

Insights into theorizing social exclusion and inequities: A perspective from the Arab World

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Abstract

Objective: To explore the influence of the global structural determinants and their pathways of action on health disparities and social exclusion, drawing on findings from research with four different population groups in an Arab context. We use a socio-ecological framework to categorise these determinants into levels to allow an in-depth look into their pathways of action on social exclusion and inequalities.

Methods: We use findings from an ethnographic study on Palestinian and Iraqi refugees in Lebanon; a qualitative research study on women's needs for labour support in three public hospitals in Egypt, Lebanon and Syria; and counselling experiences with university scholarship recipients in Lebanon. These findings were revisited using a social exclusion lens.

Results: Global forces, such as modernism, inequitable foreign policies of resettlement countries, over-medicalization of health care, modern educational systems and armed conflicts fueled by global vested interests interact to cause and exacerbate social exclusion. Palestinian refugees relate their experiences of discrimination in what is perceived to be a hostile society to policies reducing their education and employment opportunities. Delays in processing resettlement applications of Iraqi refugees and the lack of power over the choice of resettlement countries are a source of reported stress and anxiety. Over-medicalization of maternity care disrupts the traditional ways of giving birth surrounded with family through policies and practices restricting labour companionship, resulting in the isolation and silencing of women during childbirth. Scholarship students reported inadvertent exclusion from their families, societies and colleagues. Scrutiny of the findings and re-examination of the data reveals the importance of global structural determinants in explaining the patterns of exclusion reported for the population groups observed.

Conclusion: Expanding the ecological framework of determinants of social exclusion at the level of wider social/structural determinants is necessary to improve our understanding of social exclusion in impoverished and war affected places around the world.

Keywords: social exclusion; inequity; Arab; global determinants; socio-ecological framework

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Introduction

Research into social exclusion is informing practices and policies of international organizations and governments. Social exclusion means distancing individuals and groups from society's political, economic and societal processes, which prevents their full participation in the society they live in (Atkinson & Marlier, 2010); being denied opportunities to participate in activities and chances open to others in society (Popay 2010) that are important in living a fulfilling life (Sen, 2000). It is argued social exclusion is driven by unequal power relationships, operating across economic, political, social and cultural dimension and levels including individual, household, group, community, country and global regional (Popay et al 2008) resulting in the unjust distribution of resources and unequal access to capabilities and well-being for groups. These effects are experienced more acutely by women more than men (Popay et al 2008).

The adoption of a social exclusion framework for policy change has been driven by its relevance to individual and population health in many parts of the world where social exclusion has been found to impact health, quality of life and society's social justice and unity (Taket et al. 2009; Levitas et al. 2007). The concept of social exclusion first emerged in France during the political and social turmoil in the 1970s and was first used to refer to individuals who were unemployed and had limited rights (Castel, 1998). Other countries in the European Union also used the term in their antipoverty programs (Mathieson et al., 2008), replacing poverty or underprivileged populations (Room, 1995) because social exclusion was seen to have less discriminating undertones (Estivill, 2003). The popularity of social exclusion grew with thinking about sources and processes of poverty, such as inequality, power relations, and various forms of deprivation in order to improve policies. Social exclusion was later embraced by the International Labour Organization to help in developing policies in low income countries to address unemployment, working rights, and the disintegration of social union (Mathieson et al., 2008). Nowadays, research following the Anglo-Saxon tradition focuses on an 'objective' approach and uses social indicators to measure differences in socio-economic status and rights (Hoff and Vrooman, 2011).

A number of models have been used to guide the development of tools or approaches for understanding the processes and measures of social exclusion, all stemming from the Global North. Van Bergen and colleagues (2014) developed a model and an instrument to measure the multidimensional concept of social exclusion using available data from public health surveys in the Netherlands. They chose sets of variables that measure one of the four national dimensions of social exclusion (social participation, material deprivation, access to social rights and normative integration). The model does not capture other factors which they also referred to as root causes and include global and international conditions which affect people's experiences of social and health outcomes, stemming from supranational: regional or global levels.

The socio-ecological model is also used to theorize social exclusion (Taket et al. 2009). It guides the analysis and intervention for social and health issues by categorizing multiple personal and environmental factors into levels of action on social or health outcomes (Sallis and Owen, 2015). In social exclusionary processes, four main dimensions of interpersonal, social, cultural, and political determinants create and recreate social exclusion for individuals, groups and communities (Taket et al. 2009). This theoretical framework is similar to the model used by Warnecke et al. (2008) for studying and addressing health disparities to draw attention to the interplay between proximal (biological) and distal (social) determinants of health and disease outcomes.

Very little attention, however, has been drawn to global structural determinants, as directly and indirectly influencing people's livelihoods, health and quality of life. Some scholars have been

considering global structural factors, in particular, facets of global dominance in the field of development studies, showing the negative impact of western alliances on countries of the global south (Bond, 2013) and the rise of social exclusion of the global poor as a result of injustices caused by the intersection of global economic forces with local hierarchies and national political structures (Fraser, 2010). The United Nations report, *Analysing and Measuring Social Inclusion in a Global Context* (Atkinson & Marlier, 2010), discusses social exclusion measurement in national policies referring to 'global' as across countries. The 'global level' is often used to mean all countries, rather than factors operating *between* and *within* countries that relate to the many different facets of globalization.

Structural determinants at supranational levels are often unrecognized in their effects on local health and disease outcomes as well as social exclusion. 'Structural' is used to mean determinants that are deeply rooted in society, specific or limited to a country, a population, or a culture. For example, gender, family structure, education, occupation, income and social support are referred to as structural determinants which affect health outcomes (Denton et al, 2004). The European Commission's (1998) guide to gender equality indicates that gender for example, is a structural difference which affects the entire population and often reinforces differences and vulnerabilities created by other structural differences, such as race/ethnicity and class. Similarly, the WHO (2007: 24,) report on the Social Determinants of Health states that 'social determinants' include the term 'structural determinants' and this refers specifically to the "components of people's socioeconomic position." Therefore, "social class, gender and ethnicity, operate as important structural determinants" as they generate or reinforce stratification in the society and determine individual socioeconomic position therein (WHO, 2007: 26). Gender differences, or the social differences between men and women that are learned, changeable over time and have wide variations both within and between cultures, may be influenced by race/ethnicity and class.

This paper contributes to theorizing the influences of particular structural factors on people's quality of life using exemplars from the global south, particularly the Arab world. We argue that global structural determinants play a significant role on health disparities and social exclusion of populations and groups but are overlooked. We draw on a selection of findings from four different issues of relevance to the Arab context, namely, war and refugees, maternal health services and education.

Context

The literature pertaining to social exclusion in the Arab world is scanty. The WHO Social Exclusion Knowledge Network (SEKN) states that there is no research hub for social exclusion in the Eastern Mediterranean Region (Popay et al. 2008). A few researchers though point to social exclusion experiences by certain groups. Fincham (2012) suggests that the context of exile, statelessness and social and political marginalization of Palestinian youth influences the processes through which Palestinian refugee youth construct their perspectives of citizenship and belonging. Meanwhile, the widespread political and economic oppression in the region has given rise to social and health inequities and social exclusion in the entire Arab world. Resistance to this domination and exclusion has taken the form of national struggles for independence, Palestinian *intifadas* and Arab uprisings, which in some instances have resulted in violence, armed conflict, unjust welfare systems and further social exclusion (Barron, Graham & Hartwell, 2006).

Although the countries of the Arab world are linked by geographical, linguistic, religious, and historic ties, they vary in size, population, political systems, and social development. We discuss the below selection of indicators, namely maternal mortality rates, literacy rates, and estimates of refugee populations which have relevance to the examples used in this paper, namely women utilizing maternity services in Lebanon, Syria and Egypt; economically

disadvantaged students and refugees. Arab countries share a history of armed and political conflicts since the rise and fall of the Ottoman Empire through colonization, the Arab Israeli conflict and recent Arab uprisings (Tell, 2014). Consequently, migration and population movements are common to countries featured in this paper, Lebanon, Egypt and Syria, and are on the rise fuelled by political and economic interests of western countries in the region (Keiswetter, 2012), and multinational corporations' arms deals (Subaie, 2013). In Lebanon, for example, around 1.1 million Palestinian, Iraqi and Syrian refugees, asylum seekers, and internally displaced individuals are scattered all over the country (UNHCR, 2015; Bastin et al. 2013). Similar to many Arab countries, Lebanon is not a signatory to the 1951 Geneva Convention on the protection of refugees, consequently, the Lebanese law treats refugees and asylum seekers as illegal foreigners and they are hence subject to arrest, detention, and deportation (Frontiers Ruwad Association, 2008; O'Donnell & Newland 2008).

Maternal death rates also vary and are estimated to be 66 per 1000 live births in Egypt, 25 in Lebanon, 70 in Syria (WHO, UNICEF, UNFPA, World Bank, 2012) in comparison to 6 in the UAE (WHO, 2017). Birthing in healthcare facilities has been encouraged over the last three decades following global efforts ensuring skilled birth attendants, yet such practices were coupled with the uncritical adoption of western medical technologies and over-medicalization of maternity creating problems with the quality and safety of the care delivered to women around labour and birth (Choices and Challenges in Changing Childbirth, 2005).

Literacy rates among youth range between a low 71% (in Sudan) and a higher 99% in Lebanon (UNESCO, 2016). Lebanon is well known for its high standard of universities and schools in the Middle East, and the right to education is in the Lebanese constitution. Historically though, the Lebanese education system has not been able to reduce the social inequalities within the Lebanese society as this system has relied heavily on private schooling to accommodate the growing demand for learning in the country (Frayha, 2009).

Methods

We used findings from studies and practice experiences which had their own aims, not originally designed to explore social exclusion, but they present work with a diversity of population groups. The findings stem from three sources of such work with contrasting types of populations and groups, namely research studies on: refugees; women utilizing maternity services in Lebanon, Syria and Egypt; and practice experiences with economically disadvantaged students who are recipients of tertiary international scholarships in Lebanon. We use a socio-ecological perspective to describe the pathways of action of these determinants. The ethnographic exploratory studies of two refugee populations, a Palestinian refugee camp community and Iraqi refugee families in the suburbs of Beirut aimed at exploring the urban context and its influence on the lives of the Palestinian community members in suburbs of Beirut, and contrasting this with Iraqi refugees' experiences of and coping with living in Beirut. In the original study, data were collected using in-depth interviews with 50 participants, and 52 simultaneous participant observations with Palestinian families, men, women, youth and community based organizations and community leaders. Data from intervention research on youth mental health in the same community using surveys with youth, children and their parents (Authors, 2011) are also used. With the Iraqi refugees, the first author conducted a series of in-depth interviews with 47 Iraqi men, women and youth to explore living conditions, described elsewhere (Authors, 2010). We used the WHO definition of mental health to explore their reported coping with stressors. Mental health is used to mean the state of well-being which enables individuals to realise their potential in life and cope with everyday stressors, and make a contribution to their community (WHO, 2014) The data generated were analyzed using thematic analysis. The recorded interviews and observational data were coded and analyzed following the six steps of thematic analysis suggested by Braun & Clarke, (2006) including; familiarization, generation of initial codes, developing and reviewing main themes

for the final write-up (Author 2003).

We also used findings from a research study in three teaching public hospital maternity wards in Egypt, Lebanon and Syria, exploring women's needs for labour support. The qualitative interviews addressed concerns and readiness of female family members to act as birth companions, the facilitating factors and barriers to implementing a labour companionship program in these hospitals as well as women's needs regarding support during labour. In the original study, sixty-nine women, 57 female relatives, 28 obstetricians and 2 groups of midwives and nurses were interviewed (Authors, 2015). The analysis of the research data was guided by grounded theory and thematic analysis was used through familiarization, coding and emergence of themes and sub-themes. Further details on the methods are reported elsewhere (Authors, 2015).

The last exemplar employs the 3rd author's notes and anonymous written feedback from counselling and coaching sessions with economically disadvantaged first and second year university students studying at AUB, supported by the international MasterCard Foundation Scholarship Program (MCFSP). The researcher performed several readings of his notes, generated initial codes and presented emerging themes, such as changing roles and responsibilities of scholars and relationship with families and communities. This process was coupled with the researcher's reflection on the experience of counselling and how these reflections were represented in the generated themes. The data consisted of notes from individual counseling sessions, regular group meetings, skills trainings, scholars' reflection papers, written evaluations of the program, with 45 male and female scholars (32 Lebanese, 13 Non-Lebanese) as well as minutes of discussions with family members.

We used more than one theoretical lens to analyse data and identify global determinants and their interplay on social exclusion. We use a feminist lens that centralizes the social construction of gender (Barnes, 1999), in the exemplar of women giving birth. We describe a medicalised culture that undermines the validity of women's subjective knowledge and relies solely on health care providers' knowledge thus creates inadequacies, inequalities and deficiencies in the healthcare system. We also use intersectionality as a guiding theoretical framework for this and the other exemplars about refugees and the scholars. Although intersectionality originated in sociology to theorize social disadvantage that black women experienced in the US through a power analysis lens (Crenshaw, 2018), it consequently became used by sociologists for analysis to explain the processes of social disadvantage of multiply-marginalized groups. In this manuscript, the exemplars we refer to include such multiply-marginalized groups: women, youth, and refugees who experience social exclusion in order to explore the multiple layers of social exclusionary forces in a globalised world. The term "intersectionality" signifies including the perspectives of marginalised people, and a focus on seeing multiple social and political forces as overlapping in their co-determination of inequalities (Choo and Ferree, 2010).

Results

Exemplar 1. Social exclusion and refugees in Lebanon

Refugees in general often experience several dimensions of exclusion including economic and social exclusion by racist and discriminatory acts and policies in host communities which may prohibit or limit access to employment, health services, housing, education, income support, and settlement services (Taylor, 2014). Mental ill health has been associated with social disorganization, social exclusion (Payne, 2011) and living in deprived urban neighborhoods around the world (UN Habitat, 2013).

For over sixty years, Palestinian refugees in Lebanon have been denied basic social and civil

rights, and have been excluded from participating in the Lebanese labour force. In particular, the economic system has segregated Palestinians into lower wage earning groups than Lebanese in virtually all educational and occupational categories, such as restricting the employment of Palestinians in medical and health professions (Abdulrahim & Khawaja, 2011). Welfare, education and health care services are offered mainly by the UNRWA and Palestinian agencies in the camp depending on the availability of funds. International funding for UNRWA have decreased, adversely impacting the quality and quantity of its services (Brynen, 2003).

The vast majority live in impoverished densely populated suburbs of Beirut as a result of legal and political restrictions imposed on the Palestinian refugees by the Lebanese state, prohibiting significant improvements in the residential areas which are seen as temporary residence. One such suburb houses a Palestinian refugee camp we refer to in this exemplar, which was set up in the 1950s as tents and temporary housing structures (Author, 2003). Residents reported experiencing the loss of their nationality, as well as discrimination in what they perceived to be a hostile society. The social and economic conditions of the refugees were in fact worse than those of the Lebanese because of the work restrictions imposed on the refugees by the Lebanese state.

We are living here in a camp that is limited, confined, we can't do anything. Even education is useless. (19 year old woman)

My life is all misery. I don't know what I am living for. ... The 'eid (feast) is almost here and I don't have money to give my nephews and nieces, this causes psychological stress. (28 year old man)

In contrast to the Palestinians, Iraqi refugees have recently arrived in Lebanon in waves fleeing armed conflicts in Iraq since 2003 and are dispersed in suburbs of Beirut. The hardships they faced include difficulty in finding employment, limited remuneration, and being considered illegal residents. Consequently, they reported fear of detention by the Lebanese police.

I am scared they would arrest us one day. I mean I am afraid that one day we will go on an outing, and the police would arrest us and make us go back to Iraq. (40 year old man)

You know he's the owner of the business. He used to give me 100 to 120 dollars per week, now he gives me 25 dollars. I have a family. (48 year old man)

Delays in processing resettlement applications through UNHCR seemed to be a common source of reported stress and anxiety for many of the refugees as they had very little power over the choice of resettlement countries. The ethnographic study with Iraqi refugees found that Christian refugees have witnessed a quicker turnaround of their resettlement applications to receiving countries of the West than Muslim refugees. Reports of feeling anxious and distressed were concordantly, more frequent among the Muslim Iraqi refugees.

Exemplar 2. Exclusionary childbirth policies and practices in public hospitals

Medicalization of labour and birth in Arab countries interferes with traditional social systems supporting women during labour and birth, such as being surrounded and supported by mothers and sisters throughout labour and birth. Policies restricting the presence of companions during labour and birth represent one problem of this over-medicalized system of care whereby women face having to cope alone in an alienating hospital environment.

The mechanisms through which women's knowledge and needs are excluded from systems delivering maternity care in this region take many forms: rejection, segregation, isolation and silencing. Women in the study reported experiencing rejection when they are denied of their right to participate in decision-making processes pertaining to the care they receive during labour and birth:

You don't have much choice, you do what they ask of you. (Woman 12 from Lebanon).

They experience socio-economic segregation. Public hospitals in Arab countries cater for the economically disadvantaged sectors of society and offer fewer choices in labour companionship compared to private hospitals. This social segregation creates a psychological isolation for these women:

My financial status doesn't allow me to give birth in a private hospital.....I am told I will be left without my mother during labour. (Woman 3 from Syria) (Authors, 2015).

Women are also silenced as their voiced needs and preferences in the type of care are not considered by the system. Hospitals abide by their routines in the way they provide labour and childbirth care which restricts women's choices. Moreover, women are not encouraged to participate in the decision making process related to their care rather they are considered as passive recipients:

I don't want to be alone during birth. This is what happened even when I asked for my mother to stay. They did not allow it. (Woman 7 from Lebanon).

Women reported experiencing depersonalization and alienation in these hospitals when they are left alone to endure labour pain. Their discourses highlight fear of unforeseen complications, fear of labour pain and their lack of confidence to endure it and most importantly fear of having to deal with feelings of alienation:

It is a difficult experience, full of fear and solitude. (Woman 9 from Egypt).

It is like death is coming to you. (Woman 2 from Lebanon)

As if you experience death and are born again. (Woman 11 from Syria)

They talked about how the health care system has not only marginalized them but also excluded their families from the birthing process, especially their husbands:

They should also consider the right of the father to witness the birth of his son. They are taking away the happy moments of seeing your son be born from the father. (Woman 14 from Lebanon)

The restrictive hospital practices on labour companionship were described to limit communication between women and their families once women were admitted to the labour or delivery room, consequently heightening their feelings of anxiety about the wellbeing of their family members outside:

I was worried about my mother because I knew she was constantly worried about me. She was waiting in the corridor and no one was giving her information about what was happening to me. (Woman 5 from Lebanon)

Exemplar 3. Inclusion and inadvertent social exclusion in University Scholarship Programs

The Canadian based Mastercard Foundation provides scholarship for Sub Saharan African students to attain a university level education and accepts only one student from any given family (The Mastercard Foundation, 2016). The Program at FHS, AUB has supported 55 Lebanese and Palestinian undergraduate scholars to enroll in a Bachelor of Science degree in Environmental Health (EH) or Medical Laboratory Sciences (MLS), and 7 African scholars at the graduate level. The scholarship covers the full tuition fees, stipends, full lodging and psychosocial support.

The scholarship students reported tense conversations between them and other self-paying students, when the latter found out that scholarship students had received higher grades. Scholars were criticized for being perceived to have it the easy way: “*You the MCF scholars are pampered to get good grades.*” Similarly, scholars themselves reported perceiving themselves weak because of the extra support and even inquired about the reason for this special care.

Why is it that we have our own counselor? Is it because you [the staff at FHS] believe that we are going to need it more than other students?. (19 year old female scholar)

Although most siblings and parents expressed appreciation and excitement about a member of their family receiving the scholarship, some siblings complained about the unfairness in the choice.

... while growing up, my brother always got the lion's share of things, and now he got this scholarship and I can't apply for it. (18 year old brother of scholar)

Many scholars and their family members had to deal with the quickly changing roles, such as taking on responsibilities because of the scholarship student's absence, creating more pressures on all the family and resulting in feelings of guilt for the student. Many of the scholars also reported having a hard time integrating some of the new more liberal values they acquired at the university, like having friends from the opposite sex, with their usually more conservative family values. This has created family tensions and in few instances, contributed to schisms amongst family members and fewer home visits during days off, phone call exchanges between scholars and their parents, and a general feeling of not belonging, and being ostracized by close members of their communities, fellow students and relatives.

From the moment some of the scholars got accepted into the program, they reported feeling shamed and ostracized by significant members of their communities, fellow students and teachers at school, and some of their distant relatives. A few scholars mentioned how they clearly remember some of these statements:

... you are a traitor for entering an American university! (18 year old male scholar)

... how can someone like you make it into AUB without knowing someone from the inside?! (19 year old male scholar)

At the institutional level, scholars themselves reported feeling unjustly treated because non-MCF scholars are free to choose the major they want (mostly in the North American university partners) while those in Lebanon are limited to choices of majors, and because of the unavailability of funding for graduate education.

Discussion

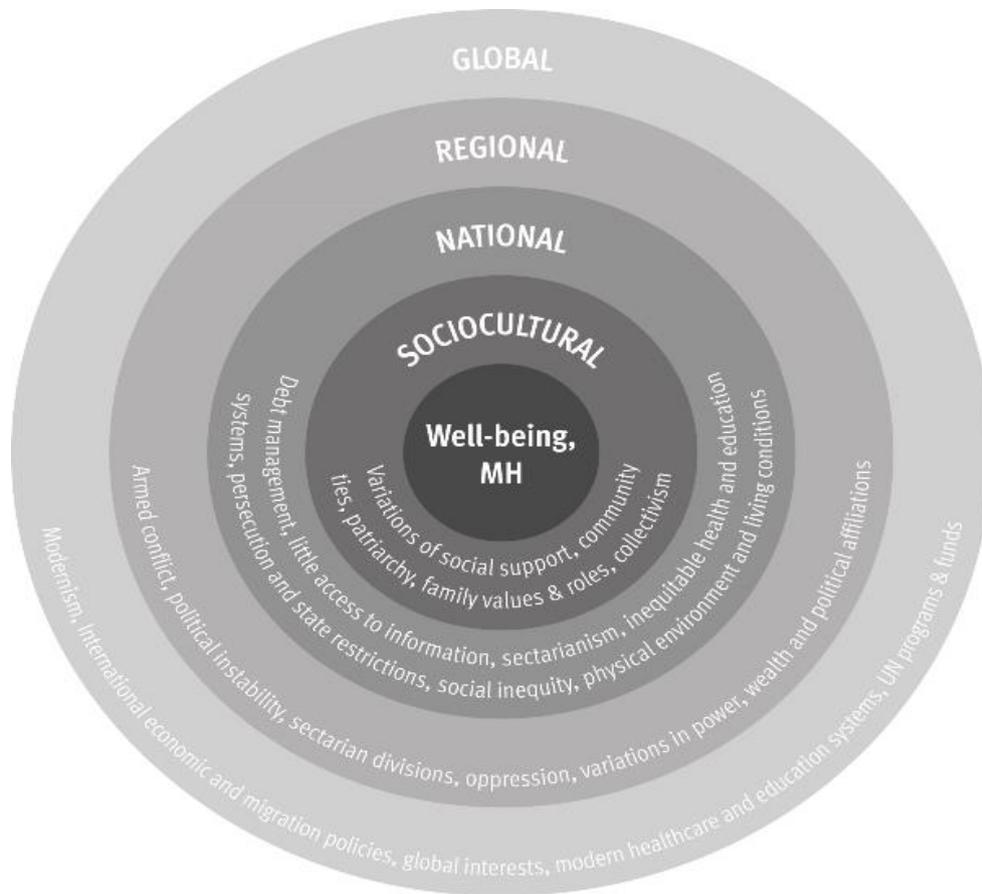
This section considers how the findings from the above, very distinct examples involve social exclusion as an outcome of complex interactions of national, regional and global forces (Figure 1). Through these cases, the socio-ecological framework for social exclusion put forth by Taket et al. (2009) expands to accommodate wider social determinants.

At the national level, sectarianism and state restrictions on refugees, hospital policies supporting medicalization, and inequitable higher education systems create exclusionary socio-cultural environments for populations. The stark differences in the economic and living conditions between the Palestinian refugees and Lebanese people play out differently in the exclusionary experiences of those in these communities. Also, the organization and the delivery of maternity care unfairly exclude women at different levels throughout healthcare provision to women around childbirth in Arab countries. Policies which restrict social support in public hospitals are in contrast with women's needs and the prevailing family support around childbirth. Similarly, the dominant private education sector excludes economically disadvantaged youth from access to higher education.

At the regional level, although the Arab region shows an apparent homogeneity, despite internal variations in vital statistics and population indicators; complex differences within the region and between countries such as power, wealth and political affiliations and relationships contribute to the volatile situation in, for example Iraq, Syria and Palestine (Israeli-Arab war). This in turn affects the fragile economic and political stability in Lebanon which has hosted Arab refugees. The refugee crisis has indubitably strained the country's social, economic and institutional infrastructure and has impacted the capacity of relief agencies to provide adequate humanitarian services.

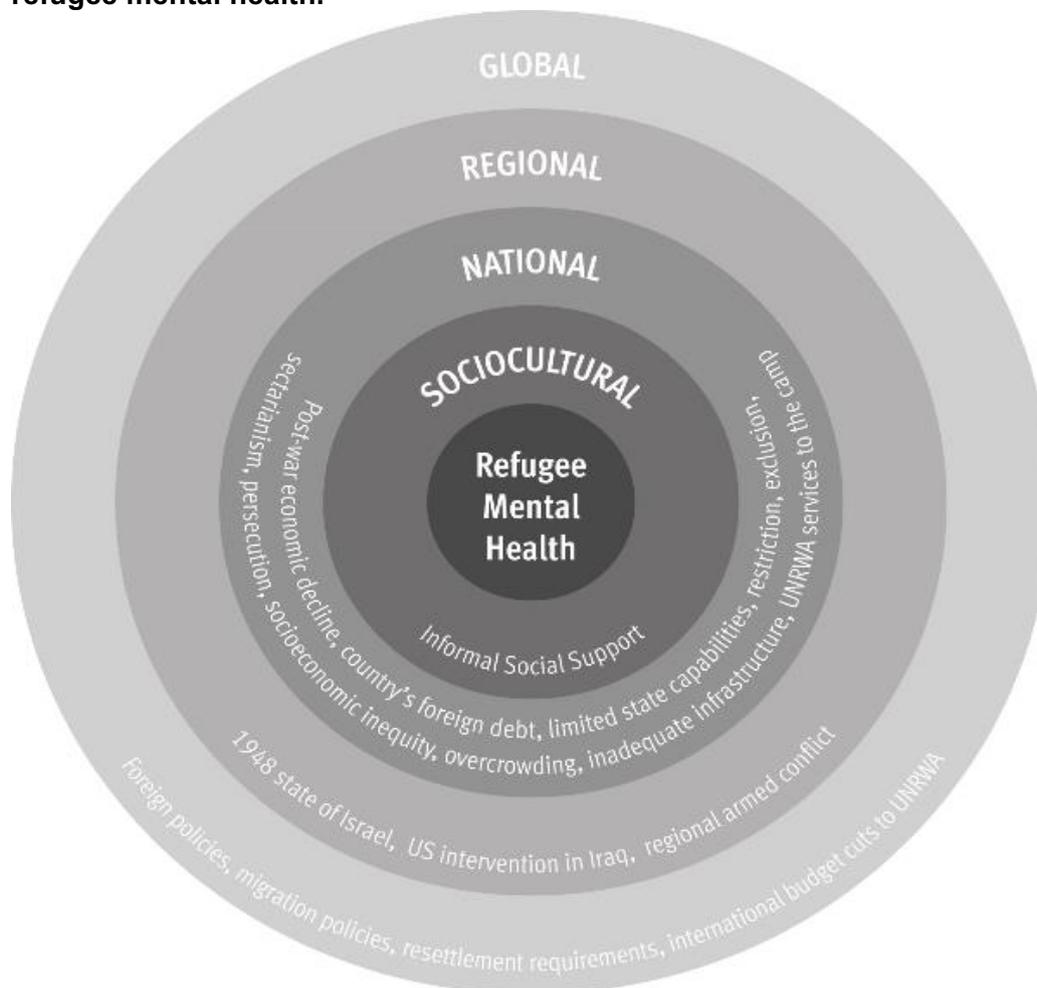
The above national and regional factors are worsened by global modernism, inequitable foreign policies of resettlement countries, over-medicalization of health care and modern educational systems, and armed conflicts fueled by global vested interests in the natural resources of the region (Figure 1).

Figure 1: Social exclusion framework showing pathways of exclusionary forces in the Arab world.



Consequently, the prevalent mental health problems among Iraqi refugees in Lebanon, is an outcome of changing foreign policies on resettlement (Figure 2).

Figure 2: Social exclusion framework showing pathways of exclusionary forces for refugee mental health.



The exclusion of women's voices from the process of care delivery during childbirth is documented in different parts of the world (Downe et al, 2018) and women's full participation is recommended for the provision of quality maternity care (Tuncalp et al, 2015). These global trends however, shape local norms and influence the context of provision of maternity care having detrimental effects on women's health especially in resource constrained settings represented in the data used in our exemplar (Figure 3). The positive trends towards women-centred care and partner involvement observed in the Western world (Berg et al 2012), have yet to reach Lebanon.

Similarly, despite the fact that university scholarship programs, mostly funded by high income countries of the West, aim to provide resources and support for financially disadvantaged students in low and middle-income countries, there are unintended consequences that can have a significant impact on the wellbeing and welfare of the scholars, other stakeholders and on the success of the program. Distal decisions to socially include economically disadvantaged students in tertiary education inadvertently produce social exclusion for the beneficiaries and non-beneficiaries of the program and shape the scholars' worldviews and those of their families, communities, and other students (Figure 4).

The scarcity of reference to the structural and global level determinants in the current literature on social exclusion may be because the vast majority of literature on social exclusion is situated in the global north or the industrialized countries of the west which are not as affected by armed conflicts, global budget cuts on relief aid, foreign policy, international debt burdens, globalized modern educational and biomedical systems.

This is also the case for to other national level determinants which play out on population health, as in the case of material deprivation for Hispanics and African Americans in the United States of America, limiting their health insurance and access to necessary healthcare in comparison to other Americans (Algeria et. al 2002). The circumstances that these ethnic groups live in which also include poor quality of the residential areas, have contributed to a poorer health in general and higher prevalence of mental disabilities (Algeria et. al 2002). Similarly, in many European countries, the different age of retirement between men and women that is set by public policy, 60 and 65 years respectively, puts women who live alone rather than with a spouse or other male family members at a higher risk of living in poverty (Ogg, 2005). In Russia, mental illnesses, such as elevated anxiety and depression were more prevalent among women in lower socioeconomic position which adversely impacts their nutritional intake when compared to males (Averina et. al 2005).

Figure 3: Social exclusion framework showing pathways of exclusionary forces for women giving birth in Arab countries.

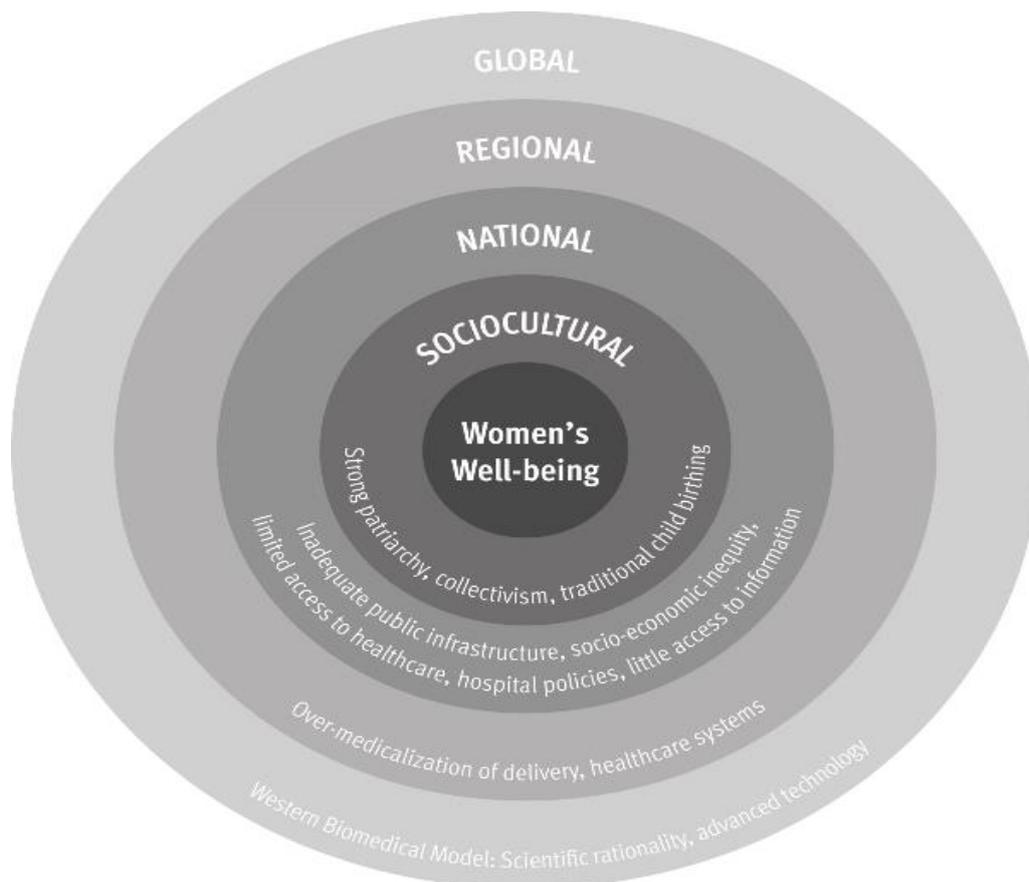
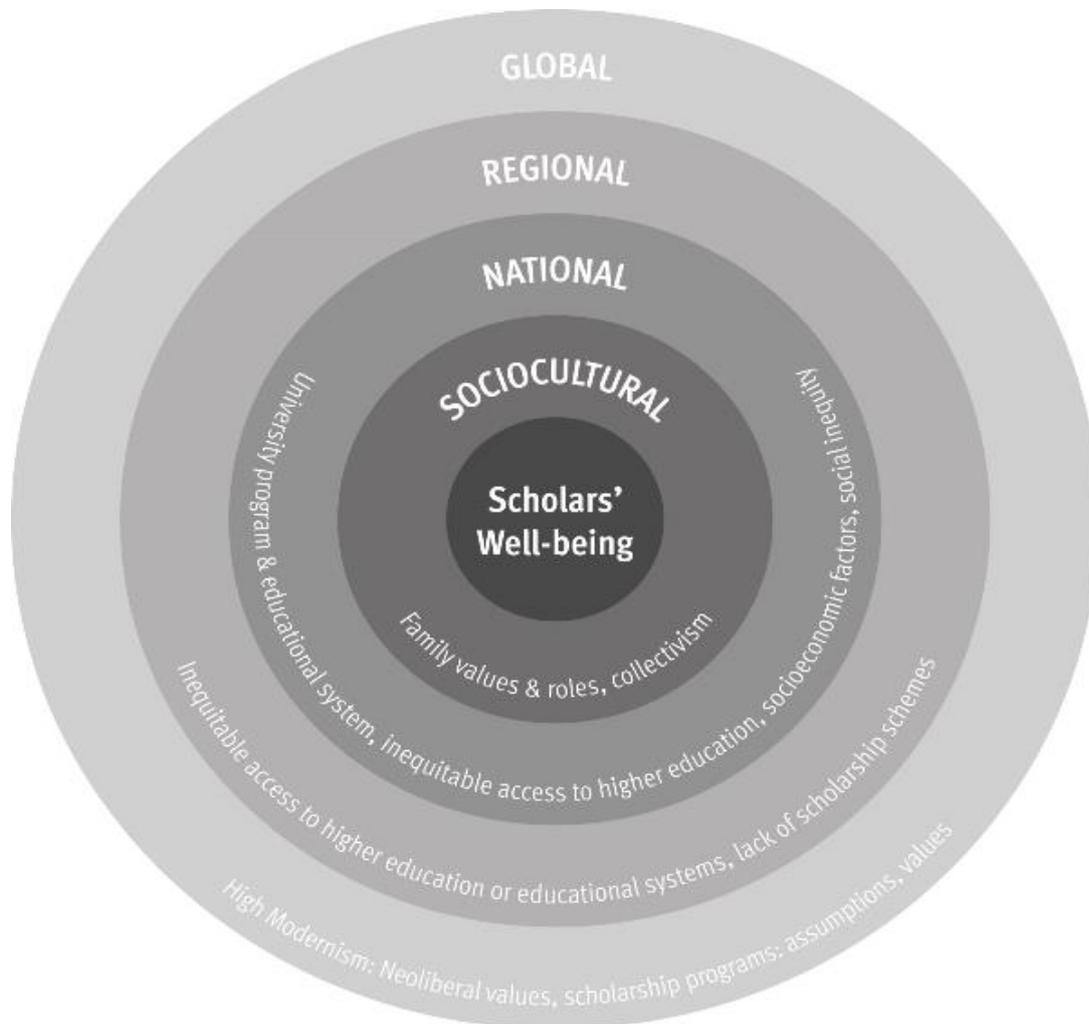


Figure 4: Social exclusion framework showing pathways of exclusionary forces for

scholarship recipients in the Arab world.



The above examples of the structural determinants of health inequities encompass all social and political mechanisms that generate, configure and maintain social hierarchies, including: the labour market; the educational system, political institutions that affect health and that generate stratification and social class divisions in society. These mechanisms are rooted in the key institutions and processes of the socioeconomic and political context (Solar & Irwin 2007). Schrecker (2016) discusses neoliberalism as one powerful structural determinant spreading consumerism to all parts of the world, and acting to limit opportunities for reduction of health inequities. A number of factors have promoted its spread, such as marketing tactics of transnational corporations, political support by international players, such as the World Bank and the IMF and alliances of the international financial institutions, private banks, and the Thatcher-Reagan-Kohl governments (Schrecker, 2016).

In this paper, we also argue that the pathways of action of exclusionary forces at multiple levels (national, regional, global) are dynamic and non-linear in direction from the global to the local. Foreign policies of the west, their vested interests in the Arab world and their consequent fueling of and support for armed conflicts therein have created massive refugee crises in the Arab world, spilling over to neighboring countries and to the west for resettlement and asylum seeking as is the case with Iraqi and Syrian refugees. This is similar to the case of the Bosnian

conflict which was fueled by a political turmoil rooted in opposing political parties which resulted in massive health outcomes and forced migration and is also in the case of the current Syria crisis (Shatzmiller, 2002). Migration policies and humanitarian aid of receiving countries especially of the EU are changing to deal with these social and economic pressures (Del Sarto, 2014).

In conclusion, this paper has theorized that the ecological framework of determinants of social exclusion expands to the level of the wider social/structural or distal determinants that bring about social exclusion. As the discussion above has illustrated, powerful determinants at regional and global levels work directly or indirectly to create and exacerbate exclusion for such populations who are already economically disadvantaged by poverty and/or displacement. The attention to such level of determinants which are often overlooked and hence unaddressed, is important for dealing with disparities and social exclusion in similar impoverished and war affected places around the world.

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