



## The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan

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### ABSTRACT

Provision of accessible acceptable health care in remote rural areas poses a challenge to health care providers. This case study of formal and informal health care provision for Bedouin in North East Jordan is based on interviews conducted in 2007–2008 involving clinic providers, policymakers and Bedouin as part of an EC funded study from 2006 to 2010. The paper explores to what extent the right to health as set out in UN General Comment 14 (on Article 12 and 12.2 of the International Covenant on Social Economic and Cultural Rights on the right to health) can provide a framework for considering the availability, accessibility and acceptability of current provision in a rural setting in Jordan. Health care is provided in the public sector by the Ministry of Health and the Royal Medical Services to a dispersed population living in encampments and villages over a large rural area. There are issues of accessibility in terms of distance, and of acceptability in relation to the lack of local and female staff, lack of cultural competencies and poor communication. We found that these providers of health care have a developing partnership that could potentially address the challenge of provision to this rural area. The policymakers have an overview that is in line with applying the concept of health care justice for a more equitable distribution of resources and adjustment of differential access and availability. The health providers are less aware of the right to accessible acceptable health care in their day to day provision whilst the Bedouin population are quite aware of this. This case study of Bedouin in North East Jordan has particular relevance to the needs of populations – both pastoralists and non pastoralists living in remote and rural areas.

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### Introduction

This paper focuses on to what extent national health policies and public sector health care provision can promote accessible acceptable health care to dispersed populations in remote rural areas through a case study carried out from 2006 to 2010 amongst the Bedouin of the NE region of Jordan (Hasna, Lewando Hundt, Smeiran, Alzaroo, 2010; Lewando Hundt, 2011).

The right to health is stated in Article 12 of the UN International Covenant on Economic Social and Cultural Rights (ICESCR) concerning the right of everyone to “the enjoyment of the highest attainable standard of physical and mental health.” (UN 1966). UN General Comment 14 (UN, 2000) elaborated and interpreted Article

12 on the right to health and stated that ‘everyone has the right to the enjoyment of the highest attainable standard of health conducive to living a life in dignity’ and it addressed both health care and the wider determinants of health – food, shelter, and water. Paragraphs 14 and 18 specifically addressed the right to health care services that are available, acceptable, accessible and non discriminatory with specific mention of rural settings and indigenous or marginalized groups.

This paper engages with the UN General Comment 14 (2000) in relation to these paragraphs on health care provision – availability, accessibility, acceptability, and non-discrimination. The way in which the right to health is operationalised by governments, health providers, communities and individuals is diverse. Social and political contexts differ and the relations between a state and its citizens are shaped by policies, legislation and financial and political constraints.

The 1948 Universal Declaration of Human Rights (UDHR) of the UN Assembly included in Article 25 the right to health and well being including medical and social care services. The UDHR has

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been critiqued in terms of its universalism and its western and individualistic emphasis (Chowdhury, 2008; Meijer, 2001) and one attempt to deal with this was the development of the Universal Islamic Declaration of Human Rights (UIDHR 1981; Azzam, 1998). Aspects of the right to health are alluded to indirectly. Human life is deemed sacred and requiring protection under Article 1 the Right to Life, Article III on the Right to Equality prohibits discrimination as does Article IV on the Right to Justice, and Article XVIII the Right to Social Security maintains that every person has the right to food, shelter, clothing, education and medical care according to what is possible within the particular setting or society.

Robinson and Clapham state that although the majority of nations ratified the International Covenant on Economic, Social and Cultural Rights in which 'the right to health is an international legal obligation that must be progressively realized at the national level, the reality is that the right to health is still not universally recognized as a fundamental human right.' (Robinson & Clapham, 2009:17). The importance of disaggregated health indicator data in terms of age, ethnicity, gender is pinpointed by Robinson and Clapham (2009) to be important in order to track this progressive realisation. The UN Special Rapporteur on the right to the highest attainable standard of health 2002–2008, Paul Hunt, has clarified that the progressive realization of this right is subject to resource availability, imposes some obligations of accountability on states to have indicators and benchmarks of progress and presents new challenges to national policymakers, health and human rights professionals (Hunt, 2006; Hunt & Leader, 2010).

Socio-legal scholars argue that 'in a human rights framework, health is a matter of justice (Yamin, 2008:46), and that this framework using a rights based approach (RBA) enables the relabelling of 'problems' as 'violations' (Yamin, 2008:48). Baxi (2010) has distinguished between human rights to health and health care justice. He postulates that human rights to health talk is utilised on the level of global and national social policy whilst health care justice can be engaged with 'in terms of fair distribution of health care opportunities and facilities' and includes both justice and care (2010:4). Within the field of public health, human rights and health care justice approaches, have the potential to result in different priorities for health planning and delivery at the national and community levels with a different distribution of resources to address disadvantage and marginalisation (Farmer, 2008).

Nancy Fraser (2007) sets out a three dimensional approach to justice involving representations, distribution and recognition. Fraser has argued also that today justice claims can be within territorial states as part of a 'Keynesian–Westphalian frame' applying to citizens within the state (2007:17), in this case Jordan, or can be part of global governance, (UN General Comment 14 on the Right to Health).

For instance Article 27 of the South African constitution states that "everyone has the right to have access to health care services, including reproductive health care, sufficient food and water and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance." It continues: "the state must take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of each of these rights" (Bill of Rights Article 27, Constitution of the Republic of South Africa 1996:12). This 'transformative' constitution (Liebenberg, 2007) has been used in the courts to develop social rights to health and social benefits. The progressive realisation of the right to health and health care is also part of the UN General Comment 14 (UN, 2000).

Rural health care poses challenges and a recent WHO International Health Bulletin was devoted to the issue of the difficulties of attracting and retaining health care professionals to work in remote rural settings. Governments were urged to address these issues at

a national level with financial incentives and support (Chen, 2010). A review of the retention of health care staff in remote and rural settings (Lehmann, Dieleman, & Martineau, 2008) identified that strategies included financial incentives, regulation, education and management and social support systems. A multi-country study involving Kenya, South Africa and Thailand (Blaauw et al., 2010) reported different incentives attracting staff such as the type of health facility or financial incentives and a recent WHO document (WHO, 2010) gives an overview of this issue.

Access to health care has been conceptualized as having a number of dimensions when applied to low and middle income countries such as availability, affordability, and acceptability rather than using measures of utilization (McIntyre & Thiede, 2009).

There is general agreement that access to health care includes availability, accessibility and acceptability and that these may differ in different settings (Gulliford et al., 2002). Underpinning this notion of access to health care as part of the right to health, is the idea of equitable non discriminatory provision (General Comment 14 2000, Para 18,19), and this is often relevant to socially disadvantaged communities such as indigenous peoples. For example, in Australia alongside lack of incentives to work in remote areas (Weller, 2005), a lack of cultural awareness amongst non-indigenous staff was identified as a barrier to access and recruiting indigenous staff was one strategy that improved accessibility (Hayman, White, & Spurling, 2009).

A comparative contextual approach provides a way forward in elucidating and problematizing the right to health care and to how health policies and provision can address issues of accessibility and acceptability in rural remote settings. This case study of the Bedouin in Jordan is generalizable in some ways to other sedentarized Bedouin and pastoralists or to indigenous peoples living in remote rural settings within nation states. These groups face problems of physical distance from clinics, often discriminatory attitudes of health providers, difficulties in communication, poor levels of provision and are often socially disadvantaged. The situation of women and children is of particular concern (Leybourne, Jaubert, & Tutwiler, 1999; Quereshi et al., 1996) in relation to childbirth, infant and child growth and nutrition (Nathan, Elliot, & Roth, 1996; Forman et al., 1995; Forman, Guptill et al., 1990; Forman, Lewando Hundt et al., 1990).

Detailed case studies in different country settings can provide a way forward for clarifying the scope of the right to health and health care and allow debate to move beyond rhetoric to pragmatic progressive realization of the development of health care justice. This case study of the Bedouin in the NE region of Jordan examines the extent health policies and provision can address the rights to accessible acceptable provision of health care, as part of a right to equitable health care mediated by the notion of health care justice by the state.

## Background

### *Bedouin in Jordan*

Bedouin in the NE region of Jordan are an example of a dispersed rural population and therefore provided an ideal setting to research the dimensions of accessibility and acceptability of rural health care provision, partly relevant to Bedouin elsewhere in the Middle East. The area covered by the study was two and half times the size of Lebanon and reflected the dispersion of this group and the challenge of delivering health care provision.

80% of Jordan's total area is semi-arid with rainfall averaging less than 200 mms annually. It extends from north to south along the eastern portion and contains about 5% of the Jordanian population. This study was conducted in the North Eastern Badia of

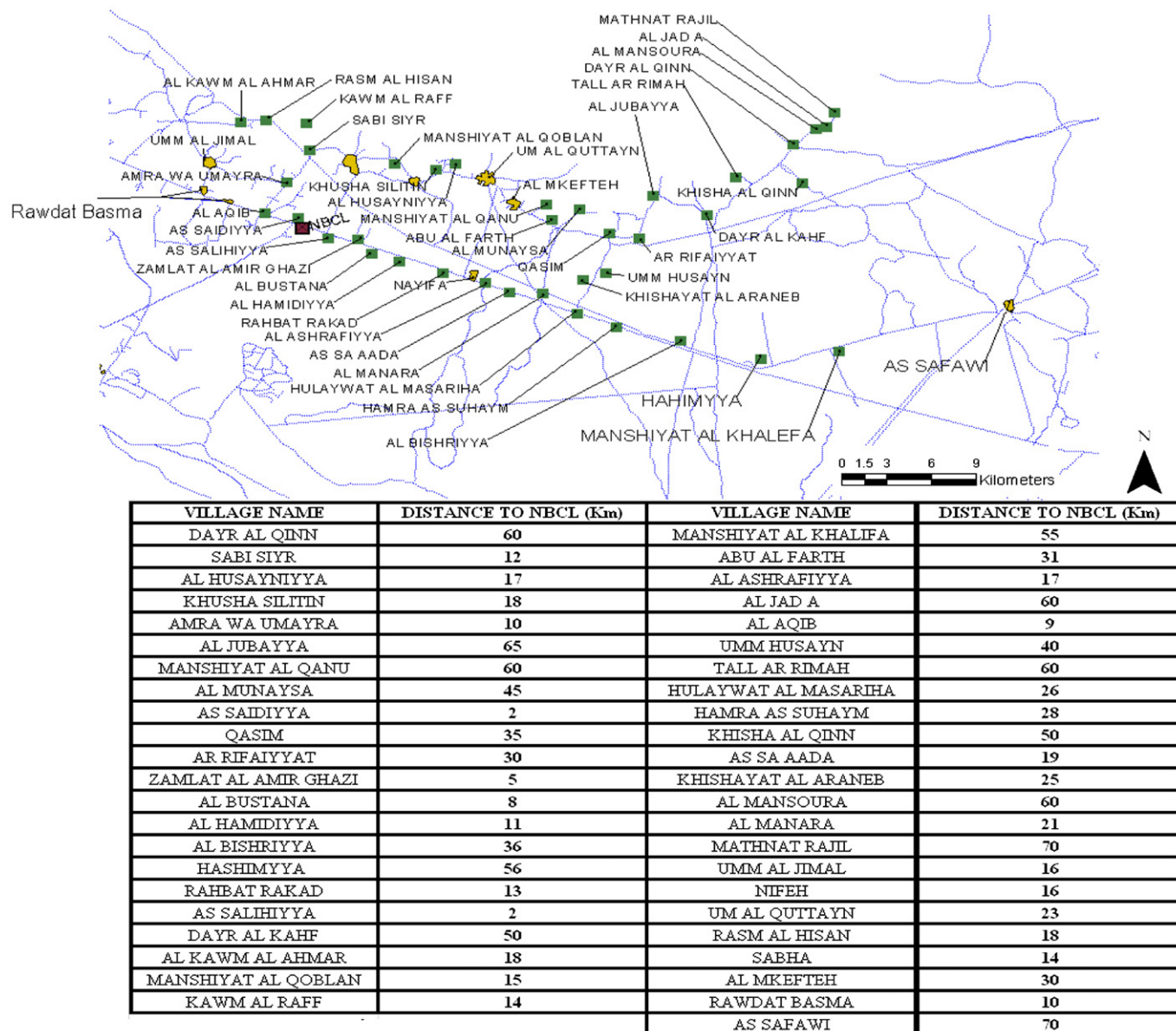


Fig. 1. Villages in the North Eastern Badia with the distances to the North Badia Comprehensive Health Centre.

Jordan, in the governorates of Mafrq and Zarqa (Fig. 1) that are 26,435 sq km (10,207 square miles) and 4080 sq km (1575 square miles) respectively. The population was 245,665 in 2007 with 4.5% of Jordan's population and a population density of 9.3 per km (DOS, 2003). Mafrq governorate covers the second largest area in Jordan, but has the second smallest population density. Bedouin constituted 66.9% of the population in the Mafrq governorate with 31% being under 15 years of age and 10% being over 50 years of age. 48% of employed men in Mafrq governorate worked in the army or in the public administration and 8% in education (Department of Statistics, 2008).

Historically, Bedouin have not been disaggregated from the general rural population in official reports; however a recent survey (Masarweh, 2009) from a DHS sub-sample in 2007 did so. The sample of 2034 Bedouin families including 1556 married women from 15 to 49 years of age, showed that the majority were settled with over 90% having electricity, sanitation and running water. According to Masarweh (2009), compared to the general population, the Bedouin had a larger family size (5.6/4.3) with more

low birth weight (15/11) and higher illiteracy (men 10/6, women 17/10). The figures for infant and child mortality were lower than for the rest of the population (13/16 and 19/21) and we would suggest that these may reflect under reporting, and a possible lack of representativeness of Bedouin who were hard to reach living in more remote areas or being nomadic.

Historically, Bedouin lived in the Arabian Peninsula and came to Jordan and the surrounding countries in the 6th century AD. Bedouin had a lifestyle and culture that was adapted to the harsh environment requiring movement in search of pasture and water, few possessions and a code of honour and hospitality. Traditionally, a nomadic lifestyle is based on herding livestock (camels, sheep and goats) with some cultivation of crops irrigated from winter rains. Socially, the Bedouin lived in segmentary structures with tribal confederations, tribes, sub-tribes and extended families (Chatty, 2006, Chatty, 2010a, 2010b). During the 20th century with the emergence of nation states, the development of new technologies for cultivating semi arid areas, the development of towns, and the loss of grazing areas for agricultural, industrial, military and

conservation purposes, has meant that the majority of Bedouin throughout the Middle East have become settled in villages and towns. A small number continue to be nomadic, and although many retain small flocks, the majority are employed in different types of wage labour and have a mixed household economy. Only an estimated 5–10% of the Bedouin remain nomadic in Jordan, whilst the majority of the population is now permanently settled in villages. Many of these villages are small and are dispersed within this remote rural area (Hasna et al., 2010). This paper therefore focuses accessibility of health care provision as part of the right to health for this group, of whom very few are semi-nomadic.

The Bedouin living in the North Eastern Badia Region in the Mafrq and Zarqa Governorates, are the predominant group scattered across the region. They have a particular status within Jordanian society. The Arab Legion that has protected the Hashemite Royal Family is composed of Bedouin and many continue to serve in the military. The Royal Family is protective of the Bedouin, and there are charitable foundations headed by members of the Royal Family to develop the region they live in such as the Hashemite Fund for the Development of the Jordanian Badia. There are six seats for Bedouin Deputies within the 71 seats of Parliament. In 2010–2011 a Minister of Health and Speaker were Bedouin and one Bedouin woman was elected. They live in a remote underdeveloped area of Jordan, with only a small proportion continuing a nomadic lifestyle, but as a group they are visible and valued. However, whilst Bedouin are viewed as embodying Arab tradition, aspects of their lifestyle today are often despised by those from the cities and towns.

#### *Health policies and provision in Jordan*

In terms of global governance, Jordan is a signatory to the Millennium Development Goals (MDGs) and UNDP (2008) has reported that Jordan is on track to meet the targets for 2015 in relation to health such as progressing in combating poverty, reducing illiteracy, decreasing under 5 and maternal mortality, and enhancing HIV/Aids prevention. Although Jordan is a signatory to many international agreements including ICESCR and UIDHR, there has been no formal incorporation into legislation of the right to health (Paterson, 2007) although there is a legal entitlement to subsidized health care for all citizens.

There are three providers of health care in the Jordanian public sector – the Ministry of Health (MoH), the Royal Medical Services (RMS) and the United National Relief and Works Agency (UNRWA) which works exclusively with Palestinian refugees and their descendants. Only the first two providers are relevant to the Bedouin population. Health insurance for the military was set up in 1963 and for civil citizens in 1965. The MoH provides preventive and curative care and the RMS focuses on secondary and tertiary care for military and security personnel and their dependants. Therefore, many Jordanians including Bedouin in the military are eligible for more than one provider (EMRO, 2005). During the study in 2008, the King issued a royal decree for the RMS to provide curative care to all those not being served by the MoH in remote areas of the North Eastern Badia. As a result a mobile clinic was set up in the north-western region and the RMS began building a hospital in Azraq with planned completion in 2011.

The Jordanian Ministry of Health (MoH) offers primary health care services at three different levels – comprehensive health centres, primary health centres and village health centres. Medical care is free till 2pm and thereafter there is a charge for cases not considered as emergencies. A primary health centre is open daily with nurses and family doctors. A village health centre would be open for a few hours several times a week, staffed by a practical nurse with a visiting physician. Free care is available if the patient is

referred from the primary to the comprehensive centre and care is available without a referral but until 2011 there was a payment to be made if the patient attended a clinic where they are not registered which affected semi-nomadic households. The immunization of semi-nomadic families in Jordan was found to more likely to be incomplete owing to difficulties of access (Spicer, 1999, 2005) even though the MoH had some mobile immunization units.

Para 12(a) of General Comment 14 (UN 2000) states that public health and health care facilities, goods and services as well as programmes have to be available in sufficient quantity. Providing health care to dispersed populations in rural remote areas is expensive, difficult and a challenge to policymakers, providers with limited budgets. The prevailing model of health care is usually clinics in a fixed place or some mobile provision. In Jordan, the primary care provision is shared by this growing partnership between the Ministry of Health and the Royal Medical Services. There is almost no provision by the voluntary sector or private sector. This is a partnership between the civil and military providers to develop the availability of curative primary health care for the population to anyone who is a citizen.

#### **Study design**

This research was part of a European Commission funded research study of access and quality of health care to rural marginal people – Bedouin in Jordan and Lebanon – which took place between 2006 and 2010 (Chatty, 2010; Hasna et al., 2010; Lewando Hundt, 2011) with partnering universities in Jordan and Lebanon. The study aimed to assess the scope of current health care delivery and the views of stakeholders – policymakers, health personnel and Bedouin and develop and evaluate model interventions to improve access to and quality of health care using semi-structured interviews, clinical record review, clinic based observations and GIS mapping. This paper presents some of the findings from Jordan.

Ethical permission was obtained from the University of Warwick and also from the Jordanian Ministry of Health with whom a memorandum of agreement was signed. Informed consent was requested and obtained from all interviewees and no identifying data such as names, clinic names, ages or affiliation were used.

Semi-structured individual interviews with 10 policymakers and 4 health providers were conducted by FH and SZ. The policymakers and health providers were those responsible for the provision of primary care in the Ministry of Health and the Royal Army Medical Services at the central and governorate and regional level as well as in directors of key NGOs working in the region. Two female research assistants interviewed 42 mothers attending primary and comprehensive clinics that were chosen to be geographically and tribally representative. In addition, 14 mothers were interviewed in their homes in natural group interviews having given their consent when visiting the clinics. Natural Group interviews (Beckerleg, Lewando Hundt, Belmaker, Abu Saad, & Borkan, 1997) using topic guides were also facilitated with health personnel at clinics, a district hospital and private practitioners by FH. 6 MoH clinics were involved in the study (4 comprehensive, 1 primary 1 village health centre) and the mobile army clinic. 7 household group interviews with women and 7 focus group interviews with men were carried out with one of each being with semi-nomadic families in the most Eastern area. The men were relatives of women interviewed in the household interviews and were done by MS and with women by the research assistants supported by FH.

The interviews with policymakers covered topics such as the challenges of rural health care, policy development and challenges, and strengths and weaknesses of provision. Health providers were asked their views on the health needs of the Bedouin and the health



provision they were providing. Bedouin were asked about illness episodes in the last month, their experiences of provision, and household health issues. Geographic Information System mapping of the distance between the clinics and households of those interviewed was analysed by MS.

The interviews were recorded and transcribed in Arabic and then translated into English by SZ. Collaborative inductive thematic data analysis was conducted using NVIVO7 (Lewins & Silver, 2007) with interviews being read independently by two researchers (GLH, SZ) to identify emergent themes which were then finalised through discussion and an agreed coding template was used by SZ who then continued coding the interviews. The topic guides were quite general and drew on concerns in the literature and from key informants concerning rural health care provision such as access, quality, challenges. The thematic analysis identified issues from the transcripts such as communication, staffing or dimensions of access and a range of views from interviews with different stakeholders were coded within these with sub-nodes, for example, physical access within access. The interviews were organised in separate document sets of policymakers, providers and Bedouin users of services so that the data from different stakeholders could be analysed separately or as one entire document set.

## Findings

### Accessibility

General Comment 14 (UN 2000) defines accessibility to health care as having a number of dimensions – economic, physical information, acceptability, non-discrimination and quality. Since health care is free or at low cost only three of these are relevant to the Bedouin in Jordan. Physical accessibility is defined as ‘within safe physical reach for all sections of the population, especially vulnerable or marginalized groups such as ethnic minorities and indigenous populations.....’ (Para 12 a, General Comment 14 UN 2000). Acceptability is defined as ‘all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned (Para 12 c General Comment 14 UN 2000). Non-discrimination is defined as care being accessible to all without discrimination and information accessibility as relating to information on health issues being available. These findings focus on the physical, non discriminatory and acceptable dimensions of accessibility.

### Physical accessibility

In the NE region, the MoH provision included 8 comprehensive care clinics, 38 primary care clinics and 36 village health centres. Clearly care is available but its quality, accessibility and acceptability is variable. When a certain number of households are living together in one place they are entitled to request a school and a clinic from the government and these requests are often acceded to. This explains the large number of small village health centres with limited opening hours and staffing scattered across the area. Therefore the accessibility to care is limited and the expenditure of resources on small centres, prevents the development of the other bigger clinics.

Some villages are close to main roads and clinics, whilst others are some distance away. Fig. 1 shows the distances of villages from the Comprehensive Health Centre in the most populated area of this region varying from 5 to 70 km. When considering physical

access, it is not only distance that has to be considered but also how close villages are to main roads and whether transport is available.

The distances that people travel in the North Eastern Badia to reach a clinic may be extensive. People reported difficulties in walking to the clinic when sick, and the lack of transport.

*“It is a long distance and sometimes we walk here carrying children and when we finally arrive we are exhausted. The person who is sick becomes worse, and honestly it’s very hard to walk here on foot, but taking a taxi is expensive”, (Bedouin Woman).*

*“All the bus lines are for the northern Azraq. We have to wait three hours until they come”, (Bedouin Woman).*

*“Transport is difficult. Sometimes I have stayed in the street waiting for a car for more than an hour or two”. (Bedouin woman).*

In addition, staff also had problems with transport to get to work in the clinics.

*“Transport is the most important problem which faces us especially for girls and women because men can manage. The girls have a deal with a bus and pay 20–30 JD monthly in order to come and reach the centre” (Provider).*

### Organizational barriers to access

Accessibility to curative care was increased during the study period owing to the establishment of a new military clinic in the area and the royal decree of giving free care to all citizens in this remote area in 2008 rather than only to the families of those working in the army.

We receive patients from all the residents of this area whether they are insured or not. We provide anybody who arrives with the necessary medical services.... If a case needs to be transferred to other military hospitals, we do that (military health professional).

Some are Bedouins who still live in tents in remote areas. Some of these people are not insured. We treat all clients; the most important thing is that they have to be Jordanian citizens (military health professional).

In order to deal with the challenges of distance and the needs of the remaining nomadic families, the Ministry of Health has mobile immunization units. Policymakers thought that the mobile units were expensive to run and that coverage was difficult to maintain since people moved around and the schedules were difficult to share with the population they were targeting.

*“We have thought a lot about the provision of mobile clinics. We think that these clinics cost a lot of money however the number of people who are served are few in number. We are studying both sides of this issue”, (Policy Maker).*

The mobile units increased immunization coverage but did not provide primary care provision. One of the problems of the irregular coverage of these mobile units was that children of semi-nomadic Bedouin who lived further from clinics, tended to have incomplete immunization was identified by Spicer (1999).

MoH clinic hours varied depending on their level of provision. This meant that accessing care was difficult for many Bedouin women if the men in their households were away at work and returned in the afternoon when fees were charged for afternoon clients.

*“They charge us more after working hours. They have two different rates; one for the working hours and the other for the afternoon. Not only the fee but also the medicine becomes more expensive. As a consequence, some patients prefer to delay their visit to the next day, and visit the centre in the working hours to avoid paying extra” (Bedouin man).*

Bedouin moving seasonally and attending a clinic other than where they were registered were charged an additional fee. This was seen as a barrier to accessing care. In 2010, the Minister of Health abolished this fee for Bedouin using clinics where they were not originally registered in line with one of the recommendations of the study to the Ministry of Health.

There was a lack of both transport and professionally trained staff to assist women in childbirth. Nurses did not deliver babies as part of their duties and there was a shortage of female midwives, in these clinics. The data collected showed that people had experienced difficulties getting to hospital to give birth, due to both a lack of ambulances, and midwives with flexible hours.

*"When my wife gave birth, we came to the centre and they told us they didn't have an ambulance to transfer her. So we asked for the midwife but she said that she wouldn't come, so we walked from here 5 km and in the end my wife gave birth in the Civil Defence car"* (Bedouin man).

*"It is impossible for a midwife to come to the centre after 8 pm. In a lot of cases women would give birth in the Civil Defence cars and that's a big problem"* (Bedouin Man).

It was not clear how often these situations occurred and there remains a need to collect data systematically in order to assess this.

Another organisational barrier to access was appointment systems in comprehensive clinics which did not suit many Bedouin families. Appointments needed to be made by phone and many women did not have a mobile phone or the mobile phones were with the men of the household. More often, women were dropped off at the clinic early in the morning and waited until a physician or nurse was available. This was a particular problem in a comprehensive care clinic in a town which offered care to both the town dwellers who used the appointment system and the Bedouin who did not.

*"When you have your child with you and you wait from 7 am until 12 or 1 pm do you stay patient? ... I went to the Egyptian clerk to register in line, and she said: 'The registration is over'. I said: 'How can it have finished?! You just opened the door in front of me and 15 people have registered on phone'. I left my children at home the first day and went to the centre, and I did the same thing the next day, and they wouldn't treat me"* (Bedouin Woman)

Bedouin felt that those having appointments were being given preferential treatment.

### **Accessibility and acceptability limited by discrimination and lack of cultural competence**

Staff who serve in rural areas are often from cities and are not from the local communities. There maybe a rapid turnover of staff, and they were quite likely to lack knowledge or understanding of the rural population, in this case Bedouin. The policymakers were aware of this problem and expressed that there was a need for training to improve the cultural competencies and communication skills of health care providers. There were no Bedouin staff in the MoH clinics.

*"When we go out to visit them we need to respect their culture, and I think that is one of the problems that builds a barrier between some of the city people and the Bedouin."* (Policy Maker).

*"I say that if there is something missing in our staff it is the skill of communication. It is important that when you work in an area you understand the culture."* (Policy Maker).

The wish to be treated with respect and dignity and to be understood is often expressed by patients from socially

disadvantaged and minority ethnic groups concerning their encounters with health care staff in many different countries (Hamilton & Essat, 2008; Jewkes, Abrahams, Mvo, 1998).

Bedouin men and women expressed feelings that staff did not respect them.

*"When a Bedouin comes to the centre they stare at him and treat him differently. When the doctor comes to examine him, he won't even touch him. He just looks at him and then he tells him to go. They don't consider him a human being although his conditions have made him like this. ... They will say this is a Bedouin who smells. Why do they say that?"* (Bedouin Man).

*"I delivered a child on the road. That was my second pregnancy.... It was better than going to the hospital and listening to their comments. They would tell you in the hospital:" "You didn't take our advice when you got married! You did not consult us when you wore your night gown!"* (Bedouin Woman).

*"They don't care about Bedouins in the eastern parts of the country. We feel we haven't got anything"* (Bedouin Woman).

There were many instances of health providers expressing discriminatory or stereotypical views when there is difference and alterity (Taussig, 2007) between them and their patients. This occurs in provision for black and ethnic minority patients (Bowler, 1993) or in care given to Gypsies, Roma and Travellers (Van Cleemput, 2010). The individuals may be stigmatised owing to their lifestyle. Often health personnel are willing but have views drawing on a 'cultural deficit' model which results in a tendency to blame their patients for late take up of care or lack of attendance rather than reflecting on the difficulties that their patients face.

### **Acceptability**

It was clearly understood by both policymakers, staff and Bedouin that the lack of female health personnel made aspects of health care provision unacceptable. This affected the delivery of maternal and reproductive health care in relation to family planning in particular. In addition, there was a lack of training for female nurses to fit IUDs, a shortage of midwives, patchy post-natal care and great variation in family planning provision.

*"We don't have a female gynaecologist here. We have a male gynaecologist but you know it's a sensitive issue for people here. I complained...., but they told me that no female doctor would come and work here"* (Bedouin Man)

*"They come for immunization or for family planning. Pills are the most used contraceptive here..... Some women come and ask about coils ..... Nobody is available here to insert coils"* (Provider).

In addition, the lack of privacy in the clinic was reported as affecting the quality of communication in clinical consultations and was a source of dissatisfaction for both providers and Bedouin.

*"My room is a public room - everybody uses it. It's a room for the GP for emergencies, for the dentist and the centre director, for the internal specialist; it's a bed for the driver and rest room for the nurses and the doctor on duty."* (Provider).

*"When we go to the doctor in the health centre in order to get treated, you sometimes want to talk to him privately and not in front of people. This doesn't happen because the female nurse, the two janitors, the male nurse and the pharmacist are all sitting there. If we say something about it, they become upset and don't leave."* (Bedouin Woman).

The most important barriers to access were therefore physical accessibility distances, organisational barriers, the lack of cultural competencies amongst providers and lack of trained Bedouin staff.

## Discussion

The implementation of a right to health approach focussing on health care justice (Baxi, 2010) could oblige governments to progressively realize ways to provide available, accessible and non discriminatory health care. In rural areas with low population density, equitable availability and accessibility to health care is a challenge on many levels and dealing with it affects resource allocation decisions. However health care justice can only be achieved as part of the right to health by tackling these issues in relation to rural and remote population groups. In this case study, this is being done through a Keynesian–Westphalian model (Fraser, 2007) by the MoH and the RMS within Jordan providing free access to care yet linked to global governance through Jordan being a signatory of the ICESCR which included the right to health. The growing partnership between these two public providers within Jordan is increasing the accessibility of health care to a remote rural population in a way that would have not been fiscally possible by the MoH as a sole provider.

Physical access to health care in the region could be transformed by improved roads and reliable forms of community based transport. If transport was better, there would be less need for village health centres and more resources could be concentrated at the primary health care centres. Implementing this would require multi-sectoral collaboration at the governorate level.

Provision of emergency care for women in childbirth has been met in other settings such as Canada, by the use of air ambulances (Douglas, 2006) and also midwifery birth centres (Chamberlain, Nair, Nimrod, & Moyer, 1998). In this setting, there is a need for trained midwives to deliver babies at the clinics and for emergency transport by road or air ambulance. This could be provided by multi-sectoral collaboration between the MoH, the Civil Defence and the RMS. There was discussion of this possibility between the MoH and the RMS at the study advisory group meetings in 2009–2010 and this is continuing.

Rural Health Care poses challenges in all health care systems owing to the remoteness and dispersion of the population. This is even more complex when some of the population is mobile. The cultural and social differences between urban health personnel and rural populations may in some instances result in lack of cultural competence, poor communication and discriminatory care. In this setting, health care is becoming more available and accessible through policy development and more provision but there remain barriers at the level of the providers.

Training on lifestyle, culture and health issues for urban health staff working in rural areas or with indigenous and minority groups is a strategy that this project developed through a Bedouin health training module (Al Makhamreh, Lewando Hundt, Hasna, Smeiran, *in press*) but others would be financial incentives, management support and training opportunities for local nurses, midwives and physicians.

Another strategy is to have community members acting as intermediaries or liaising between service providers and members of the community similar to the Pacesetters initiative on health ambassadors for Gypsy, Roma and Travellers (Van Cleemput, Bissell, & Harris, 2010; Warburton, 2008) or in Lebanon of community health volunteers (Barbir, 2010). Training and recruiting Bedouin health personnel is also a sustainable way to improve the acceptability of care.

The experience of being treated without respect, by health providers has been reported in research amongst Bedouin women in the Negev, Israel and also Lebanon (Beckerleg et al., 1997; Mansour, 2010). There are however differences in terms of status between Bedouin in these countries. Jordanian Bedouin are citizens of Jordan and are well established politically and within the

military whilst still continuing to live in remote areas. By comparison in Lebanon, many of the Bedouin are not citizens or in the Negev in Israel, they are citizens but part of the Palestinian Israeli minority.

## Conclusions

Developing health care justice through mechanisms of accountability could potentially lead to the gradual realisation of health care justice through the provision of more available, accessible and acceptable care. The aggregation of the Bedouin in Jordanian national statistics as part of the rural population hinders the establishment of indicators and benchmarks concerning rights to health care provision and to health. The provision of disaggregated data (Robinson & Clapham, 2009) about Bedouin health and health care either through reanalysis of nationally collected statistics or through sentinel sites would facilitate pragmatic and progressive health planning and policy development. The recent survey funded by international organisations (Masarweh, 2009) is an important development but ideally should be continued as part of routine data collection and facilitate multi-sectoral planning.

The delivery of available, accessible and acceptable health service delivery in this remote area is being developed through a growing partnership between the MoH and the RMS to this rural population of Bedouin in Jordan as part of a right to health care for all citizens. This case study thickens our understanding of accessing rural health care particularly in relation to issues of physical access and acceptability.

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