Youth on the Margins

Mental Health and Risk-taking Behaviours in El Kabaria, northern Kasserine and northern Tataouine

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Under the supervision of
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Introduction

Olfa Lamloum and Mariam Abdel Baky

International Alert has dedicated a great deal of attention to the social and economic rights of young people in marginalised working-class districts and border regions since it first began operating in Tunisia in 2012. By establishing sub-national offices in border regions, it has benefited from favourable proximity to and engagement with three groups of actors: civil society organisations, local government and young people's coordination committees. In 2017, these actors identified health services in Tataouine Governorate as the priority, after years of protesting the complete absence of gynaecology provision, which had led to frequent deaths among pregnant women in the region.[1] In response, International Alert launched a participative citizen study, the first of its kind in Tunisia, assessing healthcare provision in the governorate and its delegations. This study was based on a belief that including citizens in the assessment of public services was key to strengthening participatory democracy in marginalised regions suffering from inequalities in their access to basic services and to promoting a more just and thoroughgoing public policy.[2] As such, International Alert and its partners developed innovative diagnostic citizen tools intended to help young people access healthcare services, organised a series of online seminars during the coronavirus pandemic, and carried out middle- and short-term health projects in various governorates while the country was in lockdown.

This publication is the natural extension of our approach to addressing disparities in healthcare access – a constitutional right – in marginalised areas, to strengthening the mechanisms of participative government and producing a citizenship culture capable of suggesting alternative ways of meeting citizens' needs. More specifically, it focuses on how young people understand and act in the world, their problems, their risk-taking behaviours, the roots of precarity in their lives, and their experiences in prison, all through the relationship with their physical and mental health.[3] Any attempt to tackle these issues in isolation from the social and economic circumstances of young people and their geographical circumstances would be conceptually flawed. We thus carried out field studies in three marginalised regions: the El Kabaria neighbourhood, home to around 10% of the population of Tunis; the city of North Kasserine on the Algerian-Tunisian border; and the city of North Tataouine on the Tunisian-Libyan border. International Alert has had offices in these latter two regions since 2013 and 2015 respectively.

Mental health has been the subject of growing interest in the Arab world, and this publication is part of this general trend. A survey of Arab youth carried out in 2019 found that mental health was a growing source of anxiety for young people in the MENA region, with more than half of respondents saying that they found it difficult to access decent treatment for psychological issues like anxiety and depression. Moreover, half of respondents confirmed that there was stigma attached to receiving mental health treatment.[4] And despite the many pieces written on mental health in the region over the last few years, recent studies have concluded that there are still major gaps in the research, noting that there is a real need for better international funding to be made available for research into mental health and student wellbeing (Sweileh, Waleed, 2021). The value of this publication is not only its unprecedented geographical scope, covering three different regions, but also that it provides us with information on the conditions and circumstances of access to healthcare, a question that has only become more important

1 "Tatawin: al-Nisa' Yahtajjun 'ala Irtifa' 'Adad Wafayat al-Hawamil", Nasma, shorturl.at/ruFG0

2 https://www.international-alert.org/ar/publications/evaluation-public-health-services-governorate-tataouine-diagnosis-and-alternatives/

3 The WHO defines mental health as 'a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.'

4 Arab Youth Survey, 2019. https://www.chathamhouse.org/sites/default/files/2019%20Arab%20Youth%20Survey.pdf

with the spread of the Covid-19 pandemic – an event which has thrown inequalities in the right to healthcare and the right to life into sharp relief.

This publication is also part of our constant effort to carry out research in the field, in the course of which we have discussed and deconstructed how marginalisation and dispossession work in the 'interior' and in working-class neighbourhoods, dropout rates, border trade, access to justice, youth integration policy, young people's relationship to state institutions, their experiences with violence and their survival strategies.

The central question addressed by the three chapters of this publication concern what medical sociology can tell us about young people's physical and mental health in marginalised regions of Tunisia. The concepts of *structure* and *social structure* have become more and more common in the medical sociology literature since the second half of the 1980s, leading us to a more comprehensive and critical view of health and illness and their effect on the body via focus on government as a primarily structural factor in how both the healthcare profession and society approach illness (Williams, Gareth, 2003). This approach does not regard the body as simply an isolated data point. It sees health and illness as the product of social, cultural and historical context (Freund and McGuire, 2003).

As such, these studies aim to draw out the effect of social and economic circumstances on young people and on their physical and mental health. Approaching health through the interlinkages between different social, economic, political, spatial and institutional elements affords us a broader view of young people's lived experiences. Instead of looking at the effects of austerity policies in the three regions, or the shrinking welfare state and the rule of 'personal responsibility – which young people did discuss during the study – our chapters set off from these facts in order to show the vulnerability of young people with respect to access to healthcare and life strategies.

Loïc Wacquant's theoretical recasting of the 'Neoliberal Government of Social Insecurity' provides us with a better understanding of the way in which the state manages poverty via a two-prong approach of public assistance and punitive policy (Wacquant, 2009). The state's rehabilitative role disappears and its social programs are curtailed even as resort to carceral punishment for involvement in social problems increases. This reliance on a punitive regime is not a digression from the neoliberal model but a fundamental part of it. This is not restricted to Tunisia or the Arab World – austerity policies in Western countries and neoliberal 'structural adjustment' programs in the global south have both accelerated the dismantling of the welfare state (Davis and Shaylor, 2001).

Tunisia adopted its first structural adjustment program in the 1980s as part of its commitments to the international financial institutions it had begun dealing with in the 1960s (Pfeiffer, 1999). Via the first program (1986-1992) and the second program (2013-2020), Tunisia committed to and enshrined neoliberal prescriptions via intensive legislative, organisational and economic restructuring, leading to the adoption of an economic approach dominated by austerity and debt servicing at the expense of Tunisians' wellbeing.[5] The financial policies pursued over the years have included salary ceilings and freezes on government appointments, devaluing the currency, privatising state-owned businesses,[6] imposing new taxes (in particular VAT), and spending cuts. Throughout the period, international financial institutions have continued to intervene in public development policies – the same policies that represented, for many years, a source of government legitimacy.

Austerity policies have triggered extensive protests, beginning with the Bread Uprising (which began in late 1983 and escalated dramatically in early January 1984). This exacerbated the sociopolitical marginalisation of the interior, a structural pillar of the post-independence Tunisian state, which in turn accelerated the shift towards

5 http://www.economie-tunisie.org/sites/default/files/fmi_impact_of_tunisias_currency_devaluation_en.pdf

6 250 public companies were privatised between 1987 and 2010. See: http://www.economie-tunisie.org/sites/default/files/bp_11_fmi_impact_devaluation_dinar.pdf

security government of these regions. This shift has come at the expense of their economic and social security (Lamloum, 2016). All socioeconomic mechanisms, even those that are outside political control, have been subordinated to the logic of domination, and sometimes of violent suppression (Hibou and Hulsey, 2006).

Rising global incarceration rates since the 1970s have coincided with the collapse of the social rehabilitation model and the enactment of law and order measures, despite the fact that the effects of such policies can be traced back to at least the 19th century (Harcourt, 2010). Researchers have described these practices as 'neoliberal punishment', which focuses on an approach that separates the penal sphere from political economy, abstracting punishment from the economic context and making it the only space for legitimate state intervention. Based on the same logic, the economic exchange which forms the greater part of human interaction is held to be the overriding aim, and punishment becomes the only sphere for legitimate state intervention. This logic has led to an expansion of the carceral system since the 19th century (Harcourt and Hibou, 2010), often making prison a site of 'social invisibility' (Davis and Shaylor, 2001) that dehumanises and invisibleises its inhabitants (Binnall, 2009). The expansion of punitive policy against poor people is not restricted to Western countries. In Tunisia, day workers and the unemployed account for 76% of all prisoners, and overcrowding sits at 124%.

It is possible to observe regional and social disparities through the weakness of the public health system and the deterioration of hospital services in working-class neighbourhoods and the regions of the interior. Access to healthcare remains a privilege. It has not been made universal after the revolution. One glaring example of disparity is the shortage of specialist doctors and life support equipment. In 2016 (the most recent year for which figures are available), Tataouine – a governorate of over 150,000 people – had only three doctors specialising in gynaecology or obstetrics. At the beginning of the coronavirus pandemic, neither of the two regional hospitals in Kasserine and Tataouine had a single intensive care doctor. The same applies to the testing and medical services and the falling capacity of hospitals, length of hospitalisation and the difficulty of accessing public transport, as well as the limited reproductive health facilities.

This situation is the product of three decades of systematic dismantling of the public health system. Since the mid-1980s and throughout the period of 'structural adjustment', the Tunisian state has steadily reduced the healthcare budget. This policy has only become more entrenched with the passing of several laws intended to facilitate private investment in the sector. University hospitals have been given financial independence and their government subsidies have been removed, with the exception of medical staff's salaries. The government has also subsequently abandoned its support for the budget of regional hospitals, which has negatively impacted their ability to buy medication.

In 2007, the new law on insurance against illness made the National Fund for Insurance Against Illness responsible for covering all services provided by both the public and private sectors, without providing it with the necessary resources as stipulated by the agreement between the UGTT and the government. This effectively constituted indirect funding to private investors in the healthcare sector (for example, according to official numbers from 2017, public hospitals have only 48 scanners, compared to 131 in the private sector). At the same time, the health sector expanded rapidly in coastal regions and cities, while remaining stagnant in the interior.

Banking capital and even Gulf capital has poured into private health centres and drug manufacturing in Tunisia, driven by profit-seeking and the opportunity to expand into nearby markets in Libya and sub-Saharan Africa at a time when the Gaddhafi regime was under a Western embargo and European borders were closed to Africans. In 2007, government regulations covering supplementary private sector work by doctors at university hospitals were passed into law, giving many of them the right to work privately in the public hospitals that employ them

for around half a day per week. This has created dozens of new opportunities for corruption and to exploit public facilities to make a profit.

The various governments that have run the country since 2011 have failed to break with these austerity policies serving the private sector. Nor have they taken any steps to address the regional disparities in access to the right to health. In fact, the opposite has happened. Employment in the public health sector has decreased, to the point that retiring staff are often not replaced.

Despite social movements in many areas having demanded improved health services on various occasions since 2011, and despite the promises of regional development made by political parties, the main priority for successive governments has been to service the foreign debt at the expense of service provision: in the 2019 budget, for example, 23% of spending went on debt servicing and only 13% on social services. Government spending on healthcare in 2018, under the Youssef Chahed government, was lower than the 2006 figure under Ben Ali (5.2% as opposed to 7.4%). And despite protests by young doctors demanding better working conditions in the public sphere, and the migration of hundreds of doctors to Europe, this policy has not changed.[7]

With this background in mind, how can we observe the situation of marginalised young people within a broader context? With regard to the social care budget, it is clear that spending on health and education is falling, and that this is reflected in the higher dropout rates in working-class areas and the interior compared to coastal cities, the female unemployment rates (which in some regions are three times higher than the national average), the number of doctors per head (which is far lower in these regions),[8] the higher prevalence of violence in schools,[9] the near or total absence of social and cultural programs for young people, and the lack of healthcare facilities, which makes it much more difficult for young people to access them. All this is linked to the criminalisation of poverty, which explains the tense relations between state institutions, the police, and young people, and makes many of them dream of migrating (often illegally). Many young people see the criminalisation of drug use as another form of punishment, noting that the already high number of arrests is rising rapidly.[10]

This publication proceeds from the thesis that it is not possible to investigate the effects of a shrinking welfare state in isolation from its effects on young people's health, particularly the psychological effects, in both the interior and working-class districts. It adopts a systematic approach to producing knowledge: a bottom-up assessment in which young people themselves participate, which aims to cast light on public healthcare services.

Although it is clear that young people have unique social, emotional, physical and developmental needs that require easily accessible and rapid-responding healthcare services, those who live in marginalised spaces face additional barriers to accessing medical care, exacerbating health inequality. These barriers appear in particular within mental healthcare, where young people have to deal with stigma, violence and fear of healthcare workers. This is particularly true with respect to addiction treatment, due to a lack of rehab programs for young drug users and fear that asking for help will have terrible consequences given the criminalisation of drug use.

7 https://arabic.euronews.com/2021/06/04/specialist-doctors-tunisia-due-poor-infrastructure-loss-consideration-brain-drain-continue

8 *Diagnosis and Alternatives: Evaluation of Public Health Services in the Tataouine Governorate*, International Alert, 2018. https://www.international-alert.org/ar/publications/evaluation-public-health-services-governorate-tataouine-diagnosis-and-alternatives/

9 *Citizen Diagnostic of Secondary Education: Douar Hicher, Hayy El Nour and North Tataouine*, International Alert, 2020. https://www.international-alert.org/ar/publications/citizen-diagnostic-secondary-education-tunisia/

10 Jeunes et violences institutionnelles. Enquêtes dix ans après la révolution tunisienne. International Alert, Arabesques, 2021.

We would like to make three basic observations about the methodology followed here. The first has to do with how the study was conducted. During the first stage, we formed an interdisciplinary academic committee to provide independent scholarly advice to the research team. Moreover, the team developed its research tools through consultations with other researchers from a range of disciplines, who were invited to several organised research workshops to discuss the project. These workshops also reviewed the preliminary results of the study, identified its shortcomings and discussed ways of overcoming the contextual impediments to data collection. The project has also benefited from the various other works published by universities and medical institutions in France (Dusseaux, 2021), Iran (Farajzadegan, 2014), Belgium, Latin American (Lundgren, 2000), Canada and Australia. We also consulted a lawyer on the ethical and legal aspects of data collection, and included 24 field researchers who were themselves unemployed university graduates with a background on sociology in the process. These researchers were given training in quantitative data-gathering methods, and were provided with constant technical guidance and field support.

The second point concerns the aim of this publication, which aims to strengthen a participatory approach rooted in including young people from working-class areas and regions of the interior in knowledge production, both with and through them. This comes along with a great concern for ethical issues, the third dimension of the methodology followed here. During the project, we took great pains to avoid side effects for respondents that might have resulted from asking questions on issues like anxiety, fears, violence and prison. All field researchers offered respondents the number of a therapist if they indicated that they needed one. We were also keen to protect the safety of participants in focus group discussions, and as a result all names have been changed.

This publication comprises three chapters on young people in **El Kabaria**, **North Kasserine** and **North Tataouine**.

The first chapter presents the results of a **quantitative field study on young people's mental health and the risk-taking behaviours they engage in.** Drawing on a sample of 1250 respondents between 18 and 29 years of age, it takes a close look at how young people see their own health and the circumstances under which they have accessed treatment; the kinds of violence they have been exposed to, how this varies by sex, age and educational level and where violence tends to be experienced; and drug usage.

The second chapter presents the results of a field study on anxiety both as a 'state' and as a 'trait' in young unemployed people as one of the indicators of mental health, comparing these respondents with other young people who inhabit the same socially, economically and regionally unequal urban environment.

The third chapter is a qualitative assessment of testimonies given by male former prisoners in the course of three focus group discussions, focusing on their health during their period of incarceration and their view on the prison and justice systems.

We would like to conclude this introduction by thanking all those who helped to make this study a reality: the members of the academic committee, the team of researchers, editors and field researchers, the doctors who provided advice, and our civil society partners at Generation Against Marginalisation in El Kabaria, North Kasserine and North Tataouine.

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Access to health for young prisoners: Experiences from Kabaria, North Kasserine and North Tatouine

Mohamed Rami Abdelmoula

Introduction of the study

In the context of its new research project "Mental Health and Risky Behaviors of Youth in Kabaria, Kasserine North and Tataouine North," International Alert organized training workshops and conducted several quantitative and qualitative studies, and chose to dedicate one of them to studying the prison experience of young people and their health during imprisonment. This topic was chosen because of the large number of detainees and prisoners who fall within this category.

According to the figures mentioned in the study "Young people in the Margins: Representations of Risk, Politics and Religion"[11], 17.7% of the surveyed youth in the Douar Hecher area, 14.6% of the respondents in North Kasserine and 10% of the respondents in North Tataouine confirmed that they had been arrested or imprisoned during the year 2019. According to the report issued in 2014 by the Office of the High Commissioner for Human Rights in Tunisia, "Tunisian prisons between international standards and reality"[12], 55% of prisoners are between the ages of 18 and 29, while 29% are between 30-39, which means that 84% of prisoners are under the age of 40.

The topic of "Youth and Health" is rarely covered in the media or in academic studies, perhaps because many consider that this age group is in the "spring of life" and "the height of strength" and that there are more urgent issues and problems such as unemployment and drugs (which are often discussed within security and social approaches without attention to health) and illegal migration. This topic has become a blind spot in relation to young people who have served a prison sentence. Here we refer to the difficulty of conducting field studies dealing with the issue of the physical and psychological health of prisoners due to the difficulty of accessing prison institutions on one hand, and the sensitivity and embarrassment that the study may raise when asking questions to the young people who have experienced prison on the other hand.

11 *Young people in the margins. Representations of risk, politics, and religion in North Tataouine, North Kasserine, and Douar Hicher, under the supervision of Mohamed Ali Ben Zina, Olfa Lamloum and Maryam Abdel Baki. International Alert Edition, Tunis, November 2020.*

12 *Tunisian prisons between international standards and reality, a report issued by the Office of the High Commissioner for Human Rights in Tunisia, 2014.* https://www.ohchr.org/Documents/Countries/TN/rapport_prison_inTunisia.pdf

Studying the prison experience of young people from poor neighborhoods and remote areas allows us to understand more deeply:

1. How the state manages the margins and the marginalized.
2. The role played by the family and the relational environment (neighborhood and friends) in supporting and protecting the imprisoned youth.
3. Young people's representation in health studies.
4. The psychological impact of prison experience on young people and its impact on their state representation.

Although the publications and reports of experts from local and international civil society organizations and constitutional bodies on the reality of Tunisian prisons are necessary, valuable and systematic, they are never a substitute for the words of those concerned. Those who have lived the harsh experience are more aware than others of the effects it left on both their bodies and their minds. The lack of studies devoted to the health of prisoners, especially psychological health among young people during and after their sentence, makes it necessary to approach these "silent" groups so that we can hear from them directly.

Introduction of the Sample

In this context, we chose to base the qualitative field study on direct group meetings and discussions with a sample of individuals in three focus groups. We presented to them a number of problems divided into four axes:

1. The family and socio-economic situation, the education level attained and the risky behaviors of the participants.
2. Their prison experience.
3. The post-prison phase.
4. Their evaluation of the justice system, prisons and punishments, and their view of the relationship between their socio-economic conditions and their prison experience.

We focused heavily on the second and third axes, giving a central place to the issue of health in the questions and discussions. The sample included 19 participants divided into three focus groups in three regions: five from the district of Kabaria in the governorate of Tunis, nine from the northern district of Kasserine and five from the northern district of Tataouine.

The interviews with the participants were conducted at the headquarters of the International Alert branches in Kasserine North and Tataouine North, and the headquarters of the "Generation Against Marginalization" association in Kabaria.[13]

All participants were male due to the difficulty of obtaining testimonies from female former prisoners on the one hand, and the communication difficulties and discomfort that their presence in a mixed group may cause on the

13 *I would like to thank:*
- *All the participants in the three focus groups, who gave us a great deal of their time and trust to tell us about their often painful experiences and memories.*
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- *Mrs. Olfa Lamloum and Mariam Abdel-Baqi from the International Alert office - Tunis, for all the rich discussions, observations and valuable advice during the various stages of this study.*

other hand. Moreover, there are the specificities to the situation of imprisoned women, whether it is related to their health, family (pregnancy, maternity, breastfeeding, child care) and social status (exclusion and stigma) which require a separate, more detailed study. Moreover, 97% of prisoners in Tunisia are males, according to the report "Tunisian prisons between international standards and reality" issued by the United Nations.

The ages of the participants in the focus groups ranged between 19 and 58 years. Some of them had prison experience in recent years (the youth group), while others had an earlier experience during their youth (the elder group). 36% of the participants in the three focus groups had previously been imprisoned before January 2011. The period covering the various prison experiences of the participants extended from 1993 to 2020.

The crimes that the focus group participants were accused of committing, and subsequently imprisoned or detained for, vary. We can arrange them according to their frequency as follows:

1. Theft.
2. Drunkenness and violence/extreme violence.
3. Drug consumption.
4. Charges classified as serious: drug dealing, human trafficking and accidental 'killing and escaping'.

The length of time spent in prison ranged from detention for a few days or weeks to imprisonment for more than ten years.

Family and socio-economic background of the focus group participants

52.6% of the participants did not go beyond the primary stage of education, 31.7% of them dropped out of middle school (the second stage of basic education) and only 15.7% studied at the secondary stage. These figures are close to the statistics of inmates according to the educational level mentioned in the report "Tunisian prisons between international standards and reality"[14]: 4% illiterate, 50% primary education, 43% secondary education (elementary schools and secondary institutes), and 3% higher education. As for the current academic and professional status of the participants, the first observation is that they are all dropouts of school, and the second is the high rate of unemployment, precarious employment, and low wages: 47.5% are unemployed, 21% work through the government placement mechanism, 10.5% day laborers. Only 10.5% are engaged in skilled work (plumber, car body paint), and 10.5% work in the trade and tourism sectors. 73.5% of the participants confirmed that at least one of their family members had been imprisoned at some stage.

Their level of alcohol and drug consumption before entering prison for the first time became clear through their answers. 52.6% of them used alcohol and/or drugs excessively to the point of addiction. These figures confirm the results included in the study issued by International Alert in November 2020 "Youth in the Margins", where we found that unemployment then addiction were the first and second greatest social risks for young people, while crime occupied the fourth place. This data also highlights the fragility of the socio-economic situation of most respondents and its relationship with poor educational level on the one hand, and the possibility of adopting risky behaviors on the other hand. This 'individual' fragility is often a continuation of the fragility of the families of the

14 *Tunisian prisons between international standards and reality, a report issued by the Office of the High Commissioner for Human Rights in Tunisia, 2014.* https://www.ohchr.org/Documents/Countries/TN/rapport_prison_inTunisia.pdf

participants in the three focus groups. We did not notice any indications by the participants of the focus groups of family disintegration. In only two cases, we found that the respondents' parents were divorced when they were admitted into prison for the first time. The main problem lies in the low (and sometimes non-existent) family income accompanied by large numbers of family members. With the exception of the participants in the northern Kasserine focus group, most of whom confirmed that their mothers work or are retired (mainly peasant workers), the rest grew up in families supported mainly by the work of the father, which is usually precarious and low-paid: six daily workers, three workers in the barn, one shepherd, one Postal employee, two migrant workers in France, one retired, two unemployed. Four of the respondents reported that their parents died before or while they were in prison.

The most important results of the study

1. Suffering in many forms, stages, and effects

Since 2011, the demands for the revision of Law No. 2001-52 of May 14, 2001 (related to the prison system in Tunisia) by human rights organizations, constitutional bodies and even international organizations have not stopped. The demands were to revise or to replace it with a new law to conform with international standards which guarantee the physical and moral inviolability of the prisoners, as well as their dignity and health. The testimonies contained in the reports of these organizations show that the minimum basic rights approved by this law are not observed. This is also confirmed by the testimonies of the participants in the three focus groups. It would be useful to compare the theory and the practice, between what the law says, and what former prisoners say.

The most important chapters contained in the law relating to the prison system in Tunisia.

Article 1:

This law regulates the conditions of prison residence in a manner that guarantees the physical and moral sanctity of the prisoner, prepares him for free life and helps him integrate into it. On this basis, the prisoner shall enjoy health and psychological care, training, education and social care while preserving family ties.

Article 15:

The prisoners should be placed in rooms with adequate ventilation and lighting with the availability of the necessary sanitary facilities. The prison administration should also provide each prisoner with an individual bed and the necessary cover.

Article 17:

- Every prisoner has the right to:
- Free nutrition, free treatment and medication inside the prison. When that is not possible, the prison doctor should refer the prisoner to a hospital establishment.
- Shaving and hygiene supplies in accordance with the regulations in force.
- Bathe at least once a week or according to the instructions of the prison doctor.
- Meet with the lawyer assigned to defend him without the presence of a prison official for the person who is in precautionary custody or who has been convicted of an unenforceable ruling, based on a license from the concerned judicial authority.
- Meet with a lawyer, licensed by the administration of Prisons and Reform, in the presence of a prison employee, for the person convicted with final judgment.
- Meet with the penalty execution judge for the convict in the cases stipulated by the legislation in force.
- Meet with the prison director.
- Write to the lawyer assigned to defend him and the concerned judicial authorities through the prison administration.

Article 18:

The prisoner has the right to maintain family and social ties by:

- Going out to visit relatives when severely ill, or attending the funeral procession of one of them in accordance with the legal provisions regulating the institution of the penalty execution judge and the regulations in force.
- Receiving visits from his relatives and others, in accordance with the regulations in force.
- Receiving correspondence through the prison administration.
- Receiving supplies, parcels, and clothes that come to him from his family,
- Accepting transfers and checks addressed to him or sending them to his family,
- Concluding certain contracts unless there is a legal prohibition, and after obtaining permission from the relevant judicial authority for the person who is detained in custody or convicted by an unconcluded judgment, and from the administration of Prisons and Reform with regard to the convict by a final judgment.

Article 19:

A prisoner has the right to:

- Obtain writing tools, reading books, magazines and daily newspapers through the prison administration and in accordance with the regulations in force. A library is to be found in every prison which should contain books and magazines prepared for reading.
- Obtain other written documents that enable him to continue his studies/ programs in educational institutions from inside the prison.
- Engage in education and awareness programs organized by the prison administration.
- Go out for a daily break of at least an hour.
- Engage in intellectual and sports activities according to the available possibilities and under the supervision of a specialized employee of the prison administration.

- Follow entertainment programs in accordance with the regulations in force.
- Work for a wage and apply the available capabilities, for the convict, provided that the work quotas do not exceed the legal period. A joint decision of the Minister in charge of Prisons and Reform and the Minister in charge of Social Affairs determines the terms and method of employment.
- Enjoy the guarantees and rights stipulated in the legislation related to occupational accidents and occupational diseases.

Article 24:

A prisoner may not be subjected to a disciplinary penalty except after hearing him and receiving his defense and, when necessary, a translator is sought for foreign prisoners.

Article 37 -

The prisoner's social welfare aims to:

- Rehabilitate and take care of him during his stay in prison.
- Modify his deviant behavior.
- Refine his intellectual and physical energies by preparing him for a life of freedom, training him professionally, helping him to learn and improve his behavior.
- Follow up on his condition upon his release and facilitate his reintegration into his original surroundings, in coordination with the concerned relevant structures.

Article 38:

The administration in charge of prisons and reform shall allocate an office in each prison for the services of social guidance. The task of its assistants is to link the prisoners with their families and help them solve their problems in order to preserve family and social ties.

Article 39:

- Within the limits of the available capacity, the prisoner is trained in one of the professions compatible with his qualifications, in the workshops prepared for this purpose or in the agricultural farms and estates of the prisons.
- A qualified prisoner shall be given a certificate of training completion or a certificate of professional competence certified by the relevant authorities without any reference to the prison situation of the person.

A. Systematic humiliation

"When I was young, I dreamed of raising the flag of Tunisia. When I entered prison, they took off my pants." (Muhammad Ali[15], Al-Kabaria)

Humiliation without an apparent reason takes several forms: examples include insults and physical violence for trivial reasons, forcing prisoners to stand several times for counting, or saluting prison guards, breaking into cells late at night. Through the testimonies of the participants in the focus groups, we found that their sense of humiliation was growing because of their conviction that prison officials could deprive them of their rights, assault their physical sanctity and curse them without any accountability or punishment.

"The prison system is designed to insult the people. During the day they count you ten times and salute and give respect, they are raising a generation of humiliation. It is not prison and reform, this is a destruction of the psyche" (Omar, Al-Kabaria)

15 *To preserve the anonymity of the participants, we concealed family surnames and used pseudonyms in most cases. Although many participants insisted on using their real names and surnames, considering that they have nothing to fear, we preferred to preserve their privacy and safety.*

"They begin with cursing your mother and your sister. You can't do anything because they have the upper hand." (Adel, Kasserine North)

"I was subjected to the worst treatment, as if it was Guantanamo... I had a fight with the director of the prison, they stripped me naked and had dogs attack me" (Abdel Wahed, North Tataouine)

The frequency and intersection of testimonies in the three focus groups confirms that this quest to humiliate the prisoner is not just unruly practices or individual deviations, but rather a systemic course of action. The paradox is that the prisoners most affected by these practices are usually - as confirmed by several participants - the novices and the younger ones. Many of them had short sentences or were accused of trivial crimes . On the other hand, agents avoid excessive practices with those convicted in serious cases and those serving long sentences, perhaps because they have nothing to lose and may react violently.

B. Lack of comfort and privacy

The prison system in Tunisia is based on collective incarceration day and night. This was stipulated in Order No: 1876 of 1988 dated November 4, 1988 regarding the prison system, and the 2001 law was silent about it. Individual cells in Tunisian prisons are considered places to carry out sentences, and in rare cases to protect the prisoner, not as a privilege. This, according to the assessment contained in the "Guidebook for the Legal Framework Relating to Prisons in Tunisia"[16], is contrary to the prevailing trend in countries that give importance to the rights of prisoners and respect international standards in this regard.

Basically, the architecture of Tunisian prisons and their division of space was based on the fitting as many prisoners as possible. The second problem is that the capacity of prisons is greatly exceeded, which represents a flagrant violation of the rights of prisoners in prisons that are supposed to maintain their dignity. The actual capacity of prison beds does not exceed 18,000, while the number of inmates, whether convicts or detainees, exceeds that to nearly 23,000.[17]

Several reports by local and international human rights organizations, international bodies, and even constitutional bodies[18] indicated severe overcrowding in Tunisian prisons, which exceeded 150% of the capacity in some prisons. Many of the participants assured us that they found it difficult to find a bed of their own during the first days of their imprisonment, and that they had to either share a bed with another prisoner in the "head and tail" position, or sleep in the "autorot" or "communion" position (i.e. sleeping on the ground under another prisoner's bed). They were only able to obtain a bed after a bribe had been paid, or the intervention of other privileged prisoners, or after a bed became vacant following the transfer or release of another prisoner. In order to obtain a minimum level of privacy, prisoners resort to making a divider using sheets attached to the bed posts.

"The worst thing is the light which is always turned on, psychological tourtre." (Saleh, Al-Kabaria)

16 The guide book for the legal framework related to prisons in Tunisia, issued by the Ministry of Justice and the National Authority for the Prevention of Torture, Tunis, June 2021.
http://www.inpt.tn/uploads/media/MANUEL_DROIT_PENITENTIIRE_TUNISIEN_ARABE.pdf

17 *See: The intervention of Mr. Fathi Al-Jari, Chairman of the National Authority for the Prevention of Torture in the Assembly of the Representatives of the People on April 16, 2021: https://bit.ly/3prra4v -Lutter contre la surpopulation carcérale en Tunisie, policy brief publié par Avocats Sans Frontières, septembre 2019. https://bit.ly/3dlP1gE*

18 *See the previous source.*

"Somedays, I would feel like not seeing anyone with the urge to cry. I would go to the bed and make a dividing curtain, so no one can see me" (Heikal, Al Kabaria)

"As for sleeping, I met a boy from my neighborhood. I shared with him one bed in the form of head and tail. The next morning I paid ten TND as a bribe, and I managed to get a bed of my own." (Haitham, Kasserine North)

"The problem with sleeping is that you find five people sharing two beds. The division has more than 140 people, while it can only accommodate seventy or eighty people. The noise and dirt are excessive." (Saeed, Kasserine North)

"In prison, there is a problem of overcrowding. In the beginning you share a bed (head and tail) with another prisoner, or sleep on the walkway. The light disturbed my sleep" (Abdulwahid, North Tataouine)

C. Hygiene is a daily dilemma

One of the most important factors that increases the harshness of the prison experience in Tunisia is the lack of necessary conditions for the prisoners to ensure their personal hygiene and the cleanliness of the places where they sleep, live and eat. This was agreed upon by all the participants. They talked about the significant shortage in the number of toilets, which forced them to wait for a long time until one became available and then feel obliged to relieve themselves quickly in order to leave the place for the rest who are waiting. They also complained about the short time allotted for showering. Also, the temperature of the shower water was often inconsistent with the season and weather.

Some participants complained about the filthiness of the tools used for shaving hair and cutting nails, which, according to them, are used by hundreds of prisoners without cleaning or sterilization. Others talked about dirty mattresses and covers that were used for a long time without cleaning, so they became smelly. Several prisoners used only the blankets provided by their families and tried to clean their sleeping areas and clothes with their personal supplies without relying on what the prison administration provides. Dozens, and sometimes, hundreds of prisoners were placed in a closed, narrow and dirty place with a lack of ventilation. A large number of participants were infected with scabies and most of them suffered from bedbugs and other insects.

"The cover that they gave me, even the dog would be disgusted by it. The shower has a long line, and the guards are continually shouting: "get out". We finish our showers in the toilets." (Nasim, Al Kabaria)

"The bugs don't let you rest. The bugs are in every place of my body" (Heikal Al Kabaria)

"The most disappointing thing is dirt, we have a detention centers in Tunisia not prisons" (Omar, Al Kabaria)

"You would not wish imprisonment during summer even for your enemy. Heat is coming out of the floor and the sweat is seeping. 80 people stand in a row for the shower." (Haitham, North Kasserine)

"A big problem is hygiene, whether toilets or showers. A long waiting line that extends for an hour" (Abdul Wahed, North Tataouine)

D. Inedible food

Another thing which all participants agreed on: "the food provided by Tunisian prisons is in itself a punishment". In addition to its poor taste, it is unhealthy and has no variety. It mainly consists of pastries that are cooked in large quantities randomly and are tossed to prisoners. Most of the respondents confirmed that they did not eat prison food, but rather relied mainly on the "package" that prisoners' families brings on a weekly basis or the acquisition of vouchers that enable them to buy food from the prison store. Only the poorest prisoners, or those without family support, regularly eat prison food. Most of the focus group participants confirmed that they did not find any problem in obtaining edible food, as most of the inmates shared their packages. There are even agreements on the rotation of the families of prisoners to bring the packages on successive days so that fresh food is constantly and sufficiently available.

"We eat prison food only when we have no other choice. That's when we do not have a family package. We always try to share the packages." (Saeed, Kasserine North)

"My mother, God bless her, always visits me with a good package. I am fortunate." (Mohamed Ali, Kasserine North)

"When I started my imprisonment the package used to come several times a week. Now it is once a week, and it seems that they will stop it soon so that prisoners are forced to buy from the prison store." (Adel, Kasserine North)

"I never ate the prison's food. I shared packages with other prisoners" (Bilal, Tataouine North)

"In prison, they would bring us cowpea sandwiches. we would not eat them and throw them away. The family would bring me sandwiches and fish." (Sami, North Tataouine)

"The prison's food is 15 kilograms of macaroni boiled in water to be served to 500 prisoners" (Saleh, Al Kabaria)

"The prison's food is inedible. My mother is an old and sick woman who used to visit me every week and bring me a food package with her." (Naseem, Al Kabaria)

E. Violence

The ill-treatment and violent practices imposed on arrested young people do not end with their imprisonment, but rather continue, as confirmed by the testimonies of the participants in the three focus groups and tens of reports and statements issued by human rights organizations and official bodies. The violence is more severe, harmful and frequent in the detention centers of the Ministry of Interior.[19]

According to the participants' testimonies about the sources and forms of this violence, we find that the prison administration and agents are the first source of violence, followed by the "Kibran" (the room/cell overseer, a

19 *These are not mere speculations or impressions, but results based on the number of complaints received by organizations and bodies concerned with combating torture and human rights in general. See for example:*
- *The parallel report issued by the Tunisian Organization Against Torture, which it addressed to the United Nations Committee against Torture in 2016, on the occasion of the Tunisian state's submission of the annex to the third periodic report on the implementation of the Convention against Torture and Other Cruel or Inhuman Treatment or Punishment. https://bit.ly/3xVUa8g*
- The National Report on Human Rights 2016-2019 issued by the High Commission for Human Rights and Fundamental Freedoms, December 2020. https://bit.ly/3Eropqa
- Rapport alternatif pour l'examen du VIEME rapport périodique de la Tunisie par le Comité des droits de l'homme, présenté par : Avocats Sans Frontières, Ligue Tunisienne de Défense des Droits de L'Homme, Organisation contre la Torture en Tunisie et Organisation Mondiale Contre la Torture. 128ème session, 2-27 mars 2020. , https://bit.ly/3Gcuqri

prisoner to whom the prison administration unofficially delegates some authority and powers) and, to a lesser extent, the other prisoners. Participants' testimonies are consistent in the three regions studied. In Al Kabaria, the complaint was mainly about prison officers who repeatedly and unjustifiably abused prisoners, and did not hesitate to beat them in several cases: two of the participants confirmed that they had fractures in their hands as a result of severe violence by guards. Other participants also pointed out that the "Kibran" deliberately slandered prisoners and incited guards against them, exposing them to violence. The testimonies did not mention cases of violence inflicted by other prisoners, even if they did not deny its existence in the prison environment. In North Tataouine, we heard testimonies accusing prison officials of violent practices that amount to torture:

"Once a group from the army came in order to recruit us to the army after imprisonment time. I told them I don't want to be in the army, and argued with them. They cuffed my hands and legs and they beat me up" (Bashir, Tataouine North)

"I was lashed. They stripped me naked in my underwear and started beating me. After that they poured water on my legs, so that they would not blow up and leave traces of violence." (Abdel Wahed, North Tataouine)

There were no cases of violence by the "Kibran" or the rest of the prisoners in the answers. The answers of the participants in the northern Kasserine group are not very different: prison officials are the primary source of violence, mainly verbal and less frequently physical. One of the testimonies also mentioned a complaint about the confiscation of clothes and belongings of the prisoners by the guards. In this focus group also, some participants spoke of violence inflicted by some prisoners with long sentences on other prisoners, especially the youngest and the least "experienced" who do not have a supporter in prison.

In the three focus groups, especially in Al Kabaria and Tataouine, complaints recurred about the frequent use of the "Cell" punishment (solitary confinement in cramped and unfit rooms with worse treatment than the usual). More than half of the participants were subjected to this punishment at least once. One of the participants confirmed that he spent about six months - sporadically - in the "Cell". We note here that the law regulating prisons in Tunisia has devoted several chapters to specifying penalties and the conditions for applying them to prisoners and the possibility of objecting to them. We find them in the "On Reward and Discipline" section, which includes one chapter for reward and six chapters for discipline.

Article 21: The administration in charge of prisons and corrections may, upon the proposal of the prison director, reward the prisoners who have distinguished themselves by their good behavior inside the prison, or who have perfected a profession that helps them to earn a living in a free life, or who have learned to read and write during their stay in prison, and this reward is represented in:

- Visit without a barrier.
- Employment priority.
- Promotion at the job level.
- Supporting files related to conditional release or pardon.
- Empowerment when released with professional tools that are compatible with the skills gained.

Article 22: A prisoner who violates one of the duties stipulated in article 20 of this law or affects the proper functioning of the prison or disturbs its security is subject to one of the following disciplinary penalties:

1. Denial of supplies and parcels for a specified period, provided that it does not exceed fifteen days.
2. Deprivation of family visits for a specified period, provided that it does not exceed fifteen days.

3. Deprivation of writing tools and pamphlets for a specified period, provided that it does not exceed fifteen days.
4. Deprivation of work.
5. Denial of reward.
6. Prohibition of acquiring materials from the prison store for a period not exceeding seven days.
7. Placement in a solitary room with health facilities available for a maximum period of ten days, after consulting the prison doctor, during which time he will be under the supervision of a doctor who can request a review of this procedure for health reasons.

These penalties shall be imposed and their duration shall be determined by the Disciplinary Committee, regardless of the punitive consequences, when necessary.

The prison director can issue a warning or reprimand to the violating prisoner without the need to refer to the disciplinary committee.

It is forbidden to administer penalties other than those mentioned here to the prisoner.

Article 23: Multiple time-related violations committed by the prisoner requires that he be referred once to the Disciplinary Committee, according to which it is not possible to combine more than two disciplinary penalties.

Article 24: A prisoner may not be subjected to a disciplinary penalty except after hearing him and receiving his defense and, when necessary, a translator is sought for foreign prisoners.
The administration in charge of prisons and reform shall be notified in writing of every disciplinary action taken by the Disciplinary Committee.

Article 25: The prisoner has the right to object to the disciplinary measure, within a maximum deadline of the day following his notification of it, to the prison administration, which immediately submits it to the administration in charge of prisons and reform. Objecting to a disciplinary measure does not suspend its implementation.
The administration in charge of prisons and reform has the right to approve or reduce it.

Article 26: The prison Disciplinary Committee is composed of the Prison Director, in the capacity of chief, and the Assistant Director of the prison, the Head of the Social Work Office, and a prisoner of good conduct chosen by the prison director from the same room in which the violating prisoner resides, the training workshop or the workroom. The committee can invite the psychologist to consult with him.

Article 27: A prisoner who deliberately causes damage to prison property must compensate for the value of what was damaged.

F. Boredom

Despite what the legislative framework stipulates (see the most important chapters in the law relating to the prison system in Tunisia) that it is necessary to provide the possibility to practice sports, recreational, training, educational and professional activities, the statements of the participants in the focus groups confirm the extent of the gap between rights and practice, between what the law says and what the reality of prisons provides.

With the exception of some exercising, football matches, watching television and the tasks assigned to them by the "Kibran" and the "Kibran Korvi" (which distributes the tasks), most of the respondent prisoners did not practice other activities, especially outside the cells in which they spent up to 22 hours a day. None of the participants in the three groups practiced a paid or unpaid professional or rehabilitative activity inside the prison. Concerning the rehabilitation programs that are supposed to be proposed and provided by the prison administration, many testimonies confirmed that these programs are "privileges" that are not granted to all prisoners, but are subject to the level of relations, nepotism, and closeness to the prison administration.

"You don't receive anything in prison for free. Rehabilitation is provided based on relationships and bribery. I didn't want to learn carpentry or blacksmithing. I didn't practice them during my freedom, why start during my imprisonment with no return." (Haykal, Al Kabaria)

"You have to pay a bribe in order to go through rehabilitation or to be the son of such-and-such" (Nasim, Al Kabaria)

"I learned carpentry in the reformatory. In prison, rehabilitation is not for everyone, it is for privileged and connected ones." (Abdel Wahed, North Tataouine)

These programs that the prisoner is supposed to enjoy include: eradicating illiteracy, completing the educational path and acquiring professional skills, as stipulated in Chapter 37 of the Prisons Law (section "On Social Welfare"). Their objectives are to:

1. Rehabilitate and take care of him during his stay in prison.
2. Modify his deviant behavior.
3. Refine his intellectual and physical energies by preparing him for a free life, training him professionally, helping him to learn and improve his behavior.
4. Follow up on his condition upon his release and facilitate his integration into his original surroundings, in coordination with the concerned competent structures.

However, in Chapter 39, we find a casual phrase: "within the limits of the available capabilities" that undermines almost everything that preceded it, as we find neither an explanation nor a determination of these capabilities, which makes the rehabilitation programs hostage mainly to the will and discretion of the prison administration.

Only four participants read books and used pens and notebooks during the prison period. Three of them are in the Kabaria group and all of them have a baccalaureate level of education. A former prisoner from the Tataouine group used the years of imprisonment to read the legal texts and seek to know and understand his rights.

In the four cases, the participants were the ones who demanded the books, pamphlets, notebooks and pens that their families provided for them, not the prison administration. Sometimes the administration only allowed the entry of these materials after long delays. In short, some prisoners spend months and sometimes years of their youth eating, sleeping and moving in a narrow space without any development of their cognitive, physical and professional abilities, only to return to unemployment after a period of inactivity.

There remains the spiritual activity represented in prayer and supplication. Most of the participants said that they prayed for a short or long period of time during the prison period and did not do so before entering prison. Most of them stopped after leaving. Some of them indicated that praying inside prisons may expose you to problems and make you the subject of surveillance due to security concerns related to religious extremism and violent groups.

Logic, and even the law, assume that prison should have a reforming role that qualifies the prisoner to turn the page on the past and to follow the paths that keep him away from the prison gates and the behaviors leading to them. However, in addition to the weak and selective educational and vocational rehabilitation programs during the prison sentence, the mechanisms and programs for reintegration into social and professional life after imprisonment seem almost non-existent.

Even the "reintegration offices and post-imprisonment assistance" established by virtue of Resolution No. 13 of January 22, 2018, aimed at rehabilitating prisoners and accompanying them during the first period of time after their release, does not seem to have a significant impact[20]. None of the focus group participants told us about any kind of escort or follow-up, although some of them were released from prison after the establishment of these offices. Perhaps this was because the experiment was still in its infancy. Thus, most prisoners return to square one with no real possibilities for change, burdened with the effects of the debilitating prison experience for the body and mind.

G. Psychological suffering

It is no secret to anyone the extent of distress that a person who is deprived of freedom and restricted in movement for a long time may feel with a lack of hygiene, entertainment, and acceptable and healthy food. Added to all these matters are feelings that rage inside the prisoner in relation to those who share the place with him or those whom he has left outside. About half of the residents in Tunisian prisons are detainees[21] awaiting trial and the fate of their court cases. This waiting period may last for months and years. Time passes heavy on the prisoner waiting for his fate between hope, fear and despair. The pronouncement of the verdict, even if it includes a prison sentence, represents a kind of relief. Several participants in the three focus groups expressed the difficulty of this waiting period, its mood swings and the effect on their appetite and relationships with others.

We also noticed a common feeling of guilt among most of the participants towards their families, especially mothers. In many cases, the imprisonment of a family member leads to the deterioration of her financial situation and the loss of her main or secondary breadwinner. Also, it costs her the expenses of lawyers, and then the transportation expenses for the visit and the packages. This may constitute a heavy burden. The phrase "we come back sick after the visit" or "we feel bad after the visit" was repeated among the participants, despite it being an opportunity to meet the family and get things that would make life in prison a little easier. The prisoner feels that he is causing trouble and hardship for his family. The few minutes of the visit ignite feelings of longing and deprivation. There is also a feeling of oppression, especially among those who consider themselves unjustly imprisoned or receiving harsh sentences that are not commensurate with the acts attributed to them. This oppression increases with the feeling of being humiliated by the official and semi-official representatives of the prison establishment, such as the chiefs of the rooms.

There are also married prisoners who left wives outside the prison; some of them pregnant, and children who grow up in their absence, sometimes without support, which also causes a feeling of guilt and helplessness. Perhaps the worst thing a prisoner is exposed to is knowing that a member of his family has a serious illness, or when one of his parents, or both, or a brother or sister, dies, and the matter becomes torment when he is not granted permission to attend the funeral.

20 *The guide book for the legal framework related to prisons in Tunisia, issued by the Ministry of Justice and the National Authority for the Prevention of Torture, Tunis, June 2021.*
http://www.inpt.tn/uploads/media/MANUEL_DROIT_PENITENTIIRE_TUNISIEN_ARABE.pdf

21 *"A human rights organization: Tunisia's prisons suffer from overcrowding and lack the most basic living conditions," cnn in Arabic, published on May 8, 2016.*
https://arabic.cnn.com/world/2016/05/08/tunisia-prisons-overcrowding

One of the participants assured us that during the first period of his imprisonment, he did not smoke and did not consume drugs and was keen to exercise on a daily basis, but when his father died and he was prevented from attending the funeral his attitude changed and he started smoking and consuming drugs and getting into trouble with guards and other prisoners. Another prisoner confirmed that he had attempted suicide when the prison administration refused to allow him to leave and attend his father's funeral. This loss increases the prisoner's vulnerability and deepens his loneliness and helplessness. We took note of four cases of prisoners who lost a loved one during the prison period.

2. The Right to Health: The Most Significant Absence

Right to Health

- "Health is a right for every human being. The state guarantees disease prevention and health care for every citizen, and provides the necessary capabilities to ensure safety and quality of health services. The state guarantees free treatment for those without support and people with limited income. It guarantees the right to social coverage in accordance with what is regulated by law." (Constitution of the Republic of Tunisia 2014, Chapter 38.)
- Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction as to race, religion, political belief, economic or social condition." (From the preamble to the WHO Constitution)

Nelson Mandela / United Nations Minimum Standard Rules for the Treatment of Prisoners

Rule 25:

1. In every prison there shall be a health care service department charged with the assessment, promotion, protection and improvement of the physical and mental health of prisoners, with particular attention to prisoners who have special health care needs or who have health problems which impede their rehabilitation.
2. The Department of Health Care Services consists of a multidisciplinary team that includes a sufficient number of qualified individuals who work with complete clinical independence, and includes sufficient experience in psychology and psychiatry. Every prisoner must have access to the services of a qualified dentist.

Rule 27

1. All prisons shall guarantee immediate access to medical care in urgent cases. As for prisoners whose conditions require specialized care or surgery, they shall be transferred to specialized institutions or to civilian hospitals. When a prison has its own medical service department, including hospital facilities, it must be adequately staffed and equipped to provide adequate treatment and care to the prisoners referred to it.
2. Only responsible health care professionals may make clinical decisions, and non-medical prison staff may not override or ignore such decisions.

Rule 30

A doctor or other qualified healthcare professional, regardless of whether or not they are affiliated with the doctor, shall interview, speak with and examine each prisoner as soon as possible after entering prison, and as demanded thereafter. Particular attention is paid to:

A. Identifying health care needs and taking all necessary measures to provide treatment;
B. Identifying any ill-treatment that the incoming prisoners may have been subjected to prior to their admission to prison;
C. Checking any signs of psychological or other distress caused by the incarceration, including, but not limited to, risks of suicide or self-harm and withdrawal symptoms from drugs, medication or alcohol. Taking all appropriate individual or remedial necessary measures.
D. If prisoners are suspected of having contagious diseases, arranging for clinical isolation and appropriate treatment of such prisoners during the period of infection.
E. Determination of prisoners' fitness to work, exercise and participate in other activities, as needed.

Rule 31

The physician and, as appropriate, other qualified health care professionals, shall have daily access to all sick prisoners, all prisoners with physical or mental health problems or injury, and any prisoner to whom their particular attention is drawn. All medical examinations are conducted in the strictest confidence.

Rule 32

The relationship between a doctor or other health care professional and prisoners shall be governed by the same ethical and professional principles that apply to patients in society, especially the following:

A. The duty to protect the physical and mental health of prisoners and to prevent and treat disease on medical and clinical grounds only.
B. Respect for prisoners' autonomy with regard to their health and informed consent regarding the doctor-patient relationship.
C. Respect for the confidentiality of medical information, unless this leads to a real and imminent risk of harm to the patient or others;
D. The absolute prohibition of participation, whether active or passive, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experiments that may harm a prisoner's health, such as the removal of cells or tissues from the body of prisoners or removal of their organs.

Rule 34

If health care professionals discover, during the examination of a prisoner upon entering prison or during the provision of medical care to him later, the presence of any signs of torture and other cruel, inhuman or degrading treatment or punishment, they must document these cases and report them to the competent medical, administrative or judicial authority. Correct procedural safeguards shall be applied in order not to expose the prisoner or persons associated with him to a foreseeable risk of harm.

From the Nelson Mandela Rules - the United Nations Minimum Standard Rules for the Treatment of Prisoners.

Health care is one of the main concerns for Tunisians, especially with the deterioration and lack of services in public institutions and the high cost of private sector services. The issue of health becomes more urgent and dangerous when it comes to the prison environment, where the prisoner who is deprived of his freedom cannot move and take care of his health care and choose the appropriate structure or service provider for his condition. The conditions of Tunisian prisons, which are evidenced through the answers and testimonies of the participants

of this study, only show that matters are worse than anticipated. Moreover, the data gathered here shows the importance of the health issue, especially with the fragility of the prisoner's situation.

This area does not receive enough research and discussion in academic studies, health investigations, and sometimes human rights reports, so we chose to make this issue central during our work with the three focus groups. During our discussion with the participants, we were concerned with both physical and mental health, and we focused on the following elements: access to a doctor, the doctor's independence and professionalism, periodic examinations and follow-up, the equivalence of health services with what is available to the rest of society outside prison, and access to medication. In the following section, we review the most prominent results, with more space for the participants in the three focus groups to talk and represent the issue of health in prison.

To begin with, it should be noted that all participants confirmed that they were not suffering from chronic diseases or physical disabilities at the time of their entry into prison, and none of them had ever received care or treatment from a psychiatrist. Regarding their consumption of alcohol and drugs before entering prison, it was found that 52.6% of the participants suffered from excessive consumption, sometimes reaching the point of addiction to alcohol, followed by "zatla" and then narcotic pills. None of them had ever received treatment for addiction.

The testimonies of the majority of participants indicate that they met the prison doctor only once or very few times, mainly during the routine examination that the prisoner is given when he is admitted to the prison. Even this examination is, according to participants in the focus groups, merely a set of questions about the health status and medical history of the prisoner rather than a thorough and in-depth examination. We also noted that most participants did not know the role or function of the person who examined them in prison: is he a doctor or a paramedic, who works consistently in the institution or comes as part of an inspection by the supervisory authority or organizations, and what is his specialty?

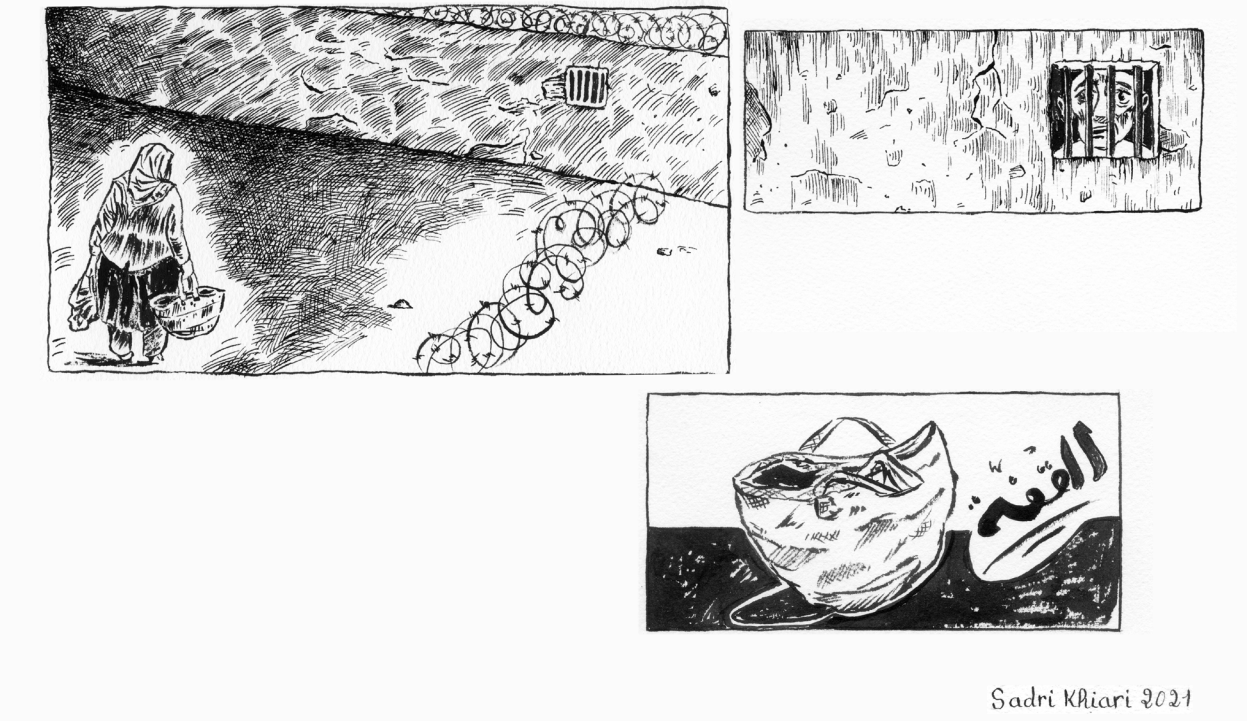
Reaching a doctor is not an easy matter in prison, as it usually passes through informing the "Kibran" the room overseer, who in turn informs the prison officers, who decide whether to take the prisoner to the doctor or not. A prisoner who suffers severe pain and shouts loudly, or who insists on being referred to the prison doctor or to be transferred to a civilian health institution, may be subjected to verbal insults and humiliation and even, according to some testimonies, to severe beatings.

"Once a prisoner who was with us in the section had his leg injured and it festered. They gave him Adol pills. They told him to grind them and place them over the wound. The pain increased so he was crying at night. The guards came and told him that they would take him to the hospital. After less than 15 minutes they returned him to the section. His back was blue from hard beating." (Muhammad Ali, Kasserine)

Participants in the Al-Kabaria group in particular confirmed that many prisoners avoid asking to be transferred to the hospital because prison officials deliberately treat them with humiliation and cruelty when doing so, with the aim of discouraging them from requesting again, in addition to the poor and degrading transportation conditions between the prison and the hospital. One of the prisoners entered prison with a stitched wound, and later had to pull out the sutures on his own using a nail clipper, preferring not to go to the hospital.

"When they take you to the hospital, they don't stop beating and harassing you from the minute they take you until they bring you back." (Heikal, Al Kabaria).

This constitutes a violation to the principle of enjoying health services equivalent to those available to those outside prison. Of course, the health services that are available outside the prison are not necessarily ideal.



The participants in the focus group in North Tataouine live in the least fortunate governorate in terms of the availability of public, and even private, health services. This is clearly shown in the participatory study supervised by International Alert under the title "A Community Evaluation of Services Public Health in the governorate of Tataouine: Diagnostics and Alternatives"[22], which provided important figures and assessment of the existing health structures and the quality and accessibility of the services offered. The situation in the northern Kasserine focus group is not much better. The participants live in a state where the average distance traveled to a regional hospital is 50 km and to a university hospital is 257 km. Also, most of the participants in this focus group spent their sentence in Al-Sars prison in the governorate of Kef, where the average distance traveled to reach a regional hospital is 44 km and to a university hospital is 206 km[23].Things are relatively better for the Kabaria focus group, as most of them spent their prison time in institutions located in the greater Tunis region and to a lesser extent Zaghouan or Mahdia, areas with easier and faster access to regional and university hospitals. Health inequity between the regions in Tunisia does not exclude prisons.

The three focus groups pointed to the diversity of injuries and diseases that the participants had during their prison sentence: scabies, hemorrhoids, severe colic, headaches, cuts and fractures as a result of accidents or violence imposed by prison staff or by infections. In most cases, the person in charge of the prison health only provides the scabies medicine "Ascapiol" or "Adol" tablets (Paracetamol) or "Aspegic" powder[24]. Sometimes the medication is not provided to the prisoners, so the family intervenes by putting pressure on the prison administration, or the sick prisoner resorts to the prison "black market" and buys "Adol" tablets and others (even those that are considered drugs) from other prisoners who provide them to those who can afford "their price." In other words, if the health unit provides medicines, they will be the cheapest and in insufficient quantities or provide the minimum to avoid widespread infection. A former prisoner from the Al-Kabaria group talked about breaking one of his fingers due to the violence of one of the guards, and how he did not receive any treatment, which meant he continues to suffer

22 *"A community assessment of public health services in the governorate of Tataouine: Diagnosis and alternatives", a joint study between the International Alert organization in Tunisia, the regional network of associations in Tataouine, the Shams Foundation for the Administration of Health Systems and the Tunisian Association for the Defense of the Public Health Service and the Rights of its Users, 2018.*

23 *Carte sanitaire de la Tunisie 2015 , ministère de la santé. http://www.santetunisie.rns.tn/images/docs/anis/stat/cartesanitaire2015.pdf*

24 *ASCABIOL/ ADOL/ ASPEGIC*

pain to this day. Another former prisoner from the northern Kasserine group spoke with irony and pain about the treatment he received when he suffered from tooth decay.

"Once I had a terrible toothache, so I visited the doctor. He told me: 'we don't have the medicine right now. I will bring it to you in a little while' He went out but did not return" (Adel)

In the same group we hear other testimonies about the extent to which the pain of prisoners is not taken seriously:

"When I met the prison doctor, he told me it's okay, read a little Quran and soon God will help you" (Karim)

"I had a severe pain in my stomach, the doctor gave me Adol" (Saeed)

"My hand was injured once, so I went to the doctor, he gave me Adol. I treated myself and it was okay" (Rabeh)

The doctor gives a few pills of the same medicine to every prisoner who visits him as if it is a magic cure. According to what many of the participants in the focus groups told us, only patients who have medical prescriptions and a previous medical history before imprisonment receive medication regularly, as if the prison health authority ruled out the possibility of a prisoner developing a chronic or serious disease during his imprisonment.

During the discussion with the participants, we noticed a lot of complaints about the lack of impartiality and professionalism of the prison doctors and lack of respect for the ethics of their profession, which raises doubts about their competence. In addition to the lack of adequate examination of the sick prisoner and prescribing medications that are not commensurate with the nature of the disease or the severity of the pain, as well as poor follow-up, there is a feeling among many prisoners that the doctors show a lack of respect for their health and their lives. In fact, some respondents accused doctors of not only refusing to treat them, but also mocking them, and even showing schadenfreude and working in collusion with the prison administration.

"Sometimes the doctor will not give you medicine and he will tell you: You are healthier than me." (Saeed, Kasserine North)

"Once I went to the doctor sick, he told me that it was my punishment as I chose to be in prison." (Yassin, Kasserine North)

"He started asking me: are you taking any medicine/drugs in prison? Who is providing the drugs? He was interrogating me in order to incriminate me." (Bachir, North Tataouine)

Things are not better with regards to mental health, they are even worse: only 15% of the participants met a psychologist during their stay in prison, although they shared the length of time spent in prison and the multiple prison experiences. According to their testimonies, the prison administration does not take the initiative to refer prisoners to the psychologist, but rather referral happens at the request of another party. One of these prisoners was referred to the psychologist after the insistence of his family, who noticed his deteriorating psychological condition during the visits, and the effects of his solitary confinement.

"A neurologist came to check me up because of the trouble I caused in prison. She gave me one pill of "Artan" and two pills of "Temista". My family are the ones who spoke to the administration in order for me to see a doctor. Every time they visited me they found me stressed and frequently admitted to solitary confinement." (Muhammad Ali, Al Kabaria)

Another participant was checked by a psychiatrist shortly after an inspection visit (he was unable to identify the party that inspected), during which some prisoners were listened to and their concerns were identified:

"The administration referred me to a psychiatrist. We had an inspection visit from Tunis. They talked to us. After a while the doctor came. I talked to him for half an hour. I didn't like his questions, they felt trivial. I asked him if that was it. He started asking me if I am taking drugs in prison or not. I told him, there are no medical drugs in prison. He did not give me any medicine, and he did not come back again" (Bachir, North Tataouine)

In one case only, a psychiatrist met with a prisoner upon his request:

"In Sfax prison, I wanted to take nerve medication. I met the doctor. I told him that I lacked medicine. He said: You are lacking in nerves. Go find a job to live off of it." (Abdel Wahed, North Tataouine)

Participants who lost close relatives during imprisonment did not receive any psychological care, or even special treatment, without any consideration for the pain and deterioration of the psychological state that the loss might cause, especially since the prisoner was not able to accompany the deceased relative in the last days of his life.

In general, most of the respondents do not trust the medical and paramedical staff working in prisons. Rather, they consider them as part of the prison institution, just like the guards, the rest of the officers and the administration. Two important things must be taken into account when evaluating health services in prisons. Firstly, the legal and administrative status of the medical and paramedical framework in the prison institution must be considered. The Ministry of Health does not supervise health workers in prisons, but rather they follow the administration supervising the detention center (temporary suspension or imprisonment). Namely, the Ministry of Interior or the Ministry of justice. On the one hand, this puts the independence of the medical and paramedical framework at stake, and on the other hand it creates a health care system parallel to the system available to all other citizens. The report of the Office of the High Commissioner for Human Rights in Tunisia, "Tunisian prisons between international standards and reality," warned of the need to transfer supervision of health professionals in prisons from the Ministry of Justice to the Ministry of Health and to link health services in prison institutions to the public health care system. Despite the commitments of the Tunisian state, there does not seem to be much progress in this matter, at least according to the assessment of the National Authority for the Prevention of Torture.

Secondly, the working conditions available to doctors and nurses working in prisons must be considered. The followers of health affairs in Tunisia know the extent to which health workers complain about the deteriorating conditions in public health institutions, including university hospitals and specialized centers. Problems include shortages of human resources, equipment, medical equipment and medicines, overcrowding, and attacks on staff. All these conditions become more difficult when it comes to a health center in an overcrowded prison institution that does not have the minimum conditions necessary for medical diagnosis, treatment and follow-up of patients. This may partly explain what was said in the focus group participants' testimonies about the poor quality of health services and strained relations with health professionals.

The prisoners rely mainly on patience and the passage of time until the pain subsides and its source disappears. In other cases they try to obtain sedatives and narcotic tablets to ease the aches and make them forget their worries. We recall once again that most of the participants live in areas with little access to health care and are "usually accustomed" to the severe shortage and/or poor quality of health services. This raises the question of youth's perception of health institutions. It is a question that International Alert is constantly trying to answer. See, for example, the pilot project "Diagnosing health services for young people".[25]

25 *Youth-friendly healthcare services, International Alert Tunisia. https://www.international-alert.org/blogs/inclusion-through-health-how-were-involving-young-people-in-healthcare-services-in-tunisia/*

3. Worries of temporary freedom: Getting out of prison is not the end of pain

Numerous official statements and human rights organizations' statements in recent years confirm that the percentage of recidivism in Tunisia exceeds 40%[26], and this is supported by the data obtained during our meeting with the three focus groups: 63% of the focus groups participants were imprisoned more than once.

"I forgot how many times. Since my first imprisonment, I kept getting in and out." (Muhammad Ali, Kabaria)

After spending a few months or several years in prison, the person returns to the same environment and the same socio-economic conditions. After the joy of regaining freedom, he begins to discover the losses: the inability to resume schooling or vocational training, the death of family members or friends, the end of a romantic relationship, the deterioration of the family's living conditions, difficulty finding work, apprehension and suspicious looks, or a "tainted" criminal record. With the exception of two respondents, one of whom found work immediately after his release from prison and the other who had savings that he could spend, the rest of the focus group participants relied on their families to take care of their expenses during the first months following their release from prison. According to most testimonies, the mother remains the main official supporter. Two former prisoners who did not find sufficient family support resorted to other solutions: fraud and armed robbery.

Despite the harshness of the prison experience and the severity of some of the losses, the participants in the three focus groups did not receive any psychological care from a specialist after release, except for one participant who received follow-up from a psychiatrist from the private sector, at the insistence of his family after they noticed disturbances in behavior and speech after leaving prison. His family covered the cost of this care as his father was retired from the public office. The treatment did not last long as the participant considered it a waste of time and money. Another participant sarcastically says, "We have doctors in every place in the neighborhood" referring to drug dealers.

42% of the participants expressed their desire to receive psychological treatment, but they consider that this is not possible for two main reasons: a shortage (or complete absence) in the number of psychiatrists working in the area in which they live (in the public and private sectors) and their inability to secure the costs of psychiatric treatment. Geographical obstacles are mainly encountered by the participants in the North Tataouine and North Kasserine groups. As for the cost obstacles, they are present in the testimonies of the three groups without exception.

"I always think of going to a psychiatrist, but I can't afford it. Moreover, there are no psychiatrists in Tataouine, you must go to Djerba or Gabes" (Bachir, North Tataouine)

"If I knew where to find a psychiatrist, and I knew he would comfort me, I would go immediately" (Abdel Wahed, Tataouine)

"We don't have anything in Tataouine. It's like a big prison" (Sami, North Tataouine)

"I suffer from stress when I stop drinking. I tried to seek medical treatment, then I said it would be better for me to cure myself." (Haitham, North Kasserine)

"We in Tunisia don't have time to get depressed. If you collapse you will be smashed under the legs. If I could, I would go to a psychiatrist, every person needs psychological support" (Omar, Al Kabaria)

26 *President of the Tunisian League for Human Rights: 42% of prisoners return to prison after their release, Africa News Gateway, April 7, 2016. https://bit.ly/3ptmaws*

After a prison experience compounding their dire socio-economic conditions and stealing years of their lives, young people find themselves in a vicious cycle that sends most of them back to prison. During the periods they spend in the "civil", i.e. outside prison, the likelihood of them adopting risky behavior increases. Most of the participants confirmed that they are looking for a "migration thread", that is, an opportunity to cross the sea towards the Italian coast illegally. Although the number of those who thought about suicide or made a suicide attempt was limited (two cases), the percentage of participants who confirmed that they tried to harm their bodies (using a sharp object to create scars in the body, hitting the fist or the head on a hard surface) is high (31,5%). Also, 36% of the participants in the three groups confirmed that they became more nervous and moody after their release from prison. As for the pattern of consumption of alcohol and drugs after release from prison, we observed two contradictory trends in the testimonies: either a noticeable increase in consumption (especially alcohol and narcotic pills), or an almost complete cessation. The latter option was out of a desire for a changed and a different lifestyle, out of fear of problems and legal consequences, or by virtue of marriage and the formation of a family (priority for the expenses of the house and children, the "disgrace" and the feeling of shame being motivating factors).

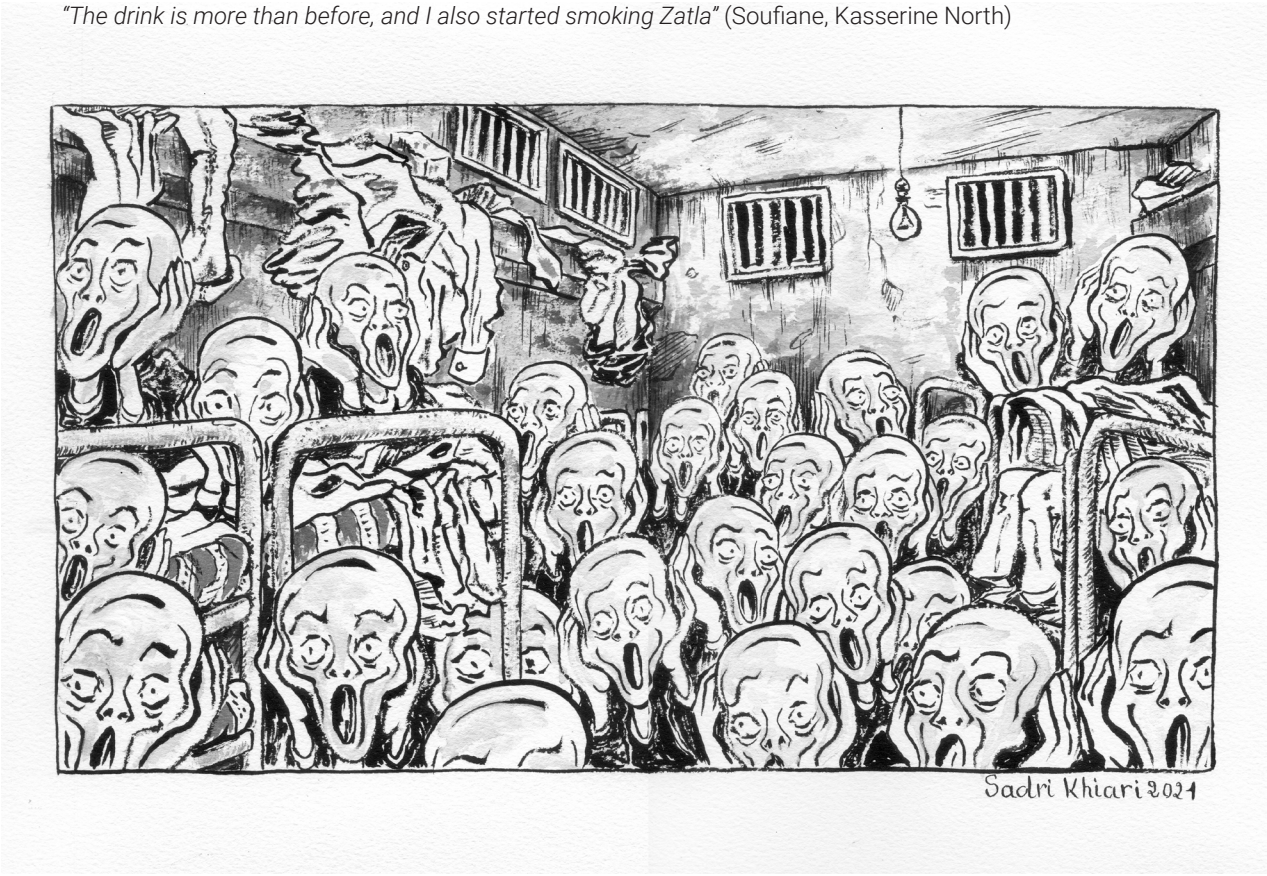
"Consumption is as usual. If we have money we use it to consume. You can't live in this country without being high" (Sami, North Tataouine)

"In the first days I used to consume more, and after that I decreased and got my life more organized. Even the availability of money controls you" (Bachir, Tataouine North)

"I smoke (Zatla) three times more than before. The situation of the country and the ruler force you to always smoke" (Heikal, Al Kabaria)

"I consume more drug and drink, I don't want to wake up" (Nasim, Al Kabaria)

"The drink is more than before, and I also started smoking Zatla" (Soufiane, Kasserine North)



4. "Collective Punishment": The family also suffers...

Almost none of the participants' testimonies are without mention of the suffering of their families since their arrest. Psychological suffering due to fear for their young sons and the violence, abuse, shortage and deprivation that they may be exposed to, as well as fear of the sentence and the loss of their future. Of course, there is great material suffering, especially since the socio-economic conditions of most of the participants' families are very bad. Most families, despite their poverty, try to hire a lawyer for their children, especially when it comes to serious charges that may lead to heavy sentences. As soon as the son is imprisoned, a new phase of material and physical burdens begins. Most of the respondents, in light of the deteriorating living conditions in prisons, as we explained earlier, depend on their families to provide food, clothing, blankets, and even cigarettes and personal hygiene items. Not only does it take time, effort and money to prepare the package (mainly food and clothes), but there are also the costs and difficulties of traveling to the prison on the day of the visit.

Many of the participants recount the hardship that their families go through to visit them, especially when the prison is in another governorate: getting up very early and traveling to the bus or train station or the minibus to get to the governorate in which the son is serving his prison term and then using a taxi or bus to get to the prison itself. The suffering does not end with reaching the prison gate, but rather they must wait for their turn for a long time and be patient with ill-treatment by the prison's agents and are sometimes subject to inspection and humiliating practices. A visit that lasts a few minutes often requires many hours of preparation, transportation, waiting and a loss of dignity, not to mention the financial cost for the apparently poor families. The state is not only depriving the son of his freedom, but it also punishes whole families, who are forced to provide everything that the state has failed to provide. This caused guilt among several participants, which made them ask their families to reduce visits and be satisfied with sending money transfers. Several families of prisoners agreed to take turns delivering the package to their children.

"When I see my mother coming to visit me, I get tired and get sick. She rides the minibus to visit me alone without my brothers. She gets up early in the morning to brings me the package instead of me helping her" (Abd al-Wahed, North Tataouine)

"I used to worry a lot about my mother. She used to get up at dawn to prepare the package and take a taxi to go down to the Basaj Garden in order to take the 23rd bus that takes her to Mornaguia. The guards treated her in a shameful way which is degrading. They used insulting words" (Heikal, Al Kabaria)

"My mother is an old and sick woman who used to visit me every week and bring the package. I asked her to come once every two weeks" (Nasim, Al Kabaria)

"I was worried about my old one. The way she used to endure the trouble and humiliation to come visit me and bring me the package. I got sick and had difficulty sleeping" (Muhammad Ali, Kasserine North)

"I was thinking about my father and mother. In addition to being imprisoned I had to trouble them with my needs" (Ramzi, Kasserine North)

The story does not end on the day the son is released from prison as he will either return to the unemployment he was living in before his imprisonment, or he will lose his job and be cut off from his education or vocational training. This means that there is a need to support him and take care of his expenses for a period that may be long or short. Furthermore, it is necessary to point out that (this is what almost all the testimonies of the participants say) the family is almost reduced to one person, which is the mother. This does not mean that the fathers - and

to a lesser extent, the brothers and sisters - are completely absent, but the image of the mother is overwhelming, as she is the one who is most keen to support the prisoner and visit him and ask about prison conditions and consult the lawyer and prison administration. Even when she does not have an income, she manages her affairs and borrows money from the extended family and neighbors in an effort to improve the son's living conditions in prison, and even provide pocket money after his release.

The testimonies about the role of the father are much fewer, and we do not find the same consensus in them as in the case of the mother. There are participants who were supported by their fathers in a full or partial way. Others did not receive any visit from the father because he was angry about his son's imprisonment. In some testimonies we find participants who said that they were afraid of facing their fathers on the day they left prison. In this regard, we noted that there are some differences in the representation of the family's role from one focus group to another. For example, in North Kasserine, through the testimonies of participants, we noticed that the role of the mother is much more important than the semi-absent father, and in most cases, she works and takes care of spending on the family by virtue of her employment in the agricultural sector, which has been feminized (for considerations related to the cost and flexibility of labor). On the other hand, in North Tataouine, where we find that the mothers of all participants are housewives, we notice a greater presence of the father's role, negative (fear of him) and positive (the breadwinner). In Al Kabaria, there is a more balance in the roles between father, mother and brothers, with a stronger presence of the mother.

5. Internal support networks in the face of the punitive machine

The immediate family (and sometimes the extended family) supports the prisoner from outside the prison walls, but he still needs additional support inside the prison, especially if it is his first time in prison, and more specifically in the first days and weeks of imprisonment. This internal support is provided by inmates from the same neighborhood and/or the region and/or the tribe to which the prisoner belongs. Sometimes friendships are formed quickly in prison. The first form of support is to negotiate with the "Kibran" (room overseer) and/or prison officials to provide a bed for the new prisoner and place him in a ward with previously acquainted prisoners. That is, providing comfort and a sense of familiarity. The second function of the internal support is guidance or education, to teach the new prisoner the rules and the routine of daily prison life: the daily program, the commendable and undesirable behaviors, the people to be avoided and wary of (slanderers, violent prisoners and guards, etc.), bartering goods and services and so forth.

The third form of support is to provide protection for the new prisoner, especially when he is young or belongs to a group that has rivalries with another group in prison. There is also the function of food support, as many prisoners do not receive a package or the money transfer from their families on a regular basis (and sometimes not at all), which makes them rely mainly on the "Komita" i.e. a group of prisoners who share what food their families send. In most of the participants' answers, we find an acknowledgment of this support, gratitude for it, and an acknowledgment of its role in alleviating the burden of imprisonment. The phrases "my neighbours", "my cousins" and "my relatives" are repeated several times in the various testimonies in the three focus groups. In only two cases, we found that the participant preferred to isolate or separate from the neighbours, cousins and relatives because they were problematic and they preferred to spend their sentence quietly without complications, or because of disputes and misunderstandings prior to entering prison.

6. Participants' perceptions of the punitive state

Through discussing the extent to which their circumstances and the socio-economic conditions of their families affected their entry to prison, most of the participants, especially in the northern Kasserine group, agreed that there is a close connection between the two. Some of the answers clarified that the family's circumstances are not always the cause and talked more about the social environment (the neighborhood) and the effect of the bad social circle and of course we can follow here that the "choice" of housing in a certain neighborhood is often linked to the financial circumstances of the family. Participants also told us about the impact of dropping out of school "voluntarily" or after being expelled as a disciplinary measure. In a few cases, participants considered that there was no link between their circumstances and entering prison, but rather that it was the consequence of adolescence and recklessness.

"Circumstances are naturally impactful. When I was young, we lived for 11 years in Monastir. I wish we stayed there. Our lives would have been better. Kasserine was destroying and marginalizing. When your father has six children and earns only 250 dinars, you have to decide who goes to school and who doesn't. The children leave school early, and they wander the streets. They revert to smoke and cola, look what would emptiness lead to" (Haitham, Kasserine North)

There is a greater consensus regarding the impact of the family's financial conditions and its relations in mitigating judicial rulings (the appointment of a well-known lawyer, bribery, interference by influential relatives) or improving the living conditions of the imprisoned son. Most of the respondents consider that Tunisians are not equal before the judiciary system and that the poor are less fortunate in securing fair trial.

"If I had a good lawyer or a lot of money, I would have left the detention center to go home. I wouldn't stand before the judge. Have you ever seen a billionaire imprisoned?" (Muhammad Ali, Al Kabaria)

"In my case, if there were no relatives: my cousin, I would have not gotten out. I don't have any money" (Sami, North Tataouine)

"Connections are the most important thing. Money can get you connections. The lawyer does not have much influence" (Abdel Wahed, North Tataouine)

This is a sample of the opinions that shows the view of the participants on the course of justice in Tunisia. In general, there is a consensus among the participants that the state does not provide jobs, services, facilities, or care necessary to protect young people from delinquency, and that it leaves them to their fate, and then holds them accountable and punished.

Regarding their evaluation of the sentences issued against them, 52% of participants considered them to be completely unjust (fabricated cases, confessions under torture, the judge did not delve into the investigation), and 68% considered them cruel and not commensurate with the acts committed. Some participants expressed their acceptance of the sentences and that they erred and deserved punishment. In a few cases, the participants considered the sentence more merciful than they expected, such as a suspended prison sentence.

We observed in general that awareness of rights, understanding of litigation procedures, and criticism of the prison and security system is much stronger among the participants in the Kabaria focus group than in the northern Tataouine and northern Kasserine groups. Perhaps the difference in educational level, proximity to the center, and frequent contact with the security and prison institutions play a role in this disparity.

The majority of the participants' testimonies regarding the conditions in prisons after establishing prison officials unions were negative, stating that the conditions were the same if they had not deteriorated further, and that the security forces and prison officials became more powerful and protected. There are other testimonies confirming that there has been a slight improvement, especially with regard to the treatment of prisoners by prison staff. This slight improvement can be justified by the pressure exerted by civil society organizations that allowed them to visit prisons after the 2011 revolution, as well as the reports and decisions of the constitutional bodies concerning human rights.

With regard to the increase or decrease in the number of arrests in their family and social environment in recent years, impressions and opinions differed from one focus group to another. In Kabaria and North Tataouine, most of the participants confirmed that the number of their acquaintances who have been arrested or imprisoned in recent years has become less (much less as some of the answers confirmed) and attributed this to "harga" (irregular immigration) mainly and to the indulgence of young people in drug consumption, which keeps them "calm" and absent. Some of them also talked about reducing the sentences in "Zatla" cases. We cannot be certain here if there is an important role for the epidemiological situation in this decrease. On the contrary, most of the participants in the northern Kasserine group confirmed that the number of arrests and prisoners in their areas has increased.

Conclusion

We do not claim that a sample of 19 individuals may give us a complete and detailed picture or conclusive results and statistics, but the testimonies and answers of the participants in the focus groups coincide and intersect in a way that makes it difficult to talk about individual cases or coincidences. The first conclusions drawn from the qualitative study, which must be revealed, even if it seems evident, relates to the close relationship between school dropouts, poverty and unemployment on the one hand, and risky behaviors on the other hand. Of course, we are not talking here about inevitability or "hereditary genes" but rather about socio-economic factors. It is not only that socio-economic factors do not protect the young men from risky behaviors and exposure to punitive and security hardships, but also deprive young people in many cases of the conditions of a fair trial: violence and even torture of the detainee in order to extract "confessions" under duress, the inability of the prisoner or his family to pay for the expenses of a lawyer, his lack of knowledge of his rights as a detainee or prisoner and so on.

The second conclusion; and here we are not revealing a secret, concerns the "philosophy" of the prison and reform institution in Tunisia, which seems to not give much weight to the second half of its term "reform" and focuses on the punitive aspect. This aspect is multifaceted, as the prison institution is not satisfied with depriving its inmates of their freedom, but rather it works to deprive them of dignity and humiliate them in various ways with the aim of subjugating them: lack of respect for privacy, resorting to verbal and physical violence frequently and semi-systematically, failure to provide conditions for hygiene, comfort, healthy and acceptable nutrition, and so on. Perhaps the prison authorities, through this ill and inhuman treatment, seek to instill a certain image of prison in society for deterrent purposes, and we cannot ignore the consequences of the state's authoritarian legacy, the failure of the paths to reform the security and prison institutions, the weak training of prison officials, and the lack of capabilities they posses to carry out their work under reasonable conditions.

Whatever the reasons and motives, it does not seem that humiliating punitive practices are effective, as the percentage of returnees to prison is very large. What is actually happening is more vulnerability, resentment and risky behaviour. Prison in general does not address the roots of the problem, whether it is related to the difficult

and dire socio-economic conditions or psychological and nervous disorders. Rather, conditions similar to those in Tunisian prisons may greatly exacerbate matters.

Third conclusion: The issue of health care for imprisoned youth and prisoners in general is almost completely absent, especially when it comes to mental health. There is a terrible failure by prisons to guarantee the right to health of inmates to the extent that it turns into a "favor" from the administration and the prisoner may be subjected to penalties and ill-treatment that deter him from requesting health care again. This negligence, in addition to the many problems and dangers that the young prisoner is exposed to, makes him gradually view the issue of health as a luxury or as a secondary matter compared to the quality of food, bedding and clothing, frequency of visits and activities outside the cell. All of the above does not mean that health care becomes much better after release. The restoration of freedom does not mean the absence of old restrictions such as difficult social conditions, addiction risks, and the difficulty of obtaining quality public health services in the immediate vicinity. New challenges may be added to them as a result of physical illnesses and psychological problems that may be caused by the prison experience. Contrary to what might be expected, a large number of participants are receptive to the idea of psychotherapy and addiction treatment.

Fourth conclusion: The harm of imprisonment does not end with the end of the confinement, but rather continues thereafter, whether through security and societal stigma (card number 3 and society's labeling that reduce second chances and the possibilities of starting a new page), or psychological impact, or security harassment. A simple mistake, which may sometimes be an expression of a psychological or nervous disorder, can lead a young man into a cycle of repeated arrests and prison sentences. Here we quote the words of one of the participants in the focus group organized in the Kabaria region:

"If the first time I was arrested, I had been given a suspended prison sentence or they had given me a light sentence, I would not have gone back to prison again."

We hope that this study will contribute to shedding more light on the issue of youth health services in prison as well as outside its walls, with utmost importance given to mental health, especially for the age and social group that is more exposed than others to risky behaviors.

Anxiety as a mental health indicator in young people: Outcomes of a field study conducted in working-class districts and regions in the interior

Donia Remili

"I have no need to introduce anxiety itself to you. Every one of us has experienced that sensation, or, to speak more correctly, that affective state, at one time or another on our own account."
(Freud, 1949, p. 449)

This paper presents the data and outcomes of a study on anxiety as a mental health indicator in young people, specifically unemployed young people, comparing them with other groups of young people who live in the same environment – an environment marked by social, economic and regional inequalities.

The chapter will present the general outcomes of the study with regard to levels of anxiety (both as a *trait* and as a *state*). It will then discuss the relationship of anxiety to certain other variables – age, education, regional background – before looking more closely at how anxious unemployed young people are compared to young people from the same social environment who are not unemployed or who are workers. We will then discuss the results and their implications given the existing literature on Tunisia and worldwide. Before going into any of this, however, we will examine some of the basic scientific concepts that are used to define anxiety and set out the methodology.

1. Concepts

Anxiety

There are many definitions of anxiety, making it difficult for researchers to agree on a single understanding of its components and features. As Zeidner and Matthews put it, "no single theoretical perspective on anxiety can readily account for the complex and multifaceted nature of this construct" (Zeidner and Matthews, 2016, p. 20).

Experts in psychology all agree that it is hard to establish consensus on a single definition of anxiety given the diversity of its components and causes and the similarity of its symptoms to those of other affective reactions. But it is possible, by referring to various authoritative studies, to draw out a consensus definition based on the most important features of this psychological disorder.

Anxiety is an emotional state resulting from anticipation of an event or danger that constitutes an external threat to a person. This upsetting feeling – fear of this prospective danger – then generates hypervigilance: the individual tries to pre-empt the threat that they anticipate internally. Anxiety is tied to neurotic character, and therefore differs from person to person.

In order to differentiate between natural and pathological anxiety, we must rely on clinical assessment (i.e. using measures of anxiety) and diagnosis, by discussing with the individual, identifying certain aspects of the anxiety that they are experiencing, and checking for the following symptoms:

5. Thought and cognitive disorders (excessive awareness of danger)
6. Negative reactions (affect) – a reaction or mood state
7. Physical symptoms (elevated heart rate, sweaty palms)
8. Behavioural reactions (flight, fidgeting)

The individual's reaction to real situations that threaten them, their ability to cope effectively and to control them, will also determine whether they are suffering from natural or pathological anxiety. Anxiety is thus one of several affective states that become negative if they reach a pathological level. Anxiety is a "complex construct" both conceptually and in terms of how it is experienced and expressed (Zeidner and Matthews, 2016, p. 22).

Anxiety and fear

According to Jim Folk, an expert in the treatment of anxiety who has worked in the field for more than thirty years, "fear is the nucleus of anxiety". There are many types and sources of fear. It is possible to be afraid of the *possibility* of something bad happening or of some harm that might affect you in the future. This makes a person feel unsafe and ill at ease and may even make them feel that there is an imminent threat that may strike at any time. They will gradually become more and more afraid of the spectre of the unknown and of possible dangers to their life, work, studies, family, etc. They begin to think about the probability of these dangers occurring – even if the probability is based on a subjective and unobjective assessment (Folk, 2020).

Hanan al-Anani, in her book *Mental Health*, likewise emphasises the strong link between anxiety and fear – a link so strong it is difficult to distinguish between them. She points out several areas of similarity:

- In both fear and anxiety, individuals perceive a danger or threat to them.
- In both fear and anxiety, individuals experience an affective state that includes both stress and pressure.
- Both drive individuals to expend energy to protect themselves.
- Both are accompanied by various physical changes. (Anani, 2005, pp. 100-101.

Zeidner and Matthews note that "[b]ecause of the ambiguous nature of the anxiety-provoking stimulus, the person is uncertain how to act; because the nature and place of the threat are obscure, it is more difficult to cope with the ambiguous threat". They consider fear to be "an intense biologically adaptive physiological and behavioral response to the occurrence of a specific, identifiable stimulus," which drives an individual to react (fight, flight or freeze) (Zeidner and Matthews, 2016, p. 5).

Freud also distinguishes between fear and anxiety, saying that "*Angst* [anxiety] relates to the state and disregards the object, while '*Furcht*' [fear] draws attention precisely to the object" (Freud, 1949, p. 443).

Anxiety and unemployment in unemployed youths

The shocking levels of unemployment in Arab societies, including Tunisian society, cannot be ignored. Under sociopolitical and economic circumstances that are deteriorating and crisis-ridden at every level, the unemployment crisis is getting worse every day. The demographic changes that have reshaped the demographic pyramid in Tunisia – with young people (defined as those between 15 and 34 years of age) making up around 1/3 of the total population in 2014, according to the National Institute of Statistics – have likewise exacerbated the problem.

Only 47.7% of young Tunisians are economically active, with a further 27.9% in education or training. This leaves 24.4% of young people who are neither employed nor in education, referred to as "economically inactive". It is worth noting that 25.5% of "economically active" young people are unemployed: 32.5% of women and 21.4% of young men (Lamloum et Ben Zina, 2014).

There is a near-consensus in the psychological literature that unemployment is a path to suffering. The form that this suffering takes differs between unemployed people, but it is a physically and mentally exhausting experience for everyone. Marie-Carmen Plante notes that unemployed young people fall prey to all kinds of fears or to a "free-floating anxiety" with a range of physical symptoms: perspiration, elevated heart rate, pallor, insomnia, and a feeling of anxiety at most times. She adds that this is the product of a feeling of insecurity, whether financial or psychological, because of dependency on their family and a sense of being rejected by society. In order to maintain their outward appearance, unemployed people suppress their fear, stress and disturbance – causing their state of anxiety to intensify (Plante, 1984).

In a similar vein, but in a specifically Tunisian context, Donia Remili comments in her study on suicide among unemployed people that the unemployed have a range of different experiences depending on personal circumstances, surrounding environment, personality and how long they have been out of work. She concludes that young people deal with the crisis of unemployment in different ways. Despite feelings of anxiety, stress and depression, some are able to adapt, while others cannot. She attributes this to the fragility of their personalities and their lack of effective strategies and psychological defence mechanisms for dealing with psychological disturbances. Some of these people resort to suicide, believing that this is the only way to escape their endless suffering (Remili, 2016).

In this study, we will try to focus on this functionalist approach to anxiety by comparing unemployed and non-unemployed people (or working people) in order to determine the factors that differentiate these two groups.

"Natural" and "pathological" anxiety

The psychologist Charles Donald Spielberger has shown that high levels of anxiety expose individuals to a range of negative effects, which appear clearly in their performative and cognitive behaviour. Spielberger carried out a three-year longitudinal study on a group of university students who suffered from high levels of anxiety. By the end of the study, more than 20% of the students had failed academically to the point that they were expelled from the university.[27]

Other studies have shown that low-level anxiety poses no risk to individuals' health – indeed, some maintain that it is necessary, or at least desirable, characterising anxiety as an adaptive function that helps us confront problems

27 In 1966, Spielberger carried out a longitudinal study on a group of students to assess their anxiety levels and how much it influenced their cognitive performance, particularly in those students whose anxiety reached pathological levels.

and difficulties in life. A complete absence of anxiety would leave individuals careless or excessively optimistic, unable to pay sufficient attention to future dangers (Zeidner and Matthews, 2016, p. 191).

2. Methodology and research protocol

Our work initially focused on an analysis of how closely interconnected the two parts of Spielberger's State-Trait Anxiety Inventory (STAI) are in the young people studied. We adopted two basic hypotheses:

1. That there is a relationship between sociodemographic characteristics (age, sex, education, region) and levels of anxiety in young people.
2. That unemployed people are more vulnerable to anxiety compared with non-unemployed people.

We adopted a quantitative approach while collecting field data and a descriptive-analytical approach when presenting and studying it and testing our hypothesis. We looked at the link between level of anxiety and various variables (sex, age, region, education), in particular economic activity (i.e. the difference between unemployed people and other demographics or employed people) in order to arrive at a deeper and clearer understanding of the data collected. We have chosen Spielberger's STAI as a research tool. How the STAI works is discussed in more detail in the relevant section.

We have chosen a social psychology and psychology of work approach as the basis for our analysis of the research problematic.

Sample description

The sample in this study consists of 510 young people chosen from a broader group of 1,265 who made up the total sample of a quantitative study on "young people and mental health in working-class districts and interior regions", which looked at young people from El Kabaria, North Kasserine and North Tataouine. It was chosen with an eye to variables like sex, age, educational level and – in particular – economic activity.

The sample can be divided into two groups:

1. The first group consists of unemployed people.
2. The second group comprises three groups of people: employed, inactive, in education/training.

The first group included all the unemployed people in the original sample. The second group is a random selection representing one quarter of the non-unemployed people in the original sample. The selection was made without determining any specific criteria. It was done programmatically using statistical technology.

The age of the young people ranges from 18 years old to 29 years old. The sample consists of 262 men and 248 women distributed between the three regions: El Kabaria, North Kasserine and North Tataouine.

The study lasted 15 days. Researchers were first trained in how to use the STAI and then carried out interviews with the participants.

Sample distribution by social and demographic characteristics and economic activity

Of the total sample of 510 young people, participants with a primary and secondary education made up the majority (320). 113 participants held a university degree, while 67 had only a primary education. Only 9 were illiterate.

77 participants were aged 18-19, 206 were aged 20-24, and 227 were aged 25-29.

The sample was distributed regionally as follows: 141 participants were from the Delegation of El Kabaria (Tunis), 189 were from El Nour neighbourhood in the Delegation of North Kasserine, and 180 were from the Delegation of North Tataouine.

With regard to economic activity, unemployed people made up 44% of the sample (225 people), while the remainder were distributed as follows: 18% were employed (90 people), 22% were in education or training (115 people), and 16% were inactive (80 people).

Research tool: Using Spielberger's State-Trait Anxiety Inventory

We chose this particular metric – one of many available – after consulting the Ethics Committee and discussing it with a number of experts in child psychology.

The STAI was translated into Arabic (Tunisian dialect). It was then tested on members of the research team in order to make sure they could easily understand the questions. Some questions were then reviewed, changed or reworded as necessary.

The STAI was first developed by Charles Donald Spielberger, working alongside Gorsuch and Lushene, in 1964. It is one of the most important psychological metrics used exclusively to measure anxiety (rather than anxiety *and* depression, as is the case with other metrics). It was developed into a series of questionnaire forms, with Form Y1 being the most famous and the most widely used internationally. This is why we have chosen to use it in this study.

The STAI is widely used to assess levels of anxiety. It has been translated to a number of languages and applied to various samples in many different countries. Its distinguishing feature is that it can be used both with healthy people or people suffering from anxiety disorders to assess feelings of fear and apprehension, determine the intensity of anxiety symptoms and measure feelings of pressure and stress, diagnosing "current" and "long-term" stress (Langevin et al, 2012).

The test is made up of two parts, each comprising 20 questions.

The first part measures "state" anxiety. To put it more straightforwardly, it expresses how individuals feel *consciously* under specific circumstances. This "state" consists of a range of subjective feelings: stress, apprehensiveness, fear, pressure. As a temporary and variable affective state, it is influenced by temporal context – by the time at which the questions are being answered. The 20 questions in this part of the test ask respondents to choose between four possibilities, each expressing how they feel at the time.

The second part measures "trait" anxiety – that is, the anxiety that is part of the individual's personality, their predisposition to feel continuous anxiety and their long-term response to external stimuli and threats. It is closely linked to neurotic personality. This type of anxiety may be conscious or subconscious. The 20 questions in this

part of the test ask respondents to choose between four possibilities, each expressing how frequently they feel a particular way in general terms: "always", "often", "sometimes", "never".

How STAI scores are calculated

- **Four points are given for each response: 1 point for "never", 2 points for "sometimes", 3 points for "often", 4 points for "always".**
- **The respondent's score on each part of the test will then range from 20 to 80.**
- **The higher the score, the higher the level of anxiety.**
- **The degree of anxiety is determined by Spielberger according to the following categorisation:**
  - Less than 35 = very low anxiety
  - Between 36 and 40 = low anxiety
  - Between 46 and 55 = medium anxiety
  - Between 56 and 65 = high anxiety
  - More than 65 = very high anxiety
- **The range 39-40 is generally considered the threshold between "natural" and "pathological" anxiety.**

The high significance of this test, especially from a psychometry perspective, has been shown by experts (Langevin et al, 2012). It is also particularly useful because the questions that it asks are simple and can easily be understood and answered by respondents. It takes very little time to complete, generally only five-ten minutes per part, and does not require any sophisticated equipment (only pen and paper).

3. Major findings

General level of "state anxiety" and "trait anxiety" within the sample group

It is very important to distinguish from the beginning between levels of anxiety as a "state", i.e. temporary feelings, and anxiety as a "trait", i.e. as lasting feelings that form part of an individual's personality.

General levels of anxiety

As shown in Table 1, the average state anxiety score was 47.65, while the average trait anxiety score was 49.87. This represents a "medium" level of anxiety, both state and trait, according to the Spielberger classification.

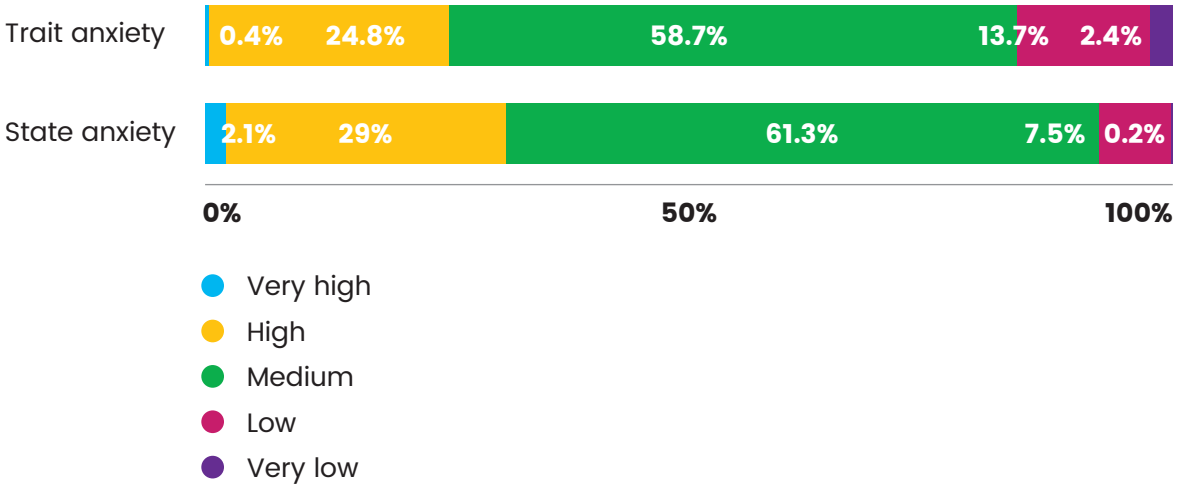
Table 1: General levels of state and trait anxiety

	No. of respondents	Average	Standard deviation
State anxiety	510	**47.65**	5.807
Trait anxiety	510	**49.87**	6.441

- **Sample distribution by degrees of anxiety**

The concentration of median state and trait anxiety is expressed by the majority of the sample falling into the "medium anxiety" category, whether in terms of state anxiety (61.3% of the sample) or trait anxiety (58.7% of the sample). The greater average trait anxiety compared to state anxiety is linked to the difference in the number of respondents who scored "high" or "very high": the total number of respondents falling into these two categories in the case of trait anxiety is more than double the total in the case of state anxiety (16.1% rather than 7.7%), as shown in Figure 1:

Figure 1: Sample by anxiety score



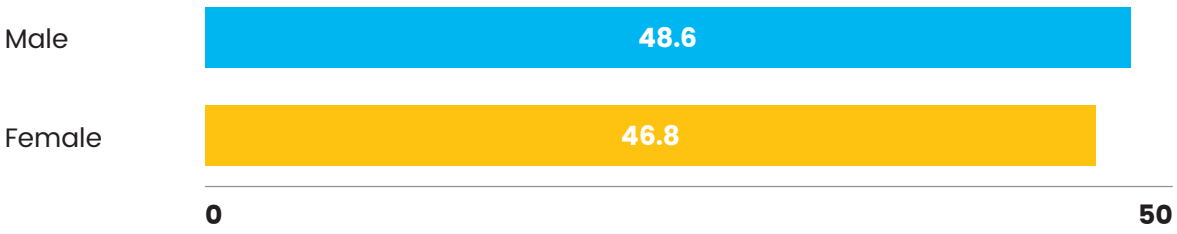
State anxiety by sociodemographic characteristics

- **Sex**

Average state anxiety by sex

As shown in Figure 2, the average state anxiety across the total sample is similar for both women and men, falling into the "medium" category, with slightly higher state anxiety among women:

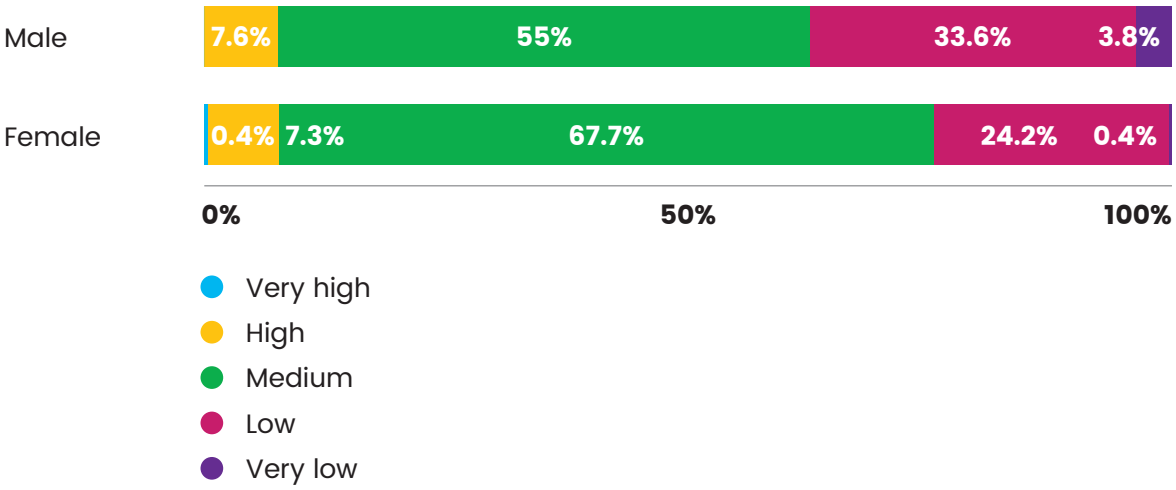
Figure 2: Average state anxiety by sex



Average trait anxiety by sex

Figure 3 shows that similar numbers of men and women scored "high" and "very high" on trait anxiety. This was not the case for the other categories. More women scored "medium" (67.7% as opposed to 55.0% of men), with the majority of respondents of both sexes falling into this category. Far more men than women, meanwhile, scored "low" or "very low" (37.4% as opposed to 24.6% of women). This is important: there is a statistically significant association between sex and state anxiety.[28]

Figure 3: Levels of state anxiety by sex

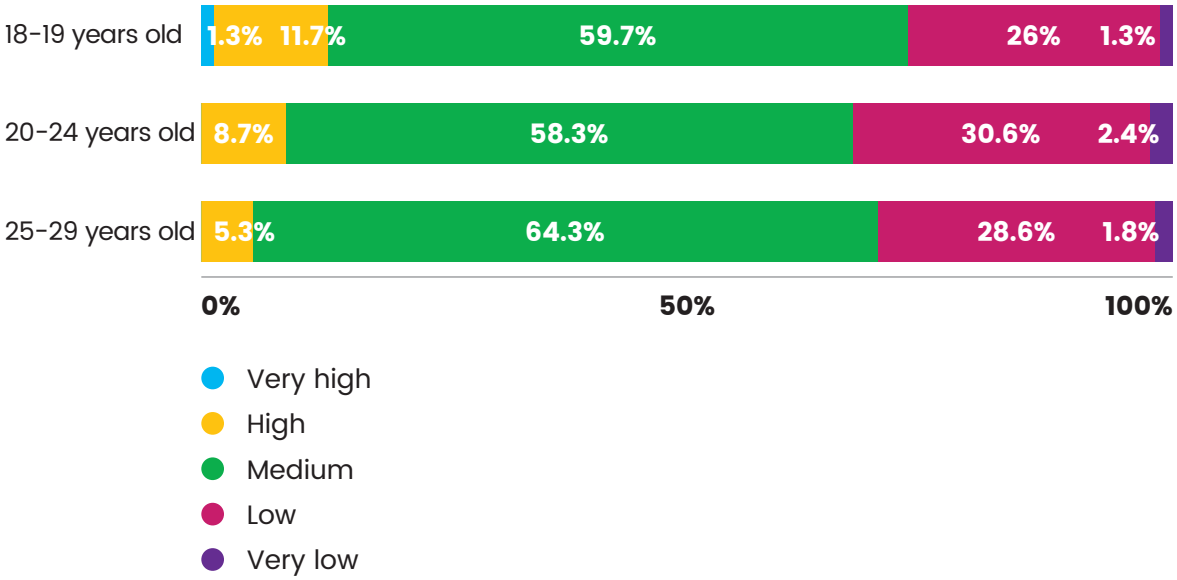


- **Age (figure 4)**

The results for state anxiety by age show that the majority of respondents in every age group still score "medium", without much variation between the different groups. It is notable, however, that considerably more respondents in the 18-19 group scored "high" or "very high" on state anxiety than in the 25-29 group: more than twice as many overall (11.7% versus 5.3%). Two thirds of the 25-29 group scored "medium", and a third of the 20-24 group scored "low" or "very low".

28 $p=0.004<0.05$ on the Pearson x^2 test.

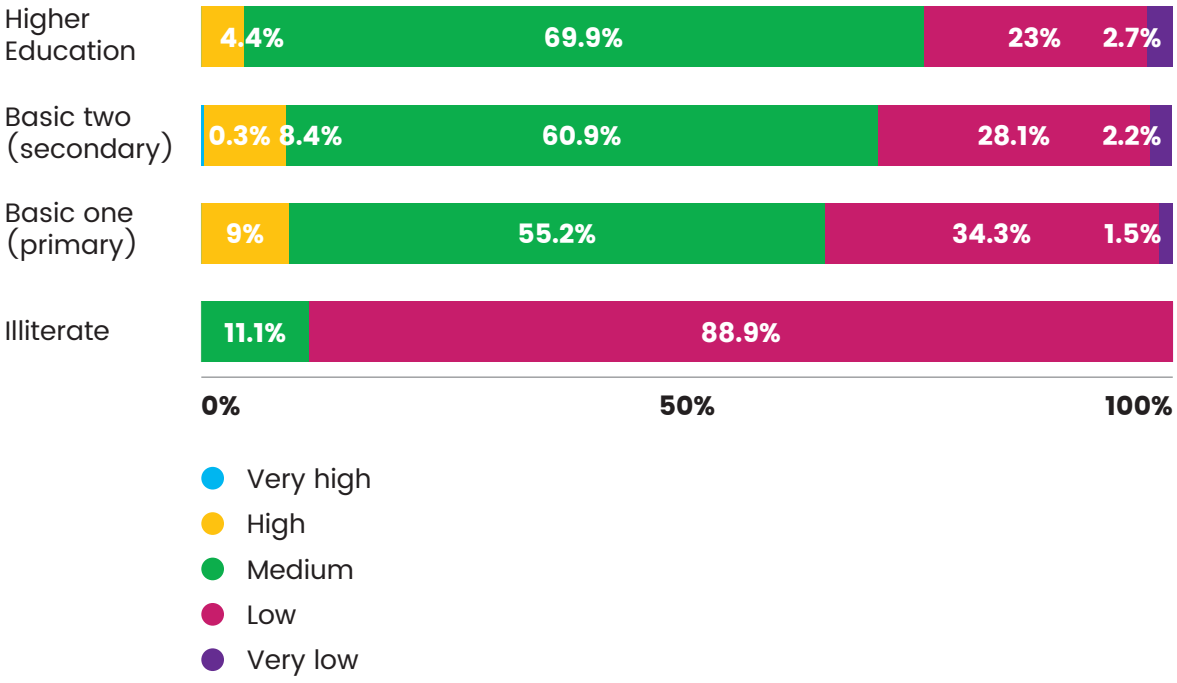
Figure 4: Levels of state anxiety by age group



- **Education**

Other than illiterate people – most of whom scored "low" on state anxiety but with very limited significance due to the small sample size (9 people) – the majority of respondents of all educational levels scored "medium", with respondents more likely to score "medium" the higher their level of education. The number of people scoring "low" and "very low" increases and the number of people scoring "high" and "very high", on the other hand, decreases with education. All these differences are statistically significant according to a Pearson test ().

Figure 5: State anxiety by level of education

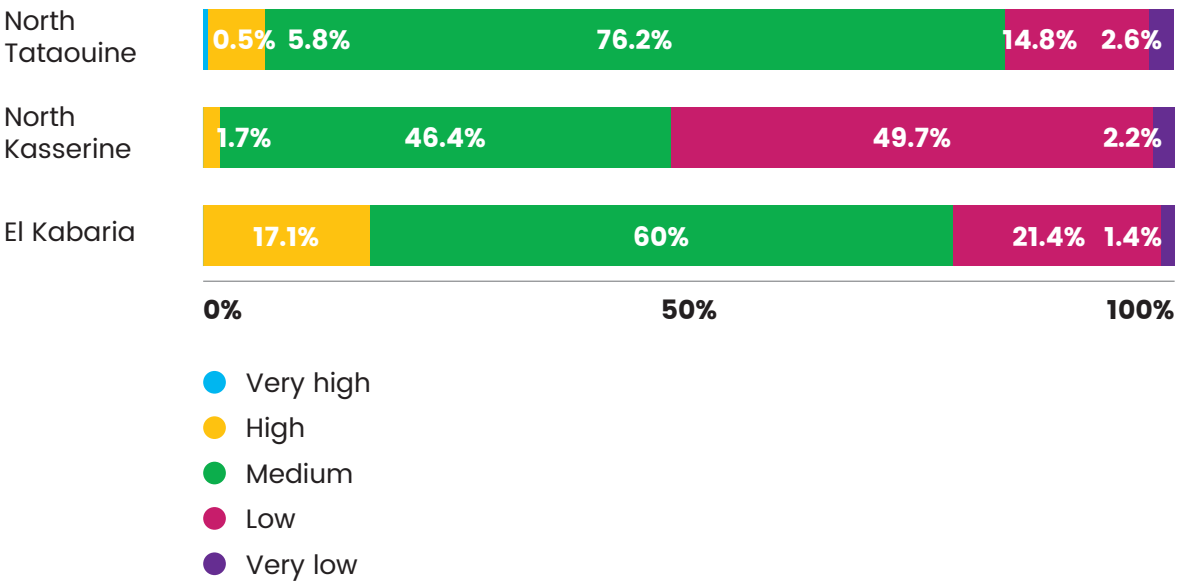


- **Region or area** (Figure 6)

Breaking down the results for state anxiety into the three regions in which the study was conducted reveals important and unexpected differences, which are statistically significant:[29]

- In North Tataouine, more than three quarters of the young people in the sample scored "medium" on state anxiety, with limited numbers of respondents scoring higher or lower.
- In El Kabaria, a suburb of Tunis, a significant number of respondents scored "high" on state anxiety (17.1%). Not only is this figure markedly higher than those recorded elsewhere, it is also more than double the percentage across the sample as a whole (7.7%). It even exceeds the combined percentage of the total sample who scored "high" *and* "very high" on trait anxiety (16.1%).
- Equally significant – if not more significant – are the results recorded in El Nour in North Kasserine, which are unmatched by any other variable in the study. This is the only category in which the majority of young people scored "low" or "very low" on state anxiety, with exceedingly few respondents (1.7%) scoring "high" or "very high".

Figure 6: State anxiety by regional origin



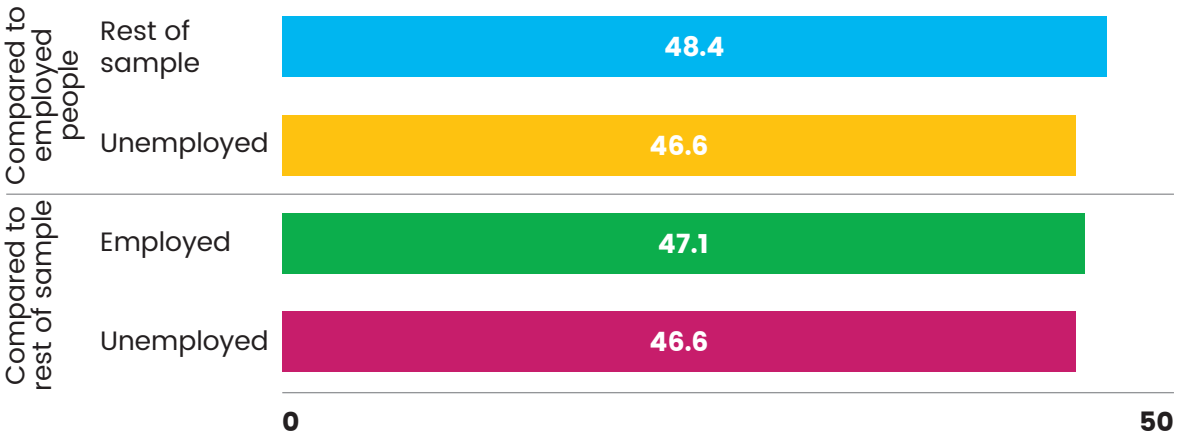
29 According to a Pearson x^2 test: p=0.000<0.05.

State anxiety by economic activity

- **Average state anxiety**

The average state anxiety score for unemployed people was 46.6, slightly lower than the average for the rest of the sample (48.4). The average state anxiety among those in employment was 47.1. This means that having a job makes no statistically significant difference to levels of state anxiety.

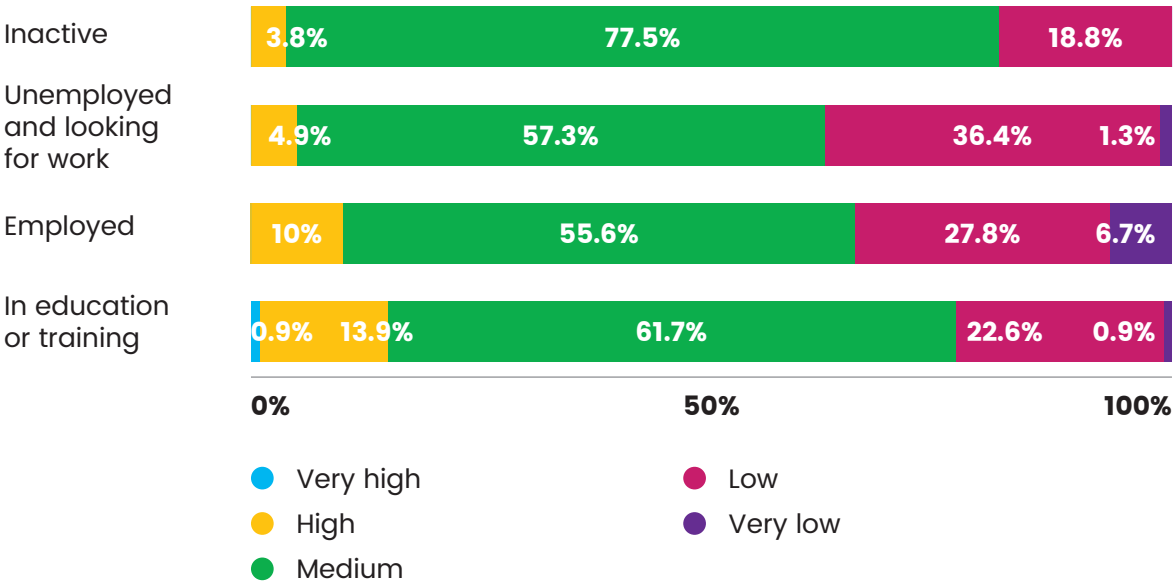
Figure 7: Average state anxiety among unemployed people



- **State anxiety in different sample groups according to economic activity**

In all groups (unemployed, employed, in education or training, inactive), the majority of young people in the sample scored "medium" on state anxiety, with some variation: more respondents scored in the "inactive" category (77.5%) scored "medium" than in the other categories (between 55.6% and 61.7%). Those who scored "high" or "very high" accounted for some 14.8% of those in education or training, with a far lower figure among those who were unemployed but looking for work (4.9%) and among the economically inactive (3.8%). A large percentage of unemployed people (37.7%) and employed people (34.5%) alike scored "low" or "very low" on state anxiety. Note that these results show a high degree of statistical relevance ().

Figure 8: Levels of state anxiety in different sample groups by economic activity



- **Comparison of state anxiety among unemployed people and employed people, by region**

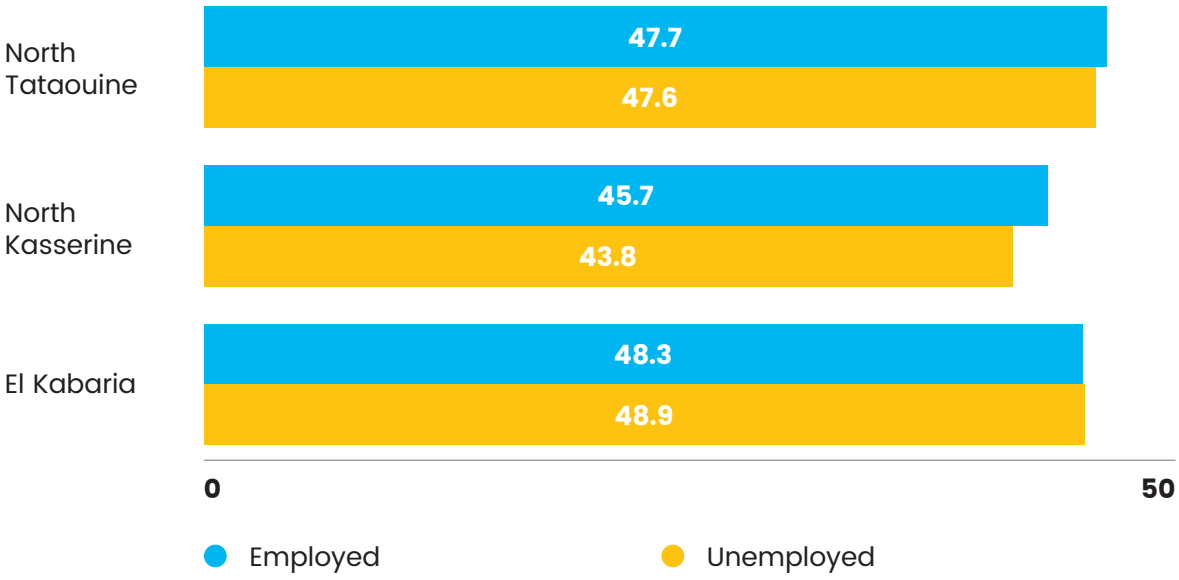
Although the average scores all fall within the "medium" range for state anxiety and are fairly close to one another, there are a few peculiarities worth mentioning:

- Average levels of state anxiety among employed and unemployed people in El Nour (Kasserine) are somewhat lower than their counterparts in El Kabaria and North Tataouine.

- Average levels of state anxiety are almost identical for employed and unemployed people in Tataouine and close in El Kabaria, with slightly higher levels recorded among unemployed people in El Kabaria.

- In El Nour (Kasserine), however, the average state anxiety level among unemployed people is lower than that of employed people. Moreover, the average score for unemployed people sits within the "low" range for state anxiety – uniquely among all the scores in this study. Note, however, that it lies just below the threshold between "low" and "medium", and is higher than 40, which is generally considered to represent the threshold between natural and pathological anxiety.

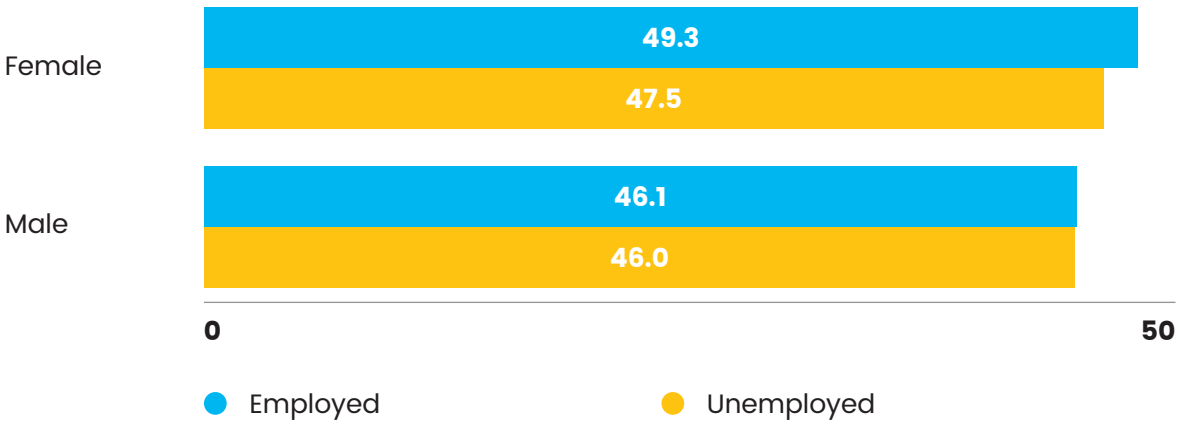
Figure 9: Comparison of state anxiety among employed and unemployed people, by region



- **Comparison of state anxiety among employed and unemployed people, by sex**

Among men, the average state anxiety score was more or less the same for employed and unemployed people. It was somewhat lower than the average scores for women, particularly for employed women, who had slightly higher state anxiety than their unemployed counterparts.

Figure 10: Comparison of state anxiety levels in employed and unemployed people, by sex



Discussion

"The thing that bothers me most, genuinely, about this time I've spent being unemployed, is the pressure I often feel, which I can't find any solution for […] Thinking about how I live makes me feel depressed. Often I tense up and start to feel anxious, and sometimes I even get aggressive with other people. The feeling is too much for me to bear. I never used to be like this."

Testimony of an unemployed Tunisian interviewee describing his psychological problems (Remili, 2016, p. 148)

Points of relevance to young people's anxiety in Tunisia: Theoretical and empirical

The complex nature of anxiety – its categorisation as helpful/harmful or temporary/long-term, the difficulty of determining point at which it is "normal" or "pathological", the diverse range of causes that can give rise to it, its close ties and similarity to other psychological disorders – make it a tricky subject to cover. We cannot cover its intricacies in detail here, so we will limit ourselves to discussing some of its aspects, drawing on a range of theoretical and empirical studies as well as the results of this study and other studies we have carried out.

Before looking at the results, it is worth noting that anxiety cannot be measured by figures and statistics alone. We have to consider the web of diverse and interlocking factors that lies behind the numbers, taking into account individuals' personal traits and ideas as well as the environment and context to which they belong. All these factors will decrease or increase the psychological component (anxiety) and determine whether its function is "natural" or "pathological" (Rachman, 2003).

- **State and trait anxiety: Between statistical data and their implications for the study**

It is worth remembering that when we refer to *trait* anxiety, we are referring to its diagnosis as a fixed quality of an individual's personality, and thus to long-term feelings of stimulation and irritation. People who display this kind of anxiety usually have a high trait anxiety score. State anxiety, meanwhile, is a cluster of temporary feelings and emotional reactions manifesting through physical and nervous tension. This anxiety is influenced by external pressures and threats. For example, giving a speech in front of a group of individuals may produce anxiety in an individual who is worried about being criticised or viewed negatively by others.

State anxiety is linked to personality and thus to trait anxiety. Spielberger notes that a person with high trait anxiety will generally also have high state anxiety, but that those with tougher personalities who deal effectively with external threats will have only moderate state anxiety. Individuals with high trait anxiety are not always predisposed to state anxiety, and may feel very calm when relaxed (Zeidner and Matthews, 2016).

For this reason, we decided to focus on rates of *state* anxiety while still taking into account the levels of trait anxiety recorded in the study. We found, significantly, that average trait anxiety (49.87) among participants was slightly higher than their level of state anxiety (47.65). According to Spielberger's theory, this may be attributable to those respondents with high *trait* anxiety displaying only limited *state* anxiety while answering the questionnaire. Only 7.7% of respondents displayed a "high" (7.5%) or "very high" (0.2%) degree of state anxiety when answering the questions, while 16.1% displayed "high" or "very high" trait anxiety (13.7% and 2.4% respectively). From this, we can conclude either that they felt relaxed at that particular moment or that they are particularly good at adapting

to their environment and therefore were not negatively stimulated or stressed in that particular temporal and spatial context (i.e. responding to the STAI questionnaire).

It is also important to note that average scores for both state and trait anxiety generally fell within the "medium" range for the test, i.e. between 46 and 55. Anxiety is thus a mental health problem requiring attention – a problem that needs to be taken seriously by putting in place effective and serious preventative, awareness-raising and treatment strategies for young people of all backgrounds.

Relationship of anxiety to social-demographic variables

- **Age and state anxiety**

With respect to the connection between age and anxiety in unemployed people, we might expect those in the age bracket 25-29 to have higher levels of anxiety. This group have completed their studies and begun to plan for the future – they have entered the jobhunting phase, which is very difficult and thus a source of anxiety and stress, particularly given the unemployment crisis in Tunisia.

But this expectation is only partially borne out by the data. 64.3% of young people in this age group scored within the "medium" range on state anxiety (i.e. above the threshold for pathological anxiety), which is more than in the other two age groups. On the other hand, we find the most significant numbers of respondents scoring "high" and "very high" in the 18-19 age group (11.7%). This is still a small percentage, but nonetheless double that found in the 25-29 age group (5.3%). It is worth noting that none of these differences overall are statistically significant.

It is possible to explain the higher percentage of 18- and 19-year-olds scoring "high" and "very high" by reference to "school anxiety", which is linked to test anxiety and stress, fear of failure and pre-emptive worries about unemployment.

- **Sex and state anxiety**

The link between anxiety and a given sociodemographic variable like sex, especially in unemployed young people, is a thorny issue. There are various considerations that must be borne in mind.

We expected to find higher state anxiety among women than men, particularly among unemployed women. Our hypothesis here was based on other studies conducted in the Arab World, some in Tunisia – the work of Mohamed Ali Bin Zina et al, for example, who studied unemployment in the Tunisian region of Ghar El Dima. The statistical data show that unemployment rates in this region are very high by national standards, with around a quarter (25.64%) of all economically active citizens unemployed. When we break this number down by gender, we find that some 46.02% of women are unemployed, compared to 21 % of men (Bin Zina et al, 2018).

Our hypothesis was borne out by the results of the study, but only incompletely. The results showed that the average state anxiety score was generally higher, even if only slightly, among young women (48.6) than young men (46.8). There was, however, a more marked difference between employed women (49.3) and employed men (46) than between unemployed women (47.5) and unemployed men (46). Similarly, while the average state anxiety score was the same for employed as for unemployed men (46), the score among employed women (49.3) was higher than among unemployed women (47.5).

- **Educational level and anxiety**

Disregarding the nine illiterate respondents, who made up only a very small proportion of the sample (one of whom scored within the "medium" range for state anxiety and the remainder "low"), the majority of respondents of every education level scored "medium" on state anxiety. A larger proportion of respondents fell into this category the higher the education level. This change is gradual at first – 55.2% of those with only a primary education scored "medium" and 60.9% of those with a secondary education – and then more marked, with 69.9% of those with university degrees scoring "medium".

At the same time, it is notable that non-medium scores go in the opposite direction. At the upper end of the scale ("high" and "very high" levels of state anxiety), the highest percentages – although they remain relatively small – were recorded among those with a primary education (9%) and secondary education (8.4%), with far lower figures among those with a university degree (4.4%). At the bottom end of the scale ("low" and "very low"), the percentage decreases at a more or less steady rate from those with primary education (35.8%) through to those with secondary education (30.3%) and those with university education (25.7%).

This disparity can be explained by the different factors involved in and causes of anxiety, which vary from group to group or from one educational level to another among young people. Among young people in education and training who have primary or secondary education, for example, anxiety is connected to fear of failure in tests or exams or their inability to complete their education. Zeidner calls this "test anxiety" (Zeidner, 1998). This kind of anxiety is seen as "natural" – indeed, it can encourage students to work hard, be competitive and attempt to overcome challenges. But when the learner has a personality characterised by trait anxiety, Zeidner notes that it is natural for their level of anxiety to rise.

Young people with university degrees, meanwhile, largely have "medium" levels of anxiety because the kind of anxiety they experience is different and generally involves fears of unemployment and a failure to meet their ambitions after all the suffering they have experienced in order to get to that level. The graduate protests we are seeing today may be no more than an indicator of the stress, anxiety, frustration and fear these young people experience in the face of an unwelcoming future. The relatively low numbers who have "high" levels of state anxiety compared to less educated respondents, despite the struggles they face, is the result of their intellectual and cognitive maturity, which allows them to control their anxiety. They also possess powerful and effective strategies for psychological self-defence, making them more adaptable than other groups. Remili's study on defence strategies among unemployed graduates and suicide reached a similar conclusion: this group usually do not resort to suicide, instead trying to use various logical, objective and well-balanced strategies to make use of their anxiety, which reduces the burden of their psychological problems (Remili, 2016).

- **Geographical distribution of young people across the three regions and anxiety**

The study sample included young people from three different areas, each of them located in close proximity to a different provincial centre. The first, El Kabaria, is a working-class suburb of Tunis. The second, El Nour, is one of the largest working-class neighbourhoods in the Delegation of North Kasserine, which is the administrative centre of the border governorate of Kasserine in the west of the country (one of the poorest governorates in Tunisia). The third, North Tataouine, is the administrative centre of the Tataouine Governorate in the far south of the country, which has a special quality deriving from its position on the border (particularly in the eastern region).

We expected that we would find similar levels of anxiety in all three regions. If we did encounter differences, we anticipated that the highest levels would be in North Tataouine, since this region has the highest unemployment

rate – our hypothesis was that unemployment would be the deciding factor in state anxiety levels – and Kasserine, where significant unemployment coexists with almost unmatched levels of poverty. These assumptions were based on previous studies on "marginalised youth" in the interior and in working-class areas, which suffer from spatial and social inequality and are underserved in education, work and development (Bin Zina et al, 2018).

Contrary to our expectations, the study found the highest levels of state anxiety among young people in El Kabaria, in Tunis (average score of 48.7), then Kasserine (44.3). This was an unexpected, even surprising, conclusion, particularly given that the majority of respondents in El Nour scored within the "low" or "very low" range (irrespective of their economic status), a unique result unmatched by any other variable in the study. In all other breakdowns by social or demographic variables or by economic activity, the majority of respondents invariably fell into the "medium" range.

With respect to the difference in state anxiety between unemployed and employed respondents in each region, the results showed that in El Nour, unemployed people had lower state anxiety (average score of 43.8) compared to employed people (45.7). In Kasserine, the rate was generally higher, with almost no difference between unemployed (47.6) and employed people (47.7), while in El Kabaria (Tunis), unemployed people had a higher average score (48.9) than those in employment (48.3).

We might explain these results by hypothesising that unemployment has become a general and permanent state in various Tunisian regions, the differences between them notwithstanding. The different levels of state anxiety among young people in different regions thus reflect the ways in which a whole range of diverse causes and factors overlap, with different manifestations, in individual and group behaviour.

This hypothesis is supported by a study carried out by International Alert, titled *Young People on the Margins*, which looked at the greatest threats to young people in three areas: Douar Hicher, North Kasserine and North Tataouine. This study found that young people in these three areas identified unemployment as the greatest danger facing them, with some quantitative differences between North Tataouine (where 62.4% of respondents answered "unemployment") and the other two areas (40% in both). Alongside unemployment, young people named several other phenomena as the most significant threat. In all three areas, addiction was the second most common (cited by 27.6% of respondents in Kasserine, 26.1% in Douar Hicher and 18.4% in Tataouine). Third place varied from area to area: terrorism for respondents in Kasserine (18.1%), crime in Douar Hicher (14.2%) and the dangers of illegal migration in Tataouine (12.4%) (International Alert, 2020, p. 23).

These data show that young people feel they are facing a range of different threats, representing social phenomena that occur across Tunisia and are prominent in young Tunisians' conceptions. Although unemployment is the main danger according to the majority of young people in all areas (to a greater or lesser degree), many of those surveyed identified one of these other threats as more important. These are realistic dangers that will naturally contribute to fear and anxiety, at least among these young people, with each person affected differently depending on environmental, social and psychological characteristics.

State anxiety and economic activity: Unemployed young people and other categories

An unemployed person's feelings about the future and their inability to clearly see whether they will be able to find work – irrespective of their skills, education and personal circumstances and of the environment to which they belong – are a mixture of fear, anxiety, temperamentality and worry. At times they will include depression, and in the worst cases they may consider suicide. Unemployed people thus experience an unending chain of psychological reactions, influenced by various external factors, some positive and some negative.

According to this study, and after consideration of the STAI results that we produced, it is clear that our original hypothesis was incorrect. There was no statistically significant difference in levels of anxiety between unemployed and employed people.

In order to analyse the levels of anxiety captured by the STAI among the various groups of young people from the perspective of economic activity, we are obliged to look more closely at the figures and the links between anxiety and the different variables among unemployed young people, the target sample of the study. We must compare them with the second group, which includes employed people as well as those belonging to other categories: the economically inactive and those still in education or training. We will try to cast light on these groups and determine the causes of their anxiety.

According to our second hypothesis, unemployed people should be more vulnerable to anxiety than those in employment. The data do not bear this out – in fact, they show the opposite, whether in terms of average state anxiety levels overall or in terms of how many respondents scored "medium" and particularly how many scored "high" on state anxiety. This in itself is a significant and crucial finding. The psychological difficulties faced by unemployed people are well known and confirmed by the literature, particularly the global literature. But those in employment (as well as those in other non-unemployed categories) experience their own multifaceted problems and a diverse range of psychological pressures, which invite confusion and generate anxiety.

Here we need to ask: What can we say about the specific factors that distinguish each of these groups in their relationship with anxiety?

- **Unemployed young people**

One of the most important psychological disturbances that these individuals suffer from is anxiety and stress due to fear of an uncertain and unknown future and financial dependency on family. This results in a loss of emotional stability and thus difficulty in creating a household and starting a family. In an article analysing the suffering of "poor" and socially and professionally "fragile" individuals – the long-term unemployed, young people with no professional qualifications – Vandecasteele and Lefebvre note that this suffering makes them vulnerable, particularly in risky situations or social exclusion, meaning that they deserve psychological and social support and follow-up. Their suffering takes various clinical forms and is at root the product of diverse social problems, including losing one's job or difficulties in finding work or a house or obtaining education, leisure, social support or care structures. This inevitably leads to instability in some individuals, which people accommodate to differently depending on their individual and psychological characteristics (Vandecasteele & Lefebvre, 2006, p. 138).

Experiencing all these psychological and emotional reactions, which are generally negative and which young unemployed men usually suppress, makes them feel thwarted. They may come to feel that they are living in a mirage, that their dreams are becoming nightmares and that they cannot find a way out. This sort of suffering can lead young men into very dangerous behaviour such as addiction, violence, suicide or illegal migration.

In the same vein but in a specifically Arab context, a UNDP report from 2016 titled *Youth and the Prospects for Human Development in a Changing Reality* noted that the difficulties, dangers and problems facing young people in the Arab region, on all levels, are a warning sign and steps must be taken to mitigate and protect from them. One of the most significant difficulties – the leading threat according to the report – was unemployment and mental health (UNDP, 2016).

- **Non-unemployed/employed young people**

Young people who do have jobs are not safe from anxiety. In fact, some young people belonging to this category are anxious enough for it to count as high pathological anxiety. This is one of the findings of this study: the average state anxiety among employed young people was 47.1, within the "medium" range, and the majority of employed young people – irrespective of the nature of their work – scored "medium" or even (in 10% of cases) "high" on state anxiety (higher than the proportion of the unemployed respondents).

There are numerous studies on the psychological and social risks of work. These studies show that the diversity of risks facing employees in all kinds of work can affect their physical and mental health, particularly when they are continuously exposed to them. A series of studies carried out by the French Directorate of Research, Economic Studies and Statistics (DARES)[30] in 2010, for example, identified a range of "socio-psychological risks" to which workers are exposed to varying degrees, depending on the nature of their work, the sort of services offered and also on sex. They showed that many workers were afraid of workplace incidents, including violence, with young people and especially young men particularly likely to face these problems. They also provided a list of factors that can exacerbate these risks: unsupportive and intolerant working relationships, either with peers or with superiors, poor organisation and inadequate management, etc (Coutrot & Mermilliod, 2010).

Another study, conducted in the Tunisian context, shows that a negative working environment, difficult conditions and a lack of financial wherewithal can lead to physical and psychological problems among workers, leading to absences and abuse of addictive substances or alcohol. Spending a long professional period under such conditions can affect employees' physical and mental health, including by causing anxiety, depression and fragile self-esteem. Young workers suffer from a range of pressures: at work, family responsibilities and stresses resulting from a lack of time (Remili, 2019).

In the same context, a recent study carried out by the World Health Organisation has shown that depression and anxiety are the most common psychological disorders, which affect our ability to work and to produce (WHO, 2017).

- **Young people in education or training**

We often imagine young people in education as individuals who have not yet experienced real hardship or genuinely difficult situations. We thus rule out the possibility of them suffering from depression other psychological disturbances.

Our findings in this study, like those of other studies on this topic, show that this conception is completely incorrect. Interest in this issue has been increasing, with some developmental psychologists identifying the type of anxiety faced by these individuals as "test anxiety", which – although sometimes normal or even a necessary motivator for students – often becomes pathological and negatively affects individuals' performance and behaviour. Zeidner and Matthews note that students whose personalities have high trait anxiety have unusually high levels of state anxiety (Zeidner and Matthews, 2016).

30 DARES is a public body affiliated with the French Ministry of Labour. It produces studies, statistics and analysis on work, employment, professional training and social dialogue.

- **Economically inactive young people**

The behaviour and opinions of this group of young people, who had the highest rate of "medium" state anxiety and the lowest rate of "low" state anxiety of any group in the study, are a general source of confusion for society. In order to analyse the level of state anxiety among this group, we must first define what "inactive" means.

The sociologist Mohamed Ali Ben Zina tells us that "economically inactive people are characterised by isolation and by staying outside the sphere of education, training or work". This is based on the work of Robert K. Merton (1965), who emphasised the "anomie" resulting from individuals' inability to fulfil societies' expectations. This produces "functional types" characterised by five different types of behaviour. Of these behaviours, we mention "withdrawal", whose definition applies to many economically inactive people. Ben Zina describes withdrawal as "giving up on goals and therefore on means, leading to a withdrawal from social action" (Ben Zina et al, 2018).

These young people experience a sort of directionlessness of thought and action. Their "withdrawal" conceals a much deeper psychological state. Isolation and stagnation indicate a troubled psyche and are characteristic of aimlessness. Not looking for work or education – perhaps not even looking for a future – ultimately conceal a search for social identity, a desire to live in the present without worrying about the future. We might consider this a defensive strategy similar to a "flight" reaction, as unhelpful or ineffective as it may be, a possibly unconscious attempt to accommodate to the reality in which they live. This group, which is vulnerable on every level, desperately needs our attention.

It is clear that anxiety has become an enduring psychological component of young people's feelings, emotions, and behaviours. Their various personal and economic positions (employed/unemployed, in education or training, or even economically inactive) are all full of factors that drive anxiety and worry. The different groups seem to be almost equally vulnerable to high levels of temporary or lasting anxiety. In the absence of public policy intended to prevent and mitigate the levels of anxiety among young people, the most effective, and perhaps the only, way of preventing more dangerous and profound psychological changes has probably been to develop defensive strategies through individual and collective experience.

Conclusion

Young people are suffering from very high levels of anxiety, and this should ring alarm bells for officials and local actors. Anxiety is a good measure of mental health, and these levels are indisputably linked to the development of psychological disorders and illnesses on the one hand and all sorts of concerning social phenomena on the other. They are the product of a range of overlapping social and economic factors.

The most significant implication of this is that mental health in general, and specifically young people's mental health, must become a major priority for health policy – not only in health ministries, but in all relevant sectors, whether with respect to causes or results. It must be treated with the same seriousness as other health priorities (novel illnesses, chronic conditions etc).

Our most important finding is that elevated levels of anxiety are no longer limited to a minority of young people or to specific groups, social or economic positions, age groups or educational backgrounds.

This study has shown, contrary to expectations, that there is no statistically significant difference in average levels of anxiety between the unemployed and other groups of young people (employed, in education, inactive). However, this is only because the latter are suffering from a level of anxiety that matches or exceeds that among their unemployed counterparts. Average scores for unemployed people and for the other groups, or for employed people alone, are now almost identical. There are a few differences, some of them statistically significant. But the average score for all groups falls within the "medium" range, above the threshold for pathological anxiety (40 points on the STAI).

Similarly, breaking the figures down by degree of state anxiety shows that the majority fall within the "medium" range. This is true not only of the sample as a whole but of every age group, both sexes, unemployed people, employed people, and all other economic groupings, as well as all education levels from primary to university.

Even the regional figures show that although in El Nour (North Kasserine) the majority had, uniquely, "low" or "very low" levels of anxiety, the average state anxiety score among those respondents was nonetheless above 45, i.e. "medium". The average score for unemployed respondents from the area, likewise, was the lowest of all the averages for any variable.

The study has also shown that a significant number of young people, accounting for some 16.1% of the sample, have chronically "high" or "very high" levels of anxiety: those who have "high" or "very high" "trait" anxiety (i.e. anxiety as a fixed quality of their personalities which causes long-term reactions and stress). Although the relatively low number who scored "high" or "very high" on state anxiety (7.7%) suggests that this trait does not always manifest, this is clearly rooted in the self-defence strategies that many of the young people have learnt, particularly those who are older, better educated, or unemployed. There may also be a relationship with certain psychological "behavioural" traits among the economically inactive. At the same time, certain groups of young people are characterised by "high" or "very high" levels of state anxiety, particularly those who are in education or training (14.8%), employed (10%), or under 20 (14.8%), and especially those who live in working-class suburbs of Tunis (17.1%).

As far as sex is concerned, the findings of the study suggest that levels of state anxiety are broadly similar between the sexes, with slightly higher average levels and slightly larger numbers scoring "average" recorded among women than among men. The number of those scoring "high" or "very high" were similar between women and men.

Young people's mental health is in danger. These data are a warning sign, and demand our attention. We must make mental illness a public health priority – both treatment and prevention. We must produce detailed strategies to prevent it from developing, to mitigate its negative effects on young people's health, and to address its underlying causes and drivers.

Note on the study's particularities, its limitations, and new horizons

This study is unique in that it gives sole priority to anxiety, neither conflating it with other mental illnesses and psychological symptoms such as depression, post-traumatic stress disorder or mood swings nor connecting it to chronic or physical illnesses. Although these issues are all important, taking a unidimensional – and often purely clinical – approach to them places certain limits on a study. The study also stands out in other ways: the large sample size, large enough to be representative of the target population. The researchers' decision to look specifically at young people, and more particularly at unemployed young people, also means it adds value, for the reasons laid out above, even if most of it is already well known to concerned parties.

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Results of the field study on mental health in young people and risk-taking behaviours in El Kabaria, northern Kasserine and northern Tataouine

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Introduction

Since it first began operating in Tunisia, International Alert has made economic, social and regional disparities – exacerbated by austerity and the "rolling back" of the state – central to its work. Through both qualitative and quantitative field studies, it has sought to deconstruct their manifestations, analyse their trajectories and draw out their effect on the inhabitants of working-class areas and the regions of the interior.

Young people from the urban and semi-urban peripheries are one of the groups our organisation has worked with most closely. There are various reasons for this, most importantly their great demographic weight: according to the National Institute of Statistics, there are more than 2.5 million Tunisians aged between 15 and 29, accounting for around a quarters of the total population. Young people also face particular social, economic and political conditions, making them some of the most significant victims of marginalisation with respect to levels of unemployment, lack of opportunities for social mobility and vulnerability to a whole range of physical and psychological dangers: violence, addiction, idleness, dropping out of school and sexual harassment.

International Alert Tunisia has conducted a number of research projects investigating young people's trajectories, their understandings of the dangers that face them, their opinions of education and healthcare and how they deal with risky behaviour. As part of these efforts, this time we have chosen to dedicate a field study to an issue that has not received sufficient attention in specialised literature: health, particularly mental health. This is particularly valuable because this is the first quantitative field study carried out on young people's mental health in Tunisia to cover three areas at once.

The study is based on a survey drafted by a team of researchers and focusing on four major themes.

The first of these themes was the socioeconomic environment young people inhabit. The survey looked into the family background of respondents, their general educational level, their distribution across different economic-professional groups, the types of activities they do in their spare time, and their desire to emigrate.

The second theme was how young people thought about their general health. Our first task was to find out how respondents rated their physical health, determine how widespread chronic illness was within the sample, and draw out their hesitations about accessing public healthcare. Naturally, we also sought to identify their opinions on the ongoing pandemic. We then focused on mental health, hoping to fill the large gap in studies of this particular issue by analysing respondents' recognition of psychological problems and illnesses. We attempted to establish how vulnerable they were to such illnesses, how they dealt with them, and how knowledgeable they were about mental health difficulties.

The third theme was drug use and addiction. These questions sought to identify young people's views on the penalties for drug use, their awareness of ways out of addiction, and how easy it was for them to access help.

The fourth and final theme was violence. We investigated all the forms of violence that young people are exposed to, breaking the data down by sex, age, educational level and location. We also asked about young people's ideas regarding the legitimacy of violence against women and children.

The sample for this study comprised some 1,265 young people between the ages of 18 and 29, distributed almost exactly equally across the three regions: El Kabaria (Tunis), Northern Kasserine (Kasserine Governorate in the southwest) and Northern Tataouine (Tataouine Governorate, southeast). The choice of these three regions – hundreds of kilometres apart from one another and separated from the capital by distances ranging from a few to several hundred kilometres – was not random but based on their similar socioeconomic profiles: marginalised and poorly maintained, with high levels of unemployment, few opportunities and poor infrastructure.

Recognising that young people are not a homogenous bloc and that there are significant differences rooted in a whole range of factors – personal trajectories, socioeconomic circumstances, relationships, upbringing – the research team identified a series of control variables: sex, age group, educational level and employment activity.

After drafting the questionnaire and testing it on a small sample before the full field study, we invited a team of experts to oversee the workshops at which young members of the field teams were trained to collect the data using tablets. A team of supervisors was also put together to oversee and support the field researchers (enumerators), who were divided up into small groups with an internal composition similar to the demographic composition of the relevant areas in order to ensure full coverage. In order to ensure the quality and credibility of the data collection process, this team of supervisors oversaw the entire process via the internet.

The data was collected by 21 field researchers[31] between 24 September and 8 October 2021.

It was then compiled, reviewed and analysed by the research team.

31 Anouer Hammemi, Najlaa Chehidi, Yassin Abidi, Dheker Zakaria, Oussema Dhahri, Yasmine Hajji, Oumaima Ben Ismail, Dhiaa Elhak Hamdi, Imen Nadderi, Marwa Ferhi, Yanes Ghodhbani, Mohamed Karem Hamzaoui, Ameni Rahmouni, Oubaid Allah Dabbebi, Najib Aidoudi, Belgacem Elhouch, Soumaya Dabbebi, Marwa Tayaa, Aymen Farouki, Halima Tezghadenti and Om Kolthoum Boufalgha.

1. Characteristics and distribution of the sample in accordance with basic variables (control variables)

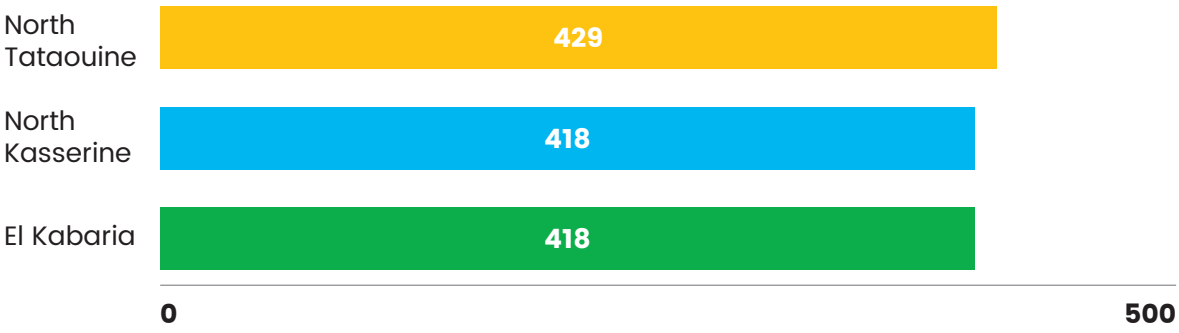
The study was conducted in three different areas: North Tataouine, part of the Tataouine governorate in the extreme south of the country; El Nour neighbourhood in North Kasserine, in the middle western part of the country on the Algerian border; and El Kabaria, a working-class district of Tunis, on the north-eastern coast.

The projected sample was to consist of 1,224 young people aged between 18 and 29, divided into three sub-samples, one from each of the areas studied. It was selected using the quota method in order to produce a particular distribution of regions and of four other variables: sex, age group, level of education and economic activity. The purpose of this was to ensure that each sample was representative of the young people of each region with regard to these characteristics as recorded in the last census (2014).

In practice, we ended up with a sample of 1,265 young people, with a distribution that did not differ significantly, with respect to these five variables, from the projected distribution.

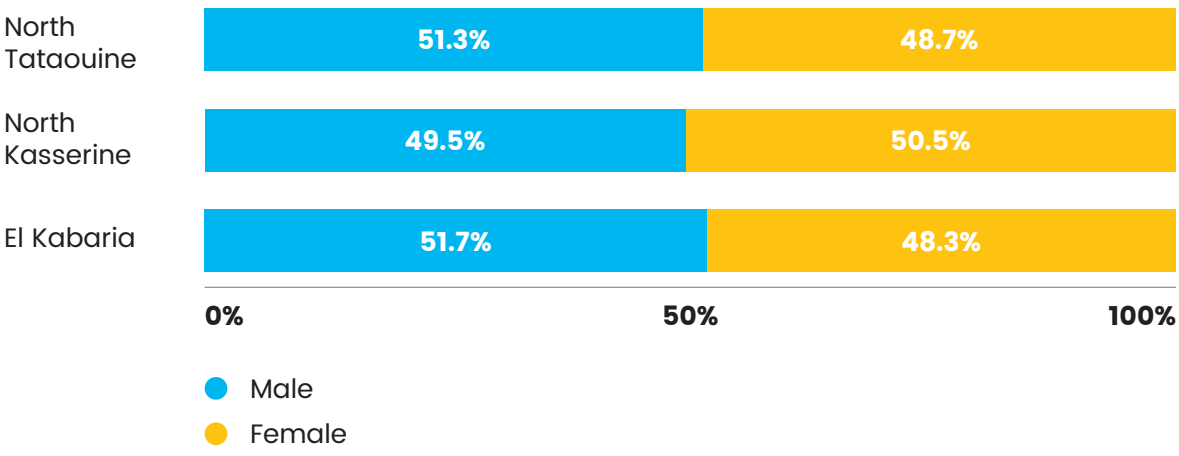
1.1 Sample distribution by area

The slight increase in sample size in order to ensure that all relevant groups were surveyed produced a slight disparity between the size of the sample for Tataouine and the other two samples:



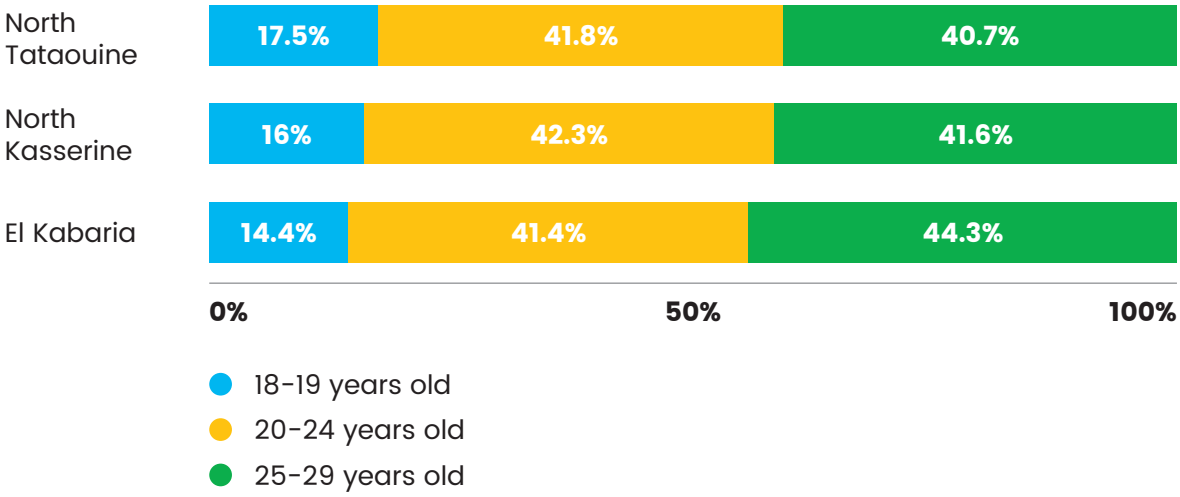
1.2 Sample distribution by sex (and area)

With respect to sex, the samples were very close to the projected distribution, diverging slightly in the case of Tataouine, where women were expected to make up 50.2% of the sample:



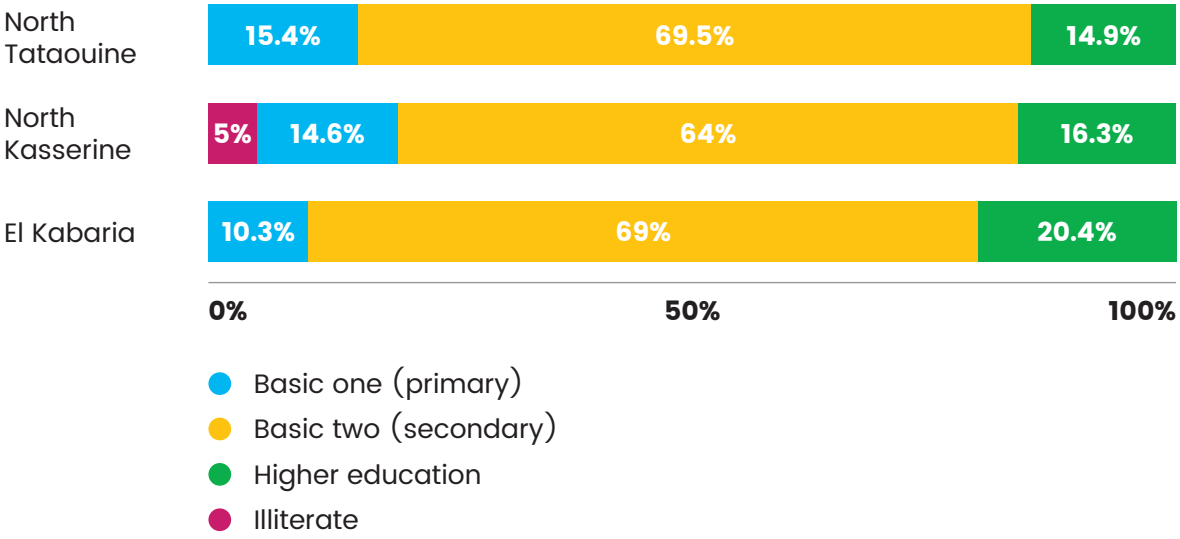
1.3 Sample distribution by age (and area)

The sample comprised three different age groups, in proportions corresponding to their proportions in the target population of each area. The 18-19 group is of course the smallest proportionally because it comprises only two year groups, whereas the sizes of the 20-24 and 24-29 groups are very similar both within individual areas and across the whole sample.



1.4 Sample distribution by educational level (and area)

Breaking down the sample by educational level shows that the proportions are very similar to those in the target population, although there were slightly fewer illiterate respondents than the 3% expected in El Kabaria and Tataouine. Breaking it down by area shows great similarity in the 'central area' and more disparities towards the edges. Around two thirds of respondents in all areas had completed primary and secondary education. In El Kabaria, the best educated area, barely 10% of respondents had got no further than primary education, while fully one fifth had entered higher education. This makes sense given El Kabaria's position in the middle of a city well served by accessible schools and close to the capital and its universities. Kasserine is not so lucky: unique among the three areas, it has a high level of illiteracy, which points to the difficulty a not insignificant number of children face in accessing education (according to census data the actual level of illiteracy is even higher at 6%) – particularly, but not exclusively, in the extreme west. Some 20% of respondents in Kasserine had either received no education at all or got no further than primary school. Nonetheless, slightly more respondents in Kasserine had made it to higher education than in Tataouine.

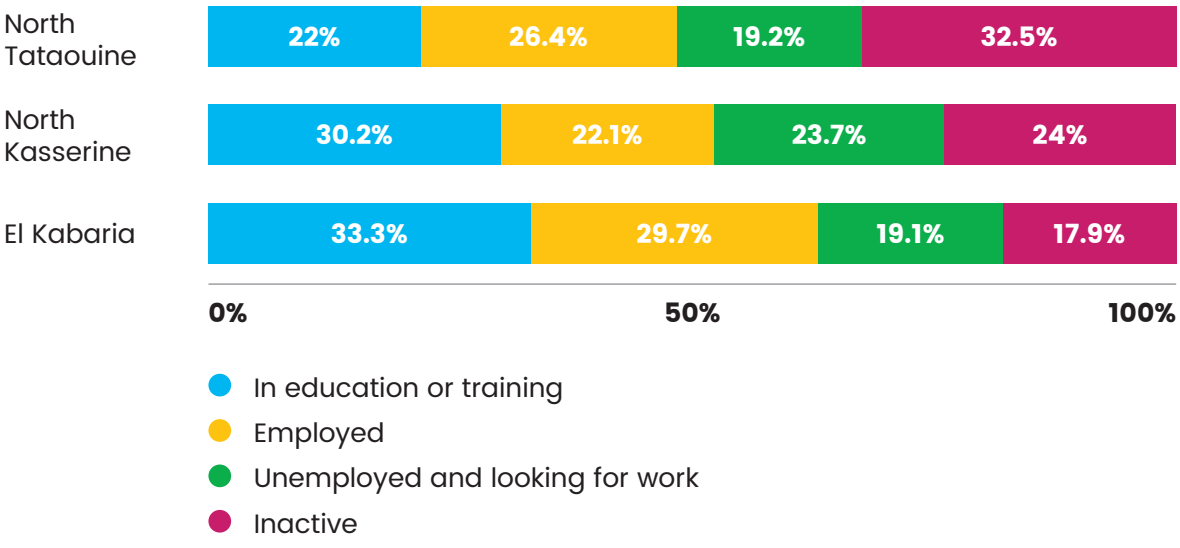


1.5 Sample distribution by economic activity (and area)

Breaking down the sample by economic activity shows varying degrees of disparity between the three areas. The Tataouine sample stands out for three interrelated reasons. There are fewer respondents in education or training in Tataouine than in El Kabaria and Kasserine, and more respondents who report being economically inactive (i.e. are neither studying, working nor looking for work), with this latter group making up around one third of the sample. As a result, this is the only sample in which those who are working or in education or training account for less than half of all respondents (even though there are fewer people looking for work than in Kasserine).

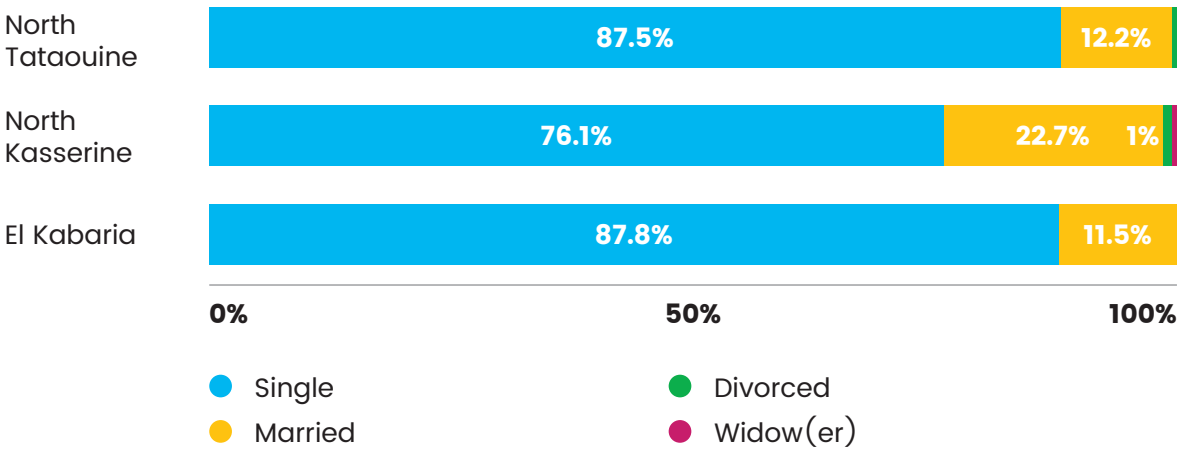
The proportion of young people who are unemployed and looking for work was high in all three areas, particularly in North Kasserine, where there were more respondents who reported being in this position than there were actually in employment. Around half the respondents in Kasserine were unemployed and were not in education or training, not far from the proportion observed in Tataouine. In El Kabaria, those not in education, employment or training made up 37% of the sample.

The proportions observed in the samples correspond perfectly or almost perfectly to the population proportions for the three areas according to the census.

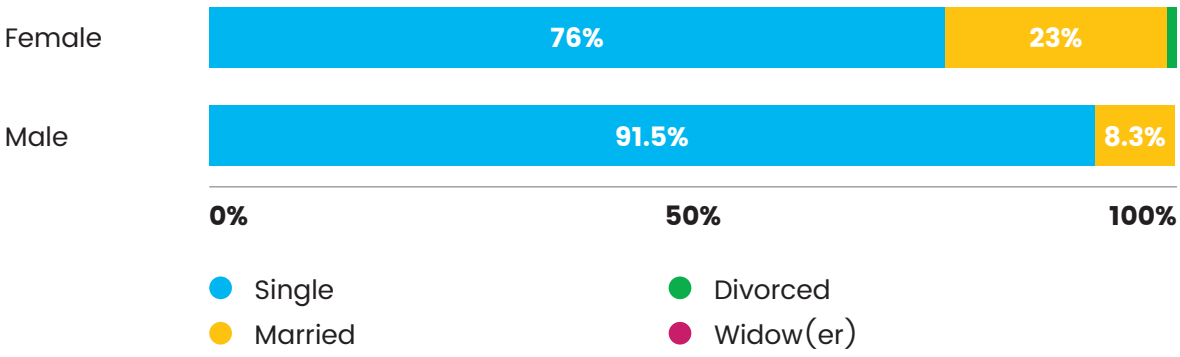


2. Respondents' economic and social environment

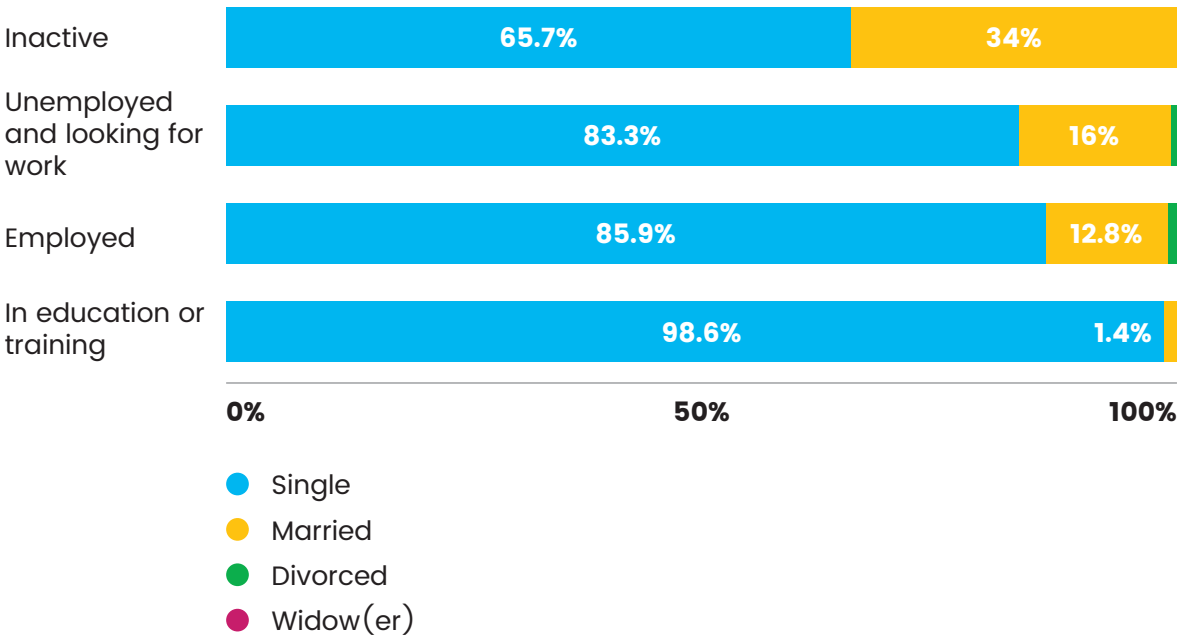
Sample distribution by marital status and area



Marital status by sex



Marital status by economic activity



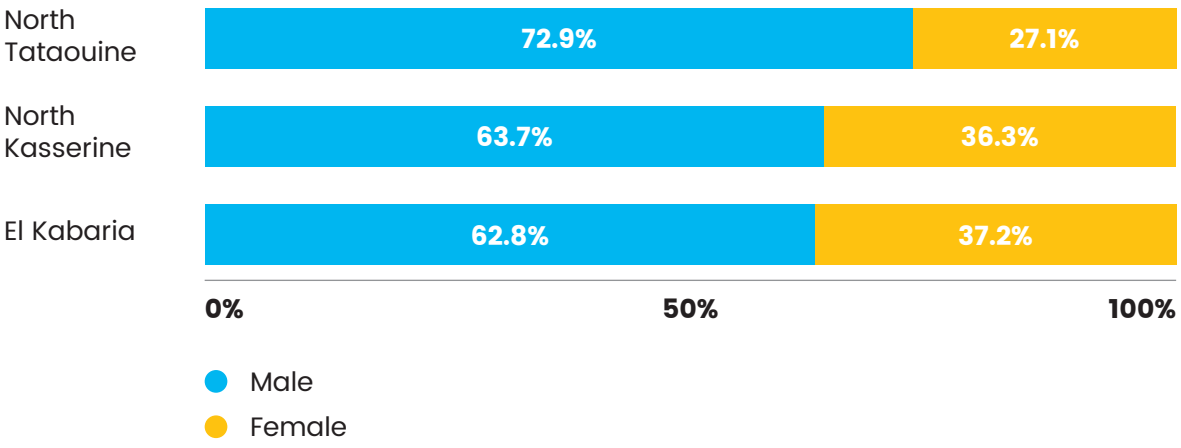
Respondents were most likely to be married if they were economically inactive (34%) and less so if they were unemployed (16%) or employed (12%). Paradoxically, however, there were more married respondents in the Kasserine sample than in the other two areas, even though the proportion of economically inactive people in that area was lower. No less paradoxical are the figures for divorce: 1.2% of employed respondents, 0.8% of unemployed respondents, 0% of economically inactive respondents. The group with the largest number of married people thus produced the smallest number of divorces. But this is of limited statistical significance since there were only 6 divorced respondents in the whole sample, less than 0.5% of the total number of respondents – a fact that is likely explained, at least in part, by the respondents' age.

Breaking down the sample by sex, we find that there are nearly three times as many married women as married men, a disparity that is likely explained for the most part by the difference in the average age at which men and women get married (with women generally marrying earlier than men).

Dropout rates

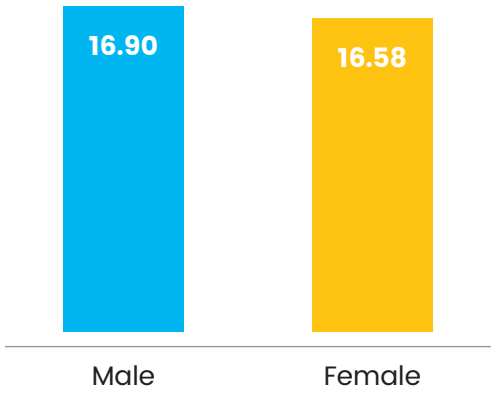
At the beginning of the millennium Tunisia had high rates of school enrolment and the number of graduates was seeing a marked rise. At the same time, over the last two decades (at least), dropout rates have been increasing at an alarming speed. There are tens of thousands of dropouts every year. In order to get to the root of this issue, we asked the respondents a series of related questions.

Dropouts by sex and region



Two thirds of respondents reported that they had dropped out of education, but with clear and highly statistically significant disparities between the sexes. Men were far more likely to have dropped out than women in all three areas, with some differences between the areas: in El Kabaria and Kasserine the proportion of men who had dropped out was less than double the proportion of women, while in Tataouine it was considerably more than double.

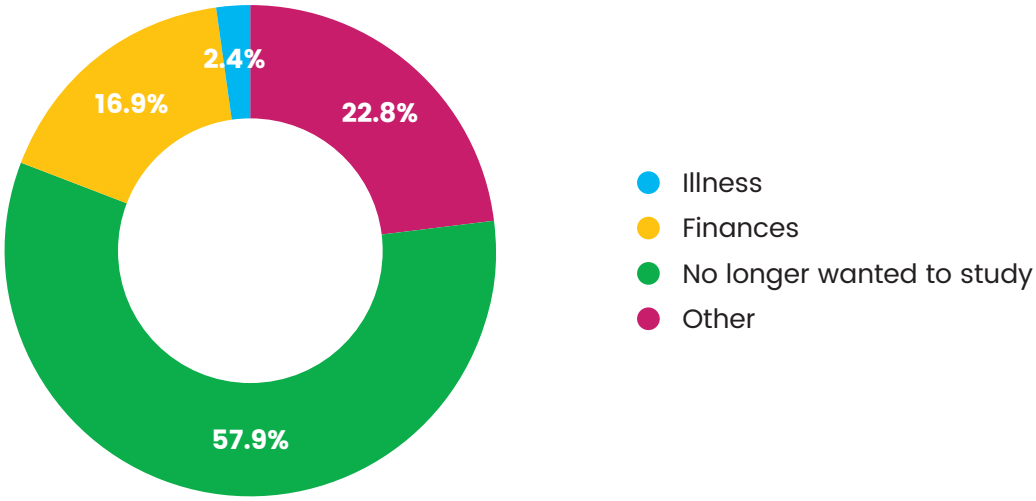
Age at dropout by area and sex



The mean age at which students dropped out of school was approximately the same in all three areas and both sexes: 16 and a few months. Women dropped out slightly earlier than men (but far less commonly) and respondents in Kasserine and El Kabaria dropped out slightly later than their counterparts in Tataouine.

Respondents had spent an average of 11 years in education.

Reasons for dropping out

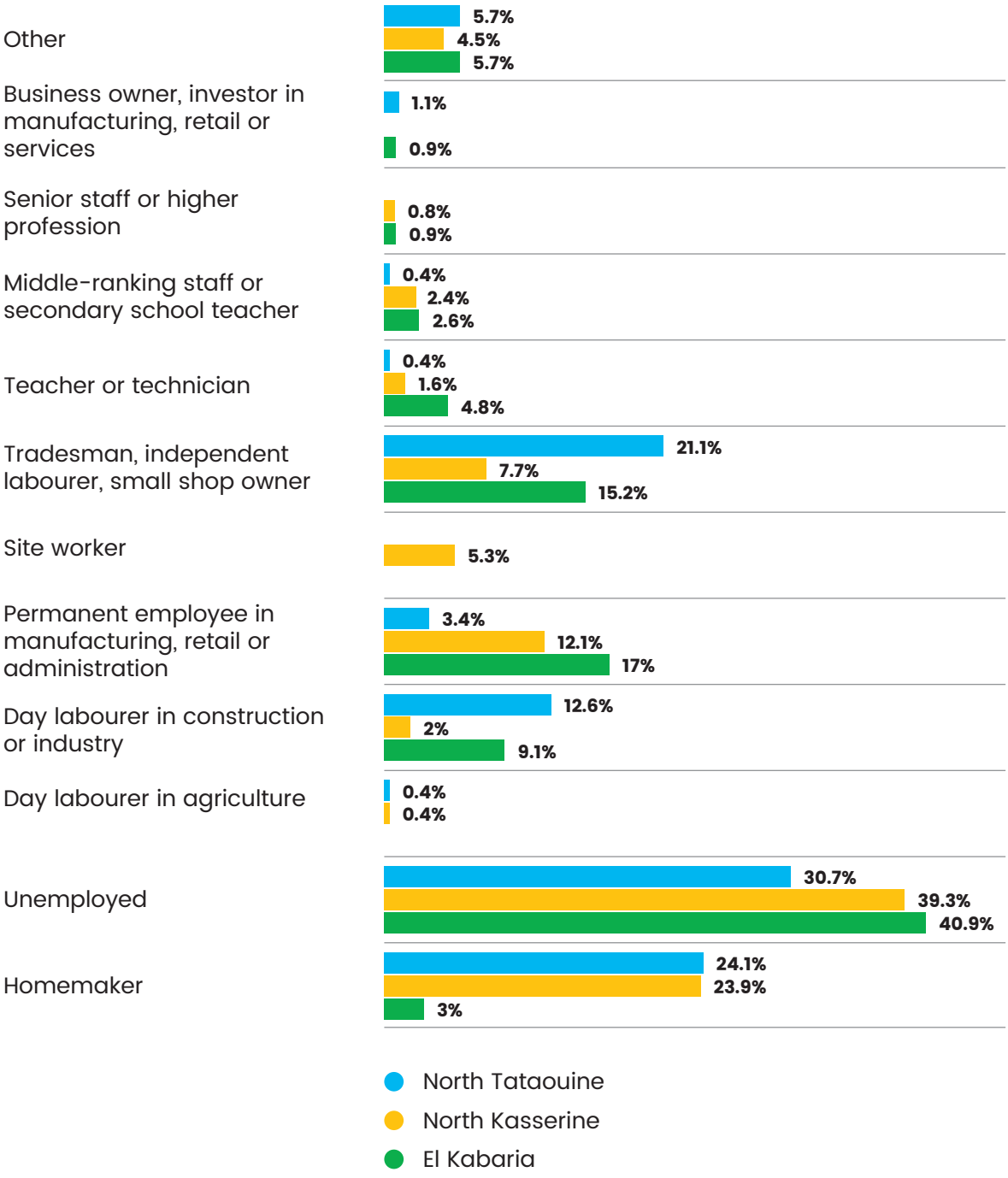


The main reason for leaving education was a loss of desire to continue, which accounted for a very large proportion of responses (58%) and confirms the extent to which education has lost much of its appeal now that it is no longer a vehicle of social mobility (as well as changes in societal values and ideas of success and advancement). Family finances were another common reason but were only the deciding factor for 17% of respondents. Illness, meanwhile, only caused 2.4% of dropouts – although this nonetheless raises the question of what the state is doing for students with chronic or rare illnesses, disabilities and learning difficulties in order to ensure that they can continue their education in accordance with the principles of citizenship and equal opportunity.

Occupation

In this section we excluded those respondents who reported that they were still in education or training.

Occupation by area



The responses given here provide us with important insights into the economic makeup of each area:

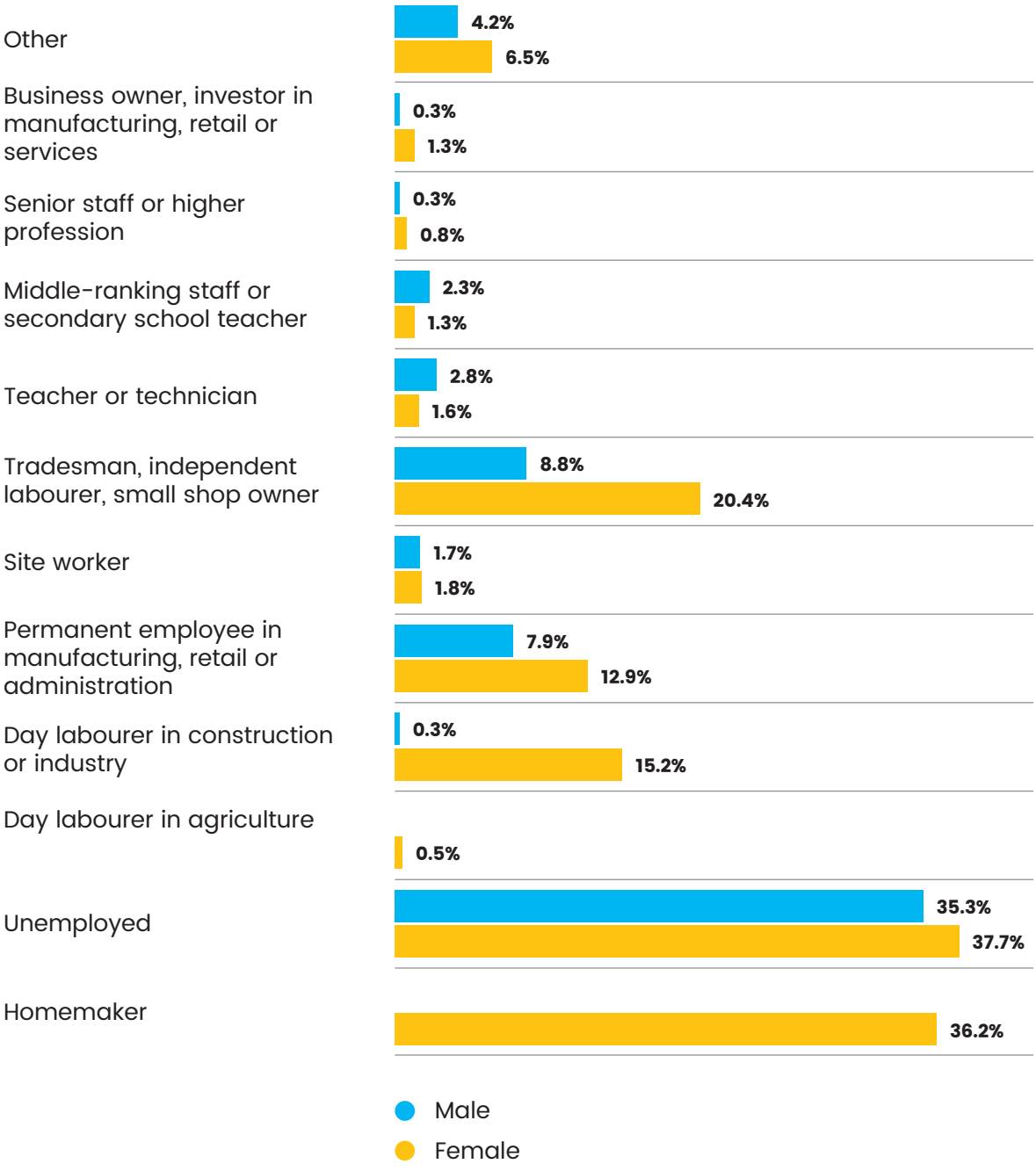
- In Tataouine there is a very high level of self-employment, whether as tradespeople or in small commercial projects. Paid work, meanwhile, is precarious: there are many more day labourers than there are permanent positions, and very few middle-ranking or senior professional jobs. There is no institutional framework of manufacturing, service or administrative jobs available in this area, and graduate unemployment is high.

- In Kasserine there are relatively few self-employed tradespeople and shopkeepers but a slightly higher number of technical specialists and professional jobs (compared to Tataouine) and many permanent employees in administrative and retail jobs. The area has a uniquely high number of 'site workers' (*'ummal hada'ir* or *ouvriers de chantier*) – beneficiaries of a precarious public employment scheme largely active in the northwest and west-central areas of the country.

- The data for El Kabaria suggests that the economic fabric in this area is more diverse, with a more balanced distribution than the other areas.

They also show differences in how the economically inactive conceptualise economic activity, especially young women. The majority of young women who do not have a paid job, whether they are economically inactive or looking for work, consider themselves to be 'unemployed', which explains why only 6% of the relevant female respondents in this region considered housework to be a job (i.e. 6% of those of both sexes in the area who are not in education or training). More than 40% of their counterparts in the other two areas (24.1% and 23.9% of the total in Tataouine and Kasserine respectively), meanwhile, considered housework to be a job. This different conceptualisation contributes to the disparity in reported unemployment rates, which are higher among young people in El Kabaria even though the number of people looking for work is not.

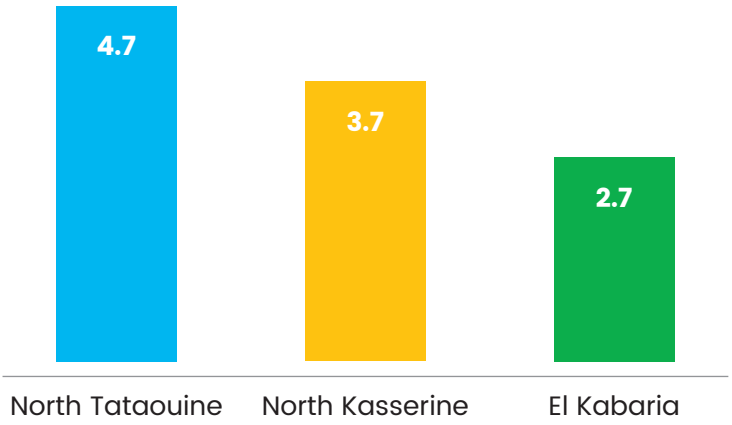
Occupation by sex



Rates of unemployment are similar between the two sexes. Only women reported being 'homemakers', who accounted for 36.2% of the sample, meaning that a total of 71.5% (including unemployed people) of female respondents who are not in education or training have no paid job, double the number of men in this position. However, more women than men work in lower and middling professional jobs, particularly in education and administration, sectors that have seen a major 'feminisation'. Significant numbers also work in manufacturing, commerce and administration, and a not inconsiderable number are self-employed tradespeople or shopkeepers. However, they are almost entirely absent from the higher professions– business and investing (which are also unusual among young men in these areas) – and day labour (with the exception of 'site workers' employed by the state).

Most female respondents said that they were not financially independent. Even those who do work are rarely self-employed or in senior positions. Male respondents' answers showed a greater range of occupations and more of a presence in both 'higher' and more precarious types of jobs: 15.7% were day labourers in construction, industry or agriculture.

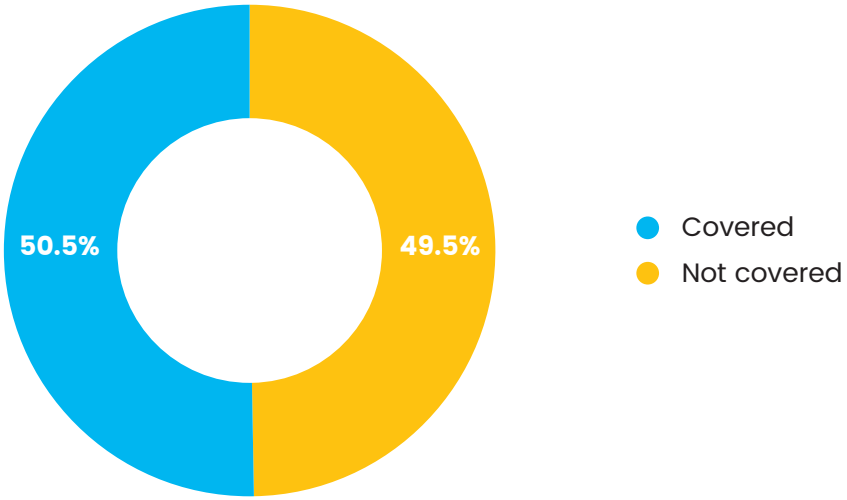
Number of siblings in family (including respondent) by area



The number of siblings in a family is an important factor in determining quality of life and educational prospects. We can conclude from respondents' answers that there are relatively important demographic disparities related both to sociocultural factors and to level of education, disparities that correspond to demographic data on the fertility rate and the average number of children per woman.

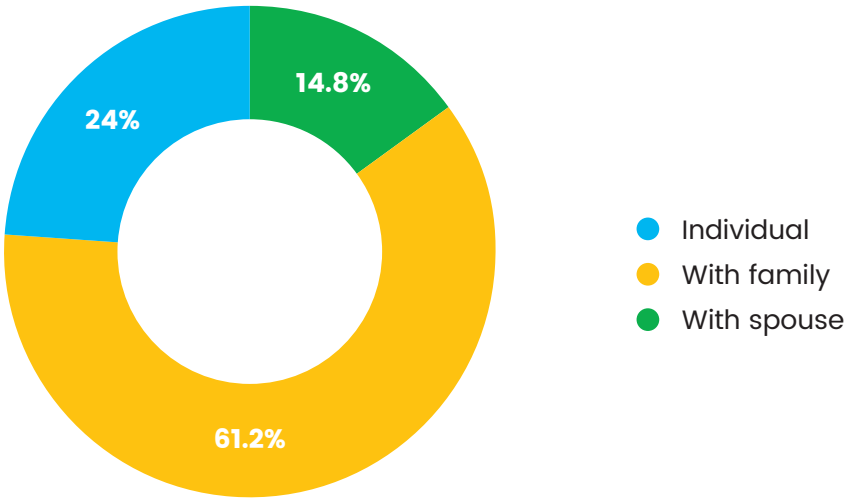
Social and health coverage

Insurance coverage (social and health):

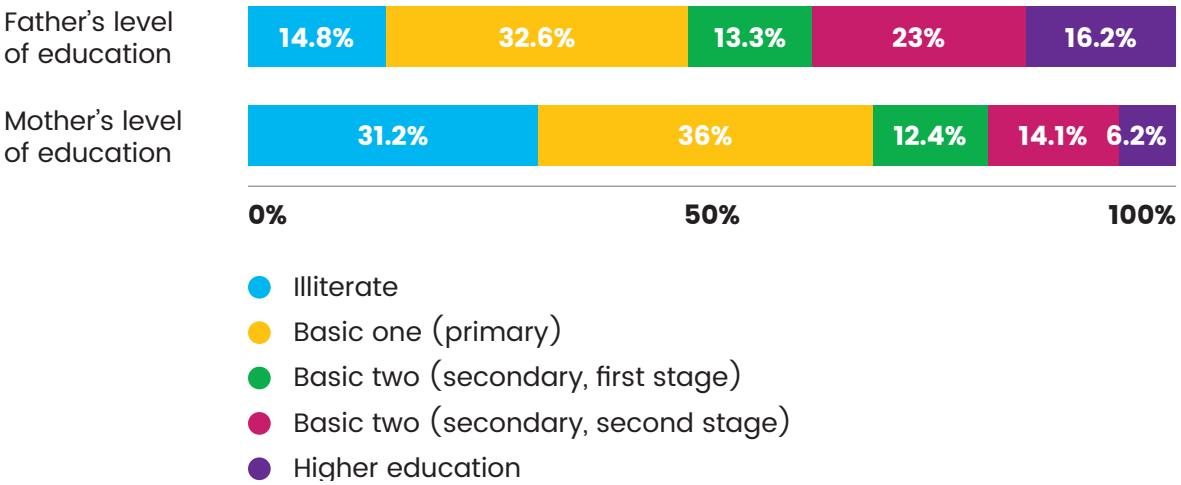


Approximately one half of all respondents reported that they were not covered by social/health insurance. Even in the case of those who were covered, fully 76% were dependent on their family or spouse's coverage. These numbers are indicative of the failure of coverage in Tunisia and the precarity of many young people's economic situation.

Type of coverage

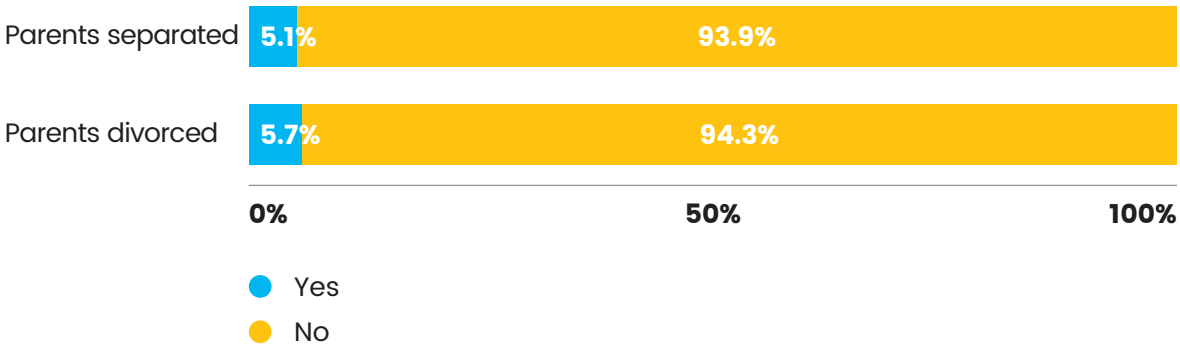


Sample distribution by parents' level of education



The graph shows that similar proportions of respondents' mothers and fathers completed primary and preparatory education, but that there are considerable disparities at other levels that point to profound inequalities between the sexes: around a third of mothers were illiterate compared to 14.8% of fathers, and the number of mothers who completed secondary education or beyond fell off dramatically compared to the number of fathers. We must not forget here, however, that we are talking about women with children aged between 18 and 29 – that is, women who are likely to be aged between 40 and 65, and who grew up at a time when marrying young and leaving school early was more common than it is today.

Divorced and separated parents

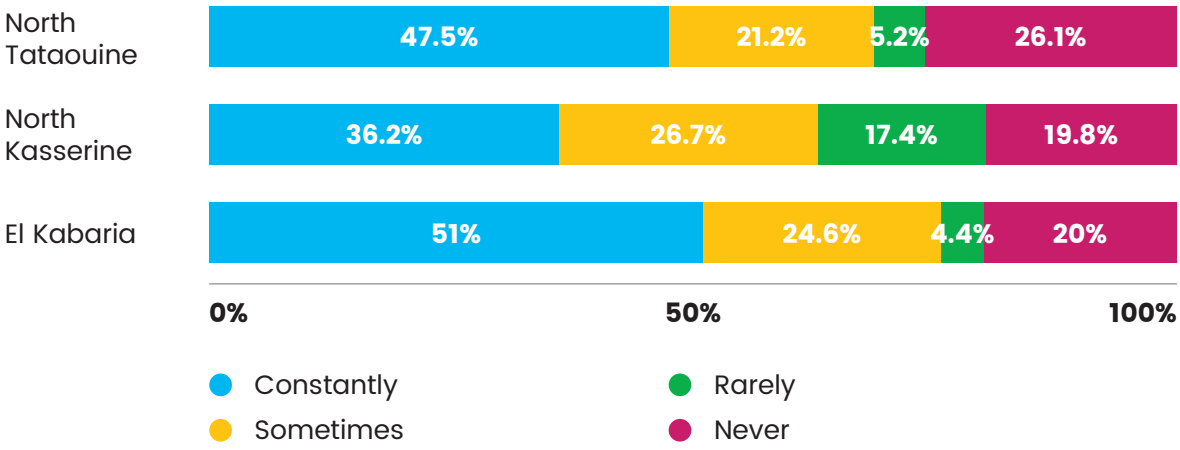


The responses show that the proportion of respondents' parents who were divorced or separated was similar to the proportion nationwide.

Migration

It is quite difficult to find a Tunisian family with no members abroad. Tunisians have a long tradition of migration dating back over half a century, from the first great waves of organised migration in the 1960s through to the smugglers' boats and brain drain of the present. Given the many-faceted crisis that has been facing the country for more than two decades, both regular and irregular migration and hopes of migrating among young people (and middle-aged people as well) are an ever-growing phenomenon, not simply as one option among many but as the primary option available. Indeed, many families take part in the 'project' of migration, whether by supporting their efforts to cross the border illegally (so-called *harga*) or by using every means available to improve their chances of securing a place to study abroad. This impression is borne out by the data.

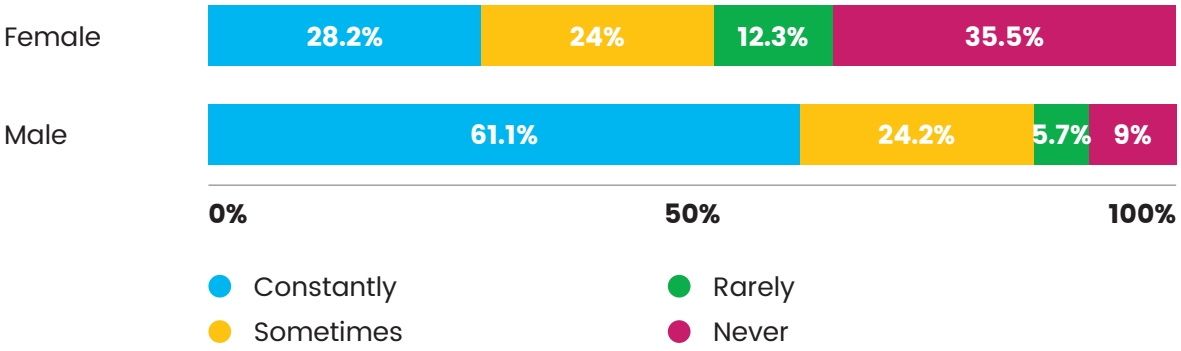
Thoughts of migration by area



Respondents in El Kabaria and North Tataouine were the most likely to think 'constantly' about migrating (approximately half the sample). In North Tataouine (and the southeast in general) there is a long tradition of mobility, and there have been several previous waves of organised migration to France since independence.

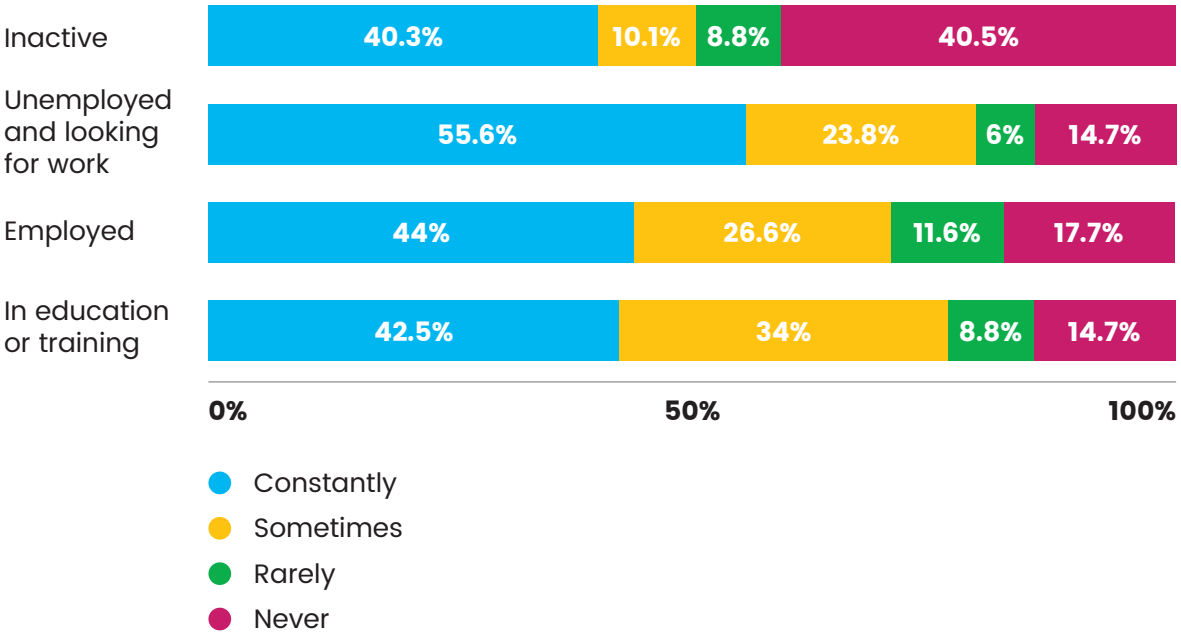
This means that locals are more likely to have family members or contacts abroad who can help them acquire the right paperwork in order to get a visa and make it easier to settle in the new country (housing, work, help with administrative issues). In El Kabaria, too, there have been many generations of organised and unorganised migration and better access to smuggling networks. The number of respondents in Kasserine who reported thinking 'constantly' about migration was much lower, but there were more who said that they thought about it 'sometimes' or 'rarely' than in other areas. This shows that the 'project' of migration is still very much present in people's minds but that the likelihood of making it a reality may be lower than elsewhere, perhaps because of the limited tradition of migration and the difficulty of getting in touch with smugglers and saving up enough money. Young people's great interest in migration cannot be separated from the other data we have provided on unemployment and dropout rates.

Thoughts of migration by sex



Migration is a constant concern for around two thirds of young men, while large numbers of young women (52.2%) think about it 'constantly' or 'sometimes'. More than 90% of male respondents think about migration (constantly, sometimes, or rarely). The high male interest in migration may be explained by the weight of social and familial pressure exercised on young men, who are in principle responsible for looking after their parents as well as acting as breadwinner for their own household. It is also easier for men to migrate than for women, and the risks that they incur by illegally migrating or residing in a foreign country are lower.

Thoughts of migration by economic activity

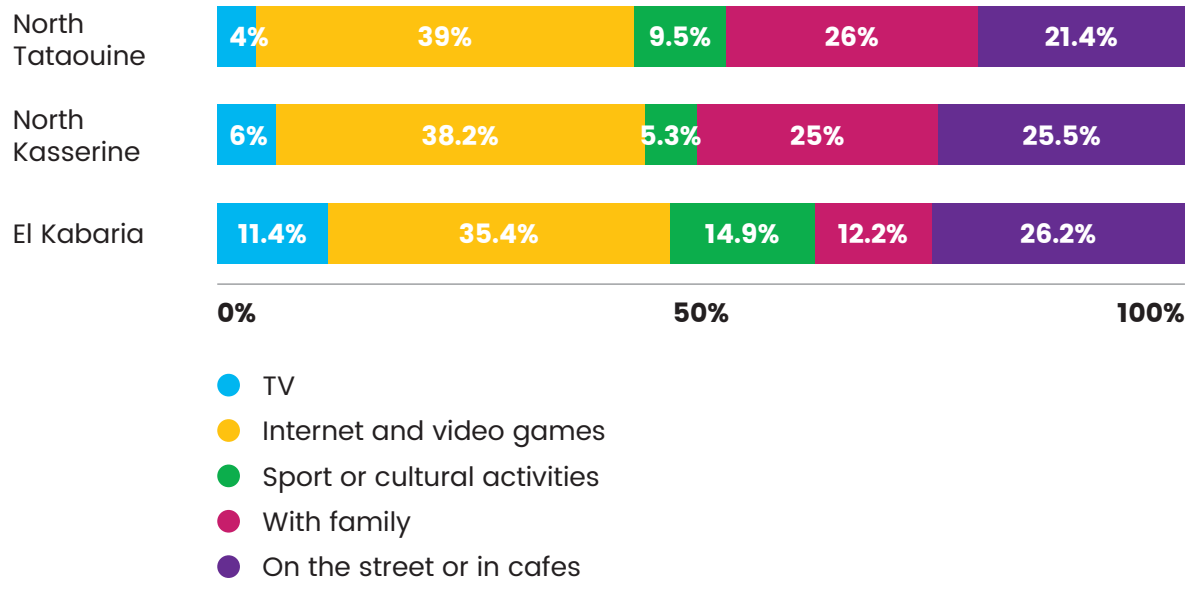


Unemployed people think most about migration. This makes sense given the ongoing economic crisis in the country, the lack of job opportunities and the limited prospects for young people – irrespective of their educational background – at a time when wages are low, the labour market is precarious, inflation is running high and the future seems entirely unclear. Similar numbers of respondents who were currently employed or still in education or training also considered migration, but often less frequently. In some cases, this is perhaps because they have more to 'lose' (a job, family stability, education) from such a risky venture without guaranteed success. Others may have had better 'luck' in improving their situation. And of course, for those who have not completed their education, migration is likely to be a long-term rather than an immediate project.

The economically inactive think least about migration. The financial factor is not the only explanation here. Their insulation from economic realities and their relatively limited social circles also reduce the feasibility of migration. Moreover, for those who are economically inactive and married, migration may not offer an acceptable future.

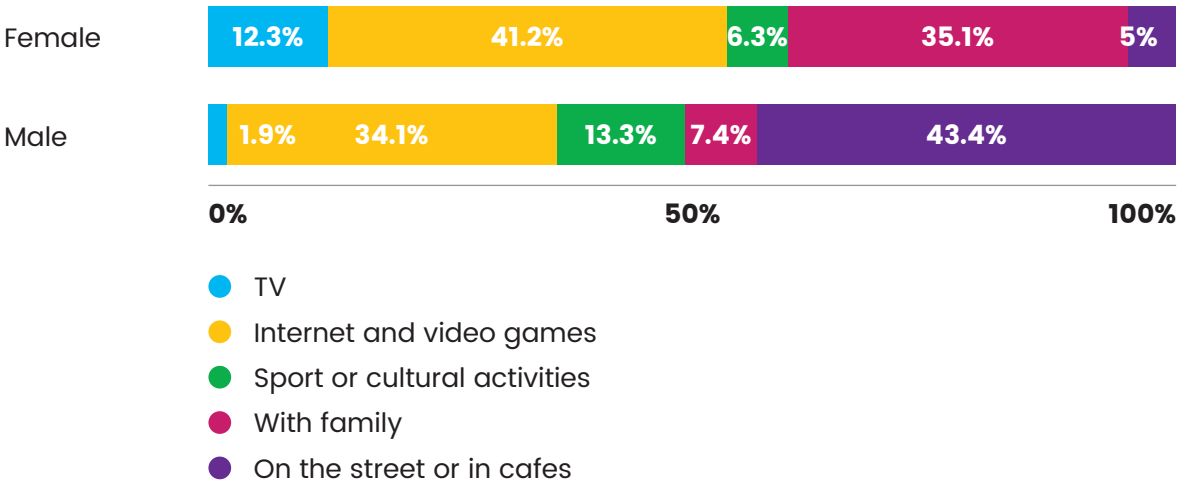
Leisure time

Primary way of spending leisure time by area



Breaking the data down by area, we find that the internet and video games are without contest the main way of spending leisure time in all three areas, accounting for more than a third of respondents, while TV is the least attractive, especially in Tataouine. We must distinguish here, however, between the TV itself and TV content. Many respondents who do not 'watch television' do consume content from TV channels via Facebook or YouTube. Spending time on the street is about as common as spending it with family in Tataouine and Kasserine and markedly more common in El Kabaria. Cultural and sporting events, meanwhile, are variably popular in the different areas: in El Kabaria these activities are three times as common as they are in Kasserine, while Tataouine sits somewhere in the middle.

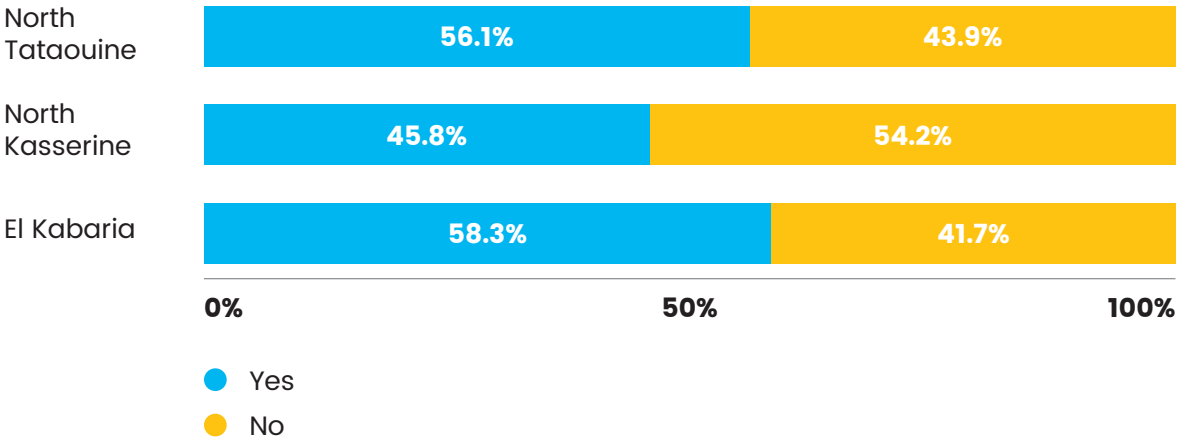
Primary way of spending leisure time by sex



The data shows that there are radical differences in how the two sexes choose to spend their leisure time, although both – to varying extents – spend a lot of time on the internet or playing video games. For young men, spending time in cafes or on the street is even more popular, with 43.4% of respondents reporting that this is their main way of spending leisure time, about nine times the figure for young women, for whom this was the least popular response. These are overwhelmingly masculine spaces, and even the word *shari'* ('street') continues to have a negative association.

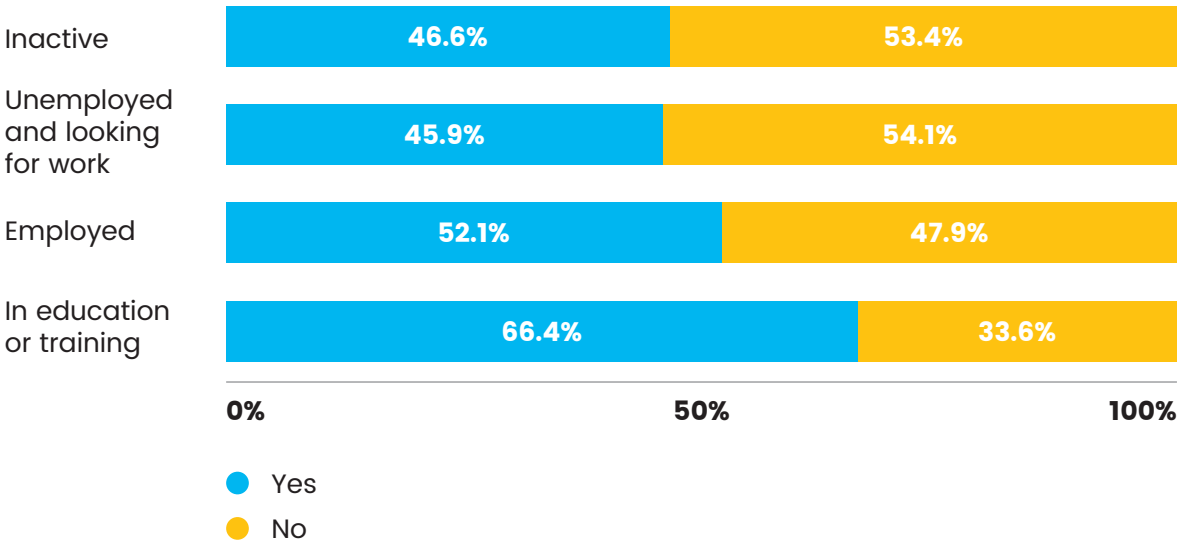
The second most common choice for women was spending time with family, which accounted for 35.1% of responses – seven times the figure for men, for whom this came in a distant fourth. Cultural and sporting activities were more common among men (where they were the third most popular response) than women (fourth most popular response). Watching TV, although reasonably common among women (12%), was almost entirely absent among young men (2%).

Spending days off at the seaside by area



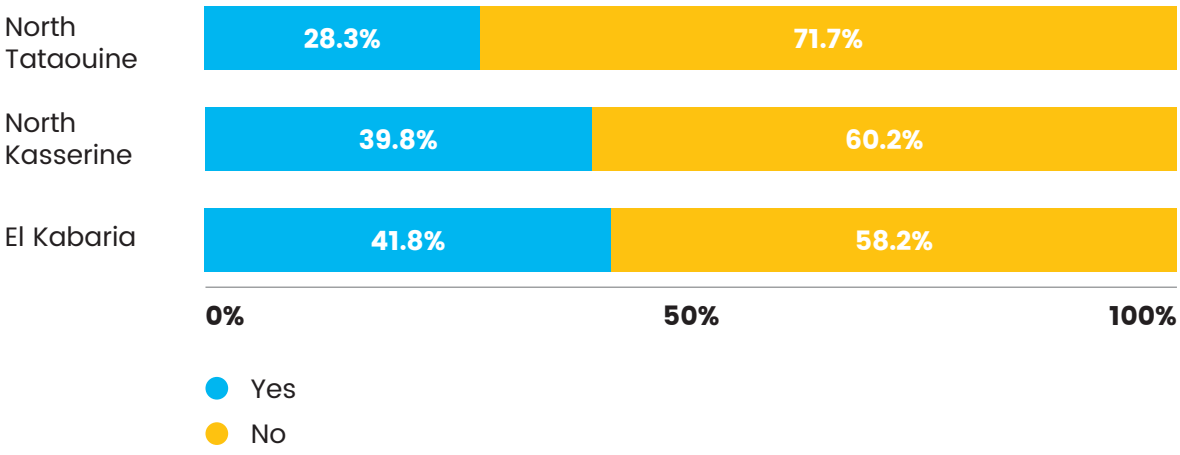
The differences between Kasserine on the one hand and El Kabaria and Tataouine on the other may partially be the product of financial factors and of the prevalence of poverty, but geography also has an obvious role to play. El Kabaria is in a coastal part of the country (Tunis) close to other coastal parts of the country (Nabeul and Bizerte). Tetouane is likewise close to the coastal areas of Medenine (Djerba and Zarzis).

Spending days off at the seaside by economic activity



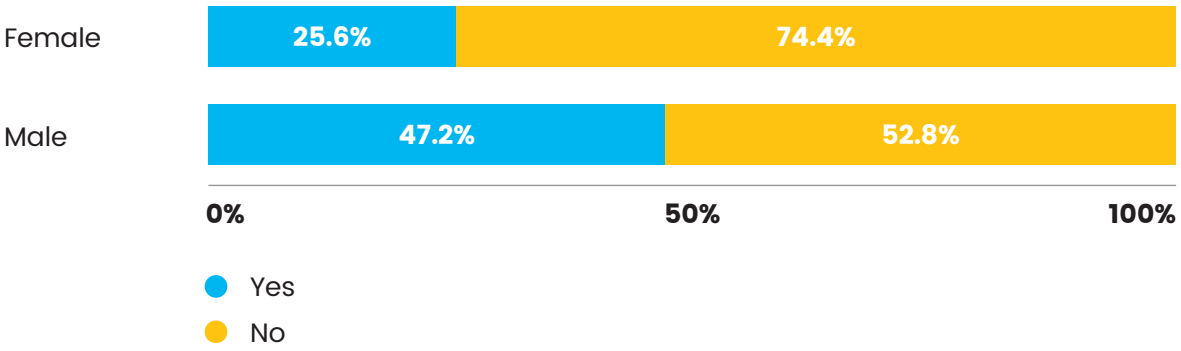
Respondents who are still in education or training were the most likely to go to the seaside on their days off (some two thirds of them). Since this is a group that lacks financial independence, families' efforts to give their children a day out are likely to play a role here. It is also worth noting that those in education tend to be more mobile and do not face the same high costs, often benefiting from discounts and other opportunities available to them because they are students or because of their parents' jobs. Respondents in employment were the second most likely group to report going to the seaside (slightly more than half). The lower numbers among those who said they were looking for work or economically inactive is probably explained by the difference in income.

Cultural and sporting activities by area



Respondents from El Kabaria were the most likely to report taking part in cultural and sporting activities. This is only to be expected given El Kabaria's proximity to the capital, which has better cultural and sporting infrastructure than the rest of the country as well as boasting more associations and groups dedicated to these purposes. The numbers were lower in Kasserine and lower still in Tataouine, where only around a quarter of respondents said they took part in such activities. These figures are once again indicative of deep regional disparities and the effect they have on young people's lives.

Cultural and sporting activities by sex



The disparities visible here demonstrate another inequality, this time between the sexes. Almost twice as many young men as young women take part in cultural or sporting activities. Families' attitudes towards these activities, and their willingness or unwillingness to allow their daughters to go out at night or travel to other cities or even abroad, play a key role in this disparity.

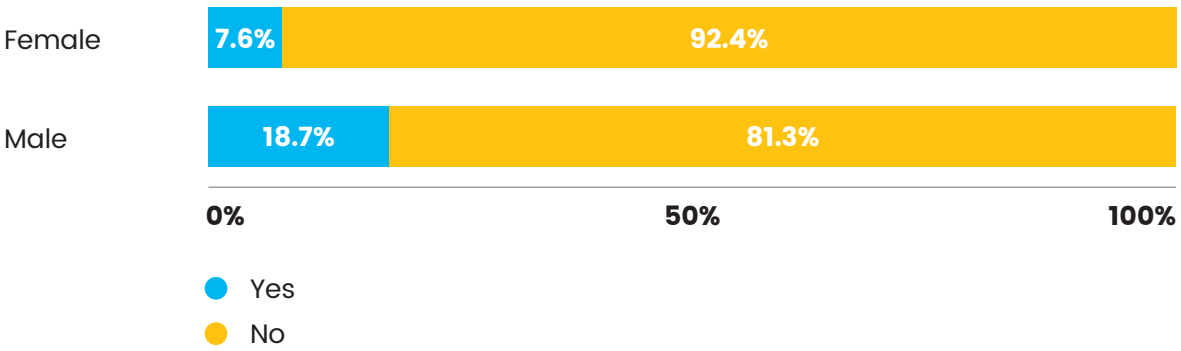
It is also worth noting that less than half of respondents reported taking part in such activities in all three areas and among both sexes.

The socioeconomic effects of coronavirus

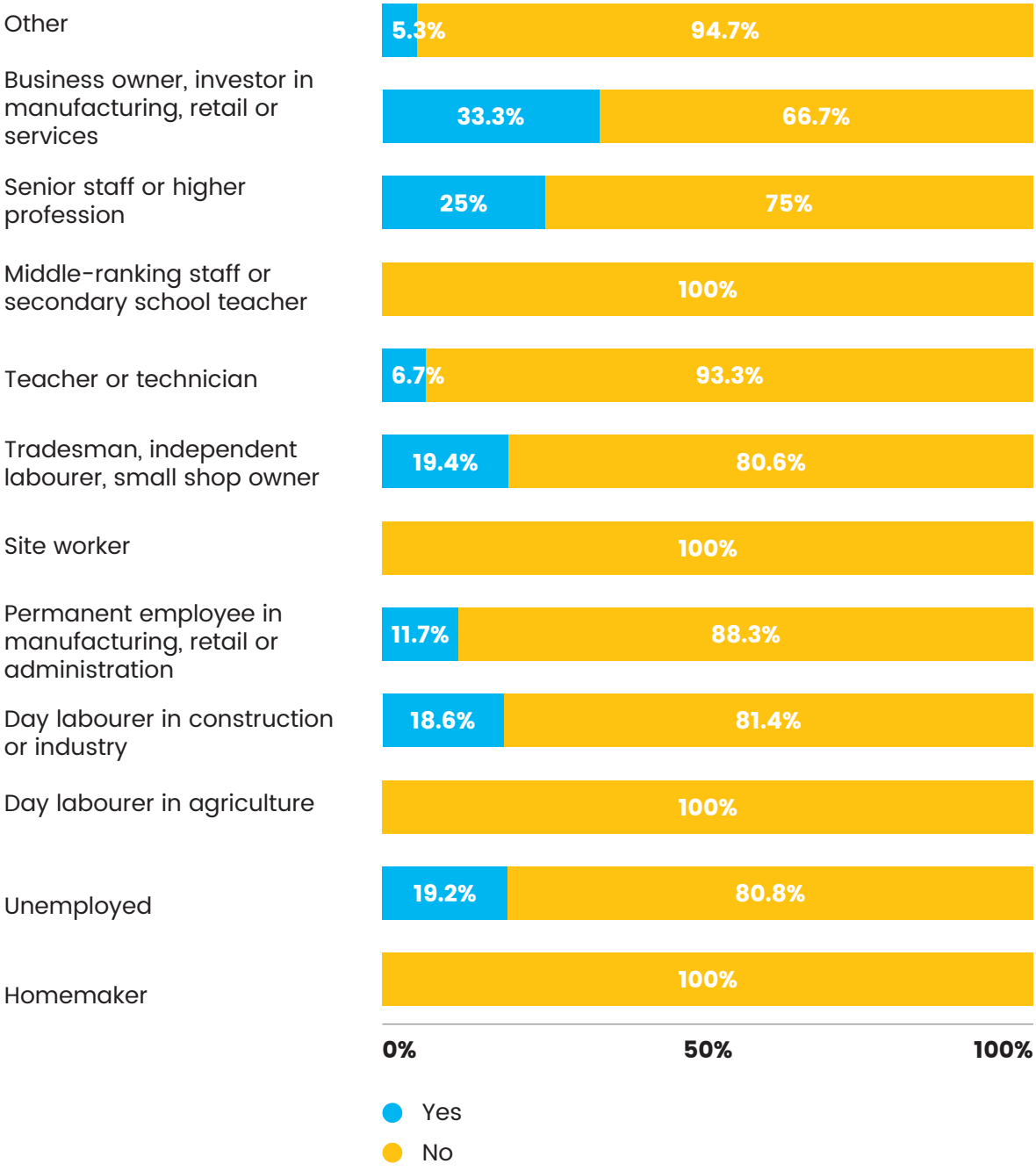
The limitations on mobility imposed as a result of the coronavirus pandemic (quarantine, curfew, social distancing, restrictions on on-the-spot consumption) have naturally had major effects on economic activity and on Tunisians' quality of life. Perhaps the most significant of these effects is economic stagnation and loss of work. 14% of respondents had been dismissed from their jobs as a result of the pandemic (not including the economically inactive and those still in education or training), with considerably higher rates among men (18.7%) than women (7.6%). The different sorts of jobs that men and women typically do has been crucial here: dismissals have been particularly common in exclusively male (day labourers in construction and industry) or male-dominated (tradesmen, self-employed workers, small shopkeepers) sectors. The sectors that employ more women have been insulated from this phenomenon, either completely (education, public administration, site workers) or relatively (salaried private sector employees).

It is important to note that around 20% of respondents who were unemployed at the time of the study had lost their jobs due to the coronavirus pandemic. 18% of respondents reported that a family member had lost their job for the same reason.

Dismissal due to coronavirus

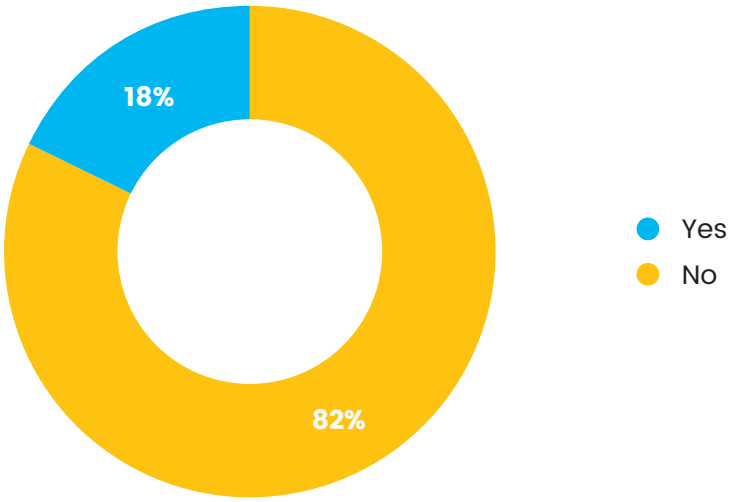


Jobs lost because of coronavirus, by profession



Note: The percentages for businesspeople and the 'higher' professions are statistically insignificant due to the small number who participated in the study (10 respondents).

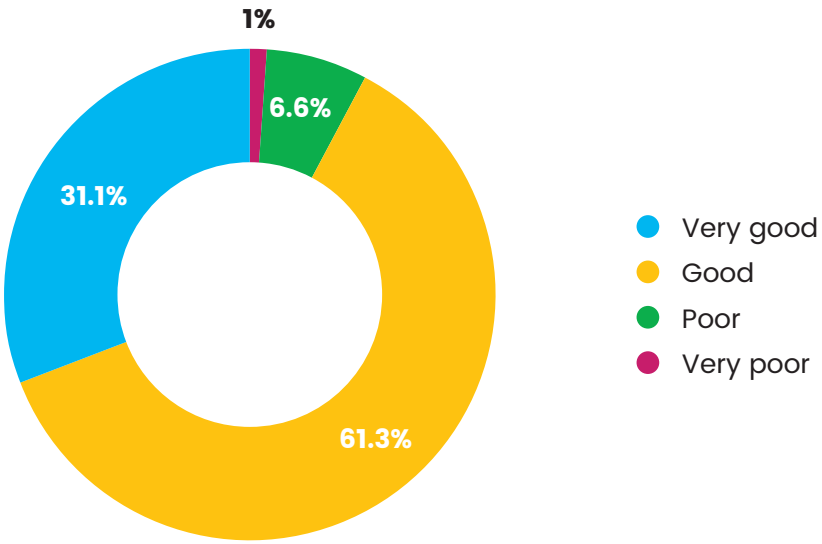
Family members dismissed due to coronavirus



3. Young people's health

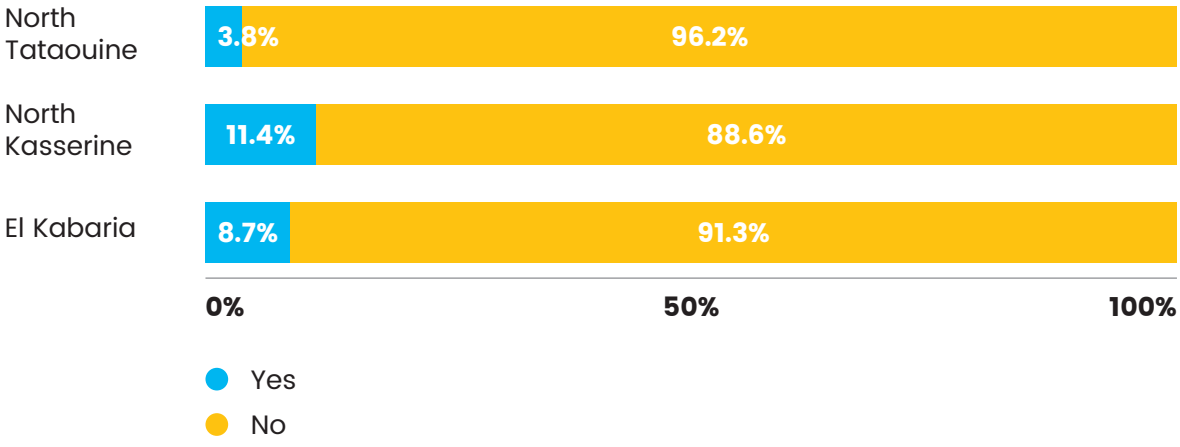
Young people's health, whether physical or (in particular) mental, receives very little attention. This part of the survey was intended to draw out respondents' conceptions of their own general physical and mental health, how often they see a doctor, and – in particular – their knowledge of mental health problems and how to deal with them, the extent to which they feel that mental health services are needed, and their assessment of the services currently available.

Assessment of own health



The vast majority of respondents (92%) reported being in 'very good' or 'good' health. This is logical given that they are all of a young age.

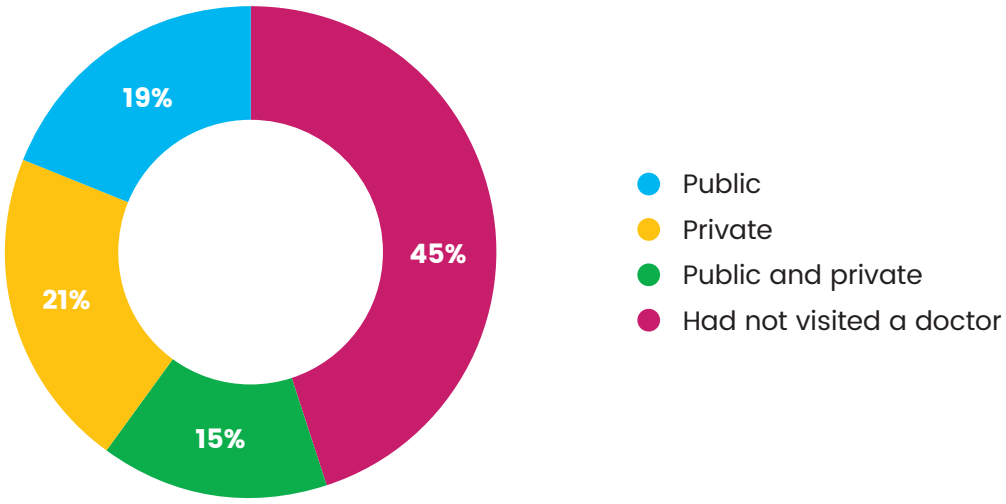
Chronic illnesses by area



The percentage of young people who reported suffering from chronic illnesses was slightly higher than those who reported being in 'poor' or 'very poor' health. There is a marked variation between the different areas, particularly between Kasserine, where chronic illness is much more common than the overall rate, and Tataouine, where it is considerably lower (only around a third of the rate in Kasserine). The rate in El Kabaria is also relatively high.

We do not have sufficient data on the nature of these chronic illnesses in the different areas or precise explanations for the higher rates reported in Kasserine. There are many factors that are likely to contribute, however: environmental, social (cousin marriage and genetic issues), and in particular environmental-social (pollution and poverty leading to a lower quality of life). The lower rate in Tataouine can probably be attributed to poor diagnostic facilities, particularly with respect to chronic conditions common among young people (asthma and many other rare illnesses). The fact that the only regional hospital in the governorate lacks specialists in most areas – as, in fact, do most private hospitals – and the distance that young people from Tataouine must travel to access specialised health facilities almost certainly plays a role.

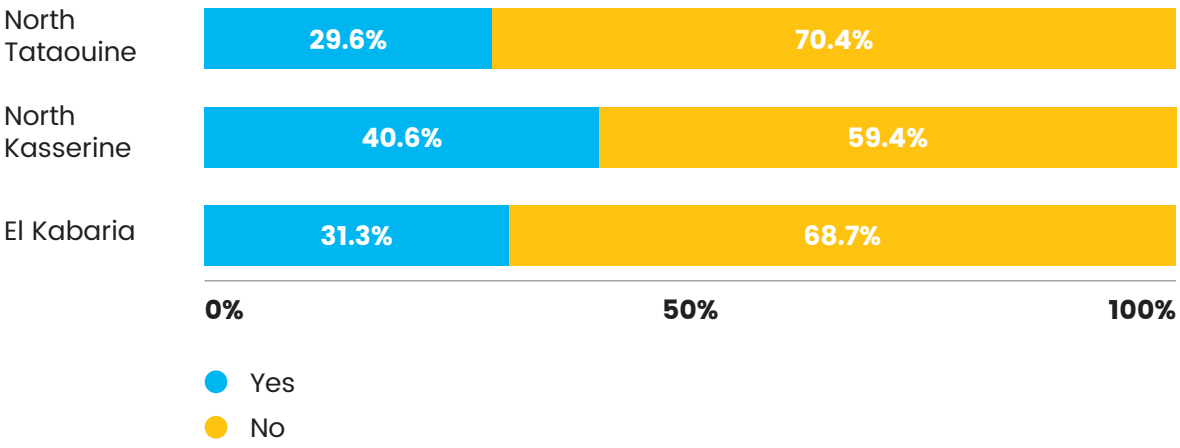
Visits to a (public and/or private) doctor within the last year



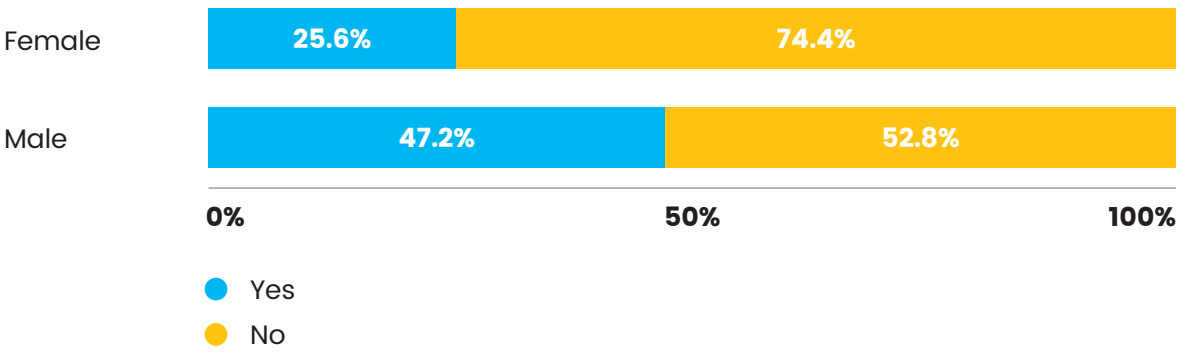
Although most respondents reported being in 'good' or 'very good' health, this does not mean that they never need emergency care or access to specific health services of various kinds. More than half of them reported that they had consulted a doctor (in the public or private sector) at least once, with similar figures in all three areas. Around a quarter of those who had seen a doctor had done so at both public-sector and private-sector facilities.

Visits to a (public and/or private) doctor within the last year by various variables

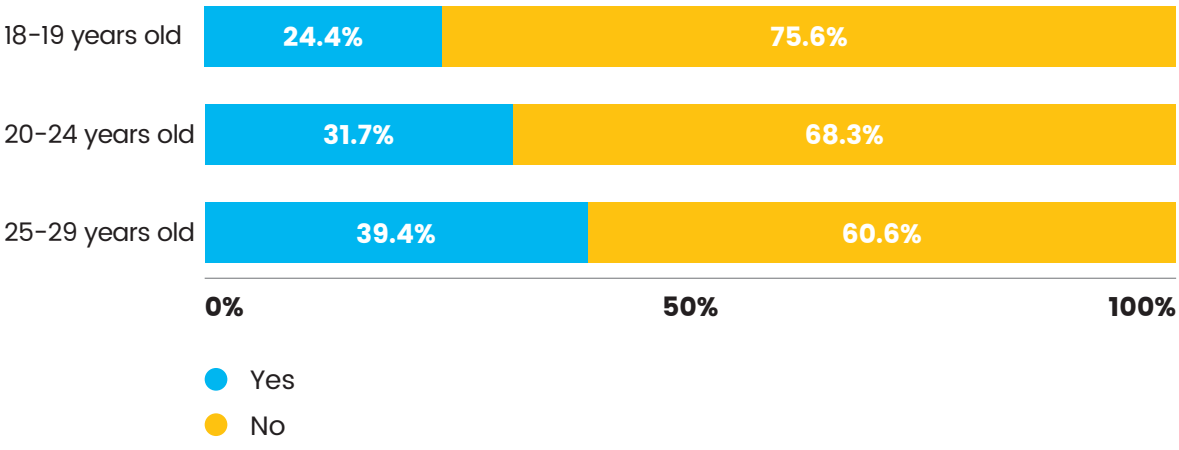
Area



Sex



Age

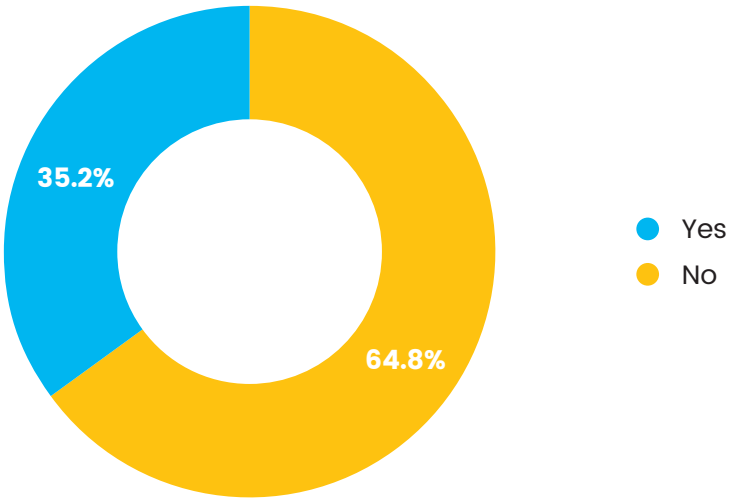


Breaking down the data on young people's access to medical services by different variables reveals three striking points:

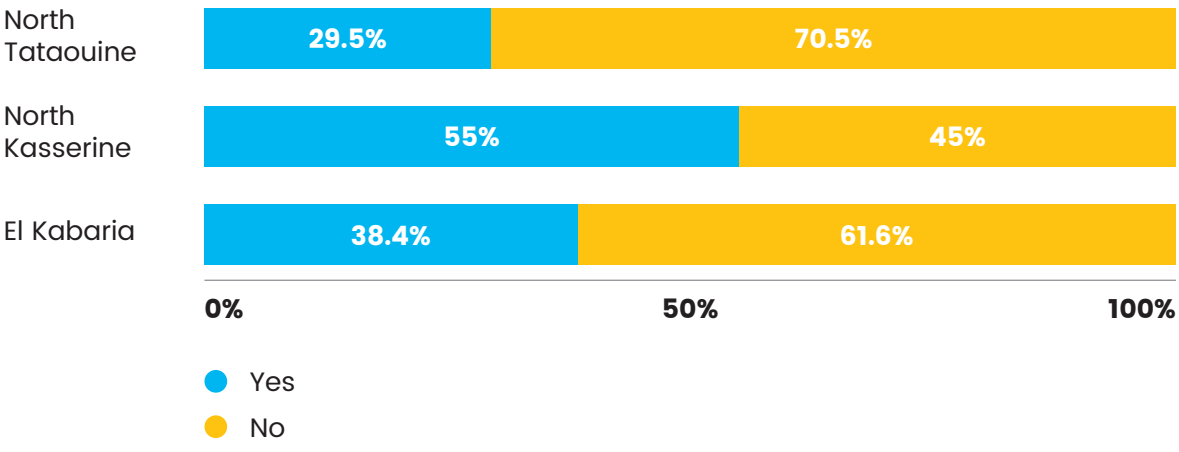
- Respondents in Kasserine were considerably more likely to have visited a doctor in the last year (40.6%), at rates almost a third higher than their counterparts in Tataouine and El Kabaria – further evidence that health in that region is a special case.
- Almost twice as many young men as young women had seen a doctor in the public sector. This is completely at odds with official statistics on normal and urgent appointments, which suggest that women are much more likely to make use of these services. It is worth noting, however, that those statistics cover all age groups, and there is no specific data available on young people. The disparity between men and women may in part be explained by the much larger numbers of young men working in dangerous or physically demanding jobs as well as their greater risk of violence or risky behaviour and their greater drug, alcohol and tobacco consumption. A more precise determination will require a more detailed study.
- The distribution by age is as we would expect: the older the respondent, the more likely they were to have needed to access medical care.

Coronavirus

'Have you had coronavirus?'



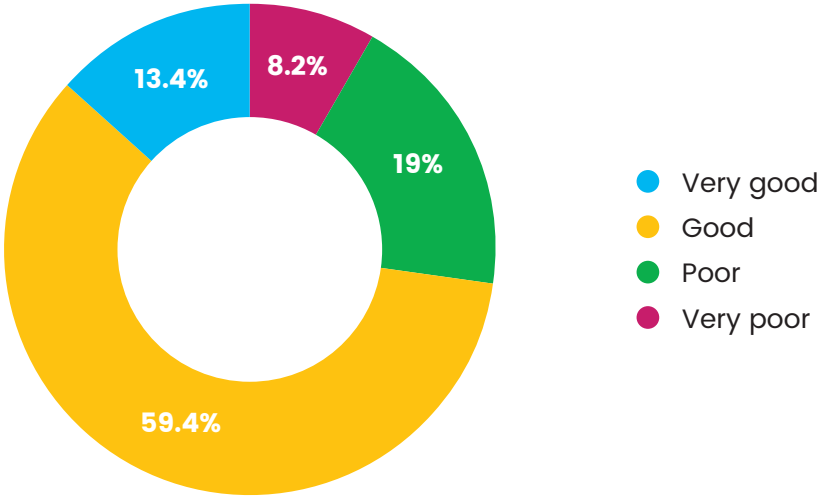
'Have you ever taken a coronavirus test?', by area



The responses show that a relatively large proportion of young people had COVID-19: 35.2%, more than a third. The proportion who reported having taken a test, on the other hand, was quite low, barely exceeding the proportion who reported having had the virus. There were significant regional differences, however: low levels in Tataouine and, to a lesser extent, in El Kabaria, and high levels in Kasserine, where some half of respondents said that they had been tested. This may be a result of the extensive testing campaigns carried out in that region after it became an infection hotspot.

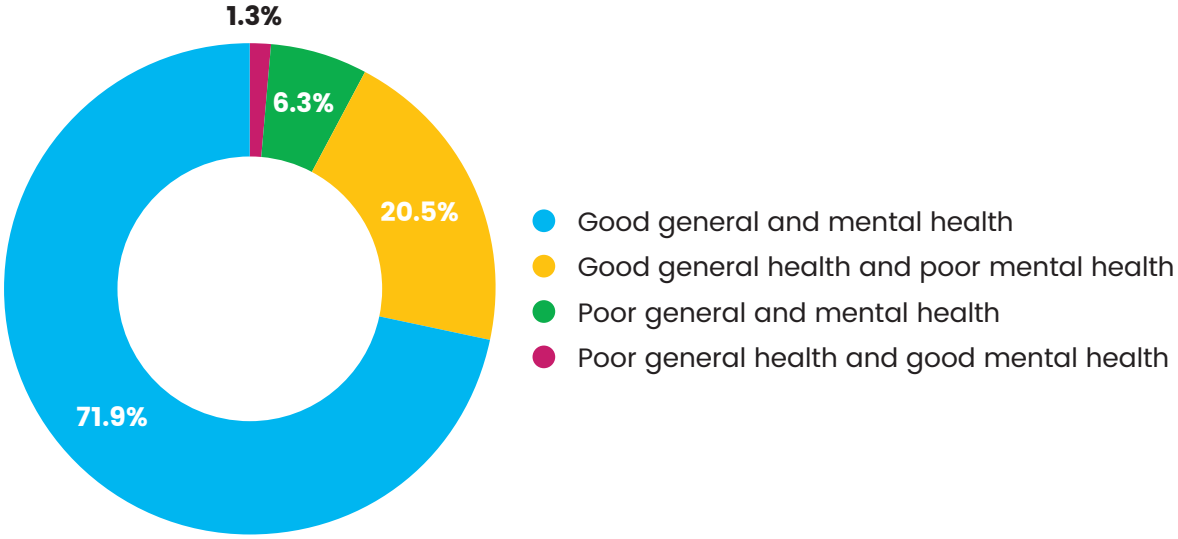
4.Mental health

Assessment of own mental health



The results show that respondents generally have a less positive view of their mental than their general health. More than three times as many respondents reported 'poor' mental health than 'poor' general health (27.2% compared to 7.6%).

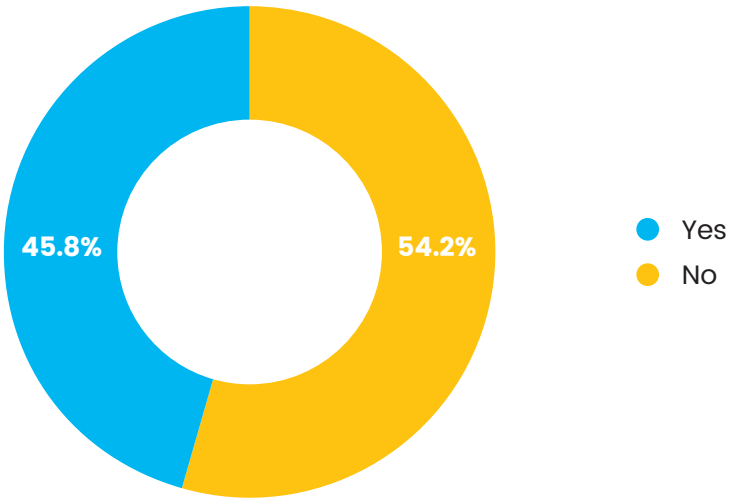
Comparison of general and mental health



[Good general and mental health, good general health and poor mental health, poor general and mental health, poor general health and good mental health]

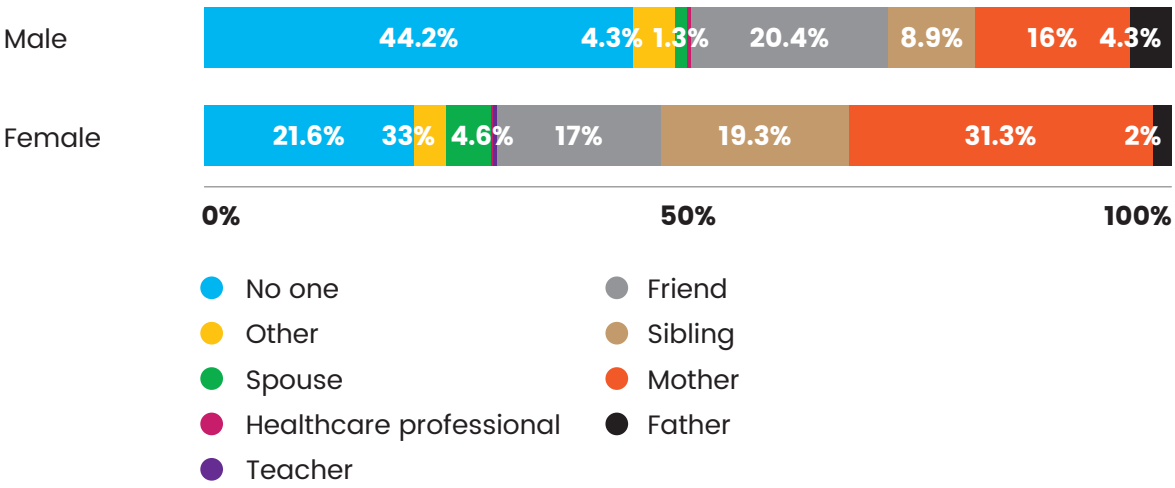
With the exception of around 1% of respondents, the general rule is that the better a respondent rated their mental health, the better they rated their physical health, and vice versa. More than 20% of young people, however, reported good or very good general health but poor or very poor mental health.

'Has coronavirus affected your mental health?'



45.8% of respondents reported that the coronavirus pandemic had affected their mental health. This was a much larger figure than those who reported 'poor' or 'very poor' mental health, implying that this effect was limited or temporary and had dissipated by the time that the study was conducted.

First port of call for young people suffering from mental health problems



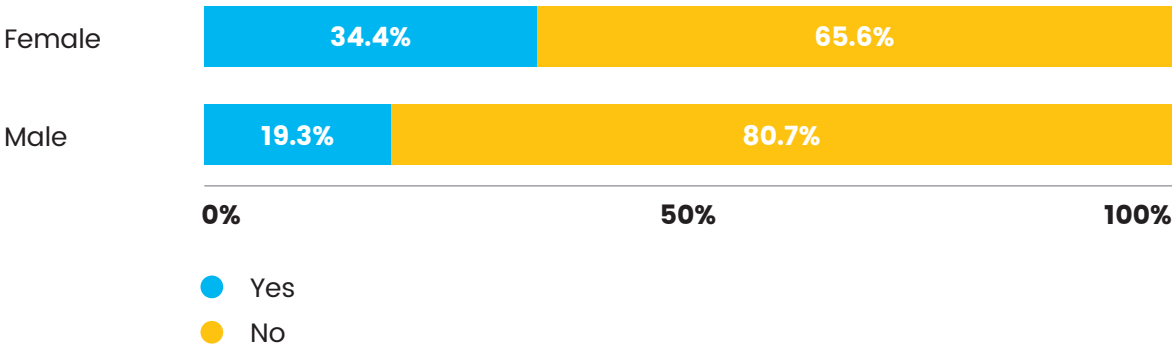
The graph above shows a very significant difference between the sexes with respect to the first port of call in the case of mental health problems. Indeed, whether respondents considered talking to anyone at all about their mental health problems differed dramatically by sex. Around 45% of young men stated that they did not seek help from anyone, while around 80% of young women said that they did seek support. This may be attributable to the different socialisation of young men and women: men get used to solving their problems on their own and often lack close relationships with their fathers and even their mothers, while women's 'softness' and solidarity has the opposite effect. Both sexes rely heavily on family members, although at different rates (29.3% of young men and 52.6% of young women) and with significant differences in the family members chosen: predominantly mothers, with fathers almost entirely absent, especially for female respondents (in line with the classical distinction of caring mother and authority figure father common in the popular imagination) and brothers and sisters somewhere in the middle. Spouses are conspicuously absent from the data when compared with the number of married respondents, particularly among young men. Friends play an important role for both sexes, but particularly for young men, who reported seeking help from friends more often than they did even from their mothers. Neither sex relies on public healthcare institutions or on educational institutions.

Need to access psychological or psychiatric care within the last year

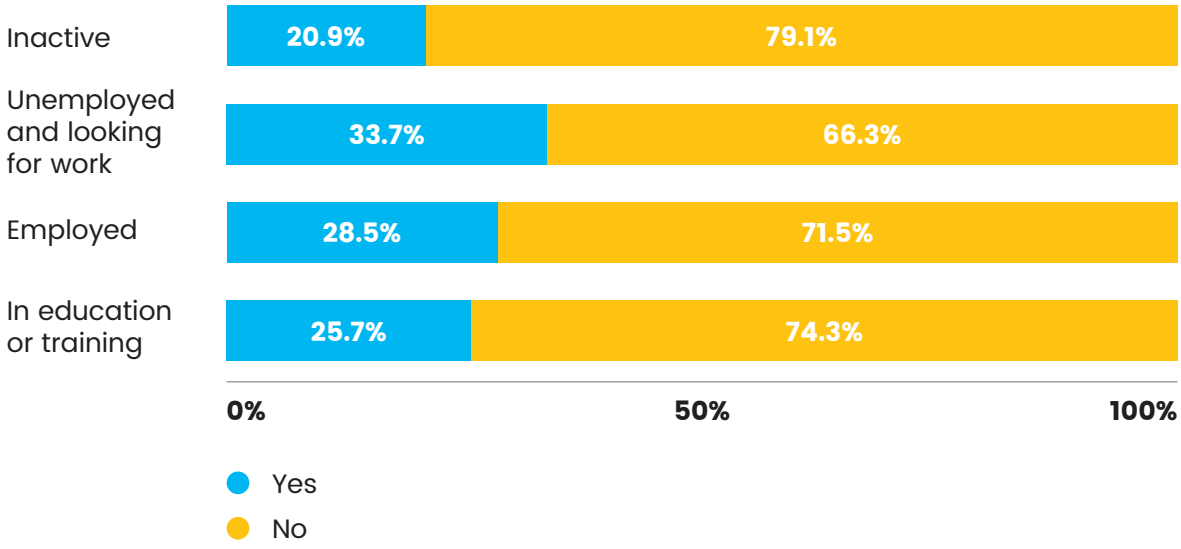
In order to establish the extent to which young people had felt the need for mental health care within the last year, we asked them this question directly. A significant proportion (26.8%), very similar to the proportion that described their mental health as 'poor', reported that they had felt such a need.

The groups that were more likely to have felt the need to access psychological or psychiatric care were:

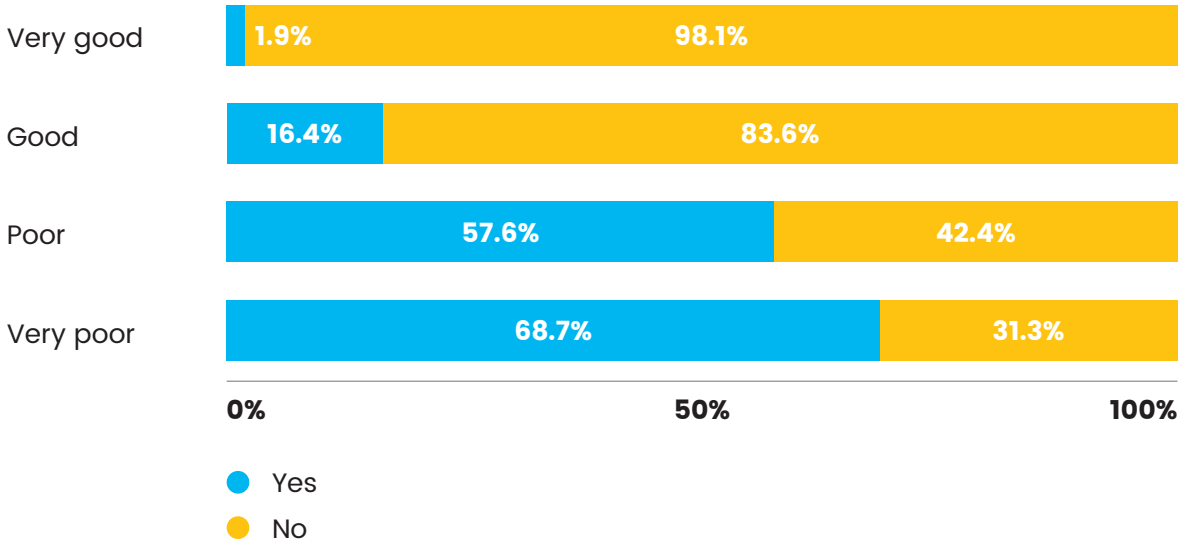
By sex: women, at a rate almost twice that among men.



By economic activity: unemployed people (33.7%), then employed people (28.5%), then those in education or training (25.7%), and finally the economically inactive (20.9%).

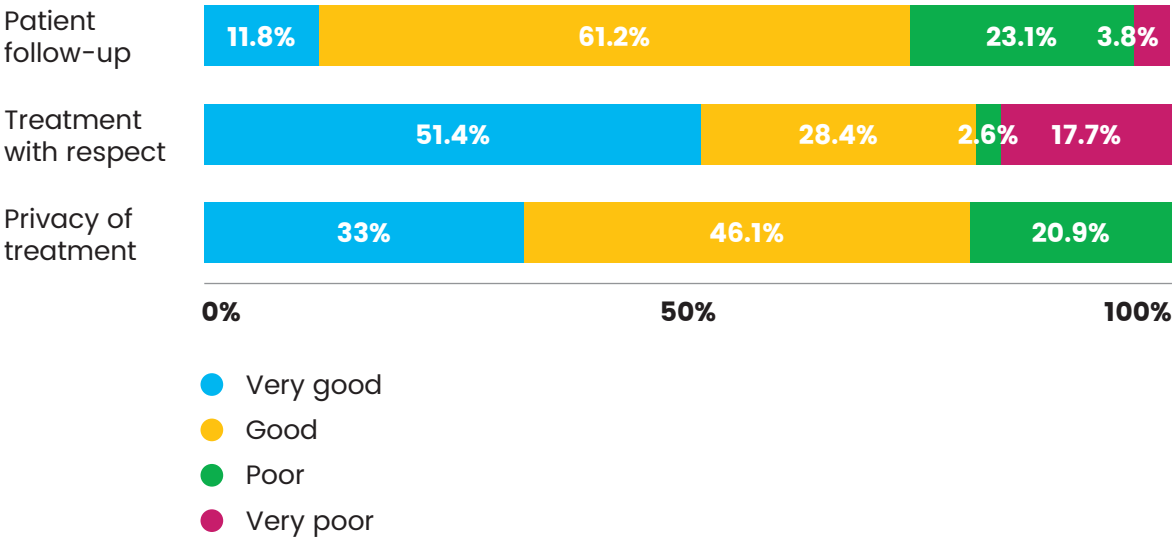


Comparison of need to access psychological or psychiatric care within the last year and assessment of mental health

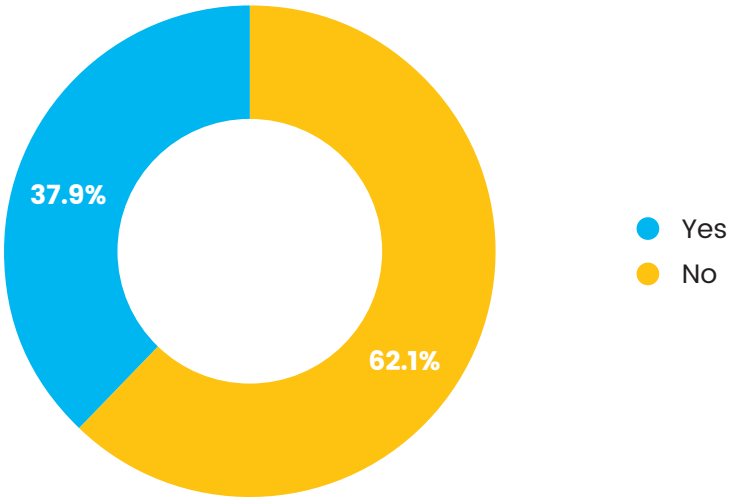


The relationship between respondents' assessment of their mental health and their need for psychiatric or psychological care is complicated. 16.4% of respondents who described their mental health as 'good' (and 1.9% of those who described it as 'very good') said that they had felt a need for specialist care within the last year. This may be the result of symptoms improving on their own or of successful treatment. On the other hand, 68.7% of respondents who described their mental health as 'very poor' and 57.6% of those who described it as 'poor', reported that they had felt the need to seek psychiatric or psychological care during the past year, as might be expected.

Assessment of service quality after seeing a psychiatrist or psychologist



'Was the care you accessed available for free?'



Those respondents who had accessed psychiatric or psychological care within the last year generally rated the service they had received well, with between 73% and 80% describing it as 'good' or 'very good', although levels of satisfaction varied with regard to the three criteria set out by the survey:

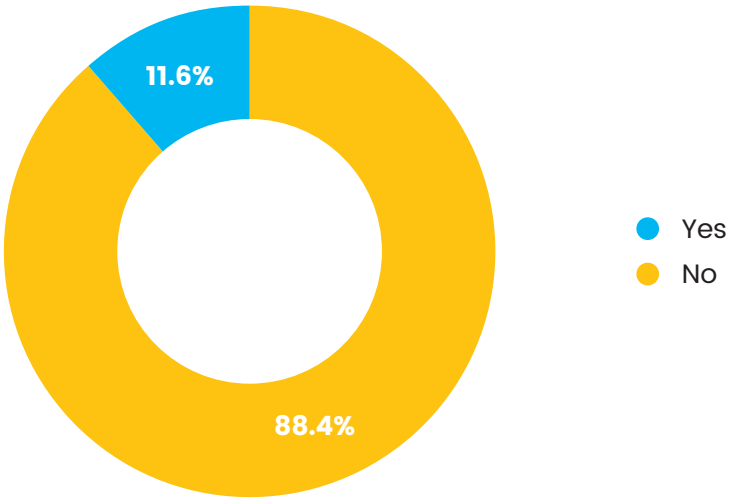
- Respondents were least likely to be completely satisfied with patient follow-up: only 12% described it as 'very good' (although 61% said that it was 'good'). Especially given the relatively high rates of dissatisfaction (27%, with 4% describing it as 'very poor'), there seems to be a general sense that there is insufficient follow-up.

- Conversely, they were most likely to report that they felt they had been treated with respect, with almost 80% of respondents expressing general satisfaction (51% total satisfaction). Nonetheless, 18% of respondents reported 'poor' or 'very poor' respect for patients.

- Respondents' assessment of the privacy of treatment was somewhere in the middle. Although 80% reported being generally satisfied, only 28% said that they were totally satisfied, and 21% said that privacy was 'poor'. No-one reported 'very poor' privacy.

The assessment of the services that young people had accessed was thus generally positive with a clear need to address some of its weaknesses. But being able to access these services in the first place remains very unusual. According to the responses, only 12% of those who had felt the need for psychological or psychiatric care had actually seen a specialist. Financial factors play an important role here: only 37% of those who had accessed specialist care reported that it was free (and around half of respondents have no social security coverage). Even more significant, however, is the almost total absence of psychiatrists and psychologists from the interior regions, particularly in public healthcare, as well as the complexity of, and lack of information on, accessing care.

'Do you have a family member who is receiving psychological or psychiatric care?'

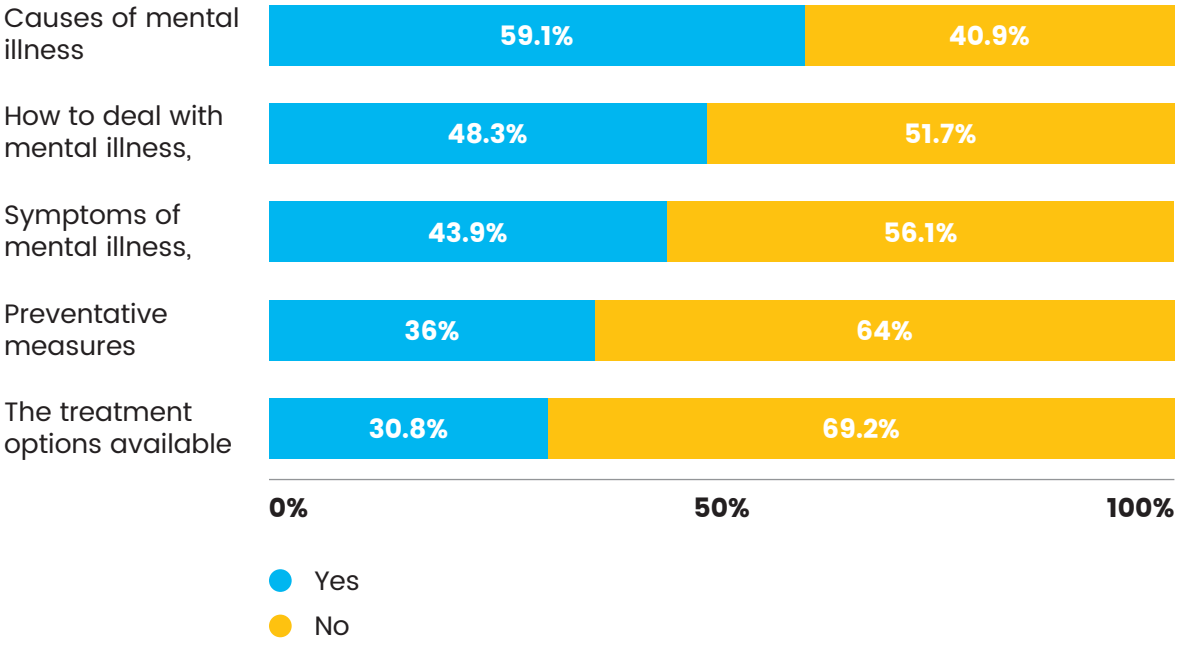


More than 11% of respondents reported that one of their family members was receiving care from a psychiatrist or psychologist. This is relatively high, especially when compared with the data on the availability of psychiatric and psychological services within the public sector[32] and the number of people who reported that they were being treated for depression, the most commonly reported mental illness in the National Institute for Health's 2016 National Health Survey.[33] The disparity is probably explained on the one hand by the incompleteness of the published statistics and, on the other, by the growth of the sort of socioeconomic pressures – particularly in deprived and marginalised regions like those targeted by this study – that make individuals more vulnerable to mental illness. This despite limited acceptance of mental health treatment in Tunisia, the financial and geographical difficulties involved in accessing it, and the keenness of many who are receiving treatment to avoid disclosure even to those close to them for fear of stigma.

32 According to Health Ministry statistics for 2019, there were 272,082 psychiatric/psychological consultations held across the whole country (0 in Tataouine; 3,142 in Kasserine; more than 120,000 in Greater Tunis; and 84,000 in the central eastern region: Susa, Monastir, Mahdia and Sfax). Even assuming one appointment per patient, this would amount to coverage for only around 2.4% of the population. "Health Map 2019" (p. 162), Ministry of Health, Directorate of Studies and Planning, April 2021, document published on the Ministry's website.

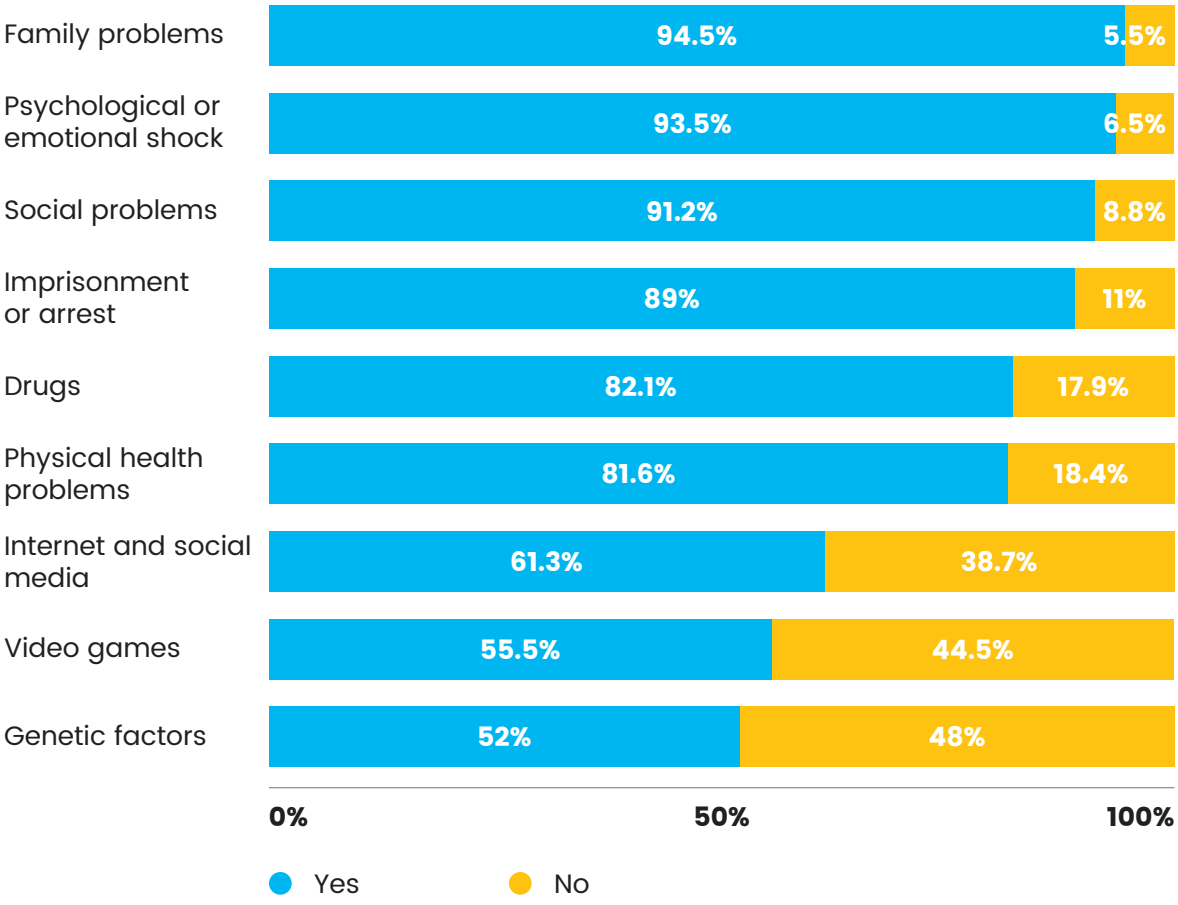
33 1.6% of the total population aged 15 years or older. See: "Results of the comprehensive survey of health in Tunisia, 2016" (pp. 191-192), Ministry of Health, National Institute of Health, February 2019, published on the Ministry's website.

'Is there sufficient information available on psychological problems and illnesses?'



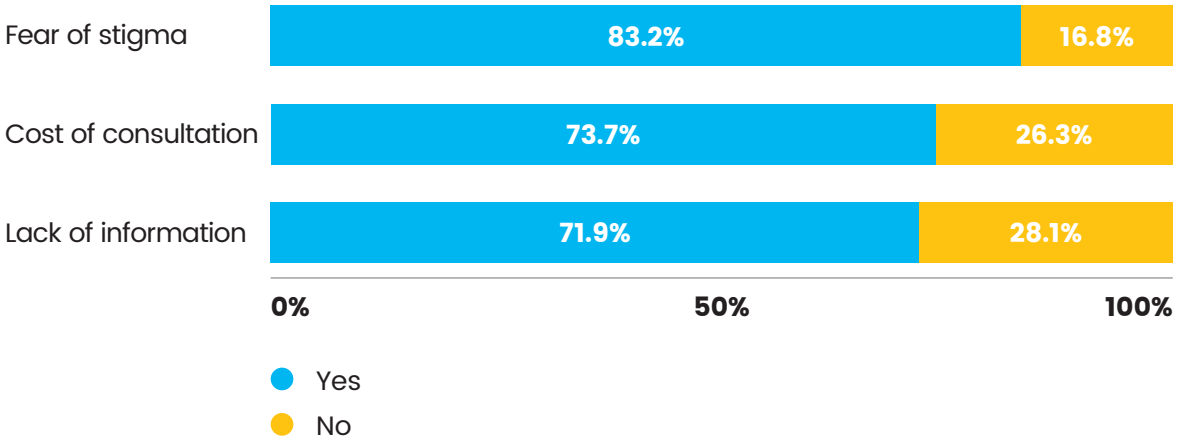
Although some 60% of respondents reported that they were familiar with the causes of mental illness, less than half – and in some cases less than a third – said that they knew how to deal with mental health problems, the symptoms of different mental illnesses, and in particular about prevention and the treatment available.

Causes of mental illness, according to respondents



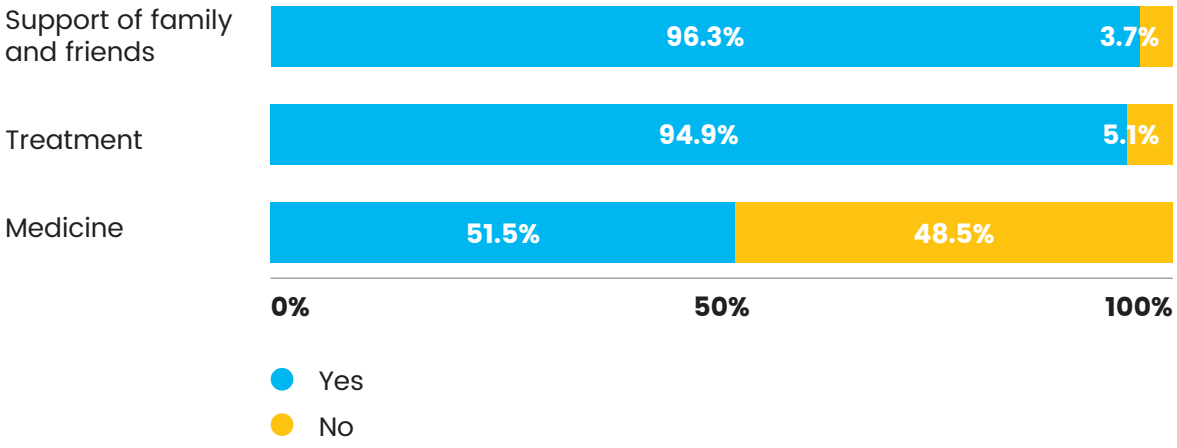
The graph shows that almost all respondents agreed that family issues and emotional and financial problems are a cause of mental illness. Slightly smaller numbers said the same thing about imprisonment, arrest, drugs and health problems. There was more variation with respect to the internet, social media, video games and genetic factors. This is to be expected, since there is no clear scientific consensus on the extent to which these phenomena directly cause mental illness.

Reasons for people not seeking psychiatric or psychological care, according to respondents



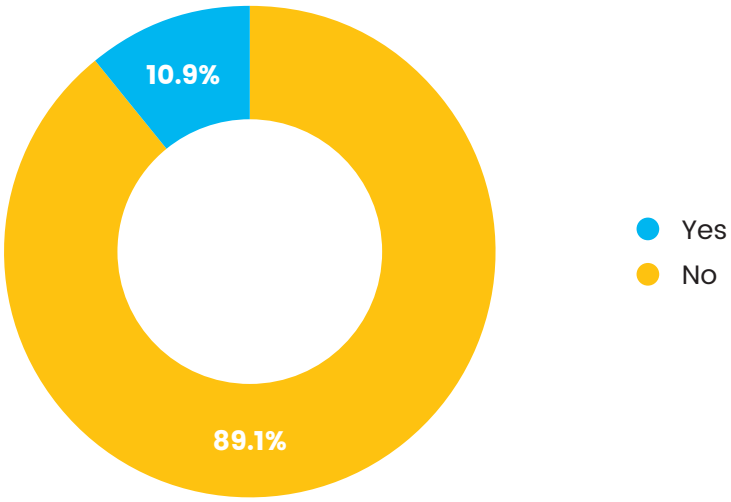
Respondents' answers confirm that fear of social stigma is the most significant concern preventing people from seeking a consultation. They also show the great importance of financial factors (often compounded by the need to attend multiple consultations due to the lack of specialists in many regions and in the working class suburbs of the big cities) and the unavailability of information (on healthcare structures and how to access care).

Usefulness of different ways of dealing with mental health problems, according to respondents



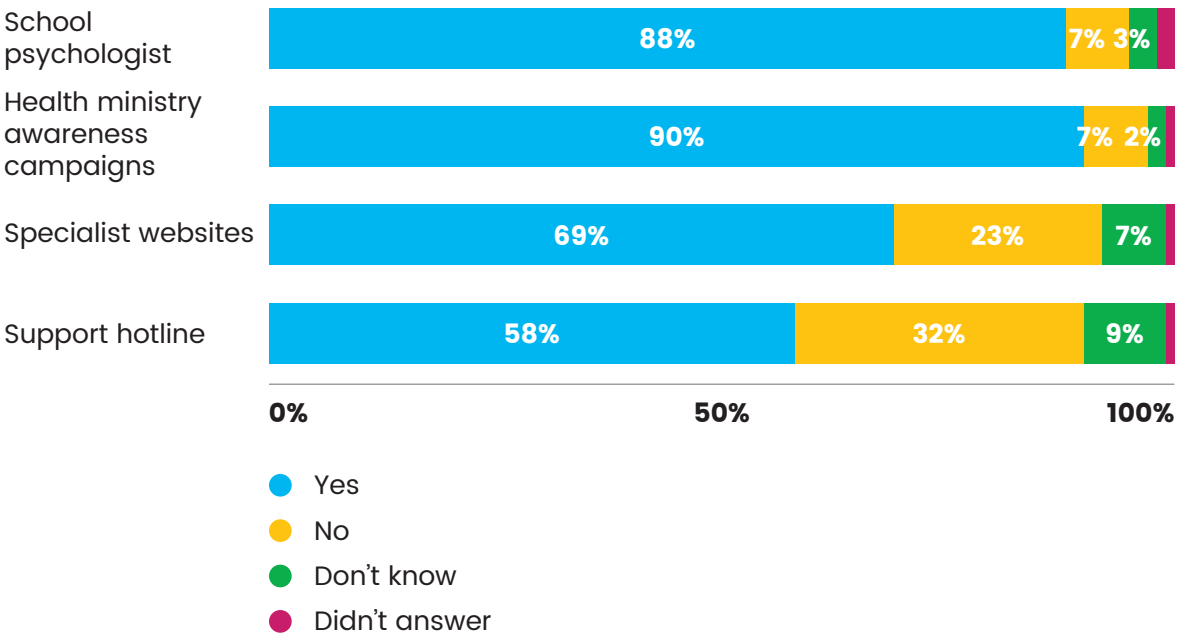
The graph shows that nearly all respondents agreed that an individual's support network (their family and friends) is important in helping them overcome mental health problems. Contrary to expectations of treatment stigma, almost as many respondents (94.9%) agreed that psychiatric or psychological treatment is helpful. There is more disagreement when it comes to medication, with an almost even split between 'yes' and 'no' (there is a difference of two percentage points in favour of 'yes'). There is a general consensus, however, on the role of individuals – whether members of the support network or professionals – in reducing the effect of mental health problems.

Reach of mental health awareness campaigns in educational institutions or elsewhere



The responses to this question show once again the major shortcomings of official and civil society efforts to raise awareness of mental health both within and beyond educational institutions. Only one tenth of respondents reported that they had been reached by a mental health awareness campaign. There may be even greater problems with content.

Ways of learning about mental health problems

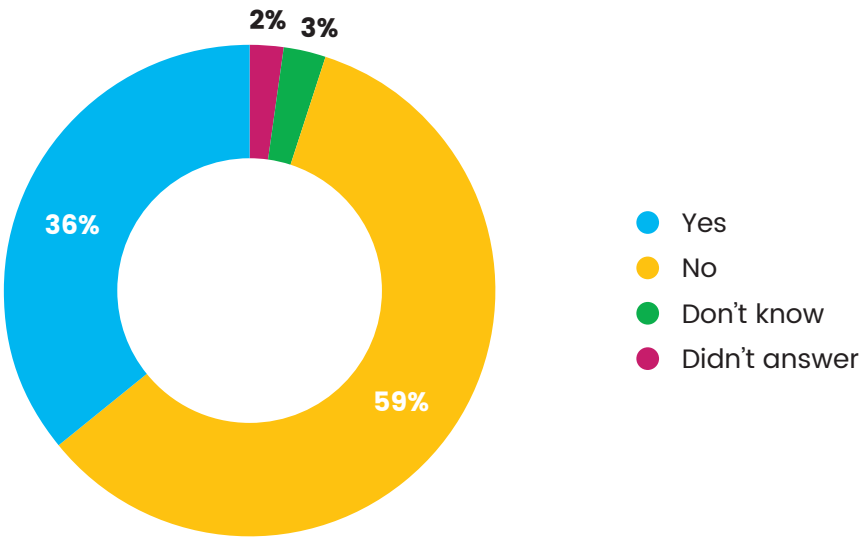


Young people seem generally to prefer more traditional ways of learning about mental health problems to more modern means of communication. This may seem unexpected, but can likely be explained by the following points:

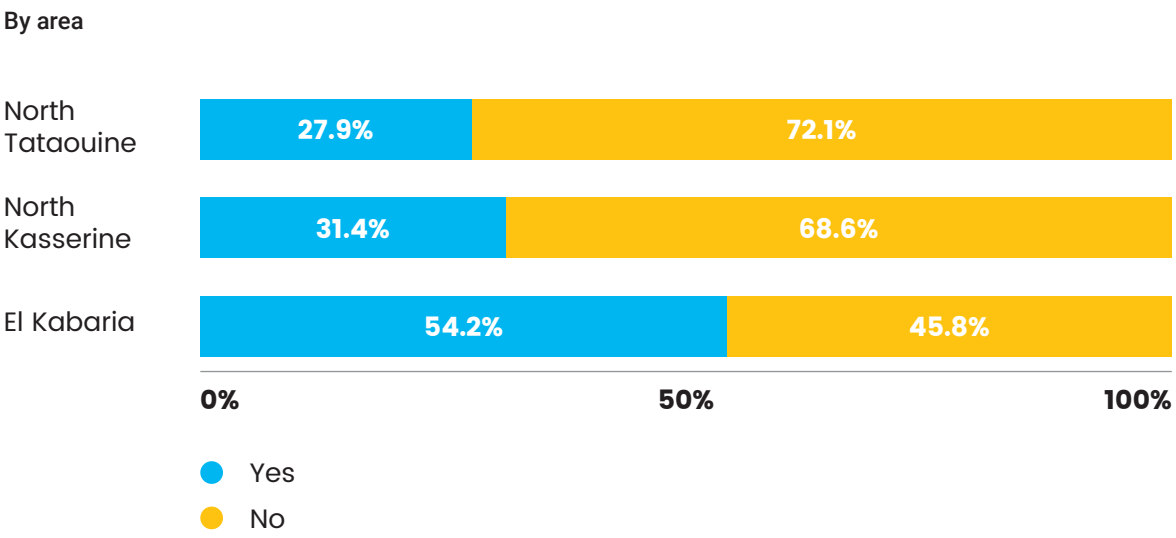
- Traditional methods provide a more dynamic, interactive and even intimate experience, at least in the case of an individual consultation, and young people are desperately in need of this in a mental health context.
- Some young people are not as adept with modern forms of communication. There are various reasons for this, perhaps the most significant being limited education and financial concerns (particularly for young people in deprived areas).
- Many have had bad experiences with digital systems and 'green numbers' during the coronavirus pandemic, particularly the Evax vaccination platform.

Young people's experience of mental health problems

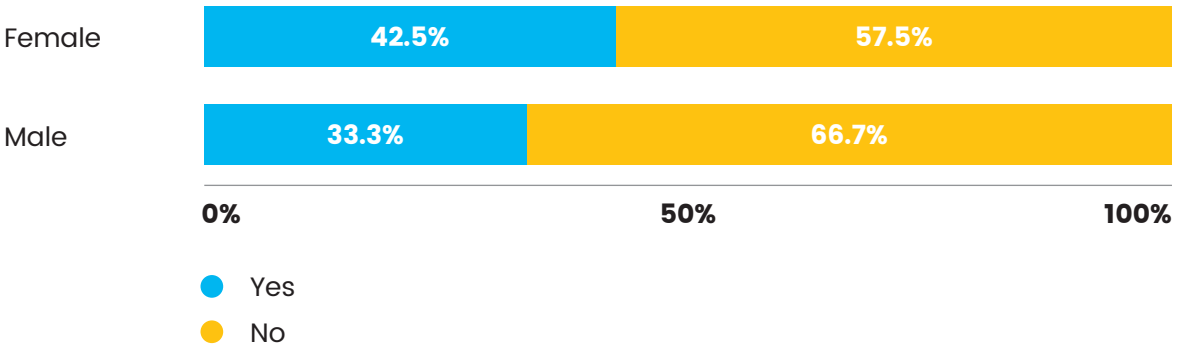
Experience of psychological problems



Experience of psychological problems by area and sex

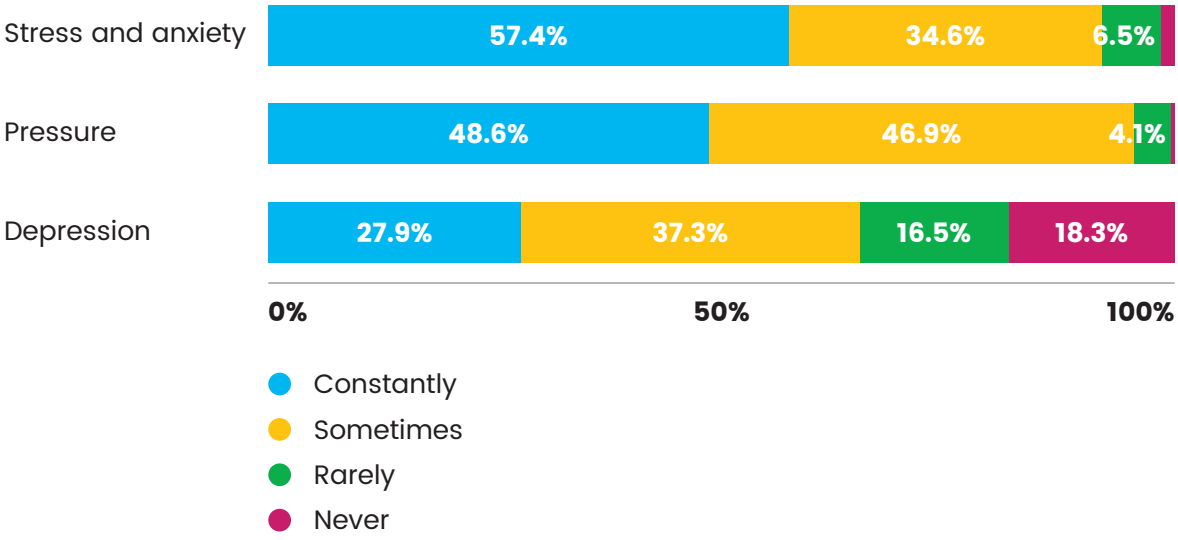


By sex



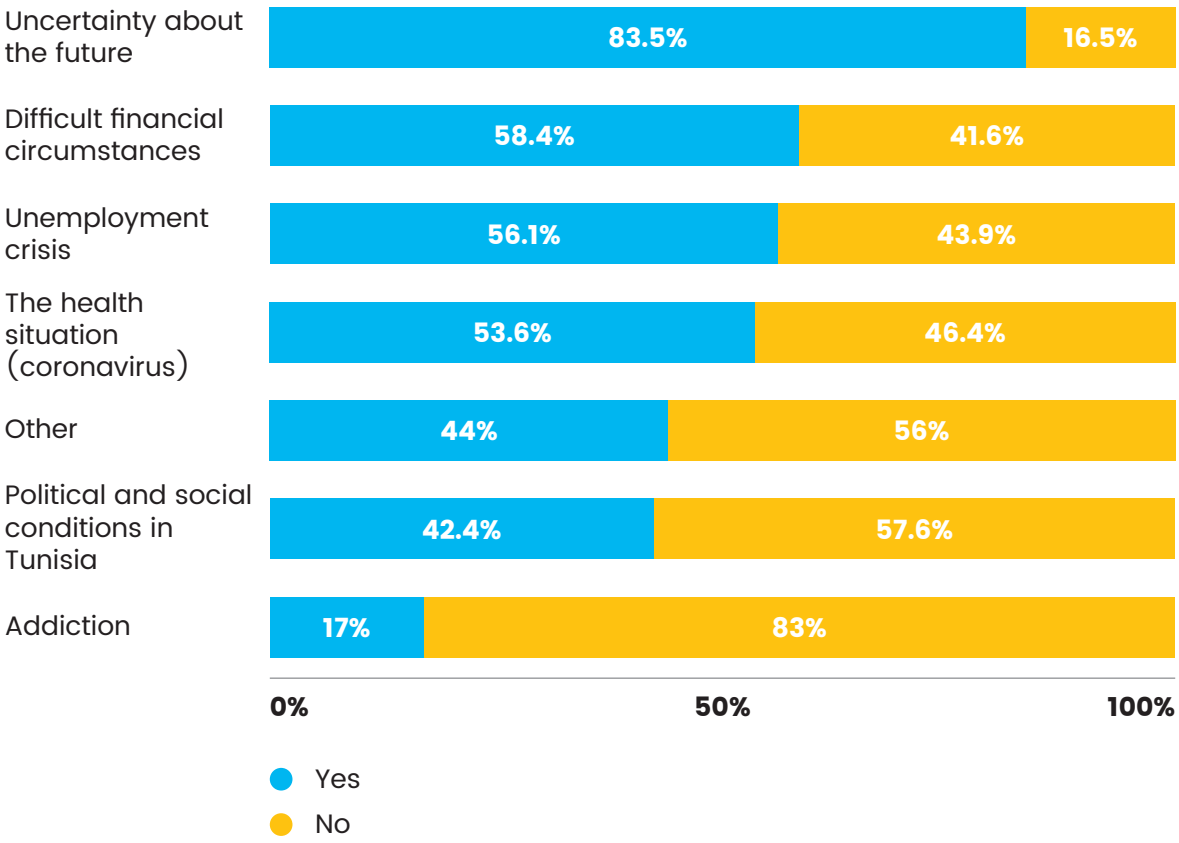
Although psychological problems are not unique to either sex or any one area, there are noticeable disparities in the responses. According to the data, women are more vulnerable than men, perhaps because of the greater societal pressures bearing down on women (behavioural, public space, private space) and the difference in 'resilience' resulting from differing socialisation. The inhabitants of Tataouine and Kasserine are less vulnerable than those of El Kabaria, with twice as many respondents in El Kabaria reporting that they had experienced psychological problems as in Tataouine. This may be explained by the reality of life in a working-class area attached to the largest city in Tunisia: greater vulnerability to risky behaviours and regular encounters with the security forces, for example. Respondents in Kasserine were the least vulnerable of all.

Young people's feelings when exposed to mental health problems



This graph shows the extent to and regularity with which young people experience different feelings associated with psychological difficulties. It is clear that constant or frequent feelings of stress and anxiety on the one hand and pressure on the other are present in almost all cases. Stress and anxiety are most common, with 57% of respondents experiencing them 'constantly'. A 'constant' feeling of pressure, meanwhile, was reported by 49% of respondents. Depression is less common: absent in around a fifth of cases and rare in another sixth, with only 28% of respondents reporting 'constant' depression. This makes sense, since depression is usually an expression of a medium-intensity psychological problem.

Reasons for concerning feelings



There are many reasons why respondents feel psychological pressure, stress and anxiety or depression when experiencing psychological difficulties. Although individuals may encounter any or all of them, however, some are more common or influential than others:

- Uncertainty about the future is the most significant factor, producing psychological symptoms in 83.5% of cases.

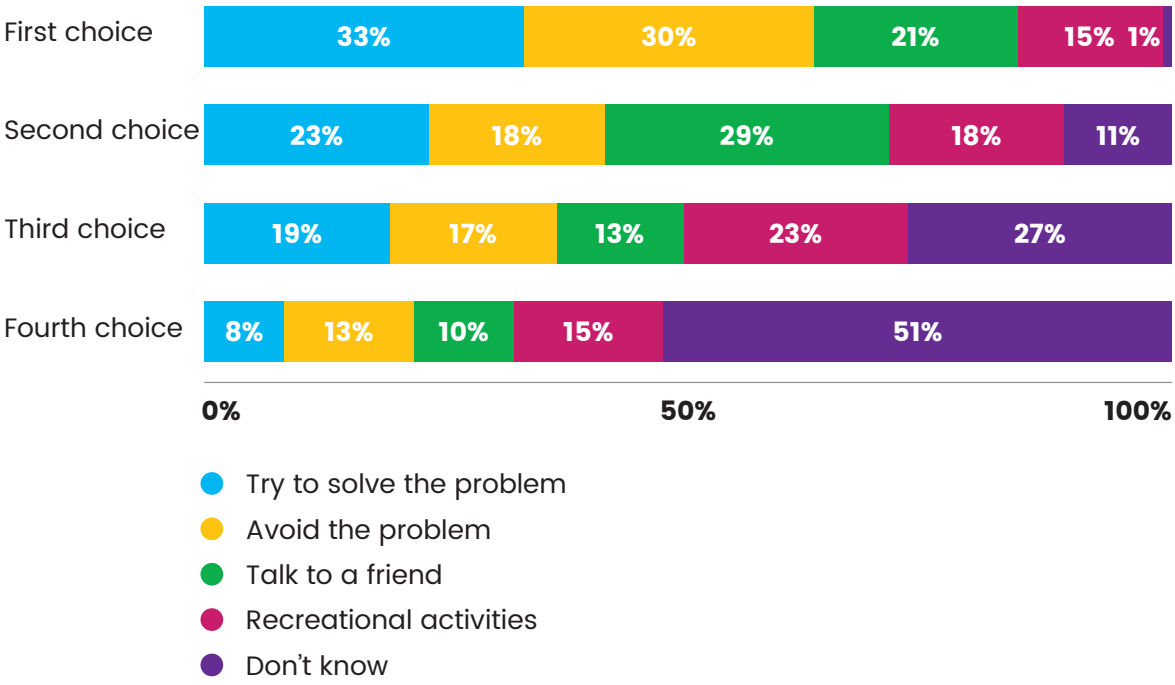
- Difficult financial circumstances and unemployment occupy second and third place respectively, with both accounting for more than half of cases.

- Coronavirus, which took over the country and the world in the year and a half before the study, was naturally an important factor. The effect of the pandemic on individuals' lives (particularly isolation, curfew and other restrictions on movement) is obvious, as are its economic effects for members of particular classes or those in particular occupations – not to mention the risk of catching it yourself and the thousands of tragic deaths that resulted. But although it was cited by more than half of respondents, it was only the fourth most common reason given.

- Political and social conditions in Tunisia were another major reason for psychological symptoms, with 42.4% of respondents who had experienced such symptoms citing them as a reason. This is a significant number, and refutes the common assertion that young people are not interested in politics or public affairs.

- Although addiction came in last place, with only 17% of respondents citing it as a reason, this figure is still concerning and reflects not only how widespread addiction is but also the awareness of at least a significant number of young addicts of the psychological dangers of addiction. Many addicts thus want to break their addiction, but have probably been unable to or do not know what they need to do.

Behaviour when experiencing concerning feelings



Around two thirds of those who had experienced a psychological problem said that they tried in the first instance to solve (34%) or avoid (30%) it. Speaking to a friend was the first option for around a fifth of respondents, while 15% sought to use recreational activities to feel better.

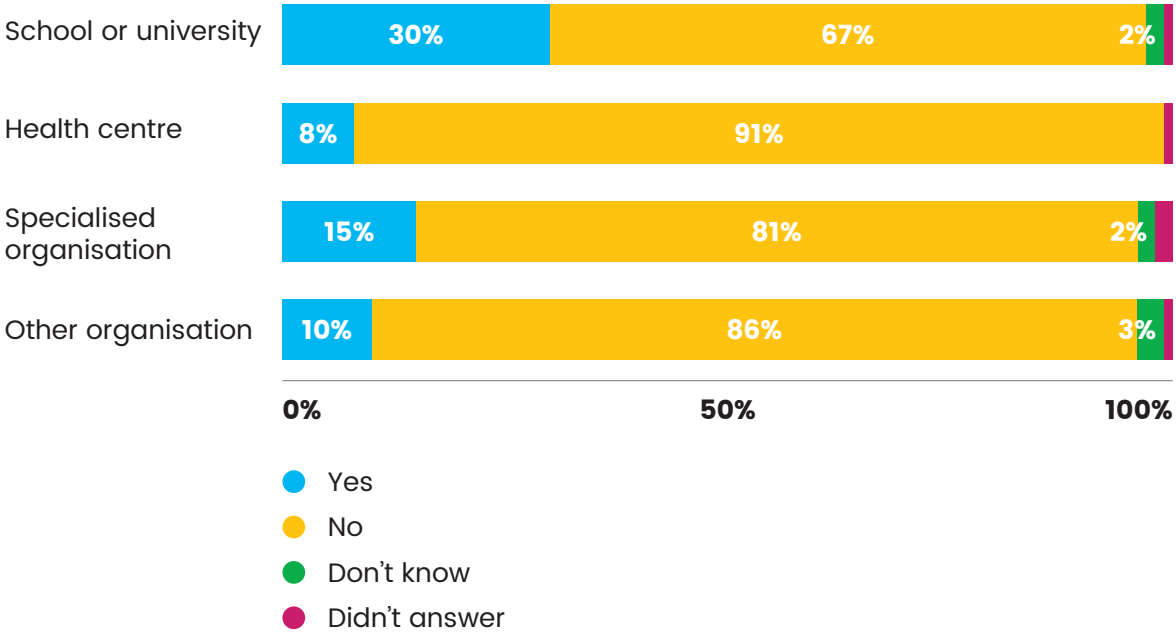
The most prominent second option was speaking to a friend (30%), and the most prominent third option was recreational activities (25%).

4. Addiction

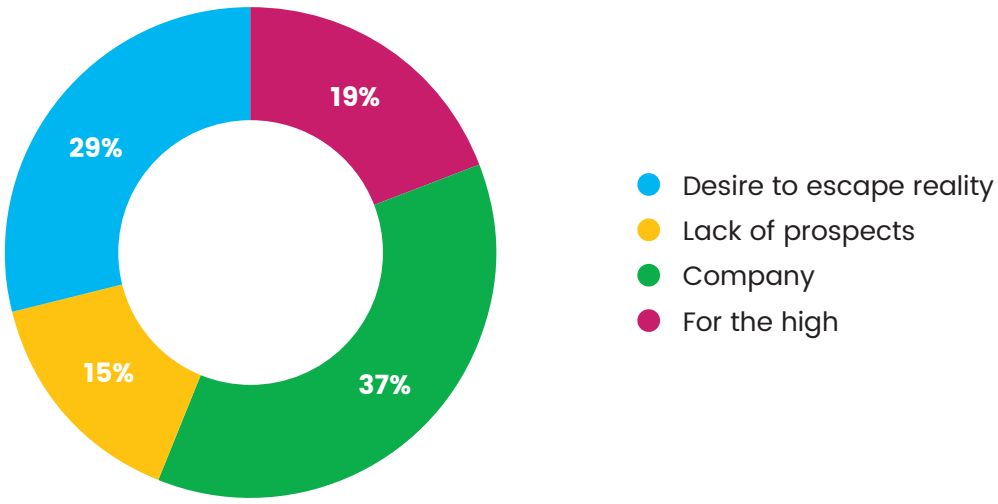
A previous study by International Alert Tunisia on young people in Tataouine, Kasserine and Douar Hicher found that respondents rated addiction as the second most significant social danger facing them. There have been several other studies over the last few years that have likewise sounded the alarm with respect to this phenomenon. In this study, we thus attempted to get a sense of how widespread addiction is, its causes and young people's attitude to it.

4.1 General conceptions

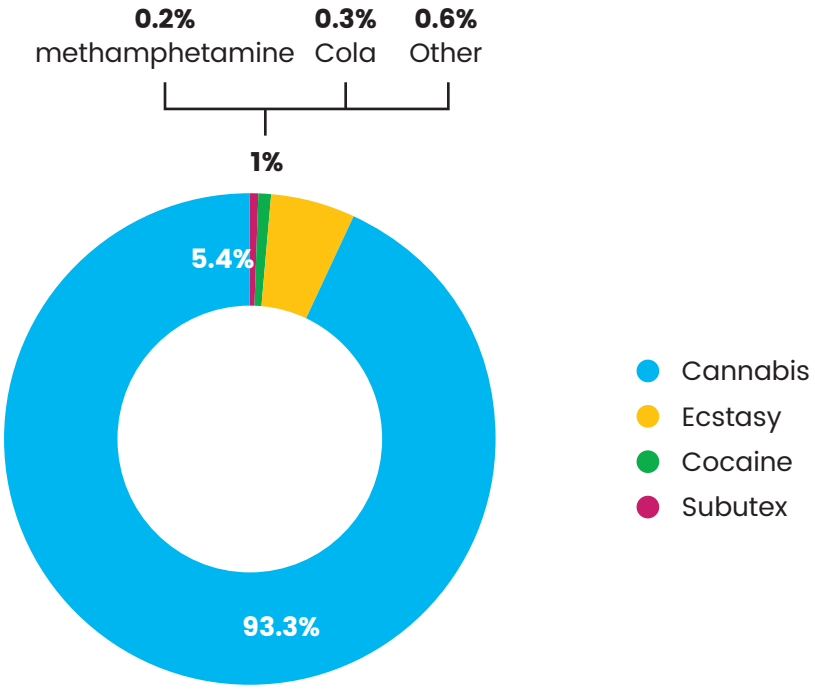
Availability of information on drugs and stopping use



Most important reason for consumption in respondents' environments



Most-consumed substances in respondents' environments



In this part of the study, we tried to draw out respondents' conceptions of drug consumption irrespective of their own consumption habits. More than two thirds of respondents reported that they had received no information about drugs or avoiding addiction in school or university, which raises serious questions about the role that educational institutions should be playing alongside public health organisations. This is particularly true given that 80% of respondents had at least begun preparatory schooling. Half as many respondents reported receiving information from civil society organisations as from educational institutions, with health organisations cited half as often again.

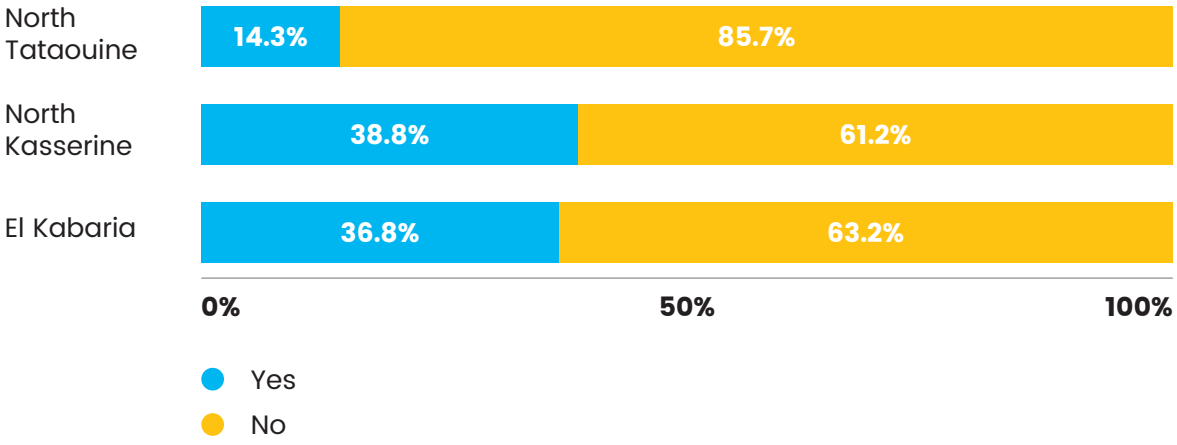
Respondents cited various reasons for drug consumption in their environment. The largest number (44%) attributed it to the harsh realities of life and to uncertainty about the future (29% 'desire to escape reality' and 15% 'lack of prospects'). There was also a clear tendency to attribute responsibility to friends and acquaintances ('company' 37%). There is only a weak link between consumption and a desire for enjoyment ('for the high'). There was also a general tendency to describe drug consumption in terms of 'compulsion' from the social environment rather than as a conscious individual experience.

With regard to the type of drugs consumed, there is general agreement that cannabis is by far the most common, followed at some distance by ecstasy tablets (MDMA). Relatively little consumption was reported for other drugs: cocaine, Subutex, methamphetamine and glue. Some 10% of respondents said that they knew nothing about the different types of drugs consumed in their environment.

4.2 Respondents' consumption of drugs

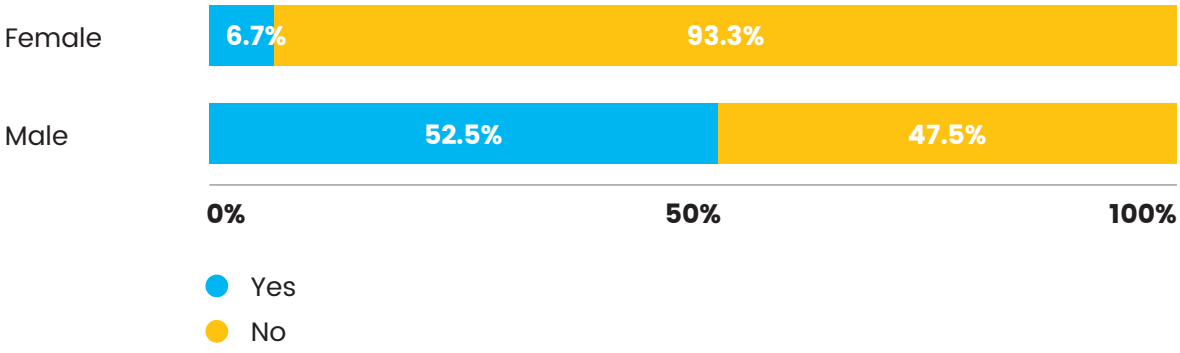
29% of respondents said that they had consumed drugs themselves (3% refused to answer or did not answer the question) with significant differences when the data was broken down by different variables.

Consumption of drugs by area



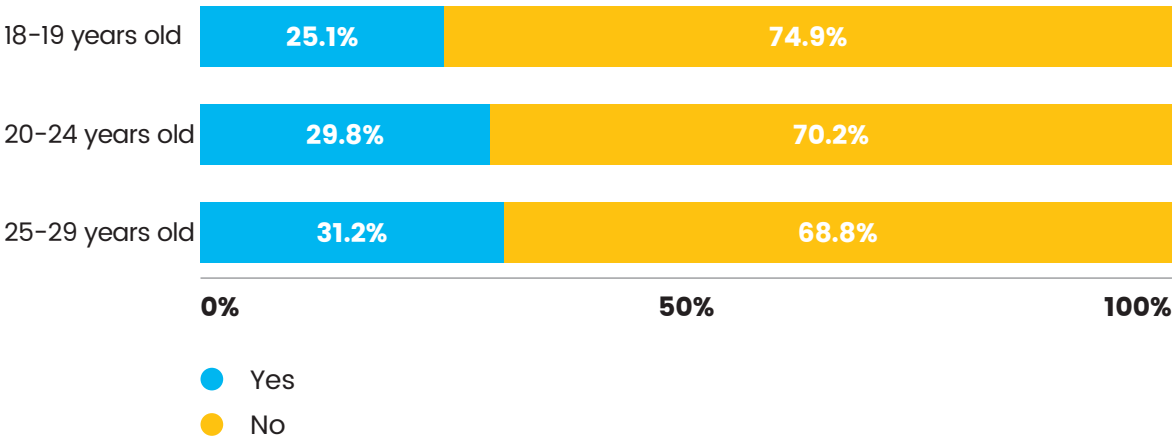
There are statistically significant differences in level of drug consumption between El Kabaria and Kasserine on the one hand and Tataouine on the other: respondents in the first two regions consume drugs at 1.5 times the rate of those in the latter, a difference of some 20 percentage points. This can perhaps be attributed to cultural and geographical factors. Respondents on Kasserine live on the border with Algeria, on a major cannabis smuggling route (Morocco, Western Desert, Algeria, Tunisia). This makes it much easier to access drugs, both in terms of quantities and prices. El Kabaria is a working-class area and part of a major urban conglomeration (Tunis), meaning that both the culture of consumption and the marketing possibilities are more significant than in semi-urban or rural areas. In Tataouine, meanwhile, family authority remains very strong, and the region is quite remote from the major smuggling routes.

Consumption of drugs by sex



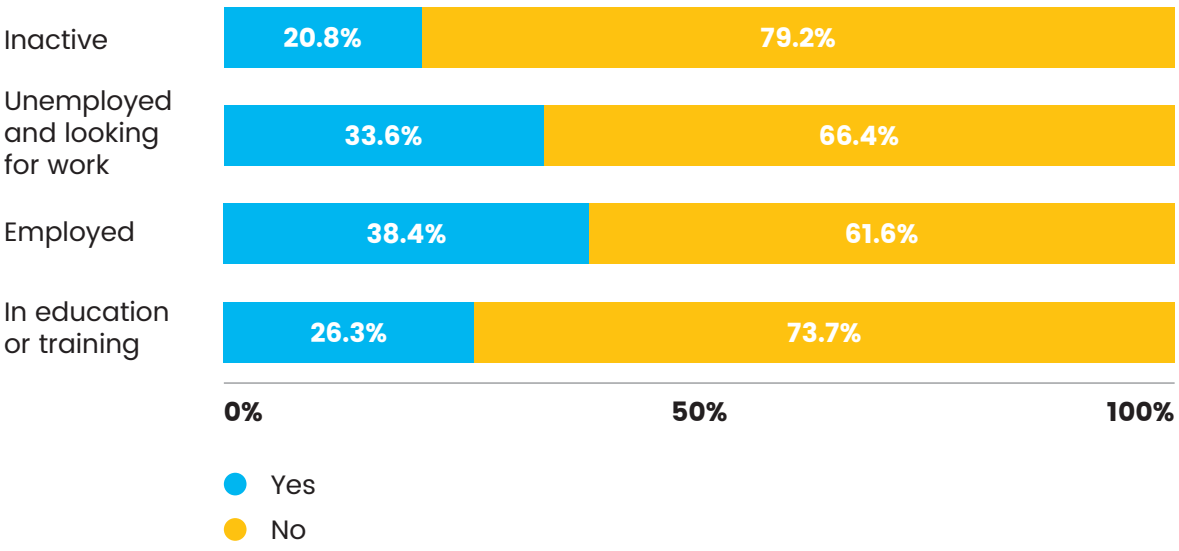
When we break down the figures by sex, we find that men are far more likely to consume than women, with more than half of young men reporting that they have used drugs – more than nine times the rate among female respondents (6.7%). Although greater consumption among men is not at all surprising and accords with the global trend, the disparity is much larger in societies like Tunisia where patriarchal culture attaches far more social and moral stigma to women than to men. Men also have far more access to drugs and opportunities for consumption than do women, since it is more acceptable for them to be out in public even late at night and in 'dangerous' places.

Consumption of drugs by age group



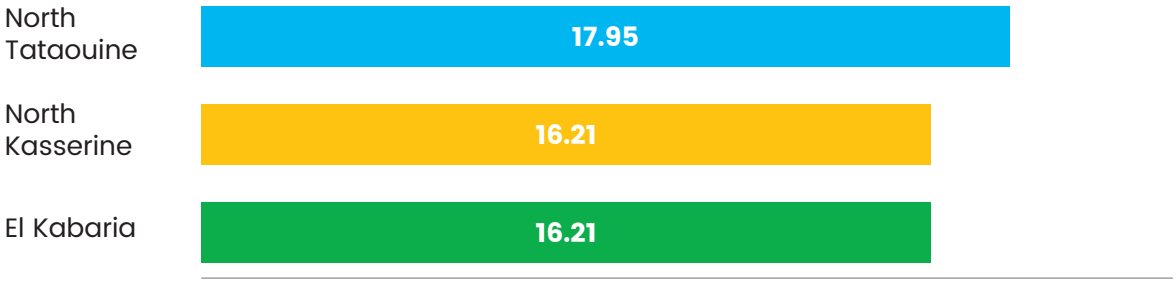
There are no very large disparities between the three different age groups. The highest levels of consumption are found among 25-29-year-olds, which makes sense given that respondents may be current users or have used drugs at a younger age. Those below the age 20 are slightly less likely to have used drugs, perhaps because of their limited financial independence and greater reliance on family authority. They may also face less social pressure and have had fewer negative experiences than their older counterparts.

Consumption of drugs by economic activity



The economically active are the most likely to consume drugs, whether those who are in employment (38.4%) or those looking for work (33.6%), more than ten percentage points more than respondents who are still in education or training and 15 points more than the economically inactive. These results seem to bear out the relationship with financial and familial independence, number of social relationships and economic pressures.

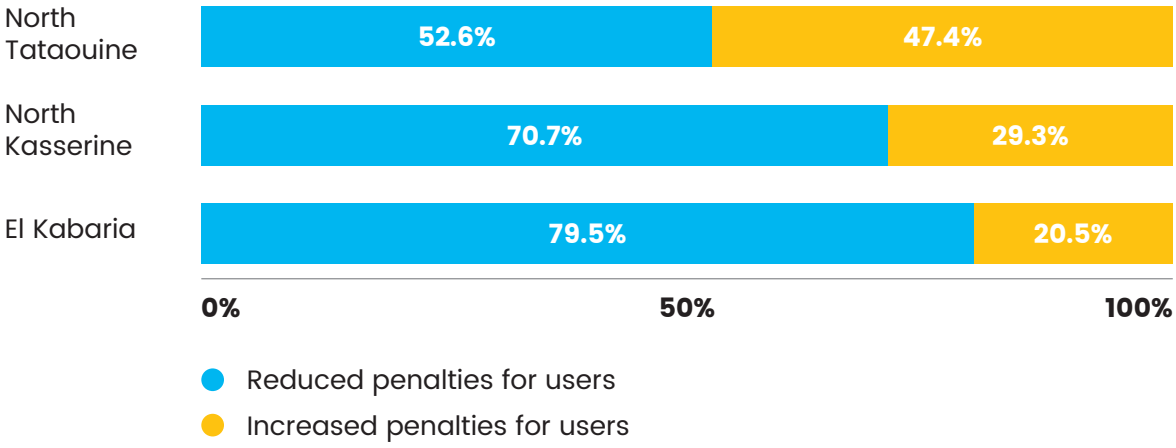
Age at first use of drugs



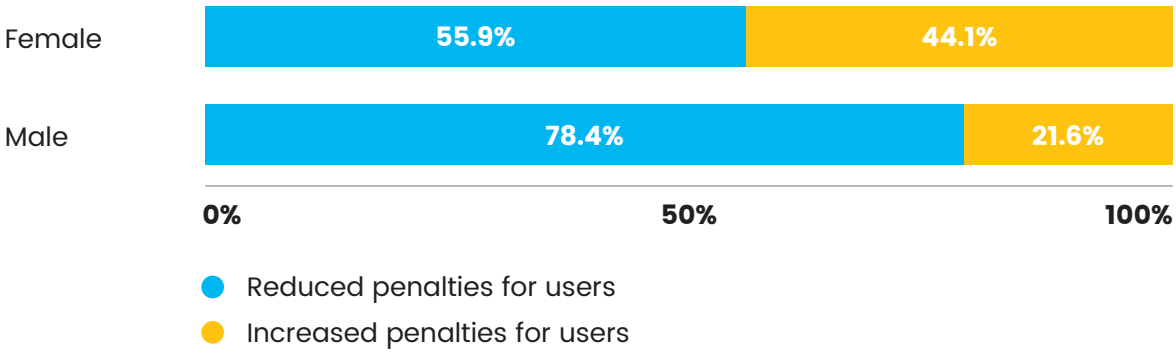
The average age at which respondents had first used drugs was the same in El Kabaria and Kasserine (16.21 years old), noticeably lower than in Tataouine (17.9 years old) and very close to the age of legal maturity. This disparity makes sense given the higher rates of consumption in the first two areas.

4.3 Attitudes to penalties for drug use

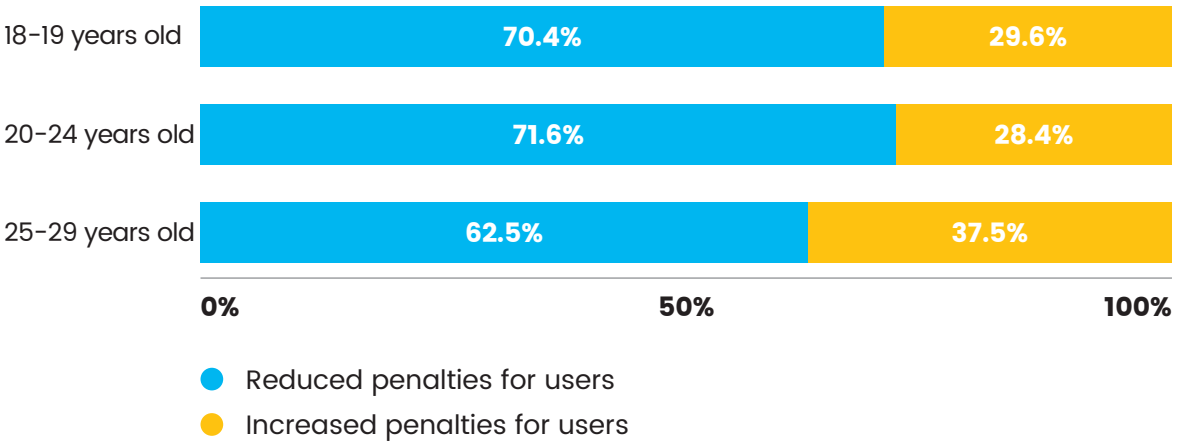
Attitudes to reducing penalties, by area



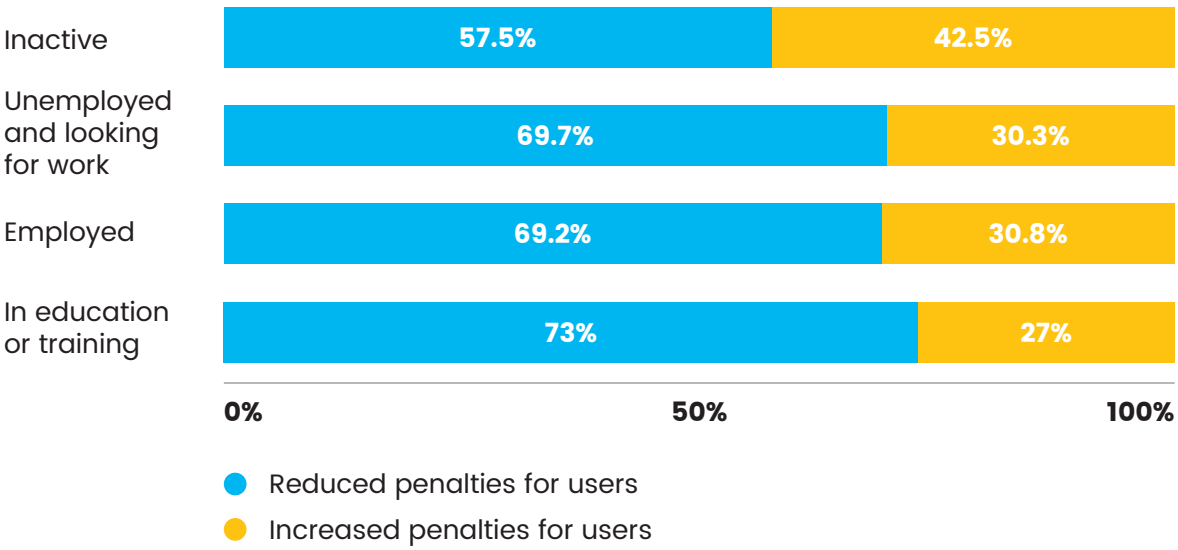
Attitude to reducing penalties, by sex



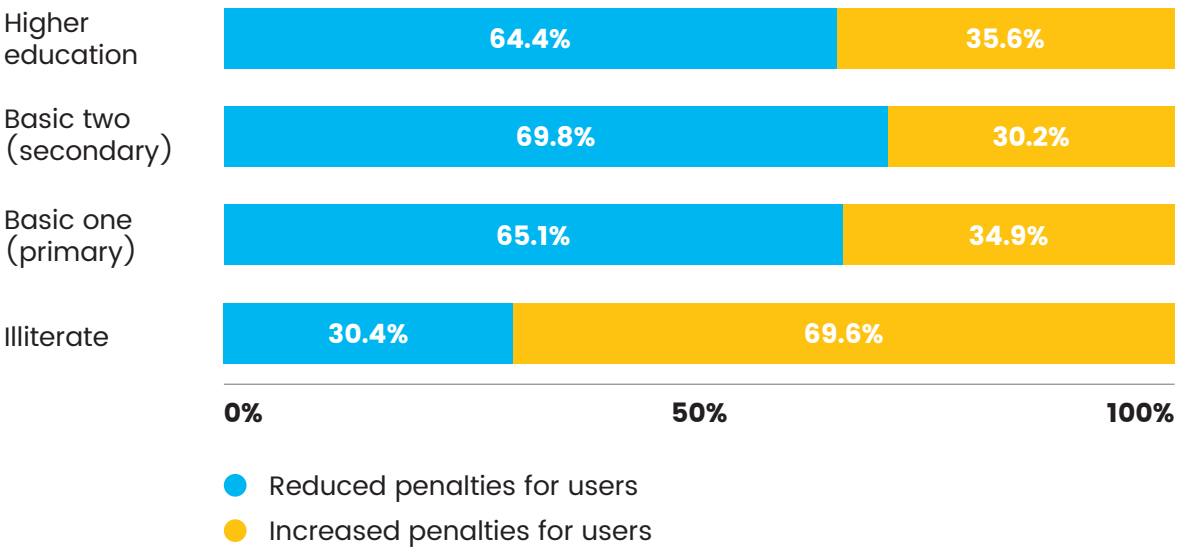
Attitude to reducing penalties, by age group



Attitude to reducing penalties, by economic activity



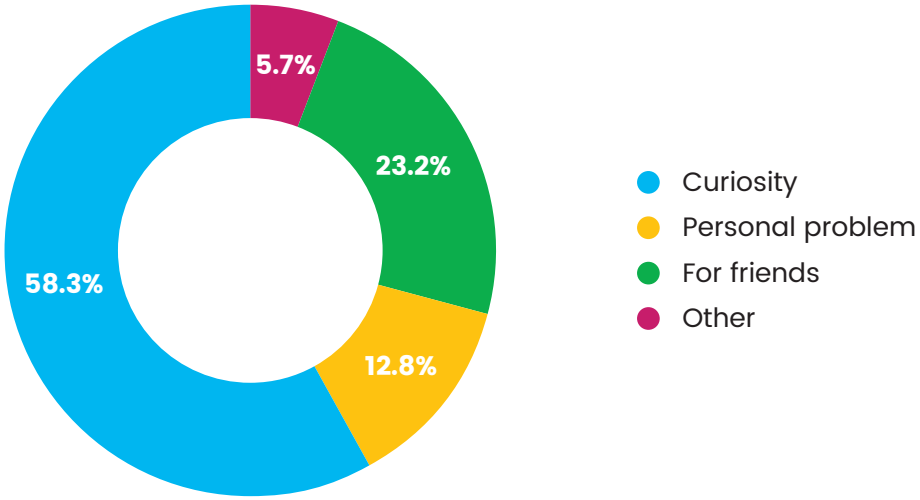
Attitude to reducing penalties, by educational level



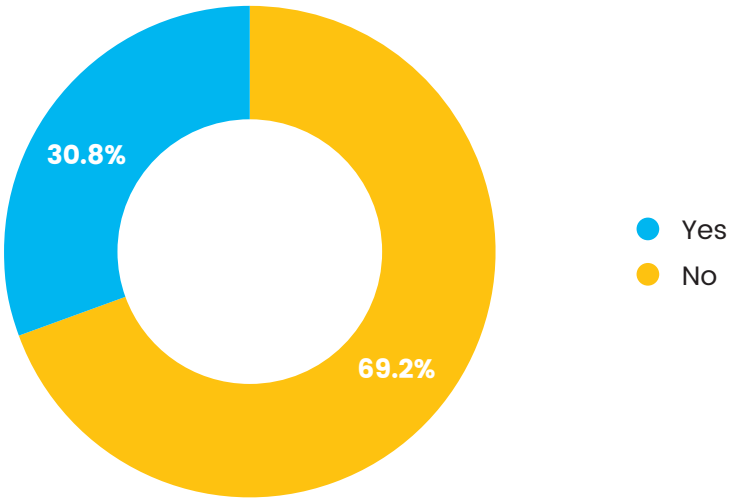
The most eye-catching conclusion that can immediately be drawn from these graphs is that a majority of respondents – irrespective of sex, region, age, economic activity and educational level – support reduced penalties for drug use. With the exception of illiterate respondents (only 24 respondents, which reduces their statistical significance), more than 50% of every group was in favour of less harsh punishments, although with some significant differences between groups. Logically there seems to be a correlation with levels of consumption in a given group: those who are more likely to use drugs are also more likely to support reduced penalties, with some exceptions. For example, 78.4% of men are in favour but only 55.9% of women, corresponding broadly to differences in reported consumption levels (52.5% and 6.7% respectively). Similarly, there was far more support in El Kabaria and Kasserine (79.5% and 70.7% respectively) than in Tataouine (52.6%), which corresponds to higher levels of consumption in the former two regions. This correlation breaks down when we look at age groups, however: 25-29-year-olds, the group with the largest number of respondents who reported having used drugs, were the least likely to support reduced penalties (62.6%, some ten points lower than the other two age groups). This 'contradiction' may be explained by their age, which makes them more 'mature' and also more likely to hold conservative views. In the same vein, those in education or training – who are less likely to have used drugs than most other groups – are the most likely to support reduced penalties (73%), perhaps because of regular encounters with students whose studies and futures have been ruined by accusations of drug use. Overall, it seems likely that the high rate of support for less serious penalties can be attributed to the fact that respondents belong to the group to whom drug use and its consequences are most obviously relevant. If we were to ask older Tunisians the same questions we might receive quite different answers.

4.4 Personal experiences

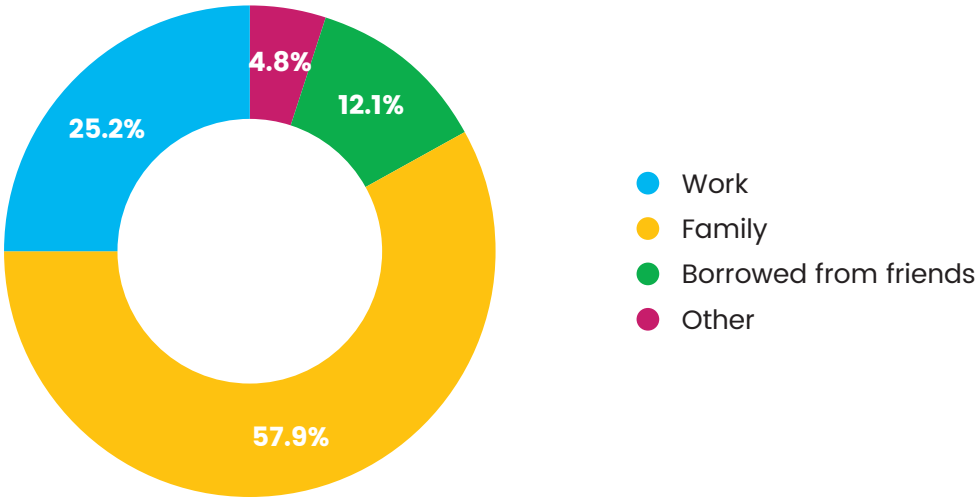
Motivations for first use of drugs



'Did you pay for the drugs taken on your first use?'



Source of money used to pay for first use



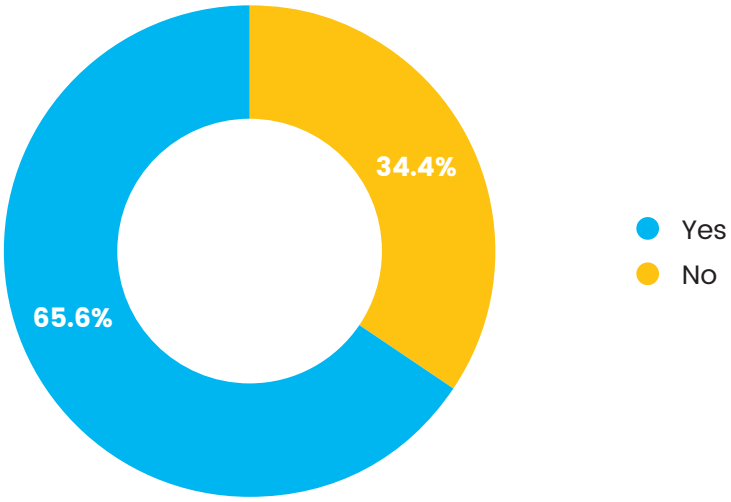
Only respondents who reported having used drugs were asked this question, which concerned their first experience of drug use.

With respect to the causes which drove young people to use drugs for the first time, the responses differed quite dramatically from the general perceptions among respondents. The main reason cited was not a desire to 'escape reality' but 'curiosity' (58.3%), followed by 'friends' influence' (23.2%) and, a long way behind, 'personal problems' (12.8%). Not having enough money was no impediment to obtaining drugs, at least the first time: 69.2% of respondents said that they had not paid for the drugs used in their first experience. This confirms that drug use among young people is at root a 'collective' experience that takes place within a group of friends or young people from the same area. Even those who did pay for their first experience generally got the money to do so from others: family members (57.9%) or friends (12.1%). The fact that the most common drug in Tunisia, cannabis, is relatively cheap by the standards of more serious drugs may explain how easy it is to get it 'for free'.

4.5 Consumption rates

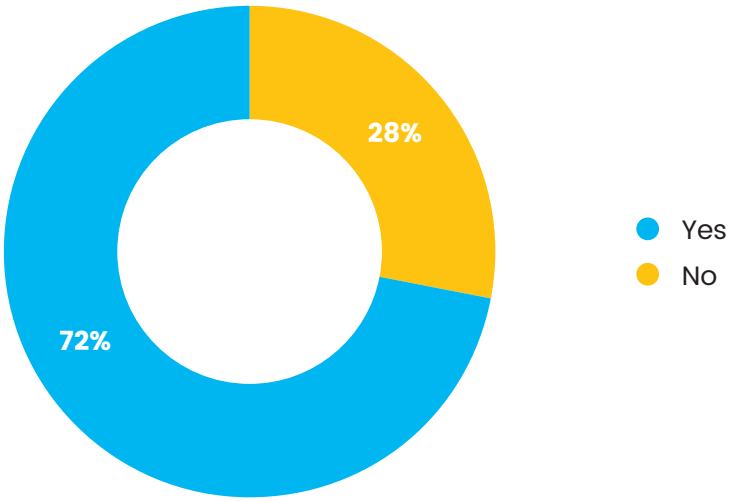
Consumption within the last year

In order to get a better idea of consumption rates, we asked respondents who reported having used drugs whether they had done so within the last year. 65.6% of them said that they had. We then divided this group into three subcategories depending on how regularly they used drugs: on a daily (1-20 times per day), weekly (1-70 times per week) or monthly (1-90 times per month) basis. We found that average consumption in the first group was 3.5 times per day; in the second group 11 times per week; and in the third group 20.3 times per month.

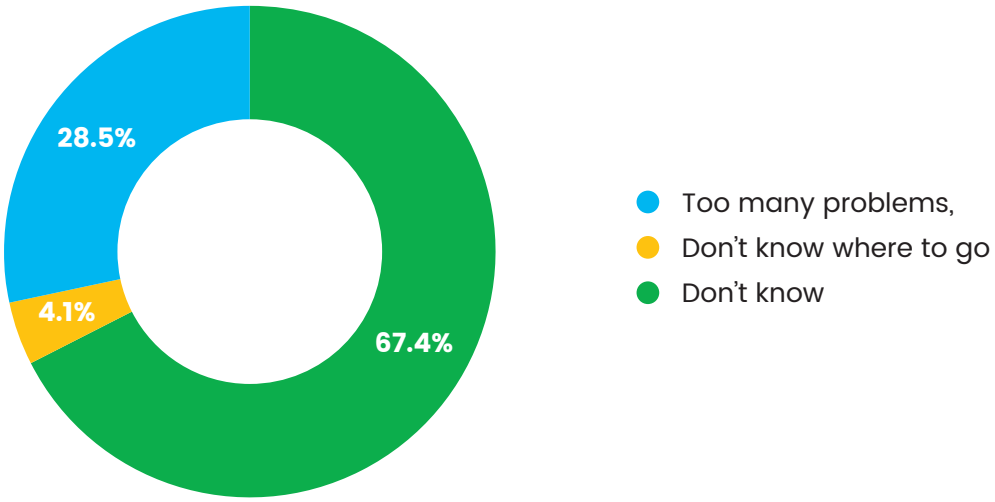


4.6 Quitting

Attempts to quit by relevant means



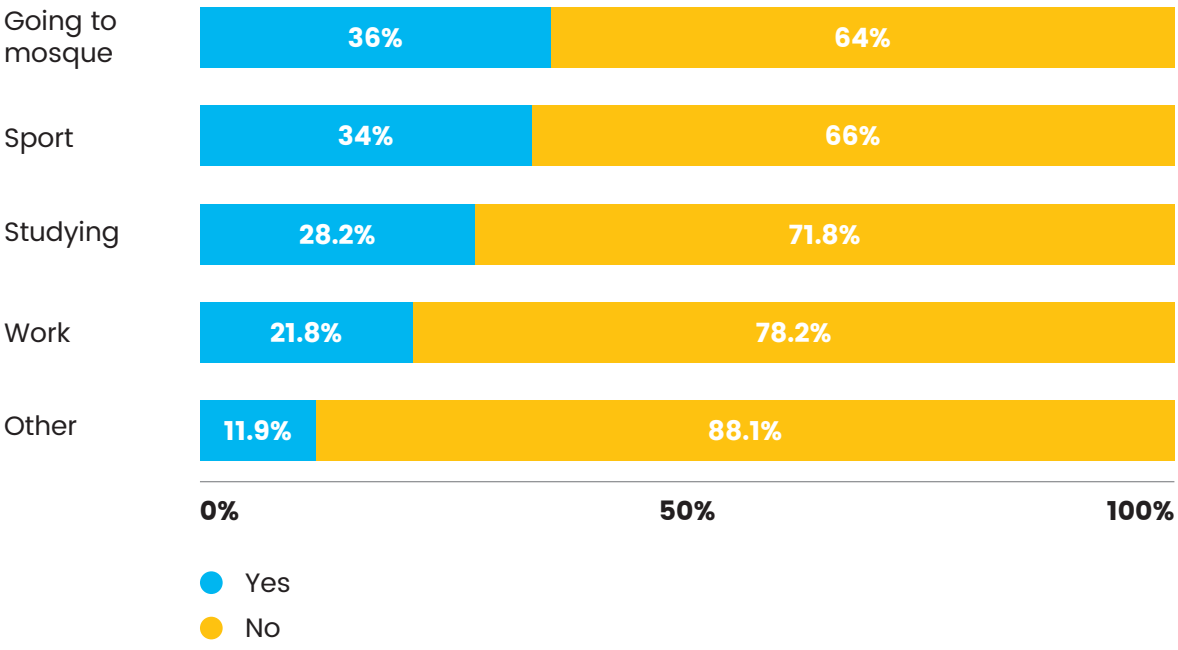
Reasons for failing to quit



Most users report a clear desire to quit, with 72% saying that they have tried to do so using their own means. We should remember here that the majority of respondents said that they had not received any information on drug use or how to stop. If a genuine national strategy and appropriate healthcare infrastructure were put in place to treat addiction then many young people would be able to break the cycle of addiction. Even among those respondents who said they had not tried to quit (28%), 67.4% reported that they did not know why they were unable to stop using drugs, while 4.1% said they did not know where to go to receive help with addiction. The shortcomings of official efforts to raise awareness and a lack of medical or psychological support are major obstacles standing between many young addicts and recovery.

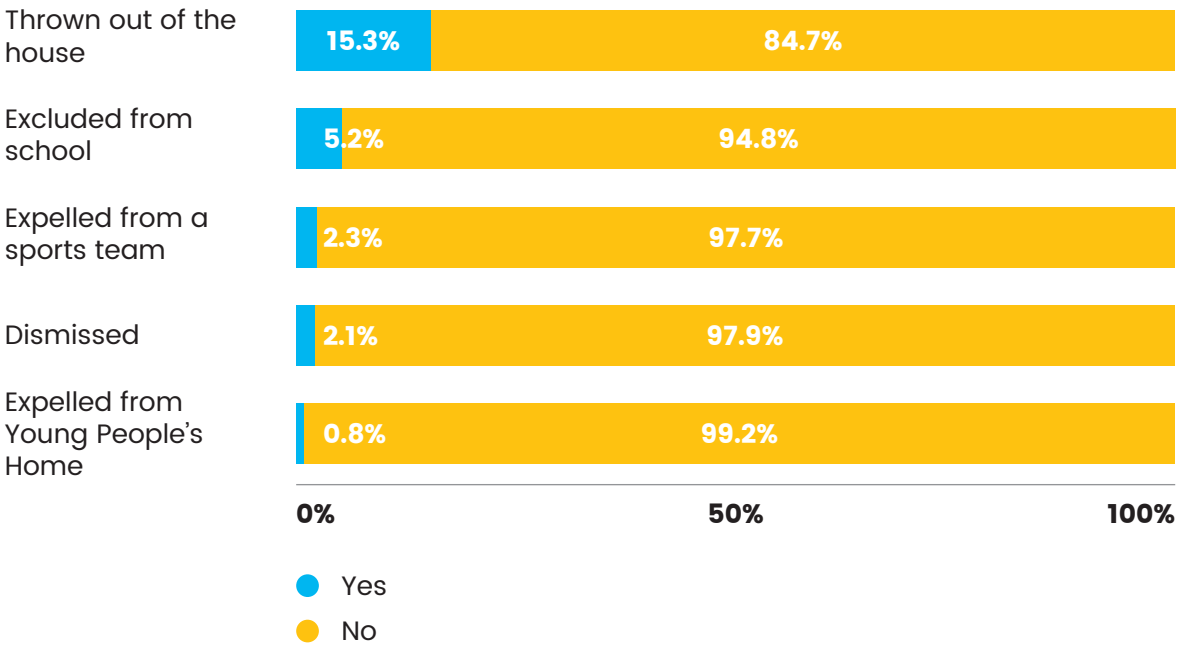
4.7 Effect of addiction on users' everyday lives and their relationship with their environment

Effect of consumption on activities



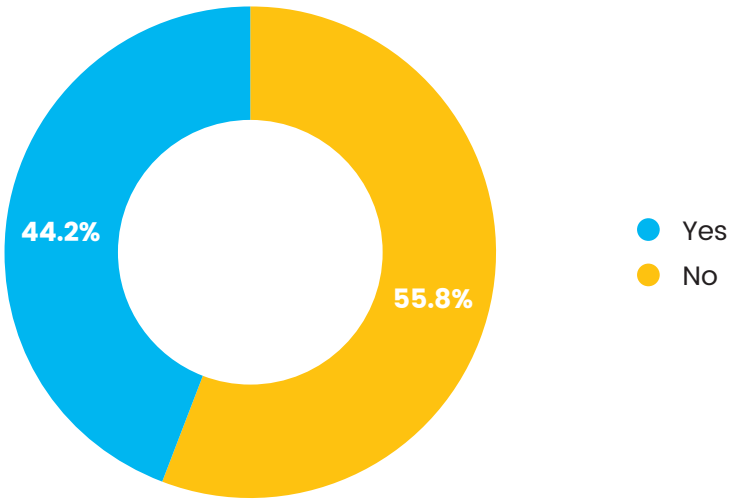
Respondents' answers show that drug use has an effect on most activities and most aspects of users' lives. Mosque attendance is the most badly affected (36%), pointing to the presence of a strong social conception that drug use is a 'sin' and that users should avoid holy places. Sport occupies second place (34%), perhaps because of the importance of sporting activities to young people – alongside the obvious physical and mental effects, which reduce users' desire (and sometimes ability) to play sports. The effects on studies and work appear to be less significant.

Expulsion as a result of drug use



Although this is a phenomenon concerning relatively small numbers of people, drug use can lead to (temporary or permanent) exclusion of users from one or more social environments. Being thrown out of the family home is the most commonly reported experience of this kind (15.3% of respondents), followed by expulsion from education (5.2%). These are concerning figures: excluding young people certainly will not help them to stop using drugs, and may make them more vulnerable to drugs and other risky behaviours.

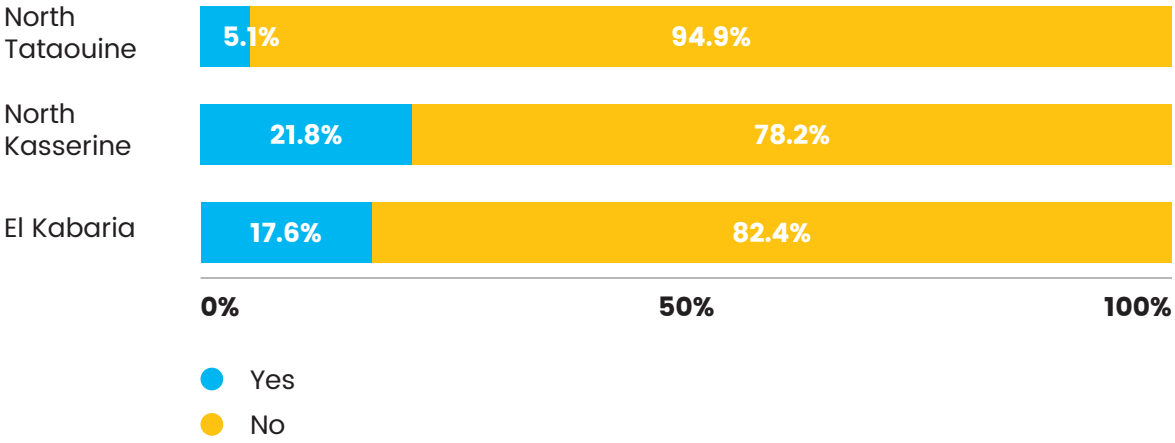
Effect of drug use on family relationships



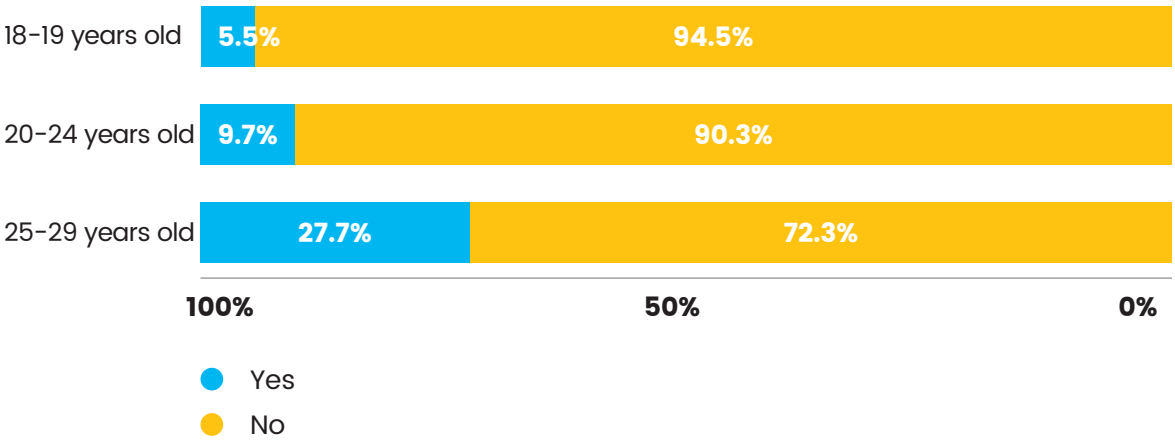
Less than half of those respondents who had used drugs reported that this had caused problems in their relationship with their families. This does not necessarily mean that most families are accepting or tolerant of drug use. It is more likely that many families are simply unaware of their children's habits.

4.8 Arrest or imprisonment because of drug use

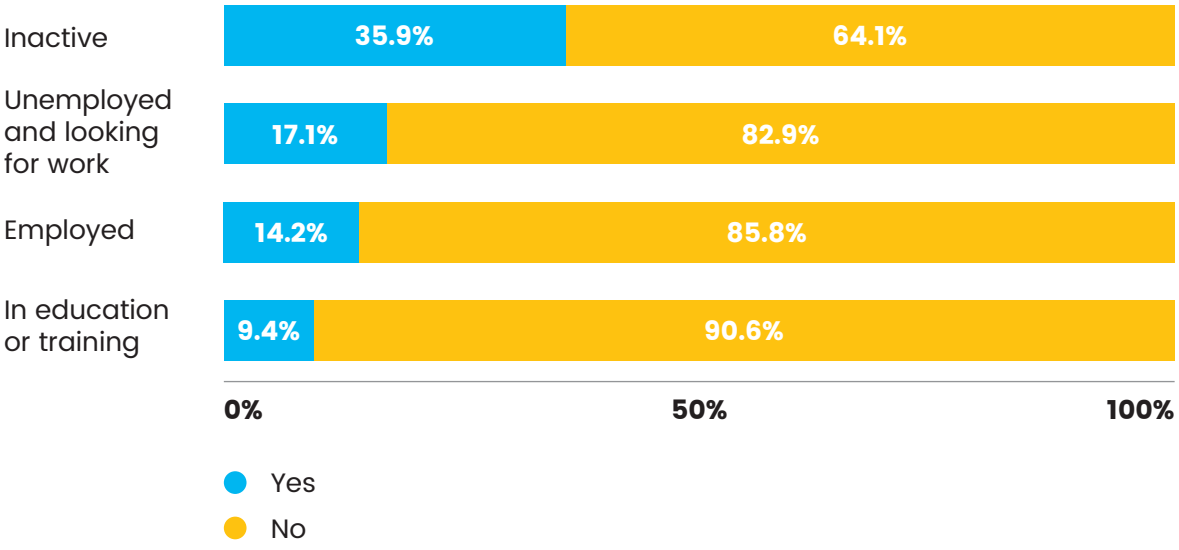
Arrest or imprisonment because of drug use, by area



Arrest or imprisonment because of drug use, by age group



Arrest or imprisonment because of drug use, by economic activity



If we compare the proportion of respondents who had used drugs with the proportion of those who said that they had been arrested as a result, we find a clear and almost total correspondence. The numbers in El Kabaria and Kasserine were both high in absolute terms (17.6% and 21.8% respectively) and between three and four times higher than the numbers recorded in Tataouine. Respondents within the 25-29 age group were the most likely to have consumed drugs and likewise the most likely to have been arrested or imprisoned; those within the 18-19 age group were the least likely to have consumed drugs and the least likely to have been arrested and imprisoned. If we break the data down by economic activity, we find a similar correlation between levels of consumption and likelihood of being arrested or imprisoned. But there is also a major paradox: the economically inactive, who are the least likely to have used drugs, are the *most* likely to have been arrested or imprisoned for drug-related reasons. There is no clear or decisive explanation for this, although it may have something to do with their relative isolation and lack of experience in avoiding arrest, making them easier to target and more likely to admit using.

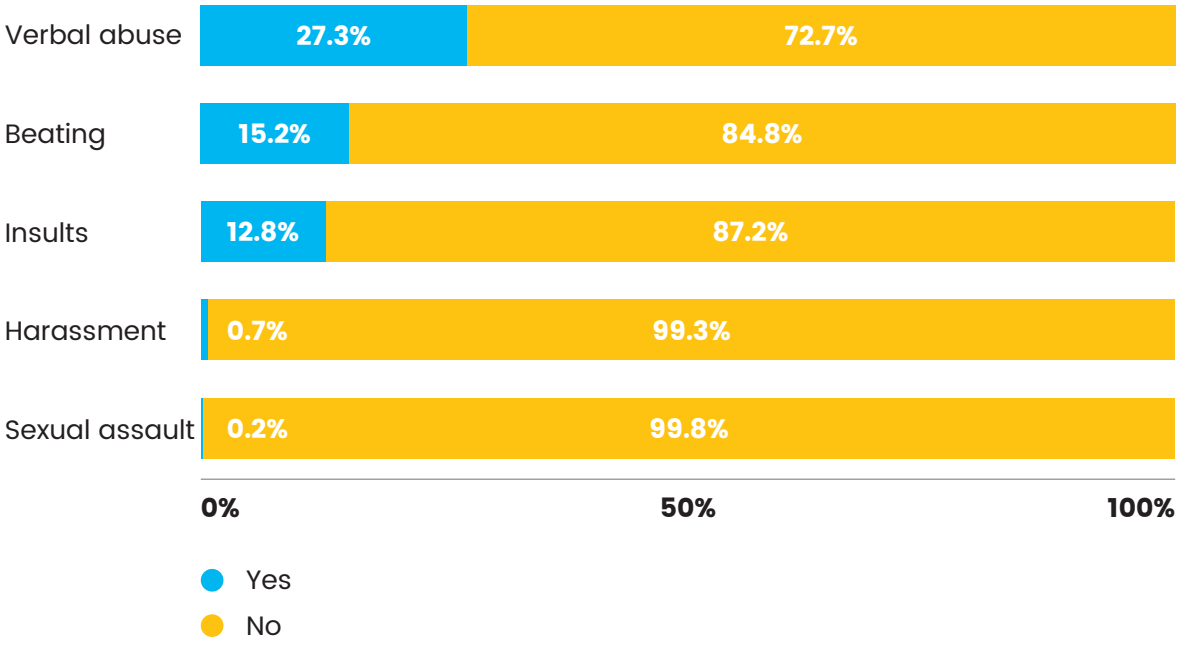
According to respondents who reported being arrested or imprisoned for drug use, the average period of imprisonment is 7.35 months. More than a quarter of the Tunisian prison population are there on drug use charges and around 55% of them are between 18 and 29 years of age.

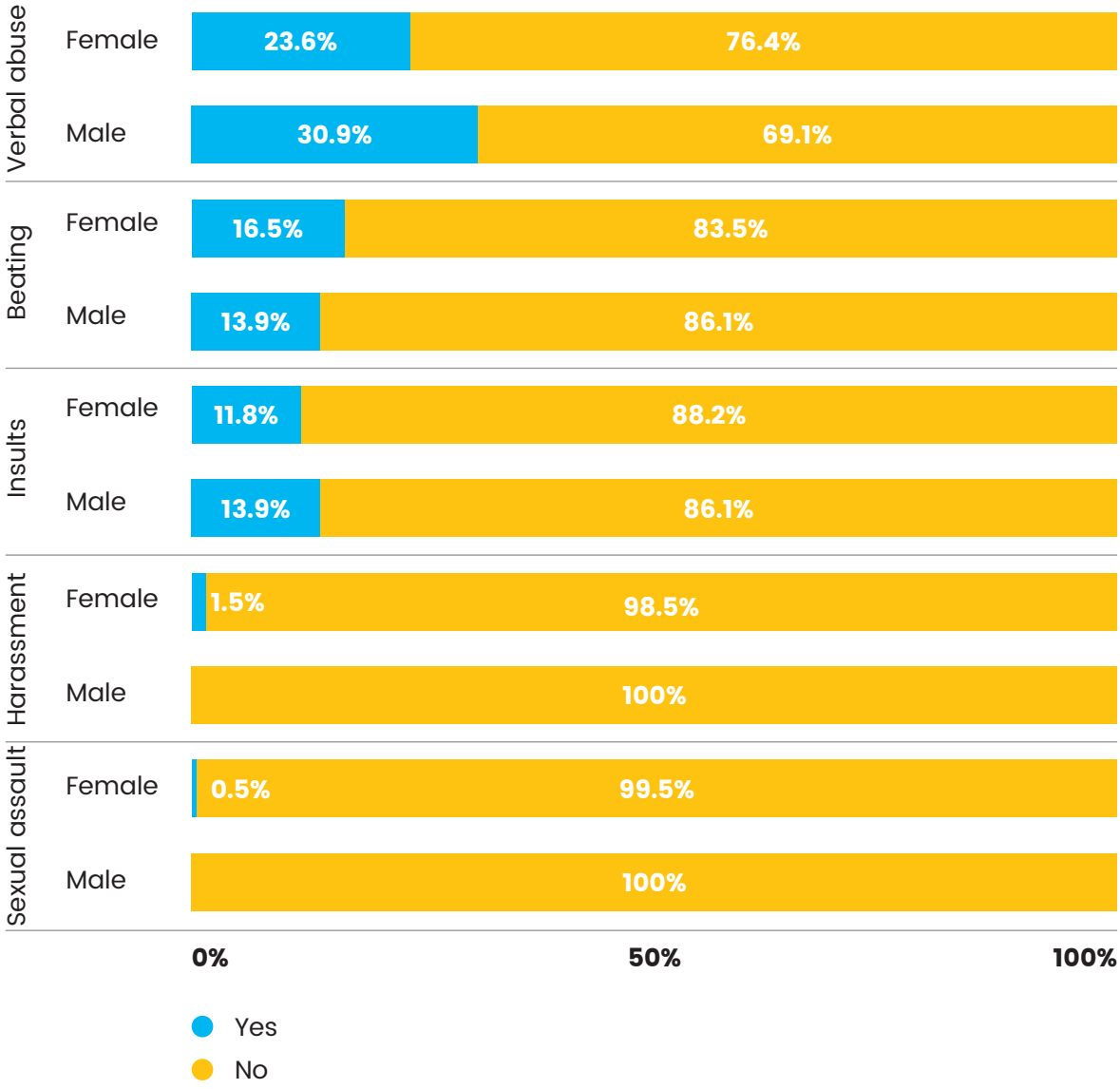
5. Violence

Violence is one of the most significant dangers facing young people today, whether in the public or the private sphere, irrespective of their sex, age or level of education. In this section, we wanted to establish how widespread violence is among young people, whether as perpetrators or victims, in terms of attitudes, conceptions, and reactions, drawing out the important disparities associated with the different variables adopted in this study.

5.1 Exposure to different forms of violence within the last year

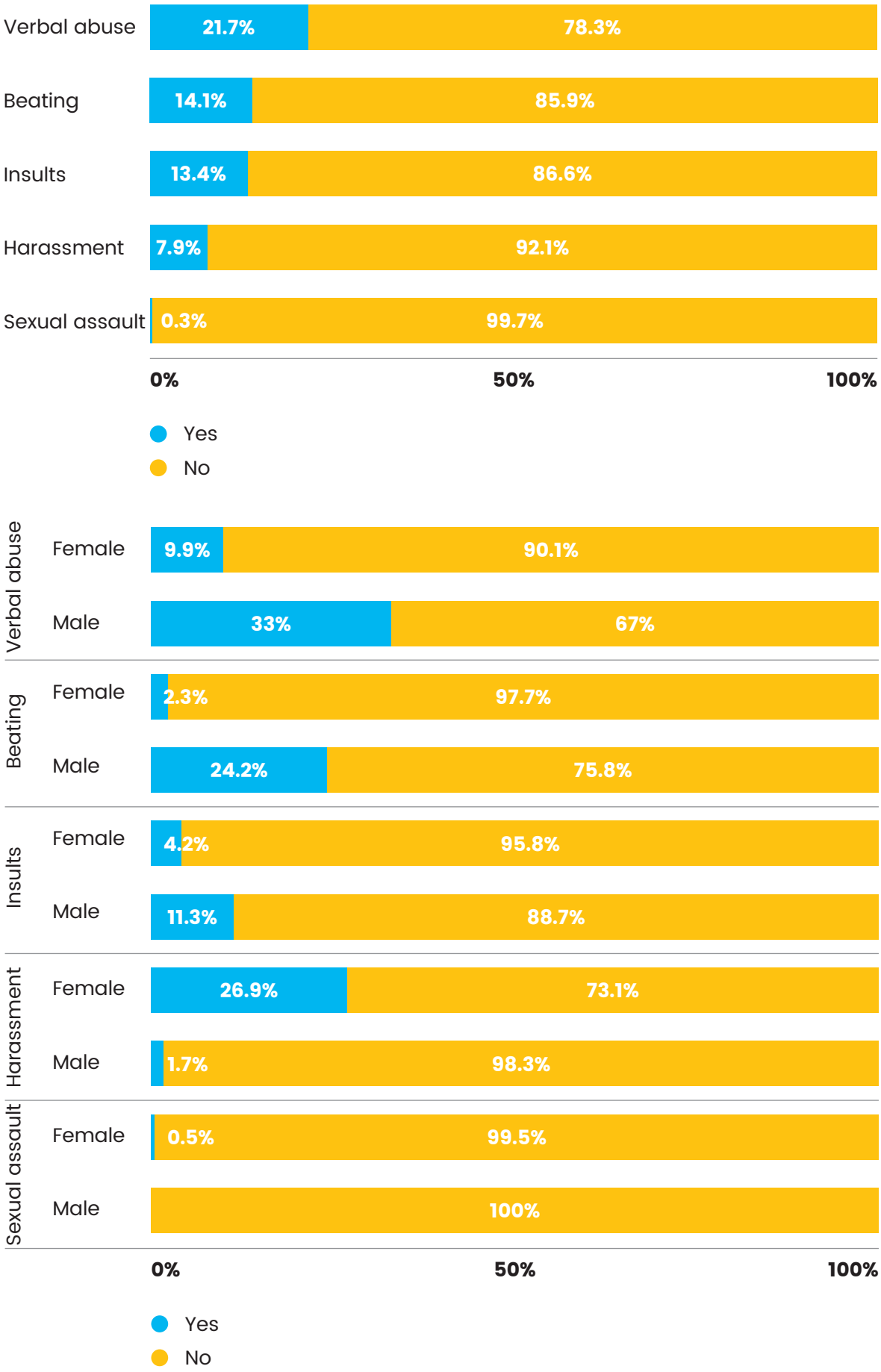
Exposure to different forms of violence within the last year, at home





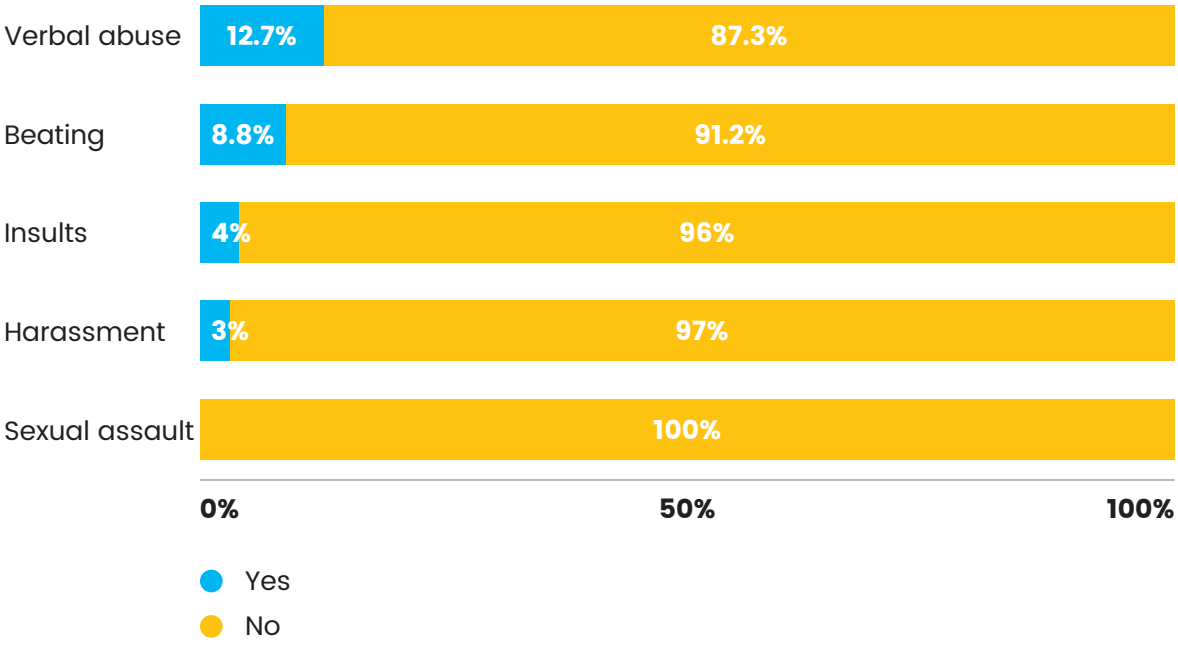
Verbal abuse was the most common kind of violence experienced at home, followed by beatings and insults. The data shows that men are more likely to be verbally abused or insulted, while women are more likely to be subjected to physical violence against their bodies: beating, harassment and sexual assault. The type of violence chosen clearly does not correspond to reactions and responses but instead results from conceptions of gender and how to deal with it.

Exposure to different forms of violence within the last year, in the street

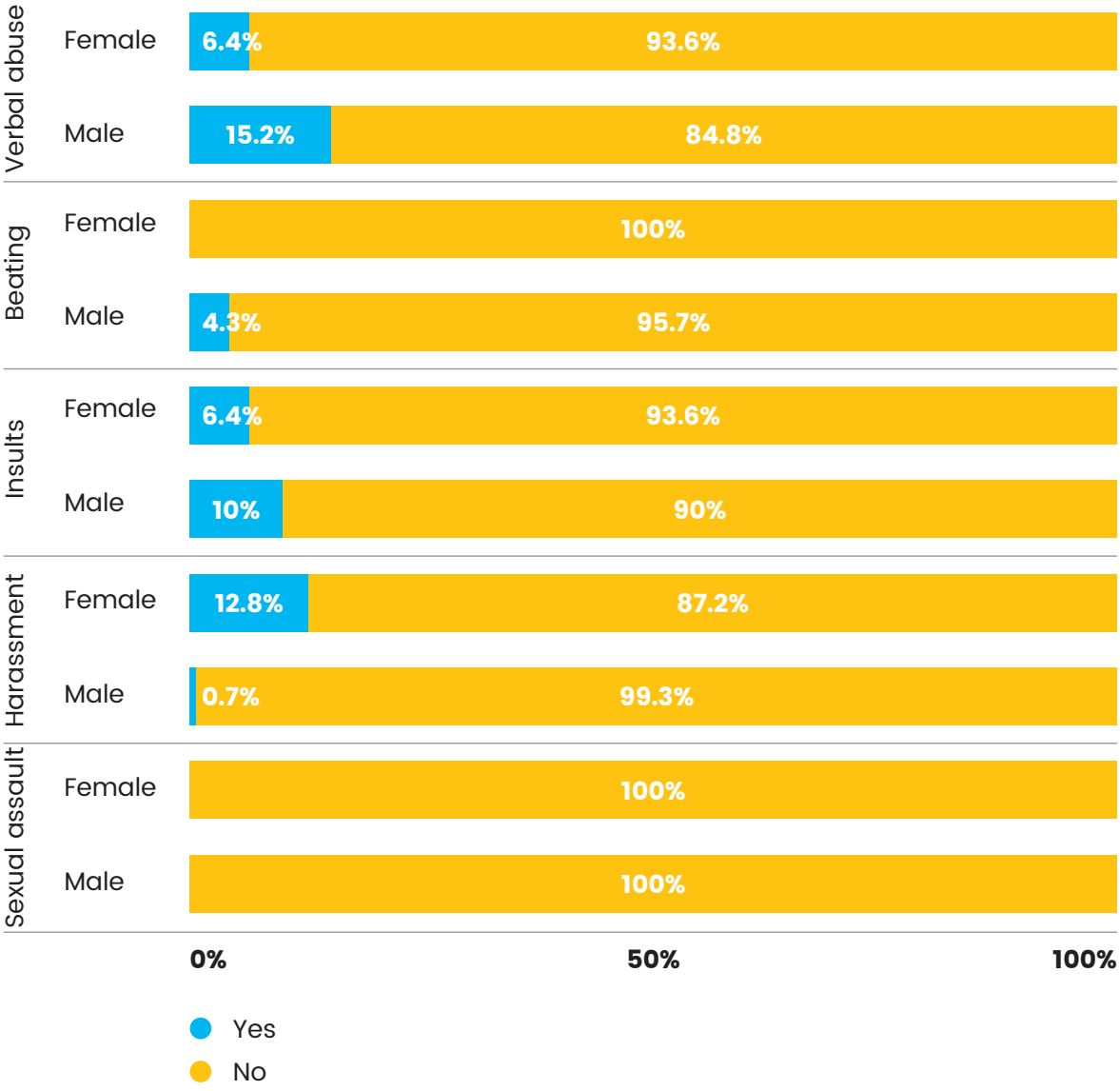


In the street we find many more reports of harassment, which is the second most common form of violence after swearing. Men are more likely to experience violence in the street, particularly verbal abuse, beating and insults, which they reported at much higher rates than women. This can be attributed to the greater amount of time spent by men on the streets as well as their greater vulnerability to risky behaviour. But this does not mean that streets are a safe space for women. Some 26.9% of female respondents reported experiencing street harassment and 0.5% sexual assault.

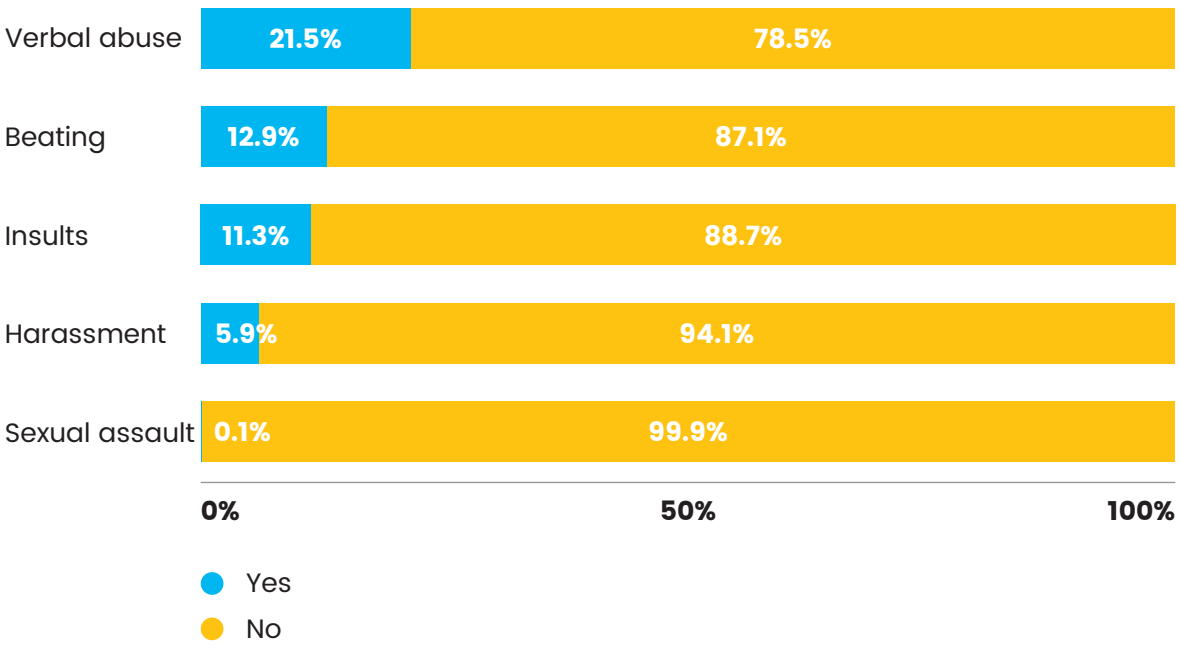
Exposure to different forms of violence within the last year, at work

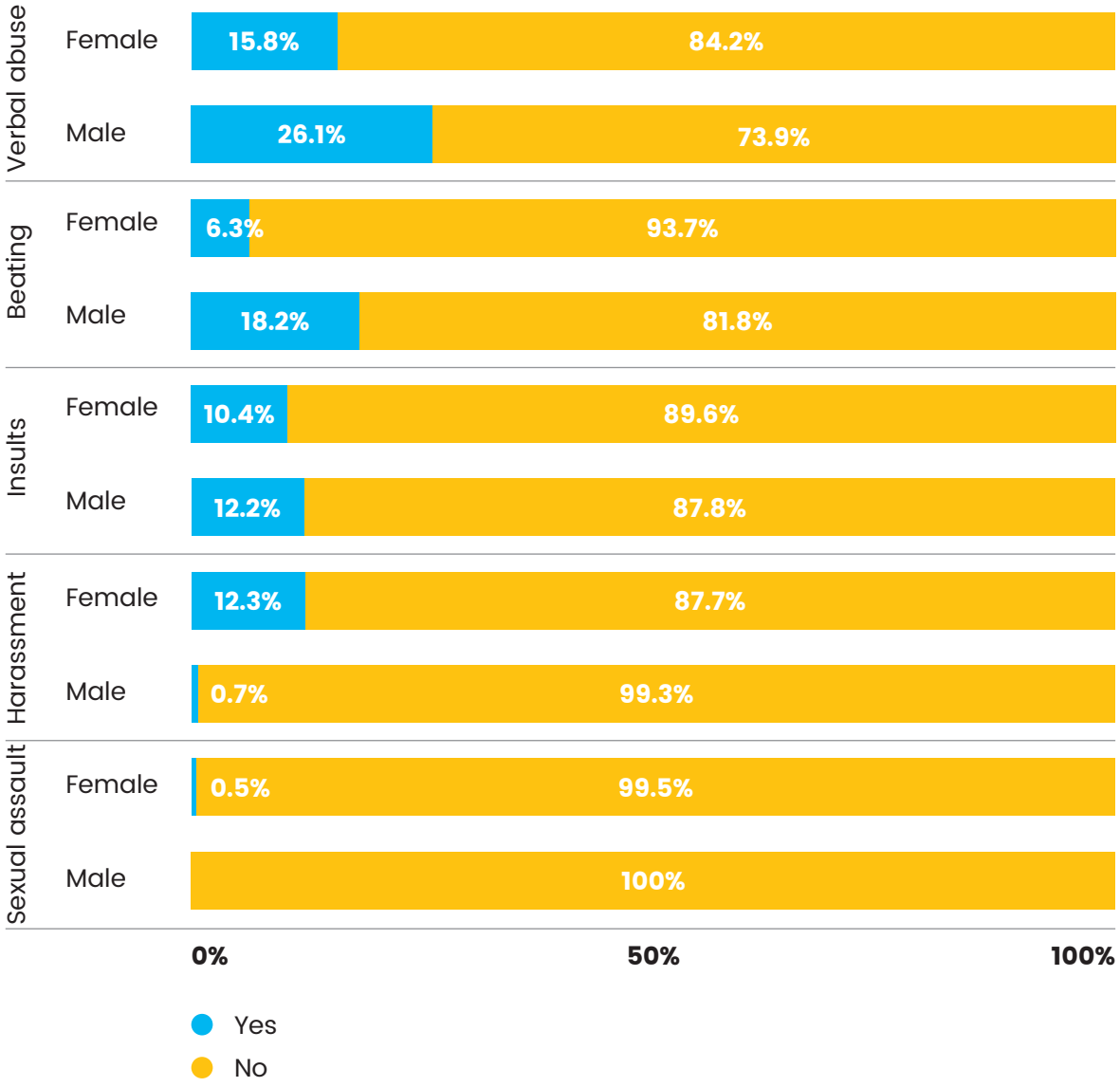


The types of violence experienced in the workplace differ somewhat from other locations. Swearing remains the most common kind of violence. Insults are more common than they are elsewhere, occupying second place, but resort to physical violence – especially towards female respondents – is less common. Men are more vulnerable to extreme violence in the workplace, perhaps because there are more of them in the job market and particularly in precarious, dangerous and unregulated jobs. There are also cultural factors: violent exchanges between men are deemed acceptable, while male violence against women who are not related to them is stigmatised. Harassment of women in the workplace is less common than in the street but still common, with 12.8% of respondents reporting it.



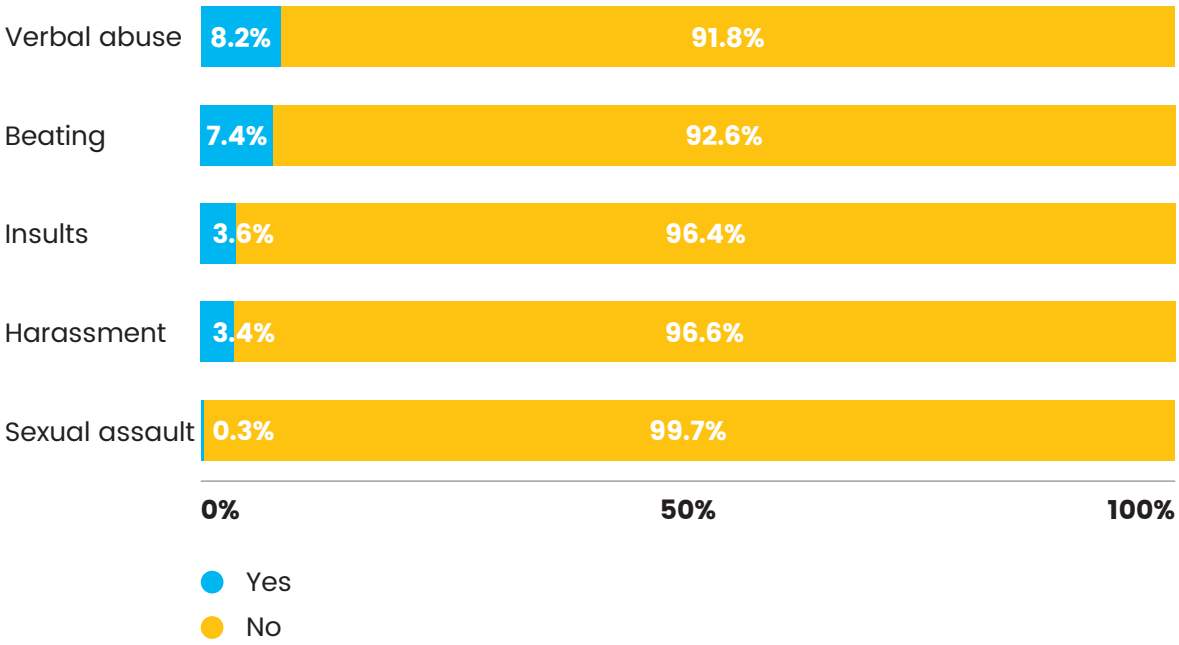
Exposure to different forms of violence within the last year, at school





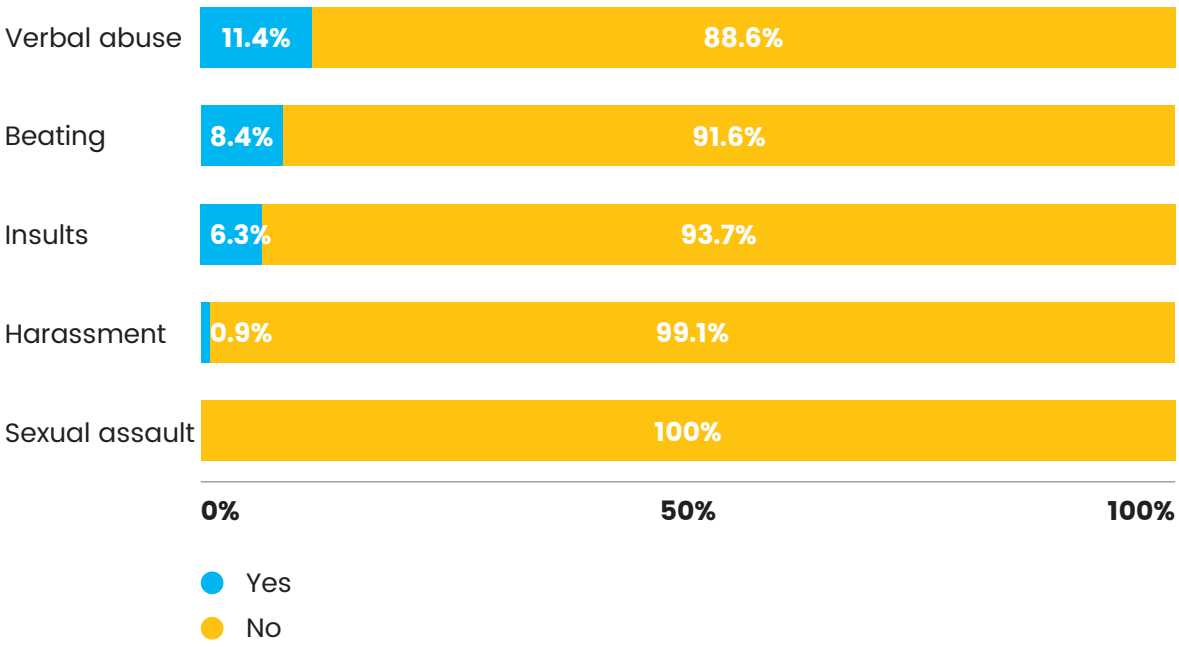
We have no data available on the perpetrators of violence in educational institutions, but the levels reported are alarmingly high in a place that should be a safe space. Nor is it simply a matter of verbal violence and insults: some 12.9% of respondents reported that they had been beaten at school and 5.9% that they had experienced harassment; there were also instances of sexual assault. Men were once again more exposed to all forms of violence except harassment and sexual assault.

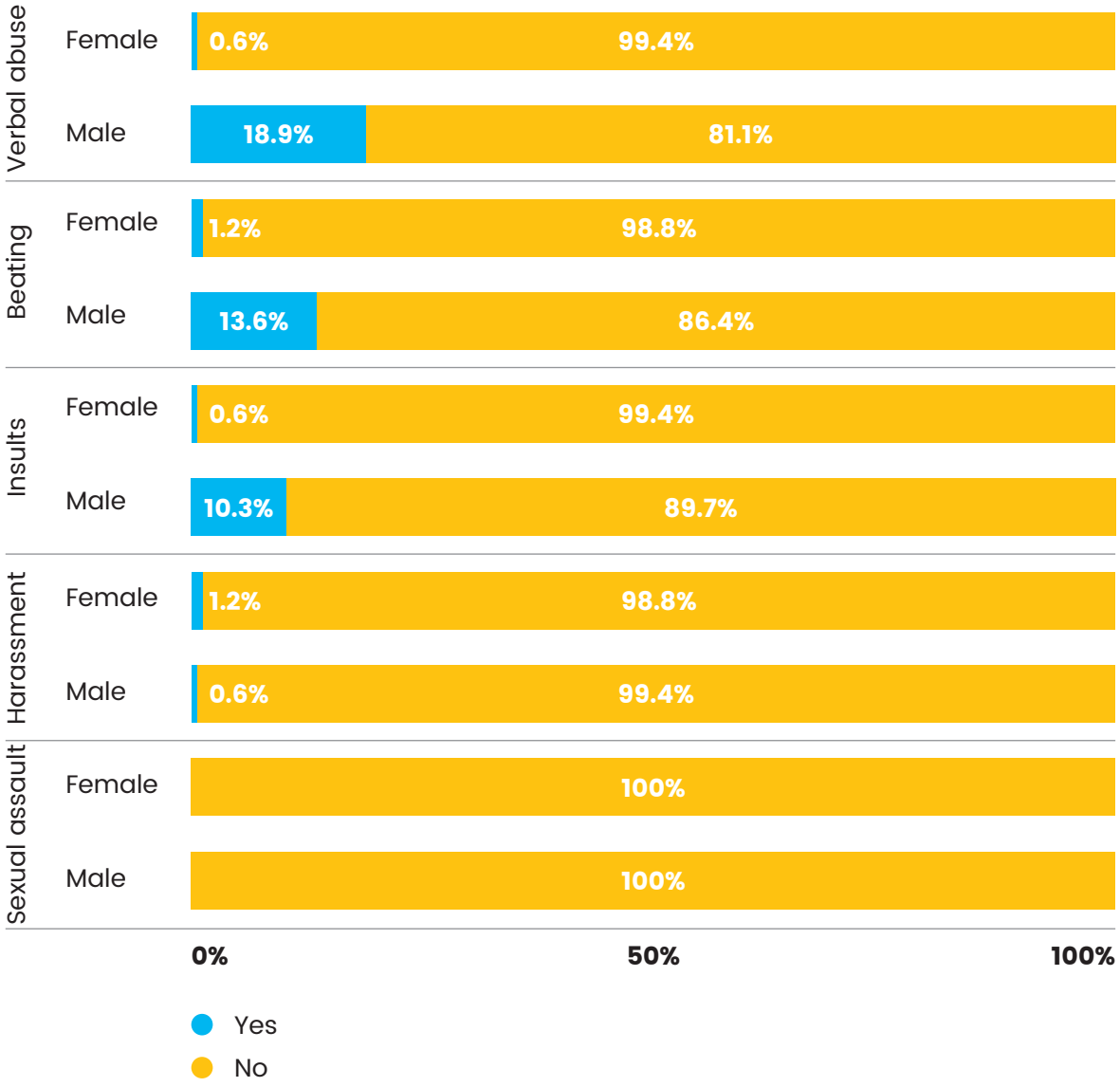
Exposure to different forms of violence within the last year, on public transport



Public transport is the only location in which verbal abuse is not the most common form of violence. Instead, harassment is the most commonly reported form of violence here, with 8.2% of respondents reporting that they had been harassed on public transport. This phenomenon affects women almost exclusively: 15.5% of women as opposed to 1.3% of men. Men, in turn, were far more exposed to beating, insults and verbal abuse. Alongside gender-related and cultural concerns, there can be no doubt that the woeful state of public transport in Tunisia – a shortage of vehicles, overcrowding, a complete lack of systems to provide protection or oversight – plays an important role in making public transport unsafe for many passengers.

Exposure to different forms of violence within the last year, in stadiums

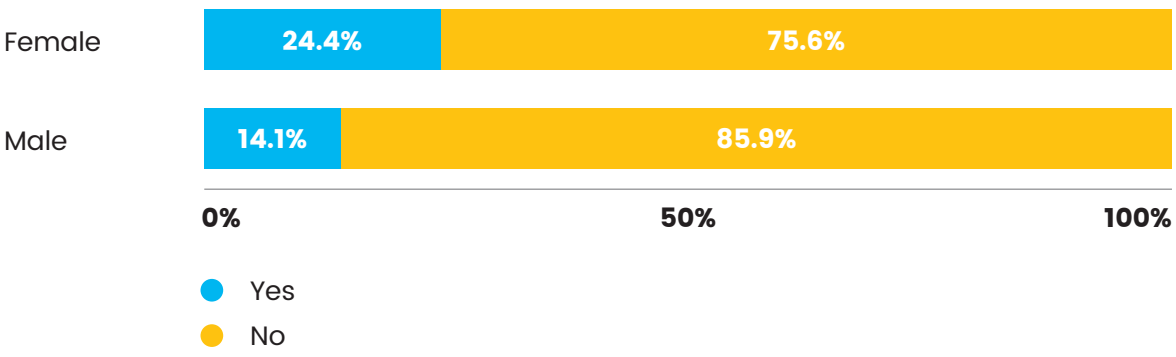




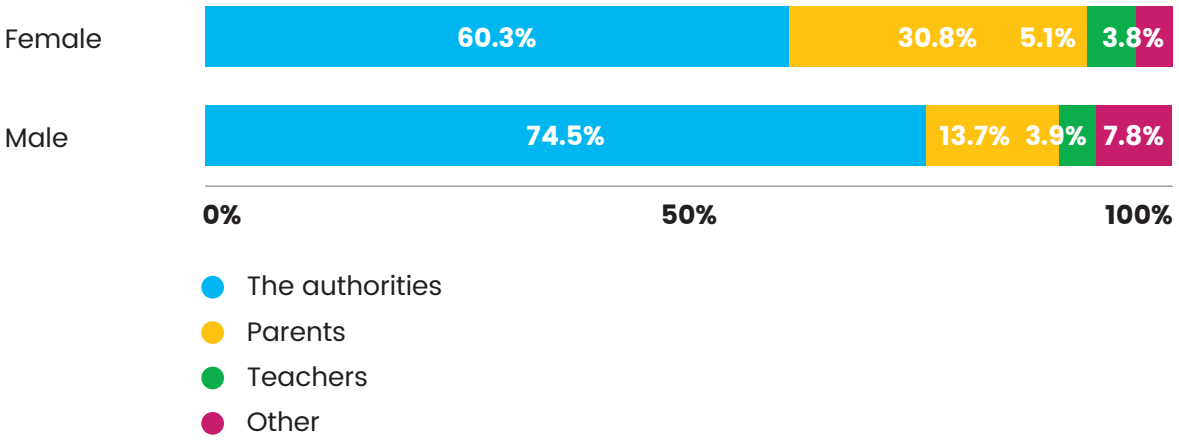
Despite growing numbers of women both on the field and in the stands, football grounds remain an overwhelmingly male space, which explains the low levels of violence reported by female respondents here as opposed to the high levels reported by men. Many women attend matches in the company of men, which makes them less vulnerable to violence. Even with respect to harassment, the figures for women – uniquely among all locations – approach those for men: 1.2% and 0.6% respectively.

5.2 Reporting violence

Reporting violence, by sex

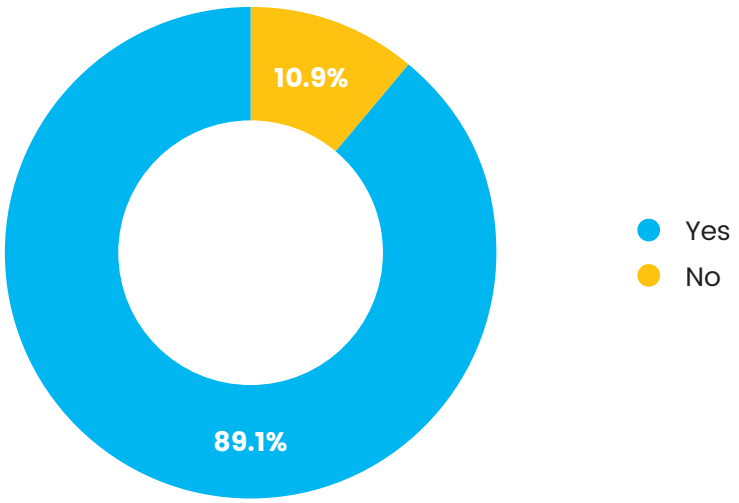


Party to whom violence was reported, by sex

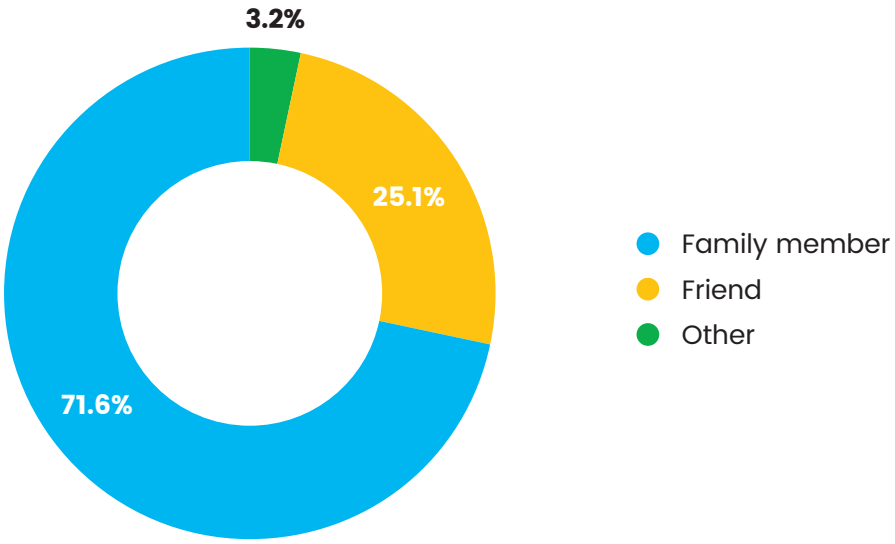


The responses here show a certain passivity with regard to violence. There are many possible hypotheses that might explain this: fear of reprisals, proximity or emotional ties to the perpetrator, reputational concerns or a belief that a complaint will not be taken seriously and the perpetrator punished. The data available do not permit us to form a full and decisive picture of how young people – and Tunisians more generally – deal with the violence they experience. Only a very small number of respondents reported violence, with noticeably higher reporting rates among women (24.4%) than men (14.1%). This may have to do with gender-related factors such as a belief that men are more able to get even on their own or that they should be tough and avoid making complaints while women need more protection. Those men who do complain are more inclined to submit a report to the authorities and not to family members or teachers (with rare exceptions). Women are also most likely to go to the authorities, but at lower rates than men, relying on family members at much higher rates than men (30.8% to 13.7%).

Talking to others about violence experienced



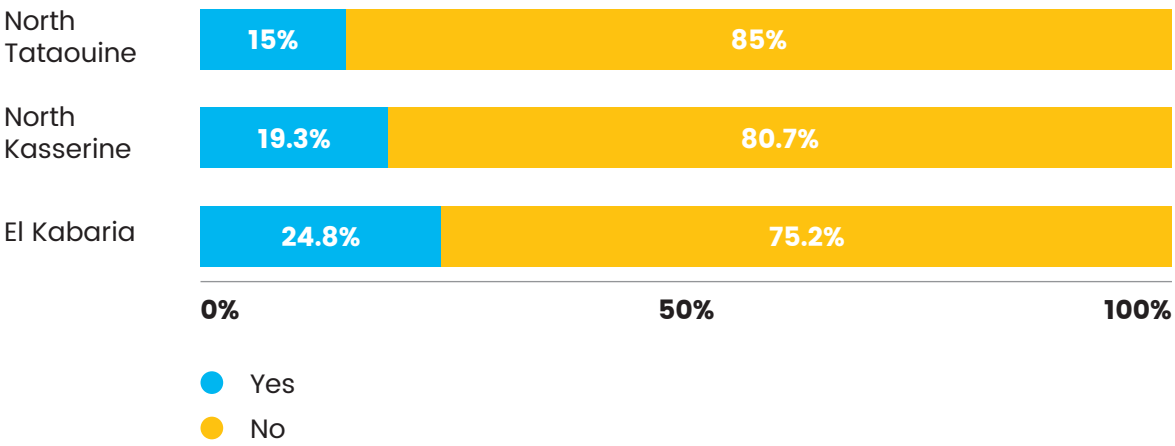
'Who do you talk to?'



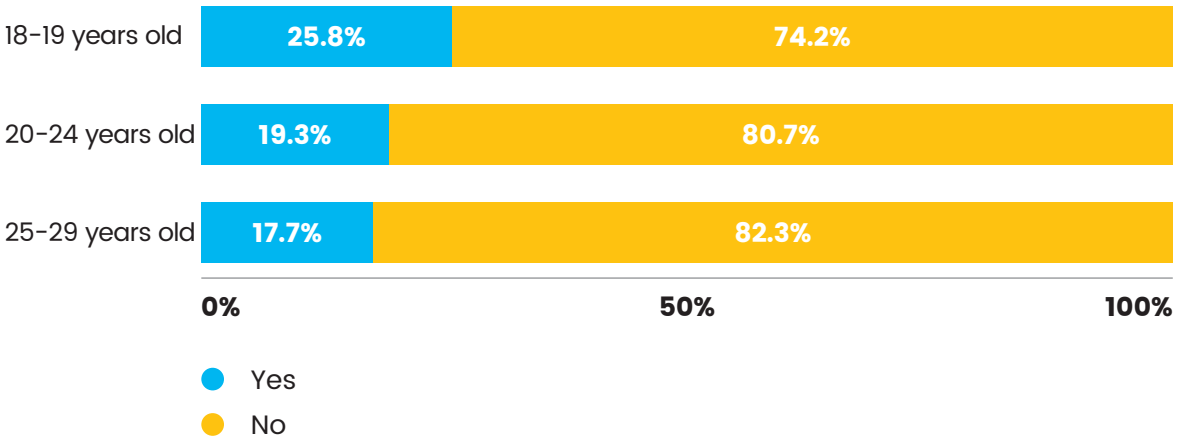
Not complaining about something does not necessarily mean forgetting about it entirely. Around 90% of respondents who had experienced violence had talked about it to one or more people, generally a member of the family or, much less commonly, a friend (one quarter of responses) or someone else entirely (in a handful of cases).

5.3 Engaging in violence

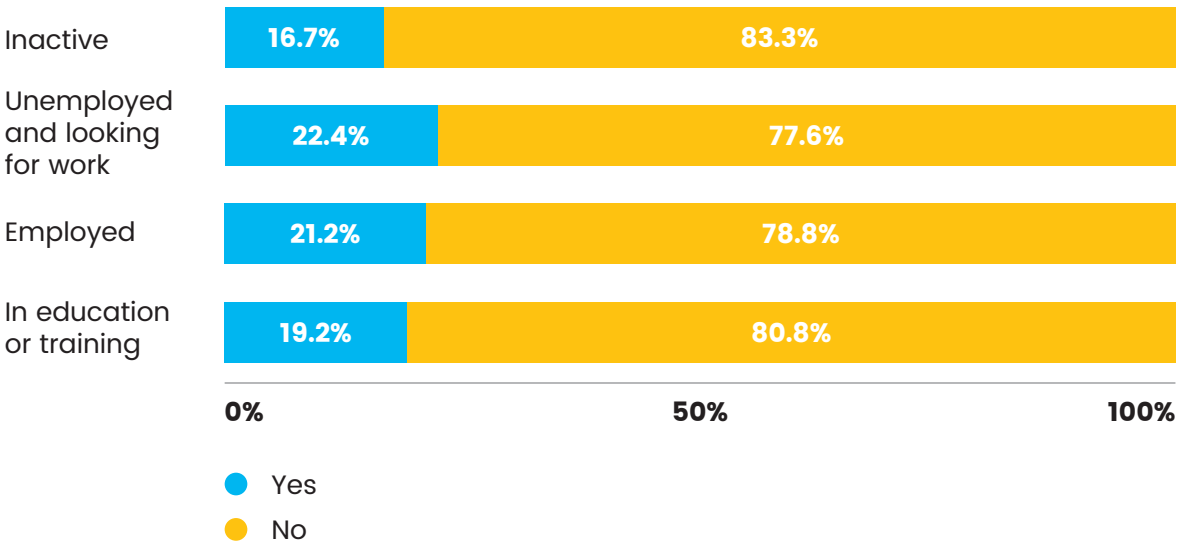
Assaults committed by respondents within the last year (by area)



Assaults committed by respondents within the last year (by age group)



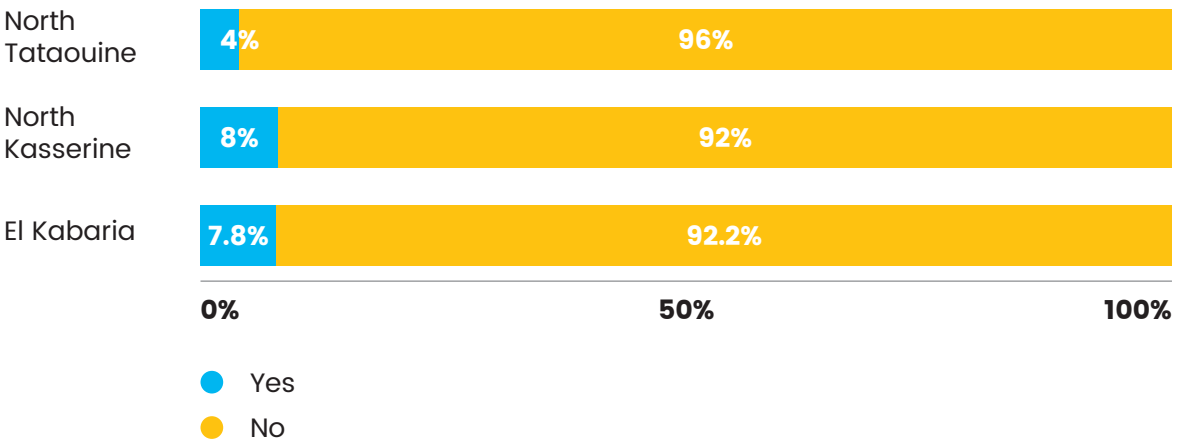
Assaults committed by respondents within the last year (by economic activity)



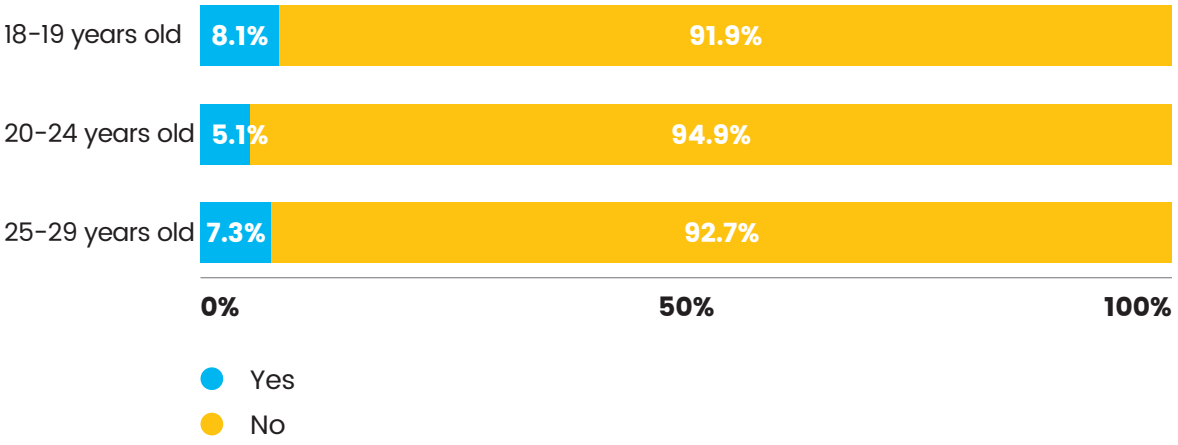
We wanted to look more closely at violence from the other side. How often do respondents engage in violence? The numbers are high generally in all three areas, but in particular in El Kabaria, where around a quarter of respondents said that they had assaulted someone else. There is no decisive explanation for the disparities between the three areas, although the greater exposure to dangerous behaviours and the greater degree of contact between young people in the streets in working-class areas on the periphery of big cities may have an effect. Cultural factors such as 'everyone knowing everyone else' and the close bonds present in the interior may also have a deterrent effect. Violent behaviour is most common within the youngest age group, and the older a respondent was the less likely they were to report engaging in violent behaviour, suggesting a correlation with maturity, integration into professional life and prospects of starting a family. Of the different economic groups, unemployed people are the most likely to engage in violent behaviour. Financial circumstances or the psychological effects of unemployment may be the driver. We find the lowest numbers among the economically inactive, which can probably be attributed to their limited presence in public spaces and their lack of contact with society.

5.4 Arrest and imprisonment due to violent behaviour within the last year

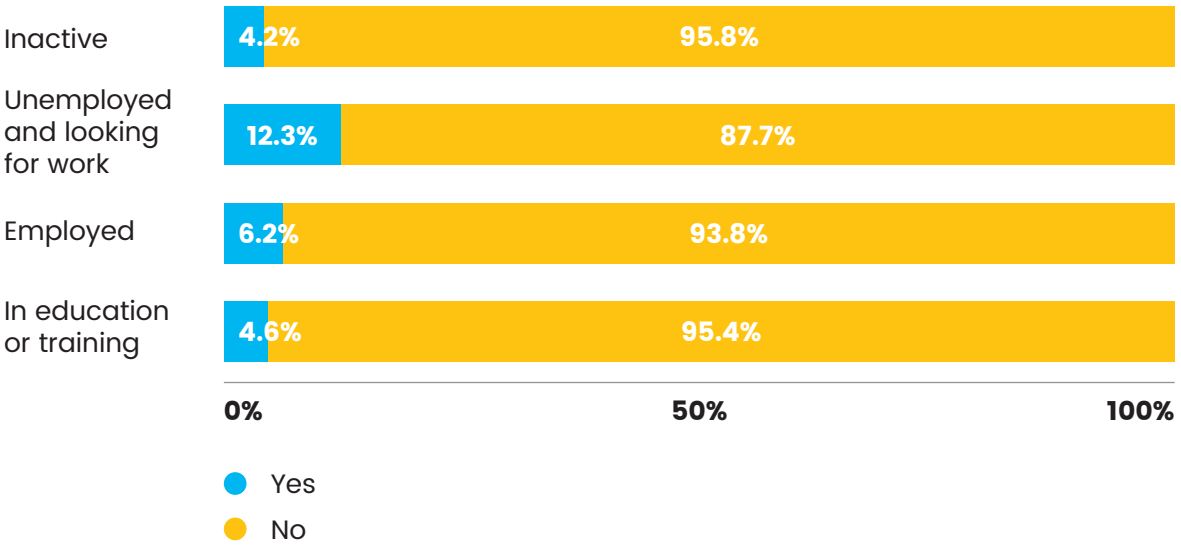
Arrest and imprisonment due to violent behaviour within the last year, by area



Arrest and imprisonment due to violent behaviour within the last year, by age group



Arrest and imprisonment due to violent behaviour within the last year, by economic activity

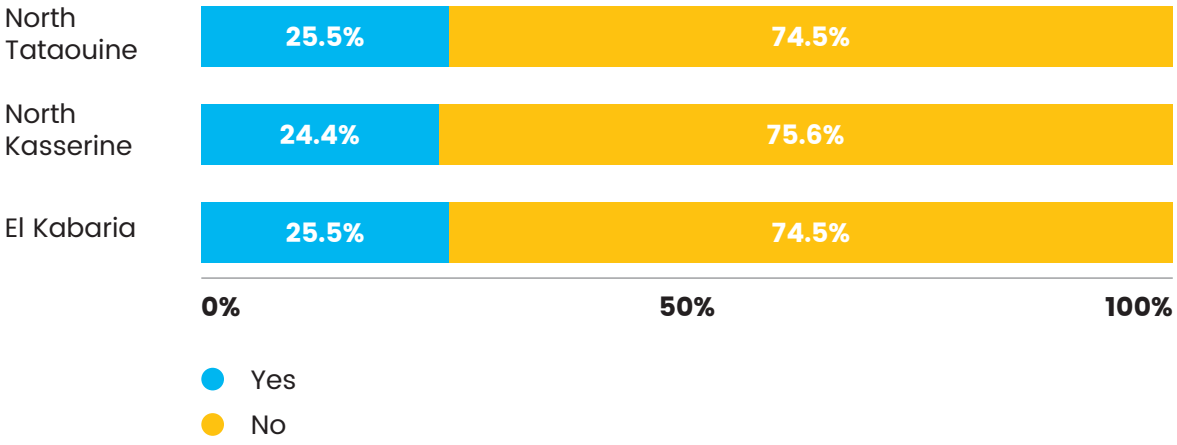


Although respondents from El Kabaria were the most likely to report assaulting someone else, respondents from Kasserine were the most likely to say that they had been arrested or imprisoned for violent behaviour. This suggests that security policy – although inclined to restrict young people's movement in the public sphere in general and to treat them all as suspects – targets some areas more than others for surveillance and punishment. The rate of arrest and imprisonment among 25-29-year-olds is also higher, despite the fact that they are less likely to have engaged in violence. This may have something to do with the level of violence involved, although we do not have the data to say. Arrest and imprisonment rates across the different economic groups correspond closely to the frequency of violent behaviour in those groups.

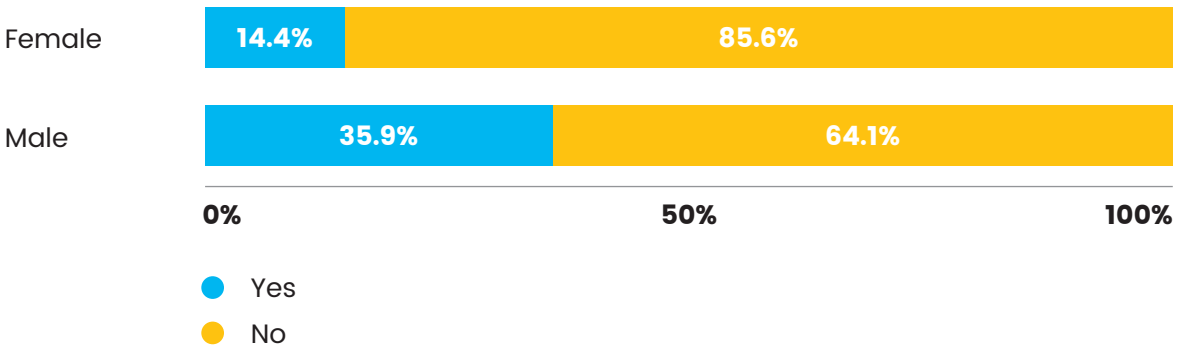
5.5 Attitudes to violence

1. 'A woman who does not obey her husband/father deserves to be beaten'

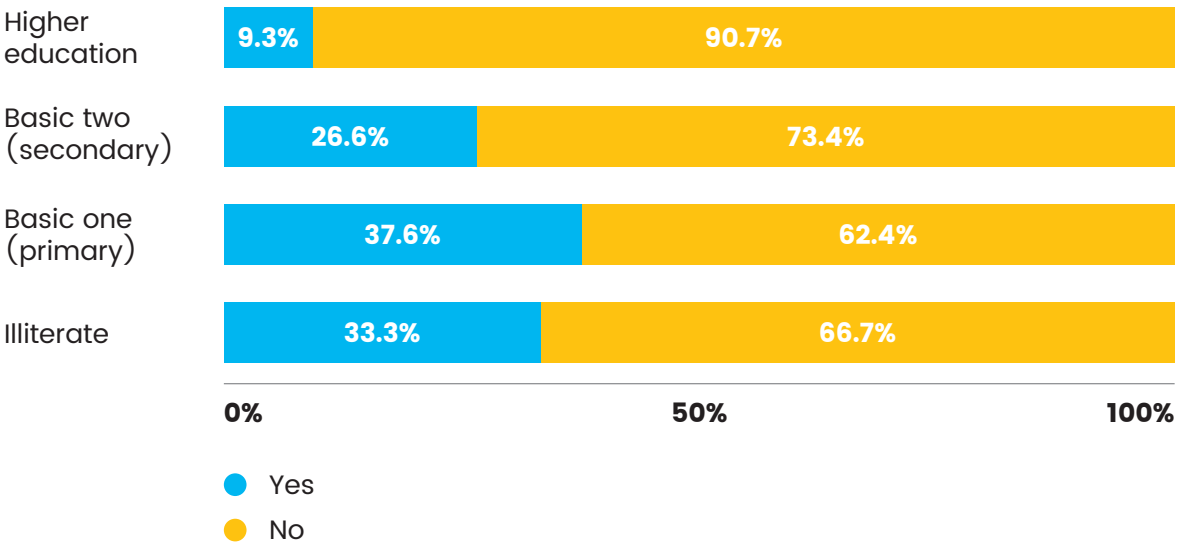
'A woman who does not obey her husband/father deserves to be beaten', by area



'A woman who does not obey her husband/father deserves to be beaten', by sex



'A woman who does not obey her husband/father deserves to be beaten', by educational level

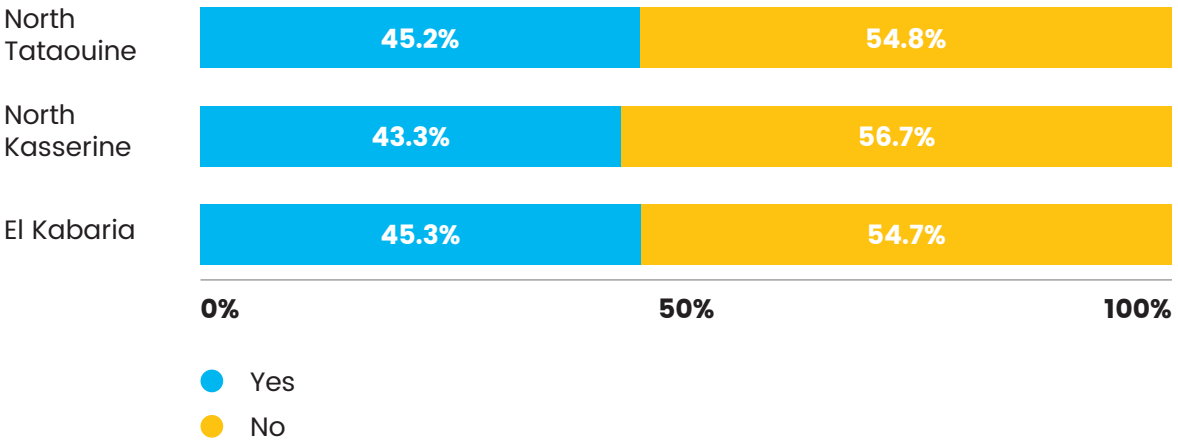


The graphs show that there is widespread acceptance of the idea that women can be beaten by their father or husband, at similar rates across all three areas: around a quarter of respondents see nothing wrong with this practice. Men are considerably more likely to hold this opinion, with 35.9% of male respondents agreeing with the proposition. The similarity between the three areas disproves the common belief that the south – generally held to be more conservative – is more patriarchal or misogynist than other parts of the country, at least with respect to this particular issue.

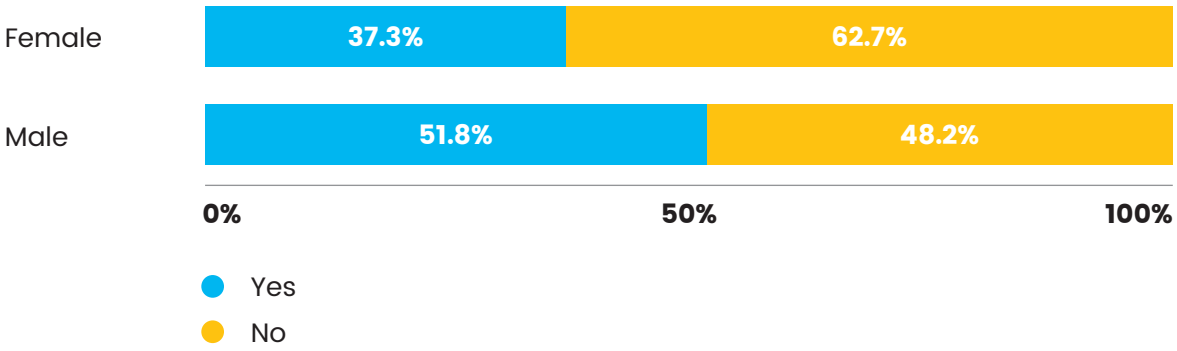
Although women are less likely to agree that a women who 'rebels' against her father or husband deserves to be beaten, the figures are still remarkably high when we consider that this is a practice they may themselves be exposed to. This shows that many female respondents have internalised the legitimacy of patriarchal violence. It is also clear that there is a strong link between level of education and attitude to violence against women. Around a third of illiterate respondents and those with only primary schooling supported the proposition, while the figure fell to around a quarter for those with secondary education and to less than 10% for those who had attended university.

2. 'A son or daughter who does not obey their parents deserves to be beaten'

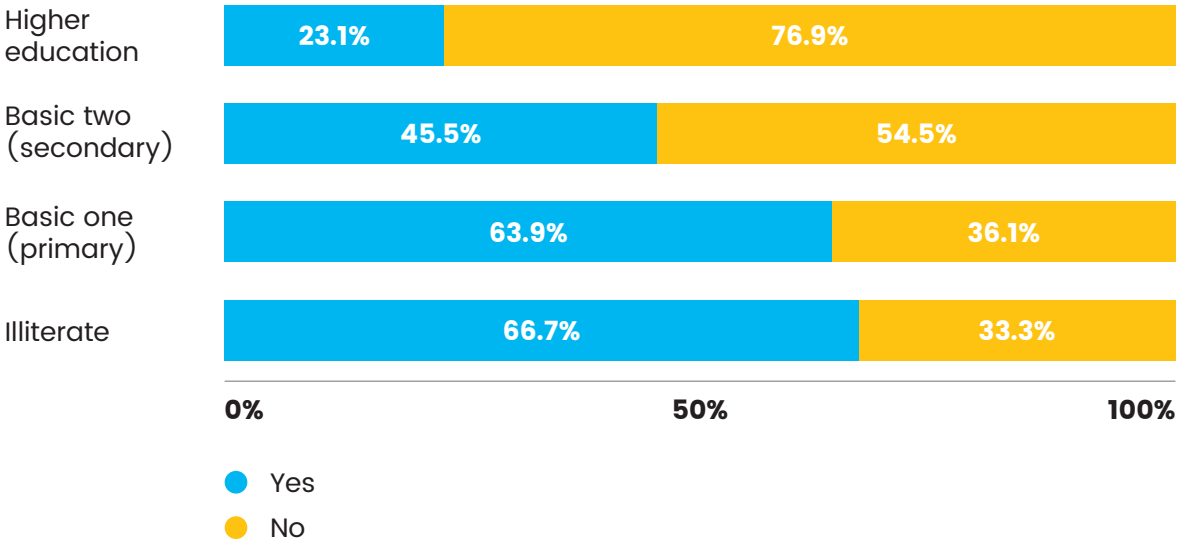
'A son or daughter who does not obey their parents deserves to be beaten', by area



'A son or daughter who does not obey their parents deserves to be beaten', by sex



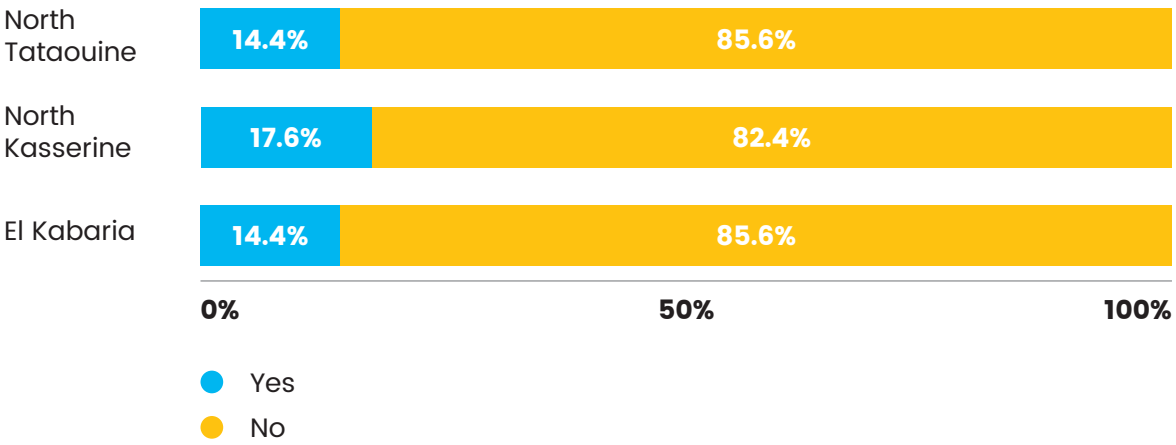
'A son or daughter who does not obey their parents deserves to be beaten', by educational level



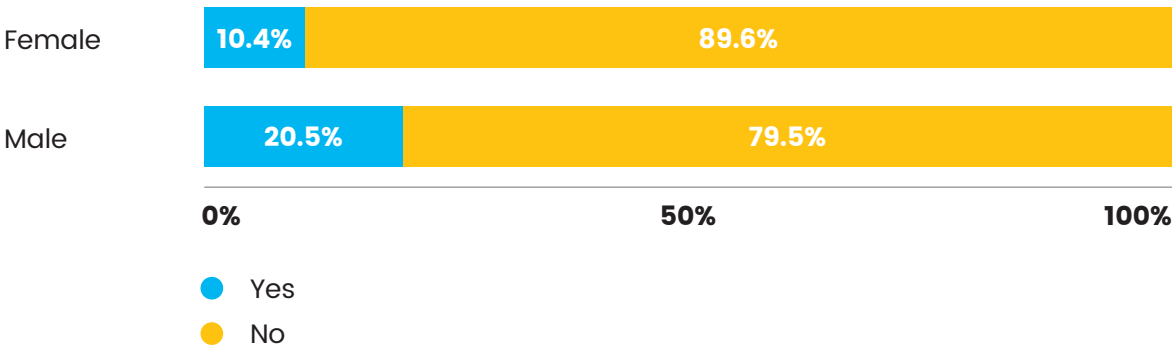
We received similar responses to this question as to the previous question, but at higher rates, which is very concerning. Around half of the sample agreed with beating children, with 51.8% of men supporting the proposition and more than 60% of respondents who were illiterate or had only received primary schooling. Beating disobedient children is entirely normalised – and let us not forget that the respondents here are young people below the age of 30, many of whom are likely to soon be starting families of their own.

3. 'A lazy student deserves to be beaten'

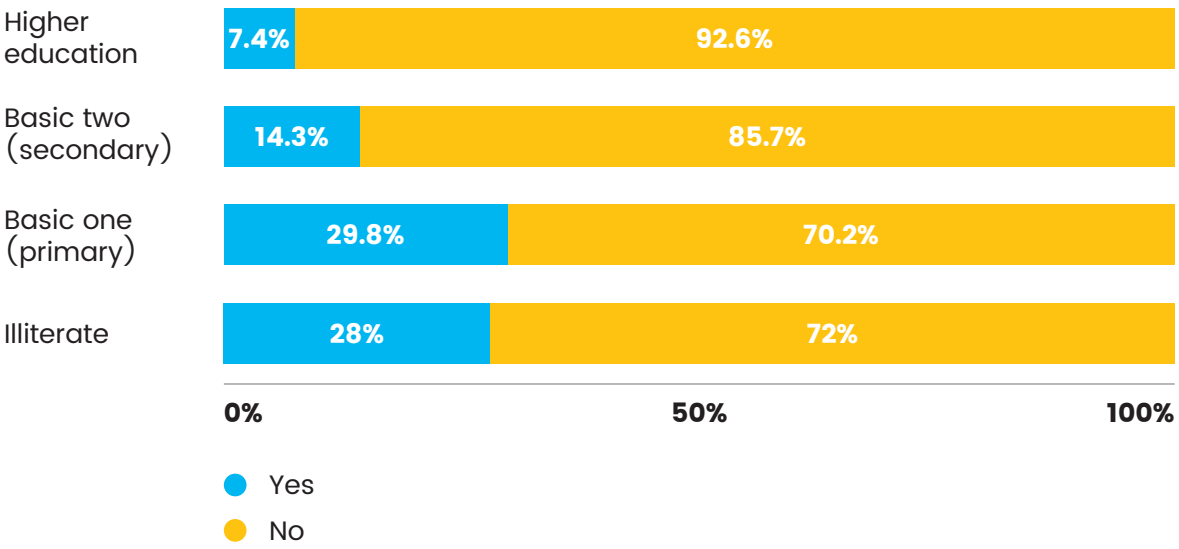
'A lazy student deserves to be beaten', by area



'A lazy student deserves to be beaten', by sex



'A lazy student deserves to be beaten', by educational level



Respondents of all groups were least likely to agree that lazy students should be beaten. The general distribution of responses was similar to the previous two questions but with considerably lower overall rates.

Conclusion

The data provided by the survey confirm two main points: the great similarities between the three regions on most of the different points (particularly between El Kabaria and Kasserine), and at the same time the significant differences between *groups* defined by variables such as sex and educational level.

Investigating the socioeconomic environment shows us, for example, that there is a great improvement in the educational level of respondents compared with their parents. But it also shows that there are regional disparities in people's ability to complete their education, and that there are closed "pockets" of illiteracy in areas like Northern Kasserine, as well as rising drop-out rates (particularly among men) at a time when school is no longer a vehicle of social mobility. It is now migration more than anything else that young people think of as their way out, especially young men, particularly given the extent of economic precarity confirmed by the numbers of respondents who are looking for work, economically inactive or day workers. This precarity has been exacerbated by coronavirus and the economic stagnation and layoffs it has caused.

The data also show rising levels of economic dependency among women. Alongside high levels of unemployment that are close to or even (for graduates) exceed those among men, there are more women than men who report being "economically inactive". This dependency has sociocultural repercussions that express themselves in a range of ways. The majority of "economically inactive" women and many unemployed women consider "homemaking" to be their "professional activity". This answer is unique to women: no male respondent reported that homemaking was their "professional activity". Moreover, many women depend on their families or their spouses for health insurance coverage, and only half as many women as men report participating in cultural or sporting activities. Similarly, very small numbers of women report spending their spare time in cafes or on the street (compared to very large numbers of men), with most of them saying that they spend it with family or watching TV.

On the second theme, although more than 90% of respondents reported being in "good" or even "very good" health, their answers to the other questions concerning general health show that these evaluations are very much relative. More than half of young people (55%) have sought medical attention within the last year (one quarter within both the public and private sector and the remainder in one or the other). More than 30% have caught Covid-19 at least once. And many respondents reported suffering from chronic illnesses, particularly in Northern Kasserine (11.4%) and to a lesser extent in El Kabaria (8.7%, compared to 3.8% in Tataouine).

The respondents' evaluation of their mental health was less optimistic than their evaluation of their physical health, although there was a degree of overlap. As a rule, the more positively a respondent viewed their mental health, the more positively they viewed their general health. But this rule did not hold for more than 350 young people, who described their physical health as good or very good but reported poor mental health.

Young people feel a need for psychological healthcare. Although only 0.4% of respondents said that the healthcare sector would be their first port of call if they felt that they were suffering from mental health problems – most of them preferring their mothers, friends, or siblings (with fully one third saying that they would not speak to anyone) – more than 25% reported feeling a need for psychiatric care or counselling within the last year, with significant disparities, particularly when we broke the data down by sex (20% of young men versus 34% of young women) and economic activity (20% of the economically inactive versus 34% of the unemployed). This only rarely translates into actually accessing such care (around 12% of those who reported feeling the need), for various reasons, including social reasons such as stigma and mockery as well as economic and practical difficulties

with access. These are the same factors that the majority of respondents identified as obstacles to accessing mental health care. The majority of those who had been seen by a specialist, around ¾, gave a generally positive evaluation of the various aspects of the service.

Similarly, more than 1/3 of respondents reported that they had experienced psychological difficulties in the past, most significantly anxiety or stress, which were experienced by more than half of them "constantly" and more than a third of them "sometimes". Depression was less common, particularly as a constant feeling; slightly more than a third of respondents reported experiencing it never or rarely.

The data that we have collected show that the majority of young people believe there is insufficient information available on the main symptoms of psychological illness and what to do when facing mental health problems, especially how to protect themselves from mental illness and in particular opportunities for treatment. On the other hand, the majority feel that there is sufficient information available on the causes of mental illness, a belief borne out by most of them being familiar with the major drivers of psychological disorders.

Most young people also believe that psychological care and the support of family or friends are two ways of helping those who suffer from psychological problems, although around half do not consider medication to be a solution. As far as awareness-raising campaigns are concerned, meanwhile, there is an almost total consensus among respondents that there should be trained psychologists in schools; only 10% of respondents had been reached by an awareness-raising campaign at school. For around ¾ and 2/3 respectively of respondents, dedicated websites and the "green number" hotline were also means of seeking guidance and support.

Respondents' answers on the theme of addiction show above all how widespread drug use is. It is ubiquitous among men in particular, with slightly more than half of men of all ages and economic activity groups reporting that they have used drugs, but is also beginning to make serious headway among women. There are disparities between the different areas for a range of reasons having to do with promotion and sociocultural differences (in Tataouine there are much lower levels of consumption than in the other two areas). There also seem to be major shortcomings on the part of the public health service both with regard to awareness-raising efforts on the dangers of drugs and to the availability of treatment.

On the theme of violence, the answers show that violence is a serious and enduring threat to young people and that its forms as experienced by respondents vary by gender and by location. Men are more likely to be beaten in all locations except the home, where women are more likely to experience this kind of violence. Broadly speaking, men experience more violence in all its forms in all places, with the exception of harassment and sexual assault which are experienced almost exclusively by women. In the street and on public transport are the least safe places for women with regard to harassment but are less dangerous with regard to other kinds of violence.

Respondents' answers also showed a high frequency of violence in educational institutions. The relatively marked presence of violence against respondents has effects far beyond the physical and psychological damage inflicted: young people who have experienced violence reproduce it, as shown by both the high percentage of respondents who reported having assaulted others (particularly high in El Kabaria) and the high percentage who maintained that it was acceptable for husbands to beat "disobedient" wives or parents to beat their children. This was closely linked to educational level.

No more neglect: Making young people's right to healthcare a reality

Jawhar Mazid

The various components of this study, which was carried out by International Alert's Tunisia office, show that there is no justification for the failure to consider young people in health programmes and public health services. Young people are forgotten almost everywhere, with the exception of a handful of ineffectual reproductive health projects, failed anti-smoking campaigns and school and university health education – whose limited effect is further reduced by outdated approaches and general neglect.

Only a quarter of young people are school or university students, but all of them have distinct physical, psychological and social health needs, as set out by the WHO. The general impression that young people are ultimately all students and largely insulated from health problems – especially when compared to other age groups – thus belongs more to the realm of fantasy than fact.

This idea is the product of a superficial, partial and one-sided view of health that sees it almost entirely as a matter of *physical* wellbeing, of chronic or difficult illnesses that affect older people (although these are also indisputably important priorities). It is rooted in the great gulf that separates those involved in health policy, including professionals, from most young people. This gulf is often visible even in direct interactions between health service providers and young service users, whether in school or university health education, clinical practice or other activities such as awareness campaigns.

The result of all this, without exaggeration, is that young people's health is neglected in both planning and practice. This makes them vulnerable at a time when they are already going through the most important transition in human life: from "protected" child who cannot be held responsible for their actions to "active" and "responsible" citizen who must look after themselves. This transition is becoming more and more confusing as time goes on, and today it is more unclear than ever.

One of the quantitative study's clearest findings was that young people need to be prioritised for health provision just as much as other age groups:

- 8% of young people describe themselves as chronically ill. This is a significant number. Although only half the number across the population as a whole (16% according to the National Institute of Statistics), it represents around 200,000 young people, an important figure. This is despite the fact that many of those who are chronically ill are not aware of their illness (for various reasons). A health system that only recognises a handful of chronic illnesses and disregards many others, including hundreds of rare illnesses often affecting young people, falls well short of requirements here.

- More than half of young people (55%) had had medical treatment within the last year. This figure is close to the general national figure (for all age groups) found by the comprehensive 2016 National Health Survey (61%).

- More than a quarter of all young people described their psychological state as “bad” or “very bad”. Around the same number had felt the need to visit a psychologist or psychiatrist within the last year.

These data, which speak directly to young people’s health, refute the notion that this social/age group is in universal good health. They make it clear that their health represents an additional source of vulnerability.

However, young people run up against serious discrimination with respect to their right to access healthcare without financial difficulty. Half of 18-29-year-olds lack health coverage. This is at least two and a half times the figure across the country as a whole, which is estimated as between 17% (National Institute for Statistics) and 20% (National Institute for Health). As is well-established, denial of coverage leads to denial of the right to healthcare (a fact borne out by the 2016 National Health Survey).

With so many young people lacking health coverage, we need an effective plan taking into account all young people and their different economic circumstances – a plan that will replace the complicated and humiliating mechanisms put in place to mediate young people’s access to healthcare under an unjust legal order.

Alongside those denied health coverage entirely, only a quarter of those who do “enjoy” coverage have it in their own right, while the remainder share a treatment card with a spouse or guardian (who has social security or has obtained a free or discounted card). Many young people thus encounter difficulties when trying to use the card to access healthcare that they feel they need. Some, for whatever reason, live far away from the cardholder. Often the cardholder will refuse to allow them to use the card or be resistant to the idea unless they give them details (the specific health problem, the service they want to access, why they want to access it, where it is, who the service provider is, etc). Moreover, if the card is paid for rather than free, accessing treatment often requires payment, and young people are often obliged to ask the cardholder for the money – even when the price is limited or merely symbolic.

Empowering young people – whatever their economic circumstances – to access healthcare without administrative or financial hassle or interference from family “breadwinners” is thus a crucial first step towards guaranteeing the right to healthcare.

But there are a range of other difficulties facing young people seeking to exercise the right to healthcare that takes into account their particular circumstances and responds to their needs.

Based on the study, **the biggest problem is still accessing mental health services**. Fewer than an eighth of all young people who reported feeling a need to visit a psychiatrist or psychologist had actually done so. Intuitively, the gap between the two figures can only be explained by the lack of coverage on the one hand – although this did not prevent more than half of young people from accessing some sort of health service – and hesitancy about seeking specific mental health treatment on the other.

It seems likely that a major reason, if not the main reason, is the difficulty of accessing psychiatric or psychological treatment. In Tataouine Governorate, for example, there are no practising psychiatrists or psychologists in the public sector or indeed in the private sector, with the sole exception of a counsellor at the Regional Commission for Family and Population (RCFP), a reproductive health centre. In Kasserine things are not much better: although the regional hospital does have a psychiatric unit, its capacity is very limited, it is already responsible for a large number of chronic patients, and it is staffed not by specialists but by a general practitioner with little training who volunteers in his spare time. All this means that it is very difficult for young people who feel that they need psychiatric care to access appropriate services. The majority of young people are unaware that there is a counselling service available at the local RCFP.

The situation is better in Tunis, but not by much. Although according to the national medical board (CNOM) the city boasts some 80 psychiatrists in private practice, Razi Hospital in Manouba is the only public sector option available to young people in Kabaria and in the capital as a whole. This raises several problems. The most important is the fear of stigma, which some 80% of our respondents gave as a reason for not seeking psychiatric care – especially when all they want is a "consultation" or "temporary" care. The hospital is more than 15km from Kabaria and the journey by public transport is very complicated. To get an appointment, young people must first secure a referral from a family doctor or a specialist in another field, a procedural requirement that many are unaware of. All these problems can be avoided by recourse to the private sector. But this comes with significant cost, which more than two thirds of young people cited as a reason to not seek psychiatric care. The same number gave not knowing how to get an appointment at the right time as a reason.

Young people desperately need less centralised mental health services, services that they and other residents can access effectively. It is high time we got rid of the "National Mental Health Improvement Strategy", which in the fifteen years since it was first introduced by the Ministry has failed to make much impact even among professionals (despite being drafted specifically to shake off the stagnation of previous "national health programmes", which remain a dead letter). We must replace it with a practical plan and provide the financial and human resources required to quickly and sustainably put it into practice. Training one psychiatrist for every interior region by 2024 is not enough. It must be part of a comprehensive and actually effective plan.

We must develop training for frontline professionals working in young people's mental health. This must include basic and on-the-job/continuing training as well as academic education such as postgraduate degrees for frontline doctors and nurses as well as other professionals (midwives and counsellors for example).

The data also show the urgent need for treatment bodies to set up consultation and counselling units, run by specialists in clinical or child psychology/young people, that can be accessed without a prior referral, giving priority to provincial centres in the interior regions and then to more remote areas of those regions. Young people have reservations about seeking psychiatric treatment when dealing with mental health difficulties and would generally prefer to consult a counsellor in the first instance, in order to avoid pharmacological treatment. Fully half of respondents did not consider medication to be helpful in getting over psychological problems, while there was a broad consensus on the effectiveness of talking therapy.

Alongside general mental health services, the study shows that young people in prison urgently need mental health services run by the Ministry of Health in partnership with other ministries, social/academic bodies specialising in mental health and rights organisations.

The findings of the initial quantitative study and on anxiety also show that young people in employment are no less vulnerable to mental health disorders than their peers. Studies in Tunisia and elsewhere, as well as our own study on anxiety, make it clear that work is a major source of mental health problems.

It is thus crucial to incorporate specialists in workers' mental health into occupational health/health and safety teams and to set out mechanisms for intervention and make sure they are effective. This will naturally require more and better training (including expanding training to universities outside the capital).

Alongside these efforts to develop, implement, evaluate and improve mental health treatment programmes, our studies show that the government and its subsidiary bodies must also take responsibility for coming up with plans to address the direct and underlying causes that have led and continue to lead to deteriorating mental health among young people. Moreover, they must genuinely include young people in this process through civil society organisations active in this area or related spheres. If they do not, this deterioration will continue unchecked, no matter how many therapeutic options they make available.

Our study on anxiety, for example, shows that the average level among young people is above the "pathological" threshold, no matter which of the various well-recognised regional or socioeconomic variables you use to break down the data. This will require a far-reaching effort to address the underlying factors behind these high levels of anxiety. The responses of participants in the quantitative study, meanwhile, chimed with well-known drivers for poor mental health among young people. The most commonly cited causes of psychological problems (chosen from a list provided) were family problems, psychological and emotional shocks and social circumstances. Young people who said that they had experienced psychological problems (more than one third of participants) attributed them to fear of an uncertain future, financial difficulties and the unemployment crisis (in that order).

The Ministry of Health will have an important role to play in this regard, but it must break with its long-established vision of mental health as a matter for traditional, one-sided scholastic health education which – despite attempts to improve it – remains didactic and paternalistic. This vision has produced decades of useless activity, much of it confined to demonstrations or even ceremonies held on important days. It needs to be revolutionised if it is to direct activities for young people, whether in school and university or beyond (including physical health provision, which has also failed to prevent many students from abandoning their studies, as the study shows). It must give a prominent place to mental health by putting in place new mechanisms and new human resources. Specialists must play a broad and sustained role, whether in training young people generally in mental health skills or in providing counselling and talking therapy on an individual basis to those who request it or as part of active investigation. This means reassessing the parts played by various intervention agencies in order to make sure that professionals are free to intervene, particularly with respect to individual care. It also means guaranteeing serious follow-up and disciplined practice so as to ensure that services provided outside healthcare frameworks are not treated as secondary activities to be dispensed with whenever difficulties or personnel shortages occur. Monitoring, self-evaluation and accountability are all important here, but so is finding new ways to ensure precision and clarity.

The most direct means of prevention is to help develop young people's ability to deal with difficulties (and "temptation" to engage in health-endangering behaviours). This will require review of school curricula, which will need to be changed in order to replace traditional didactic content with active engagement of a kind that helps students equip themselves with valuable life skills. State cultural organisations for children and young people should be able to attract young people from all sorts of different backgrounds and offer them spaces to develop activities that are educational while also speaking to their interests.

Ensuring a healthy environment that helps reduce the impact of the various problems that young people suffer, reducing psychological, physical and social health risks is a task that will require cooperation between all sectors and all levels of government, including local government. It will rely first of all on the will to make it work and secondarily on a common strategy bringing together interested parties and civil society, with the necessary means to implement it and mechanisms for evaluation and review (with the active participation of concerned parties).

Responsibility for the most far-reaching tasks lies with the state as a whole – primarily with state organisations (and secondarily with its community elements, which can lobby, suggest and act as partners in the elaboration of visions and policies and in monitoring and evaluating them). It is the state that must contend with unemployment and working conditions, which for many employees in every line of work have become a major source of unjustified psychological and physical exhaustion. Social wellbeing is one of the three corners of the "health triangle" identified by the WHO (alongside physical and mental wellbeing), but the precarity of work in many sectors does not provide even the most limited level of security. Similarly, the large number of "economically inactive" young people – whether those (men and women) who describe themselves as "unemployed" or those who see homemaking as their main occupation – require their own special programmes. The results of the quantitative study and the study on anxiety are not encouraging for this section of society. Although it seems that they are less likely to suffer from

mental health problems, reporting lower levels of anxiety than their peers, this may conceal a much deeper-rooted vulnerability tied to social withdrawal (discussed by Donia Remili in her paper on anxiety and at length by MA Ben Zina in a 2018 study[1]) and its many effects on physical, social and mental health.

The final two sections of the study, which discussed addiction and violence, show the depth of the health crisis faced by young people socially and especially psychologically (but with obvious physical ramifications in both the immediate and longer terms). They also point to the responsibilities of the health sector and of other sectors (education, professional training and employment, young people, culture, social affairs, higher education, municipalities, civil society, women and families, justice).

The first observation that must be made with respect to addiction is that while repeated drug consumption is now a veritable epidemic and almost as common as smoking – with the first use free in around two thirds of cases and great efforts made by dealers resulting in many people becoming weekly or even daily users – there is still a culture of silence regarding drug use. More than half of young people have never received any information about drugs or how to stop using them from any organisation (with schools and universities the most common place to find information).

It is thus not surprising that we find that most young drug users have tried to quit but returned to the habit in the absence of clear information on how and where to get help. The social and physical effects of addiction are generally not felt immediately, with initial problems typically limited to difficulties with family relationships, school or work, although one in five users said that their psychological problems were linked to their addiction. Arrest and prison are the most significant negative consequences of drug use, with more than one in six users saying that they had been arrested or jailed (in some cases for as long as two years) as a result. It is worth noting that of all participants in the survey, around 90% and more than 80% respectively described time spent in prison or addiction as a cause of psychological problems.

It is clear from the data that we need to abandon our disingenuous approach to drug use. We need to stop treating it as a criminal phenomenon or occupation and distinguish it from real criminal activity (sale, production, smuggling, laundering of proceeds). We need, in fact, to see it as the social-psychological disease that it is. We must use an integrated approach bringing together the various preventative and therapeutic aspects of anti-drug policy throughout the public health sector in partnership with young people's neighbourhood, and mental health organisations. At the same time, educational, youth, cultural and arts institutions – even companies and businesses – must play their part in early warning and helping young people learn how to say no, taking at-risk youth in hand before it is too late. Our educational, working, leisure and cultural environments must change in the best interest of citizens generally and young people in particular. And as previously discussed, the state needs to find effective solutions to the problems of unemployment, neglect of the interior regions and working-class peripheries and the failure to provide many citizens with the basic components of security as set out by the government itself.

Although it has its own particularities not shared with addiction, violence is the other side of the social health crisis experienced by young people. It may even be the most significant indicator, given how widespread and normalised it is throughout society. More than half of young people said that they had been exposed to violence in course of the last year. Young people are most likely to experience violence at home, followed closely by the street, in school, on public transport, at work or in the playground.

1 Ben Zina et al (2018), *On the Sociology of the Margins in Tunis: Studies in Border Areas and Popular Districts,* Tunis: Dar Mohamad Ali al-Hami li'l-Nashr.

Profanity is the most common form of violence everywhere, with the exception of public transport, where harassment is more common. Harassment is frequent in the street (second place) and at work (third place), and is more common at school than at work although it is only the fourth most commonly reported form of violence there. Only a small number of young people admitted experiencing harassment at home (or in the playground), but physical attacks were the second most common form of violence reported at home, in school and on the playground, and the third most common in the street. Insults are the second most common at work and the third most common elsewhere with the exception of the street (where they occupy fourth place).

Perhaps one of the most significant findings was that with the exception of harassment and sexual assaults – which only a small number of young men said they had been victims of – more men than women generally reported experiencing different kinds of violence, including physical violence. At home, physical violence is more commonly experienced by women, but the opposite is true at school. Physical violence in the street or at work were notably reported almost exclusively by men and harassment by women. Profanity and insults were experienced by both, but more commonly by men.

The most alarming finding, however, was that one in every five young men admitted to assaulting someone in the last year, and more than 6% had been arrested for violent crime. Even more concerning, not insignificant numbers considered beating sons or daughters (45%) or wives (22%) to be legitimate, views that were shared by similar percentages of both young men and women across all regions, educational levels, age groups and economic circumstances.

Our findings on violence generally show that the social dimension of young people's health is deeply troubled. We must work together to develop a comprehensive understanding of the direct and underlying causes and work out a multifaceted and multisectoral approach to dealing with these problems.

Young people's health should enjoy the same priority as that of other age groups. If we are to succeed in meeting the challenges that it presents, we will have to go back to a set of basic principles that we are all familiar with but do not take seriously enough in real life.

- First: we need to proceed from the basic health triangle – physical, mental, and social health – and a conviction that young people's health is in a bad way.

- Second: we have to break with our outdated and traditional vision on the one hand and our propaganda-focused "big occasions" approach to young people's health activities on the other. This is not just a problem for institutions' own activities but also for the majority of activities carried out on their behalf by community organisations.

- Third: government and non-government bodies alike must recognise their responsibilities. Active community partnership in all programmes, and at every stage, is crucial.

Finally, we will need the political will to make all this work – the will to make the necessary resources available to translate what is agreed into an effective and decisive reality. One clear example of political will would be turning away from the general policy of austerity in the social sphere, and in particular in healthcare. The government should return the Ministry of Health's portion of the state budget to pre-2005 levels and make appropriate allocations to the sector – rather than, as is planned for 2022, making unprecedented staffing cuts numbering in the thousands. It must end the widespread culture of patronage and undeclared conflicts of interest.

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