregnant woman in southern or central Sinai goes into labour, the two hospitals equipped with more than the minimum medical supplies for childbirth are Sharm el-Sheikh Hospital and el-Tur Hospital. If the pregnant woman lives in or near Dahab and rushes to the hospital when labour begins, she can have a standard birth there. However, if a Caesarean section is required, Dahab Hospital is not equipped to provide it. According to a doctor at Dahab Hospital: 'I have spent eight months working at Dahab Hospital. There is not a single anaesthesiologist.'[25] Even if there were an anaesthesiologist at the hospital, he or she would be able to work on only one case, not on two cases at the same time. This adds to the tragic lack of health services that families are facing.

After looking deeply into the state of medical specialisms in Sinai amid the Covid-19 pandemic, it became clear that there is no orthopaedic medicine at Nuweiba Hospital. In the event of patients with fractures coming there, Nuweiba Hospital will not be able to serve them and they will have to travel to Sharm el-Sheikh Hospital or el-Tur Hospital. In Dahab, meanwhile, there are no specialists in dermatology or otorhinolaryngology (ear, nose and throat treatments), and a radiologist is at the hospital only part of each month. According to one doctor, there are almost no neurologists or psychologists in the entirety of South Sinai. When a neuropsychiatric patient came in, they were forced to transfer him to Ismailia, outside Sinai and hundreds of kilometres from Dahab.

The isolation of the Sinai peninsula has contributed to the relatively mild spread of Covid-19 there compared with other parts of Egypt. This isolation is due to several factors. First, in geographic terms, the peninsula is in far eastern Egypt and is linked to the rest of the country by only three roads: Salam Bridge in North Sinai, Martyr Ahmed Hamdi Tunnel in southern Sinai, as well as the el-Fardan Railway Bridge. This isolation is intensified in the case of North Sinai as a result of the military campaigns initiated by the Egyptian government in 2012. This may be the first time Sinai's isolation has served it instead of inflicting daily damage in the form of marginalization and a lack of public services, including medical services. In the case of the pandemic, the isolation and social distancing measures helped to limit the spread of Covid-19, and Sinai has been relatively fortunate so far in that there has not been a full-blown outbreak of the virus there. If that were to happen, the medical system would not collapse, according to the doctors and others interviewed, because it has collapsed already.

When the global outbreak of the coronavirus began, and it was announced that it had reached Egypt, the first case documented in Sinai was in Dahab, South Sinai, in late March 2020. According to the treating doctor, the patient came in just for testing, because he had interacted with his son, who had come from Europe and was not sick. The patient showed no symptoms, but the test came back positive. A panic spread, and doctors abandoned the hospital because of inadequate resources and because they feared risking their lives in vain. Many Bedouins also went up into the mountains and moved away from the cities as a precaution against the possibility of a Covid-19 outbreak in the cities of Sinai.

Following the story of the first known coronavirus case in Sinai and how the matter was handled, it became clear that the first diagnosed patient worked in the tourist police. He was asked to do a swab and refused, and State Security intervened in the matter. When the swab came back

positive, quarantine was arranged for the camp where the first patient had mixed with others, and a hotel was set aside for them.

As Covid-19 cases rose across Egypt, with the first wave reaching its peak in the winter of 2020, many residents preferred to nurse their sick relatives at home. Based on their experience with government hospitals and health centres in Sinai, sending the sick to be treated there would make little difference and be of no benefit. As one put it, 'If one of our relatives were to catch the coronavirus, we would keep him. It would be better for him to die among us.'[26]

Having moved to South Sinai to work remotely, high-income individuals who have comprehensive health insurance with private companies in Cairo often complain about the lack of access to many medical specialisms in the Sinai cities in which they reside, especially Dahab and Nuweiba in South Sinai. Some have even been unable to obtain their monthly prescriptions because they cannot find Sinai branches of the major pharmacies contracted by their medical insurance companies, whereas such branches are widespread in Cairo and most of the Nile Valley cities.

Aswan

Nubians in Aswan

Nubians have been indigenous for millennia in the territory of Nubia, in what is now the border region of southern Egypt and northern Sudan. However, in the modern era their land rights have been steadily eroded by state encroachment and the mapping of national borders, driven in part by colonial Britain. Beginning with the construction of the Aswan Low Dam in 1902, the Nubian population has been repeatedly uprooted by development programmes in the region.

Their struggle for the right to resettle in their territory has continued for decades, culminating in the drafting of the Development Authority and Resettlement of Ancient Nubia Act in 2014 – a landmark agreement that outlined a roadmap for the return of displaced communities to the original sites of their villages. However, instead of being passed to parliament for approval, the text was shelved and since then large areas of Nubian territory have either been designated as military zones or allocated for construction projects without the involvement of Nubian residents themselves. Community activists have regularly protested these and other injustices, including hate speech and cultural repression, with many demonstrators detained and imprisoned by the authorities.[27]

Aswan's economy has relied for decades on international tourism, given its rich Nubian heritage and ancient Egyptian temples, in addition to the warm weather it enjoys in both autumn and winter. Tourist figures had reached an all-time high in Aswan in 2010 with 442,000 people visiting that year, tourism plummeted following the 25 January Revolution in 2011: according to the governorate's official records, 153,000 tourists visited in 2011, a figure that dropped to 137,000 in 2012 and to around 115,000 in 2013.[28]

The region has fared no better than Sinai when it comes to health care: Aswan has just 19 governmental hospitals with a total of 1,364 beds, serving some 1.5 million people, according to the most up-to-date governmental statistics.[29]

A Nubian teacher at a state school described how the spread of the epidemic led to the death of many Nubians, especially the elderly. The inhabitants of Nubian resettlement villages are predominantly elderly now, following the migration of young people to seek work and earn a living. Nubians in Cairo or Alexandria are reportedly in a better position to face the epidemic relative to many Nubians in Aswan because of the latter's deteriorating health services.

This Nubian teacher had recently had to call emergency services to ask for an ambulance because of the complications the disease had caused for her mother. After the ambulance took the mother from her residence in one of the Nubian resettlement villages to the nearest government hospital in Nasr el-Nuba, they demanded that she pay for the ambulance service. She was surprised, having thought that the ambulance was supposed to be a free, public service. She was also startled, upon arriving, to find that there was no main hospital building, as it was under construction. Instead, some small structures had been set up as a temporary replacement for the hospital. Because of the limited capabilities there, she was forced to take her mother to Aswan University Hospital in the city of Aswan. That doubled the costs she had already borne to transport her sick mother, not to mention the costs of treatment and care.[30]

The Covid-19 outbreak led many patients with the virus or other illnesses to choose not to go to their doctor. This followed the closure of Aswan General Hospital in New Sadaka to all medical services other than Covid-19 treatment and an increase in admission and occupancy rates at all Aswan hospitals while this research was under way, from October 2021 to February 2022. Ultimately, many residents were forced to travel to Asyut in the heart of Upper Egypt, or to Cairo, because the doctors there are better than their counterparts in Aswan, according to the residents' preferences and experience in dealing with doctors. The equipment is better, too.

The predicament faced by many community members in need of complex treatment was illustrated by the experience of a young man who, while the fieldwork for this briefing was being conducted, was suffering from dental pain. In search of treatment, he went to the medical unit in the city of Abu Simbel in far southern Egypt, just north of the border with Sudan. According to him, despite the centre's very limited resources and the rundown

condition of the building, he had no other choice. After more than an hour, the young man came out in greater pain than when he had gone in. The doctor candidly admitted to him that local capabilities were limited and he lacked experience, and advised him to go to the city of Aswan, about a three-hour drive from Abu Simbel. Forced to take a day's leave from work, he went to Aswan, but the doctor there also did not help him. Finally, he had to travel to Cairo for treatment. He lost more than a week's work, in addition to the significant travel and accommodation expenses, which cost him more than a full month's wage.[31]

According to a former government official in Aswan, Abu Simbel's hospital has fairly good resources at its disposal, making it reasonably well equipped relative to other facilities in Upper Egypt or in Sudan, according to the cross-border experiences of Nubians in both countries. At the same time, however, he emphasized the low quality and limited efficacy of the doctors working there. The upshot is that the hospital, whether before or after the outbreak of Covid-19, is useless. It is merely a place where doctors and staff punch the clock.[32]

According to one elderly Nubian, visits to the doctor in Aswan are cheap compared to the prices in Cairo. At the same time, based on his experience, doctors in Aswan write patients prescriptions for a lot of medications compared to doctors in Cairo, and in the end many of the diseases the patients complain of go untreated. Therefore, their preference is to contact their Nubian relatives in Cairo and find out which doctors they prefer to see, then book the earliest suitable appointment through them and travel there for treatment. This is why there are networks of support and solidarity among Nubian families and associations to try to alleviate the enormous costs for some of the people unable to afford them.[33]

The phenomenon of medical tourism is not unfamiliar to most Nubians in Aswan. According to one Nubian leader, there is no household that has not been forced to travel to Cairo, or at least to Asyut, for a family member's treatment.[34] Nubians in Sudan and other Sudanese are also obliged, if their finances allow, to travel to Cairo for treatment. Some of them stay in Aswan merely as a transit stop. It is certainly no secret that the development of health services in Aswan would have a positive impact on the lives of millions. It would save them the extra costs they are forced to pay and provide them with the minimum care for a decent life. It would also ease some of the constant congestion and overcrowding in Cairo through the adoption of a more effective decentralization policy.

According to a local activist, the Sudanese revolution led to waves of Sudanese migration to Egypt. Many Sudanese live in Aswan because they cannot afford the enormous costs of travelling to and living in Cairo. This has created more pressure on the already inadequate resources and services in the city of Aswan, including health services,[35] amid the Covid-19 pandemic and especially since the reopening and operation of border crossings with Sudan. The Egyptian government had shut the border for months as part of a package of Covid-19 preventive measures in 2020.

Magdi Yacoub's Aswan Heart Centre is the only example of reverse medical tourism to Aswan. Yacoub's initiative to create a charitable cardiac hospital in the city of Aswan because of the purity of its air, contributing to decentralized development in far southern Egypt as an alternative to the crowding of projects in Cairo alone, has resulted in a unique model in which many Egyptians travel from various governorates to be treated there. Magdi Yacoub's hospital, and Yacoub himself, have a very good reputation among all the Nubians interviewed as part of the research.

Matrouh

Amazigh in Matrouh

Amazigh have been indigenous in Matrouh for many centuries, living more or less autonomously around the Siwa Oasis until the construction of a road through the region under President Anwar Sadat. This brought profound change to what until then was a largely isolated part of Egypt. Despite many benefits, including electricity, increasing contact with the rest of the country has also threatened to undermine the unique heritage of the Amazigh population.

In particular, while their distinct identity is still in evidence, the exposure of the community to an influx of Arabic speakers and other platforms such as television, dominated by Arabic language content, has steadily eroded the use of Siwi (traditionally spoken by Amazigh in the area). There is therefore an urgent need for the language to be taught in schools to prevent its loss and reverse the wider attrition of Amazigh culture in Egypt.[36]

The level of health services in Matrouh Governorate does not differ significantly from that in Sinai or Aswan. Medical tourism and obligatory travel to Cairo for treatment are a major phenomenon there as well, but with some differences in destination. Just as some Nubians travel to Asyut in Upper Egypt for treatment, some Amazigh and residents of the city of Siwa travel to Alexandria on the Mediterranean coast, a journey of more than five hours by car.

One respondent described how he and his wife lost their third baby while she was in labour, as it usually takes more than three hours to travel from Siwa oasis to the nearest hospital in Matrouh (a distance of over 300 km). Siwa oasis is part of the larger Matrouh Governorate, yet the main city of Matrouh has the most resources, reflecting the tendency towards centralization that is common across Egypt. According to the most up-to-date governmental

statistics, the whole of Matrouh Governorate has only 5 hospitals – the lowest number of hospitals among all the 28 governorates in the country – with just 468 beds serving more than half a million residents.[37]

One of the positive health outcomes evident in Matrouh is the high proportion of citizens who have received the Covid-19 vaccine. According to the Deputy Minister of Health and Population, the vaccination rates in Matrouh on 20 February 2022 were as follows: 72.4 per cent of the total 294,175 citizens over the age of 18 whom the state aims to vaccinate had received a first dose, and 70 per cent had received a second dose.[38]

Regrettably, on the other hand, 13.5 per cent of those with confirmed infections (in likelihood only a fraction of those who have in practice contracted the virus, given limited testing capacity) in Matrouh have died. There have been 627 deaths out of a total of 5,663 documented coronavirus cases in the two years since the coronavirus reached Egypt (February 2020–February 2022)[39] This can be attributed to the decline and deterioration of health services in the governorate, as the positive fact of high vaccination rates does not necessarily reflect advances at all levels of health services in the governorate. According to an Egyptian doctor at the World Health Organization, Egypt has historically had considerable experience and competence in vaccination and wide distribution of various doses to the population, with one recent example being polio vaccination.

4 Conclusion and recommendations

A review of the health service experiences of minorities and indigenous peoples in peripheral regions in Egypt during the Covid-19 pandemic shows that, despite some efforts by the state to develop, monitor and channel significant investments into strengthening health services across the country, there are still many challenges, gaps and deficiencies that are important to address. Whether the shortcomings stem from mismanagement of the health system[40] or deliberate neglect, the need to address them is urgent because, to put it simply, they are costing Egyptian minorities and indigenous peoples their lives on a daily basis under the weight of the pandemic.

With this in mind, the following recommendations are designed to achieve better health services in the peripheral areas of Egypt.

- **Ensure free ambulance services as a basic right** – especially in the border areas where various minorities and indigenous peoples are concentrated, such as Nubians in Aswan, Bedouins in Sinai and Amazigh in Matrouh, as the poverty rate in some of these areas is more than half of the population – considerably higher than the national poverty rate.
- **Redistribute health sector budgets more equitably** – so the line items for medical staff and equipment costs in border areas exceed spending on the external appearance of government medical facilities there.
- **Address the root causes of the ongoing health crisis through education** – with more medical faculties for residents of borderland areas and incentives for them to continue working there after graduation. Though mobile health clinics organized by both the government and civil society can provide some immediate relief to the most neglected areas, local training and capacity development are more sustainable in the long term.
- **Sponsor and support doctors' initiatives to improve the health services in peripheral areas** – through the implementation by the government of decentralization policies so that border areas can achieve self-sufficiency with respect to their health needs, and through continuing to prioritize these areas within the comprehensive health insurance system, which is projected to be fully implemented by 2032.
- **Take an intersectional approach to medical care in peripheral areas** – by ensuring that services targeting marginalized groups within minority and indigenous communities, including women, children, older persons and persons with disabilities are prioritized. Attention must be paid to ensuring access for minority and indigenous women to decent and reliable obstetrics and gynaecological care in their vicinity, in order to reduce the long distances they currently need to travel.

Notes

1 An interview with an assigned doctor, class of 2021, working in Upper Egypt, and the interview was conducted in Sharkia Governorate, February 2022.
2 Assignments Department, Egyptian Ministry of Health, official website: http://mhealth.cu.edu.eg/
3 There is disagreement as to whether Aswan is a border governorate. 'Border governorates' are often used to, refers to five governorates: New Valley, Red Sea, Matrouh, North Sinai and South Sinai. The government excludes Aswan governorate from consideration as a border governorate, despite the fact that it borders Sudan. Because of its position on the Nile, it is sometimes classified as one of the Nile Valley governorates. Arab Republic of Egypt (2014) Egyptian Constitution of 2014, with Amendments through 2019, Article 18.
4 Young, M., 'Medicine on the margins', Carnegie Middle East Center, 10 December 2010, available at: https://carnegie-mec.org/diwan/83414
5 See Minister of Planning and Economic Development, Sustainable Development Goals Localization Reports, 2019: *Aswan Report*, p. 6; *Matroh Report*, p .6; *North Sinai Report*, p. 5. Available at: https://mped.gov.eg/DynamicPage?id=107&lang=en
6 *Ibid.*
7 Documents and statistics from the Ministry of Planning and Economic Development, Egypt.
8 Documents and statistics from the Ministry of Planning and Economic Development, Egypt.
9 See Minister of Planning and Economic Development, Sustainable Development Goals Localization Reports, 2019: *Aswan Report*, p. 6; *Matroh Report*, p .6; *North Sinai Report*, p. 5. Available at: https://mped.gov.eg/DynamicPage?id=107&lang=en
10 Interview with a doctor on assignment in South Sinai.
11 Interview with a doctor, South Sinai.
12 Interview with a specialized staff member in the Office of the Minister of Health.
13 Mahfouz, M. (1966) *The Life of an Egyptian Doctor,* Edinburgh and London, Livingstone
14 Magdi Yacoub Foundation for Heart Diseases website, 'Mission', available at: https://www.myf-egypt.org/about/
15 Pelham, N., Sinai: The Buffer Erodes, London: Chatham House, September 2012, p.1.
16 For more information, see Minority Rights Group, *Justice Denied, Promises Broken: The Situation of Egypt's Minorities Since 2014,* London, 2019, pp.22-25.
17 State Information Service, Sinai, Untitled text on Sinai, 1996, available at https://www.sis.gov.eg/newVR/sinia/html/sinai02.htm
18 Central Agency for Public Mobilization and Statistics, annual bulletin of health services statistics, 2019, p. 33.
19 Interviews with people from North and South Sinai.
20 Interview with a doctor in Nuweiba, South Sinai.
21 Egyptian Initiative for Personal Rights, The Right to Health in North Sinai: Challenges and Community Solutions, Cairo, 2017.
22 Interview with a doctor, South Sinai.
23 Interview with a local resident of North Sinai.
24 Interview with a doctor, South Sinai.
25 Interview with a doctor at Dahab Hospital.
26 Interview with a local resident, South Sinai.
27 For more information, see Minority Rights Group, *Justice Denied, Promises Broken: The Situation of Egypt's Minorities Since 2014,* London, 2019, pp.27-32.
28 Mohyeldeen, S., 'Photo essay: Aswan, an Egyptian border region in waiting mode', Carnegie Middle East Center, 16 October 2019, available at: https://carnegie-mec.org/diwan/80060
29 Central Agency for Public Mobilization and Statistics, *Annual Bulletin of Health Services Statistics,* Cairo, 2019, p. 33.
30 Interview with a Nubian teacher, Aswan.
31 Interview witn a Nubian young man, Abu Simbel.
32 Interview with a former government official, Aswan.
33 Interview with a Nubian elder.
34 Interview with a local Nubian leader, Alexandria.
35 Interview with a Nubian activist, Aswan.
36 For more information, see Minority Rights Group, *Justice Denied, Promises Broken: The Situation of Egypt's Minorities Since 2014,* London, 2019, pp.25-26.
37 Central Agency for Public Mobilization and Statistics, *Annual Bulletin of Health Services Statistics,* Cairo, 2019, p. 33.
38 *Shorouk News,* [Health in Matrouh: 82.6% of Covid-19 fatalities were unvaccinated], 20 February 2022.
39 *Ibid.*
40 Mohyeldeen, S., 'Healthcare in Egypt's border regions: When money is not enough', Carnegie Middle East Center, 19 November 2020, available at: https://carnegie-mec.org/2020/11/11/healthcare-in-egypt-s-border-regions-when-money-is-not-enough-pub-83206

working to secure the rights of minorities and indigenous peoples

minority rights group international

Health services for Egyptian Border Communities during the Covid-19 pandemic

This briefing reviews the experiences of minorities and indigenous peoples in Egypt during the Covid-19 pandemic, including their living conditions and access to public health services. In particular, it focuses on the experiences of Nubians, Bedouins and Amazigh in the border regions of Aswan, Sinai and Matrouh.

While the dispatch of mobile health clinics to the most neglected areas can provide some relief, there is still an urgent need to address the root causes of the health care crisis. New policies addressing both education and health in those areas can help to resolve the issues most effectively. For minority and indigenous communities resident there, who already contend with high levels of poverty and marginalization, the need is especially acute.

In all three regions, despite a general surge in spending on health care across the country, many shortcomings remain. The briefing closes with a set of recommendations to address these challenges, focused on targeted prioritization measures in border regions, greater attention to training and capacity building of local personnel, as well as sustainable delivery, with more budget dedicated to staff development and service improvements.

Minority Rights Group International 54 Commercial Street, London E1 6LT, United Kingdom
Tel +44 (0)20 7422 4200 **Fax** +44 (0)20 7422 4201 **Email** minority.rights@minorityrights.org
Website www.minorityrights.org

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