16

NOMADIC PEOPLES AND ACCESS TO HEALTHCARE

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Introduction

Nomadic peoples are diverse and heterogenous groups who have high levels of mobility and move from place to place, often with their livestock, in search of resources, work, and food. Examples of nomadic or mobile peoples are African pastoralist groups such as the Turkana, as well as the Bedouin, and Mongolian Herders. It is difficult to estimate the number of nomadic peoples globally, due to their high level of mobility, and because they often inhabit remote and isolated places (Wild et al., 2019). In relation to nomadic pastoralists, some estimates put the number at 20 million pastoral households (de Haan et al., 1997: cited in FAO, 2016) or 200 million pastoralist individuals (Rota and Sperandini, 2009). These latter numbers, however, do not include other nomadic peoples, such as San hunter gatherers or groups such as Gypsies, Roma, and Travellers who have cultural traditions of nomadism. Access to healthcare is often highlighted as being problematic for nomadic peoples and is said to contribute to poor health outcomes. This chapter will explore access to healthcare for nomadic peoples, and link this to critical theory in relation to marginalisation, invisibilisation, and social justice.

Marginalisation, Invisibilisation, Health Inequalities, and Nomadic Peoples

Nomadic peoples are often described as marginalised (Moazzam et al., 2019; Shibli et al., 2021). Marginalisation is defined as 'a process…in which certain groups of people are pushed to the margins of society, and thus excluded from the mainstream' (Thompson, 2011: 92). Marginalisation can occur because of many factors such as socio-economic status, poverty, discrimination, ethnicity,

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religion, geography or physical location, sexuality, culture, language, way of life, gender, illness, and disability (Thompson, 2011). Another term, often used for marginalisation, is 'social exclusion' (Duffy, 1995). Marginalisation is said to be problematic, because it can lead to inequalities between groups and individuals, which can impact upon quality of life and wellbeing. Social justice, which is often said to relate to the Rawlsian concept of 'fairness' (Rawls, 1972), is an issue in relation to marginalisation (please see Chapter 6 for a discussion of social justice). Marginalisation of groups and individuals can mean that they do not have 'fair' access to services that others have access to. Nomadic peoples, for example, often have difficulty accessing healthcare services, which impacts on health outcomes and increases health inequalities. This is true for Gypsies, Roma, and Travellers in Europe, also reported to have worse health outcomes, compared with the majority population, and poorer access to healthcare (McFadden et al., 2018). From a social justice and health rights perspective this is challenging, as health is perceived as 'one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition' (WHO, 1946). It is also important to note how intersectionality can increase the effects of marginalisation and discrimination; Bedouin women, for example, can be marginalised not only because of being Bedouin but also because of their gender (Queder, 2007; Shibli et al., 2021). Crenshaw's (2019) theory of intersectionality is relevant, particularly the emphasis on group-oriented and structuralist approaches towards social change and how discrimination and disadvantage may be contingent upon other applicable intersecting categories. The intersectionality of ethnic group and gender can in turn further reduce access to healthcare services and increase health inequalities (for a discussion of intersectionality, please see Chapter 5).

The concept of 'invisibilisation' is also relevant to marginalisation. Invisibility can result from belonging to a marginalised social group, which reduces the group's social influence in society, and can impact upon the ability, as agents, to precipitate change. This simultaneously results in the group's needs, voices, and representation, not being mainstream priorities. Biehl (2005:259) defines this process as 'technologies of invisibility' and using the work of Foucault (1991) demonstrates how 'bureaucratic procedures, informational difficulties, sheer medical neglect, and moral contempt… all mediate the process by which (marginalised) people are turned into 'absent things''. Through 'technologies of invisibility', marginalised groups become ignored; they become invisible to mainstream society, and as a result, their needs are not recognised, increasing their marginalisation. Technologies of invisibility can, therefore, be perceived as forms of structural and symbolic violence, which renders injustices and people invisible (Bourdieu, 1977; Galtung, 1990). Please see Chapter 12 for a discussion of structural and symbolic violence.

Nomadic Peoples and Barriers in Accessing Healthcare

The World Health Organisation (2007) identified six building blocks which are essential to strengthening health systems. These include efficient, effective, and

accessible health services, availability of well-trained staff, and the availability of medicines, vaccines, and medical technologies to all. Access to healthcare is a social justice issue and is important in improving health inequalities, reducing marginalisation, and supporting universal health coverage for essential health services. The United Nations' Sustainable Development Goal 3.8 target aims to 'achieve universal health coverage, including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all' (United Nations, 2015: 18). Access to comprehensive primary healthcare (PHC) is seen as one way in which this target can be achieved, especially for those who are socially or geographically marginalised (Sacks et al., 2020). However, there are issues in achieving this target, with more than half of people lacking access to universal essential health services worldwide (WHO, 2017) and primary care facilities still too far away for many isolated groups (Sacks et al., 2020). This is problematic as access to healthcare has been on the global health radar since at least the Declaration of Alma Ata (WHO, 1978: 1), which asserts that access to appropriate healthcare was essential to achieve 'health for all' by 2000. This focus on health for all, and the importance of access to healthcare, was reiterated in the Declaration of Astana in 2018 (WHO, 2018).

Nomadic peoples mostly have lower access and uptake of healthcare services than the general population (Sheik-Mohamed and Velema, 1999; Moazzam et al., 2019). For example, nomadic peoples in Eastern Africa were found to have lower access to maternal health provision, which contributed to higher rates of maternal mortality (van der Kwaak et al., 2012), whilst Roma in Europe were found to be three times more likely to have unmet health needs (Cook et al., 2013). There are many barriers to accessing health services, for nomadic peoples, including geographical location, lifestyles factors, affordability, language, and cultural norms, poor quality services, as well as marginalised status, which leads to their needs not being prioritised by governments and policy makers (Moazzam et al., 2019). The World Health Organization's (2007) six building blocks for health systems also identify the importance of health information systems, which capture reliable data, to inform service provision and delivery; however, there is a lack of data and academic literature on nomadic peoples and healthcare, which supports their invisibility and marginalisation in relation to service planning and provision (Randall, 2015). For example, Wild et al. (2020) found in their systematic review of the literature on nomadic health, that most academic studies were conducted in East Africa (64%), mainly in Ethiopia (30%), with the focus primarily on maternal health and TB. Sternberg et al. (2021) also note that nomadic peoples tended not to be included in COVID-19 assessments. Given that nomadic peoples are diverse groups, and live in most areas of the world, this lack of representation, or 'technology of invisibility', to quote Biehl (2005), is problematic, contributing further to their invisibilisation, marginalisation, and poorer health outcomes.

As was mentioned, one of the main barriers to accessing healthcare services for nomadic peoples is that of geography and mobility. Many nomadic peoples

live in remote or isolated places, with very little healthcare provision available to them, as most healthcare provision is focused on urban areas and static populations (Moazzam et al., 2019). As a result, nomadic peoples may have to travel long distances to access healthcare; this is compounded by transportation issues (poor roads and lack of transport), having no one to look after their animals, whilst attending provision, and the cost of transportation to health centres, which means that accessing healthcare is often impossible (Caulfield et al., 2016; Jackson et al., 2017; Government of Mongolia, 2021). Moreover, geographical and mobility issues can result in services being too expensive to be provided directly to nomadic peoples in their own location (Schelling et al., 2008). Local provision of services is also challenging because many nomadic peoples live in areas with high levels of armed conflict, and this too can further impact the direct provision of services (Moazzam et al., 2019). Nomadic peoples are often missed by health and immunisation campaigns (Wild et al., 2020) with some research showing, for example, that among the Nigerian Fulani group, 99% of children were not immunised (Gidado et al., 2014). Movement throughout the year, because of their nomadic lifestyles, can also mean that they are absent during routine outreach community health interventions, especially if their needs and mobile lifestyles are not accounted for by service providers (Wild et al., 2020).

The quality of services can also be poor, which impacts on the take-up of services by these groups. Health services not only need to be accessible, but to ensure take-up, those provided need to be of effective quality, responsive, and acceptable to the local community. Shibli et al. (2021) highlight the importance of cultural competency for practitioners in their work with Bedouin women in Israel and detail how one woman, for example, was told to improve her diet by changing her traditional foods to blended drinks of bananas and cherries. Unfortunately, this was problematic advice for this group of Bedouin women, who did not have access to electricity for the proposed blender, or access to these fruits in their vicinity. Moreover, this advice devalued their traditional foods. The language of the Bedouin women was also not effectively accommodated for in healthcare settings and many of the women, especially the older women, did not speak Hebrew or Arabic, which impacted upon experiences of the services provided (Shibli et al., 2021). Affordability of healthcare is also an issue given that many nomadic groups do not have the financial means to take up healthcare services if they must pay 'out of pocket' expenses (Moazzam et al., 2019).

Marginalisation impacts on nomadic groups' access to healthcare services because their needs are often not prioritised by government or other agencies (Moazzam et al., 2019). Furthermore, the resulting discrimination against nomadic groups, who are often ethnic minorities within their country, can mean that services, when available, are poorly resourced and poor quality. This discrimination, in turn, can make it more likely that they did not take up services. For example, Caulfield et al. (2016) reported that pastoralist women in Kenya felt they would be shamed, or verbally or physically abused, if they went to hospital during childbirth. Whilst Wilunda et al. (2014) found comparable results with

pastoralist peoples in Uganda, who reported negative attitudes towards them from hospital staff, and lack of respect. For the Bedouin of southern Israel, it was reported that there was 'bi-directional distrust between them and health institutions' (Hermesh et al., 2020: 1) and institutional healthcare discrimination was found to be widespread and a significant issue for Bedouin peoples in Lebanon (Chatty et al., 2013).

Improving Provision of Healthcare to Nomadic Peoples

Healthcare for nomadic peoples needs to be accessible, affordable, acceptable, of good quality, and culturally appropriate. It has been stated, in relation to educational provision for nomadic peoples, that this needs to be 'complementary to, rather than in competition with' pastoralist livelihoods (Dyer, 2014: 180). Similarly, healthcare should be understanding of nomadic lifestyles and livelihoods and be conducive to the continuation of nomadic lifestyles. Training of healthcare providers and policy makers around nomadic healthcare issues, cultural sensitivity, and lifestyles is, therefore, a priority. Moreover, the strengthening of rural healthcare facilities that cater to nomadic peoples is also a key consideration to ensure sustainability and coverage. This includes ensuring that awareness of healthcare services is increased amongst nomadic people, as there is often low awareness of provision, amongst some groups (Moazzam et al., 2019). The participation of nomadic peoples in the planning and implementation of healthcare provision is important to ensure that services are culturally appropriate and accessible.

Mobile healthcare or outreach services have been highlighted as one way in which to support the uptake of healthcare services for nomadic peoples (Moazzam et al., 2019; Wild et al., 2020). The Government of Mongolia introduced the 'Expanding use of mobile health technology in PHC towards universal health coverage in Mongolia' or M-Health' initiative, where PHC services were offered in remote areas to Mongolian Herders, through home visits, mobile health services, as well as a fixed health centre service (WHO, 2021). The use of telemedicine was also utilised, and Mongolian Herders used their phones to access information about healthcare services and preventative services. Other examples of mobile services include the Ng'adakarin Bamocha intervention for the Turkana nomadic groups of Kenya, whereby container health clinics were moved to the traditional migratory routes of the group, so that health services were within walking distance (Jillo et al., 2015). The use of Health Extension Workers including 'traditional birth attendants', who are local people from the same communities, is also recommended. These workers are trained to offer local healthcare services, which are safe and of good quality to nomadic groups (Kikuku Kawai, 2012; Umer, 2012). Mongolia has also introduced 'maternity waiting homes' for herder women in remote areas, who are at high risk of a problematic pregnancy, to stay in before they give birth, so that they can be monitored and transferred, more easily, to a health facility if needed (Maternal Health Task Force, 2018).

However, to achieve improved health outcomes, and health access to services for nomadic peoples, it is important that governments and policy makers ensure that the needs of these groups become visible and address their marginalisation. Their invisibility in relation to data collection and government priorities is an issue and contributes further to their marginalisation. For example, Gypsies, Roma, and Travellers in the UK are not included in the NHS data dictionary as an ethnic group, resulting in their needs not being recognised or well understood. Malagi (2012) reports of a community-based health management information system, used in Tanzania for nomadic peoples, that could be of use. This consisted of local people being trained to record information about key events in their lives, including deaths and births, as well as reproductive health, which was then shared with the Ministry of Health and community workers. Community-based initiatives, such as this, not only build local capacity but are also important to ensure data is available for remote, marginalised, and invisible groups, so services can respond to their healthcare needs. However, these types of initiatives do not absolve governments and policy makers (both international and national) from their responsibility to ensure that social justice measures such as universal health coverage, including data collection, are a priority for all including nomadic peoples.

Conclusion

Globally, there are many barriers for nomadic peoples in accessing healthcare services, and this may impact on health outcomes and increase health inequalities. We have argued, in this chapter, that it is important to understand how processes, such as marginalisation and invisibilisation, impact on the exclusion of nomadic peoples from healthcare provision. Nomadic peoples tend to be invisible to governments and practitioners, as well as invisible in relation to healthcare policy and data collection. This invisibility can impact on the healthcare provision that is available to them and, as a result, impact on their health and wellbeing. Sustainable, culturally appropriate initiatives, and interventions to support nomadic peoples, are required, as well as a commitment from governments and policy makers, to ensure the needs of nomadic peoples become visible, and are perceived as important. Access to healthcare is a social justice issue and is key to ensuring universal health coverage to reduce health inequalities and inequalities in access to healthcare provision.

Research Points and Reflective Exercise

With reference to the discussions in this chapter, begin to reflect upon the following:

- Reflect upon some of the barriers to healthcare for nomadic or semi-nomadic groups in your own country.

- How could these barriers be overcome?
- How is invisibilisation a factor in healthcare access for these groups and other marginalised non-nomadic groups?

Further Resources and Reading

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