Reviews and reports

Strategies for enhancing the use of primary health care services by nomads and rural communities in Saudi Arabia

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Introduction

It is a matter of serious concern to all those seeking the advancement of humanity that in parts of some developing countries people still fall sick and die of diseases which are easily preventable and treatable. One of the main targets of governments and WHO is to achieve health for all by the year 2000. This effort should aim at providing people of the world with the basic health services. Planners consider primary health care (PHC) as the key vehicle to deliver these basic health services to all people. However, when compared to the urban populations, rural communities and nomads are greatly underserved everywhere, especially in developing countries. This is the case in Saudi Arabia, despite the fact that PHC centres were established in both urban and rural areas and with the intention of equity. Nomads in any country constitute the extreme part of the adversely situated populations because of their special features, such as dispersion, low average population density and mobility, which collectively create specific problems regarding health, social services and education [*1*]. By and large, they have the right to use PHC services.

The availability of basic health services to the adversely affected population in a country might be used as a yardstick to measure the extent of its development. The objective of this paper is to describe some strategies which, if implemented, might enhance the proper and timely use by nomads and rural populations of PHC in Saudi Arabia.

Health needs and problems of nomads and rural populations

There are innumerable problems within health care delivery systems which affect

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the whole population. However, minority groups tent to be more affected than others. An assessment of these problems and needs is important to assure easy accessibility to health care services by rural people. Apparently, people living in remote areas show an adaptability that allows them to adjust to the adverse conditions. Critical observation of some groups of nomads, for example Masai in east Africa, reveals satisfactory physical health and resistance to disease, but they are not without health problems [*1*].

The health and health-related problems of nomads and rural people include the following:

- High mortality and low average life expectancy, due to lack of access to health services [*1*]. It is unfortunate that systematically collected data are lacking about levels of morbidity and mortality in rural communities, especially among nomads in Saudi Arabia. Despite the availability of PHC services, these groups tend to underuse the services. Various reasons can be found for the underuse of the services provided: a) difficulties associated with transportation and communications, [2]; b) high rates of illiteracy among nomadic and rural peoples [*1*]; c) traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which create a tendency to overutilize the services of traditional healers; and d) lack of understanding of PHC among health professionals and decision-makers resulting in poor quality services [*3*].
- Uneven distribution of health services, and shortage of physicians, nurses and trained health personnel in rural areas.
- Endemic diseases prevalent in their provinces, such as malaria and trachoma [*1*].
- Zoonotic diseases as a result of their close contact with animals as part of their way of life.
- Poverty associated with poor housing, unsatisfactory environmental sanitation, polluted water and food which predispose to malnutrition and infectious diseases [*4*].
- Lack of dedicated health services for nomads owing to cost [*1*].
- Intractable political problems at every level of administration, especially in developing countries, which further aggravate the existing difficulties encountered [*5*].
- A tendency to press older children into adult responsibilities early [*6*], resulting in psychological problems due to role conflicts.

Clearly most of the problems and needs of underserved populations are multifactoral in origin and require multidisciplinary interventions.

Current status of PHC services for nomads

In most countries where PHC services are available, they serve the entire community, but especially mothers and children, through PHC centres. These centres act as filtering centres for those who require specialized services (i.e. secondary and tertiary) at specialized hospitals and research centres. Modern medical services are new concepts to rural populations, who require some understanding of their nature. There are many variations in the ways that medical care is given to rural people. The psychosocial health of nomads is a neglected aspect of services provided [*1*]. Gaps remain in the knowledge needed to respond satisfactorily to identified problems [*7*]. Al-

though, in principle, PHC envisages intrasectoral and intersectoral coordination and community participation, it is often lacking when put into real practice. Overcrowding and long waiting times in health centres prevent people in rural areas from utilizing PHC services. In general, nomadic women are the most underprivileged and chronically neglected segment of society. One study found that nomadic women, when compared with the urban population, significantly underuse maternal and child health services [*8*].

Strategies for enhancing the use of PHC services by nomads and rural communities

1. Restructuring PHC services

Appropriate changes to the functioning of existing PHC services would enhance the use of services by these groups of people. Public health goals at all levels of government are influenced by demographic and background variables. So it is important to gather as much information as possible about community needs. Their proper evaluation, coordination with different sectors and incorporation into existing PHC services will bolster the use rate of services by underserved populations. Moreover, new programmes could be developed to meet their unfulfilled needs [2].

Accessibility may be further improved by either relocation of the existing PHC centres, or adding more centres at the village level to bring the services within walking distance of the population of the catchment area [*9*]. It is essential that PHC personnel are trained to orient people towards the concept and principles of PHC. Likewise, the skills of traditional birth attendants are enhanced by adequate and pertinent training. It is suggested that they should be incorporated into the national health system.

Independent mobile units intended to meet the needs of the nomadic population have proved ineffectual and far too costly. As such units are not cost–effective, PHC services should be based on fixed structures with a reasonably wide coverage, sufficient flexibility and adequate mobile capacity to fulfil their obligations to all sectors in the population [*10*], especially the nomads. The establishment of temporary camps near the nomads would be a better method of serving them. If need be, changes in the working hours of the PHC centres should be made and more emphasis should be placed on the care of specific groups, such as mothers, children and the elderly.

Local legislation can be enacted in the case of special services like immunization [*11*]. Family health files should be prepared with all information related to health, so that they can be taken by families on the move from one place to another for quick acceptance, greater access and prompt management [12]. Health committees can be formed comprising health personnel, community members, including nomadic people, and women. Health personnel affiliated to the health centres should periodically evaluate the impact of new health programmes and policies. Secondary-level health care facilities should be motivated to strengthen PHC services [*12*]. In these facilities priority for complete examination and management should be given to those referred from rural PHC centres.

2. Role of local people

Trained local people are an important component of the health delivery system. Besides delivering adequate services, they help a great deal in ensuring professional commitment to achieving the goal of health

for all. All health professionals today face an ever-increasing demand for a shift of emphasis from acute care to the prevention of disease and promotion of health, education and research. Health workers should try to achieve the maximum possible while trying to solve other deep-rooted problems so as to make health the right of every individual. Professionals working in outreach areas need to develop confidence and expertise in making decisions, even under extreme conditions [2].

It is advisable to accord suitable rewards and recognition for work under difficult and rigorous conditions to boost the morale of the workers. In rural areas, medical personnel often have to find nonmedical solutions to medical problems [1]. For PHC centres established in rural areas, local people are selected, trained and posted as auxiliary health staff. By and large they speak the same dialect or language, and are familiar with local health beliefs and practices. To boost the interest of these people to come forward for training and work, special incentives can be given, e.g. trained nurse aides or midwives could be induced to migrate with their own tribes, and thereby be permanently available [1]. However, this cannot be generalized because of the high rates of illiteracy among the groups concerned. Team spirit among professionals is essential, and they should remain conscious of their own abilities, potential and the contribution they can make within the team in providing the community with the best quality care.

3. Securing political support for social equity

A clear political commitment to health for all and to equity in all sectors, is essential to tackle the existing inequalities in the provision of health. Government planners must recognize health and its maintenance as a major social investment. Formal support from the government and community leaders is required to reorient national health strategies, especially the transfer of a greater share of resources to underserved populations. Authority should be given to local administrations regarding decisions about matters related to local needs. Those in power need to go to the people in order to receive and hear their complaints and take the necessary steps to solve them, especially in rural and nomadic settlements. Political commitment is a crucial factor in the process of policy formulation and implementation to ensure adequate services to the neglected sections of society [13].

Certainly, the political environment has a prime role in making accessible to every person the complete range of health, psychological and social services, including prevention and rehabilitation, thus meeting the needs of underserved individuals, families and special groups. Fortunately, health planners in Saudi Arabia have already realized this need and are extending full administrative support to make equity a reality amongst these groups.

4. Raising awareness

To enhance the utilization of the health services by people, it is most important that they should recognize the need for such services. This need will only be felt if they start to value health as a worthwhile asset [14]. For this, they need adequate, relevant, scientific information and education about health, disease and hazardous environments [14]. Maximum efforts should be made to study the beliefs and practices about health and disease prevailing among different tribes and population groups. Traditional healers serve as the best source of information in this regard. Practices should be categorized into those that are clearly beneficial or clearly harmful.

The information provided should be expressed in simple but quantitative form [*5*], starting from simple matters, such as personal hygiene, and gradually progressing towards more comprehensive health education, fostering behavioural changes and community action for health. The language for communication should be the same as that of the local people, audiovisual aids used must be produced locally and be appropriate, and finally the educational programme should be carried out by trained and experienced personnel from the locality [*13*].

Health personnel must be aware of the harmful effects of rapid intervention. It is easier to change practices rather than beliefs because the latter are deep rooted, especially among the rural people and nomads. The commitment of rural people to religion can be utilized to support the health messages through quotation from the Quran and *hadith*. Local beliefs can be interpreted to fit in with the desired health practices [*15*]. Traditional media, such as folk songs and puppet shows, are very useful in educating illiterate people, especially nomadic women, who need a rigorous campaign to utilize effectively the maternal and child health services provided at the PHC centres. Health information should be available to the public in the communication media they know and use regularly [*7*]. Adequate knowledge and desirable attitudes about health are necessarily accompanied by appropriate practices. Therefore, nothing less than the full mobilization of all societal forces for human health and well-being is needed.

5. Liaison with other agencies

Promoting the involvement and collaboration of other related sectors in the improvement of global health as part of total socioeconomic development is extremely important. It has been emphasized that no sector involved in socioeconomic development, especially the health sector, can function properly in isolation [*16*]. Health is influenced by general social factors such as education, housing, agriculture, transport and communications [*15*], and by economic factors too. So collaborative efforts with the relevant sectors are especially important for worthwhile mutual benefits. Collaborative efforts focused on economic development and progress lead to better health.

Educational institutions have a notable role to play in the health status of the community, especially in the field of prevention. Teachers can help in the early detection of ill health in students. Students are used as messengers of health to the community. In rural areas literacy programmes have a great impact on equity-oriented development [*13*]. University students should participate in health education and other health activities in rural rather than urban areas.

The educational status of the mother plays a pivotal role in the health of the family. As maternal education among rural and nomadic groups is relatively lacking, adult educational programmes would be of great help. The mass media can contribute effectively to the dissemination of health messages to the population at large. The health sector must play a leading role in health supportive public policies. Health activities should be undertaken concurrently with such measures as the improvement of nutrition, particularly that of children and mothers.

Coordination of health-related activities should avoid duplication [*16*]. A grand alliance of people, with social and community support, of policy-makers and health professionals is necessary. To make intersectoral coordination a reality, concerted

efforts should be made to demonstrate how ill health and disease are closely related to illiteracy, poverty, poor sanitation and environmental conditions, etc. [*13*].

6. Active community participation

Increased awareness of the public, but especially of nomads and rural communities, about health problems, as a result of encouragement and stimulation from health professionals, leads to the mobilization of community resources and greater control over the social, political, economic and environmental factors which affect global health. This is necessary because health begins at home and in the work place. It is where people live and work that health is made or neglected. So the involvement of the community in devising health plans cannot be overemphasized [*5*].

The participation of the public in defining problems, planning, implementation and evaluation of community resources makes them feel responsible, not only for their own health but also that of others. All members of the community can be involved in some aspects of the health programmes [*5*]. In rural areas especially, the cooperation of local people is fundamental. Their participation can be encouraged by disseminating relevant health information, increased literacy and making the necessary institutional arrangements. Mutual support between the community and the government is highly needed. Planners should realize that individuals need not feel they are obliged to accept solutions unsuitable for them. The approaches to the delivery of PHC for nomadic and rural populations should, therefore, be practical and feasible [*17*].

Women from nomadic and rural communities constitute a major health risk group. So, in PHC programmes, if women are actively involved and treated as responsible and concerned members, they can play an enormously effective part, not just in improving the overall health status, but in achieving greater social justice within their own communities as well [*5*]. PHC, being people-oriented, should make use of all channels through which people express their concerns over health and health supportive policies and programmes. A social climate can be created in which various groups in society accept the health practices recommended, and thereby help individuals make wiser choices. An enlightened community (i.e. a public that knows its rights and responsibilities, supported by political will and awareness at all levels of government) holds the key to making health for all a reality.

7. Technical appropriateness

Technical appropriateness means that whatever policies and procedures are used in the delivery of health care, they should be acceptable to all concerned. When introducing any new technology, the authorities must be assured that it will not contravene the beliefs and practices of the local culture [*1*]. The whole health system should be used in a rational way to satisfy the essential health needs of nomads and rural people, by using methods acceptable to them.

Conclusion

Health is the fundamental right and responsibility of all, whether urban, rural or nomadic. There is worldwide inequality in the distribution and utilization of existing health services. While PHC centres are relatively uniformly distributed throughout Saudi Arabia, nomads and rural people tend to underuse the basic health services. Although there is no single solution to this problem in Saudi Arabia, some strategies

have been outlined which could result in enhancing the use of health services by these groups. The responsibility for perpetuating existing inequalities as regards the use of health services is shared by all. Responsible health personnel can build a new social order, based on greater equity and human dignity, in which health for all by the year 2000, including that of nomads and rural populations, will no more be a dream but a reality.

It is extremely important to distinguish between nomadic and rural communities. Each has its own characteristic profile. The authors have identified various useful strategies, and specified which is the more suitable to each of these two communities. Capacity building and empowerment of communities through orientation, mobilization and community organization as regards training, information sharing and continuous dialogue, could further enhance the utilization of PHC services by nomads as well as rural populations.

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