

Bedouin in Jordan: exploring their rights to health



The right to the highest attainable standard of health is part of the 1976 UN International Covenant on Economic, Social and Cultural Rights, which includes the right to available, accessible and acceptable health care. Nevertheless, providing good access to health care can be a challenge for many countries; in places that are remote and only sparsely populated, where people

may also have a nomadic lifestyle, ensuring equitable access to medical services can be particularly difficult.

In Jordan, for example, which has a population of 5.23 million, just 3 per cent of people live in a huge region known as the Badia, which accounts for about 80 per cent of the total area of the country. The Badia extends along the eastern part of Jordan—an arid or semi-arid region with a harsh climate and little natural vegetation, running from the north to the south.

This is where the Bedouin live. Although traditionally nomadic or semi-nomadic, living from herding and agriculture but moving on when water or pasture runs out, most Jordanian Bedouin are now settled in villages in the North-Eastern Badia.

Because the area is so remote and underdeveloped, it is difficult to attract health professionals to work there. What is more, until recently, the official statistics aggregated those living in the North-Eastern Badia as 'rural' residents, without specifically counting how many were actually Bedouin; the Department of Statistics rectified this omission last year by producing a report on Bedouin in Jordan.

Providing evidence of the quality of care supplied by existing services is one of the first steps towards improving them.

To this end, a study that is coming to completion in 2011 has aimed to assess the provision of basic health care for Bedouin in Jordan and Lebanon.

Gillian Hundt, the coordinator of the Bedouin Health Project, Professor of Social Sciences in Health and Director of the Institute of Health at the University of Warwick, says: "We have looked at the availability and accessibility of care, the quality of care and the need for non-discriminatory care for the Bedouin population. The foundation for this work rests on the Rights to Health approach—the concept that people have a fundamental right to health care."

The Bedouin Health Project—which has the longer title, "Improving Access to and Quality of Reproductive and Child Health Care to Marginal Peoples: Bedouin in Jordan and Lebanon"—began in 2006. Teams have worked in both Jordan and Lebanon.

The team leader in Jordan, Fadia Hasna, Associate Professor of Nursing, and Dean of the Faculty of Nursing at the University of Philadelphia, Amman, Jordan, says: "We have been very fortunate that, while this project has been going on, the Bedouin people have been very high on the political agenda in Jordan. As a result, His Majesty, King Abdullah, frequently visits the area where our study took place. This is an impoverished area, with 36 per cent of people defined as living in poverty."

The area is bounded by Syria, Saudi Arabia and Iraq. The Ministry of Health provides primary health care through village, primary and comprehensive health care centres. During the project, a Royal Decree led to health care becoming more readily available and accessible: although the Royal Medical Services (RMS) formerly served the families of soldiers, since 2008 there has been free access for all Bedouin who are Jordanian citizens to the primary health care services provided by the RMS.

Health care providers need to be sensitive to the Bedouin culture and lifestyle

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Khat: custom and controversy in Uganda



Most human cultures use substances derived from plants to make mind-altering products—wine, beer, tobacco, cannabis and heroin are all examples. Some of these are legal in most countries; others are illegal in most countries; some would be illegal, had their ill effects been known about before their use became widespread.

Sometimes, new plant-derived substances that can be classed as drugs appear in new settings, carried by migrants from one country to another, as economic and political upheavals stimulate human movements around the globe. In their new environments, such drugs can challenge preconceptions about what substances people should be allowed to use freely, and which should be banned. Khat is one such substance—a stimulant drug obtained by chewing the leaves of the tree, *Catha edulis*.

Khat has been used for at least a thousand years by people in the areas now known as Yemen and Ethiopia, and for decades by people from Somalia. It grows at high altitude and users must obtain the leaves within 36 hours of harvesting as the main active ingredient, called cathinone, breaks down quickly.

Over the past several decades, Yemeni and Somali migrants to Uganda and other countries of East Africa have brought the custom of khat-chewing with them; as *C. edulis* also grows wild in some parts of East Africa, production and trade in khat has also grown up. And, as tends to happen, other people in these countries have adopted the habit of khat-chewing...and yet others have expressed strong views about its ill effects on society.

Susan Beckerleg, a social anthropologist and Senior Research Fellow at the University of Warwick, has been

studying khat in East Africa since 2004. In 2010, she published a book on her research in Uganda, *Ethnic Identity and Development: Khat and Social Change in Africa* (Palgrave Macmillan, Basingstoke). This research, funded by the Economic and Social Research Council, ended in 2009.

Susan says: “Almost everything about khat is disputed—its effects, whether it is dangerous or not, whether it should be banned or not, whether its use should be regulated. It is a substance that is controversial in every single way, whether it is about gender, politics, mental health, taxation, law and order. And that is what makes it interesting.”

Her book documents the production, trade and consumption of khat in Uganda—and included that well-known method of social anthropology, participant observation, which (in this case) involved many hours spent chewing khat, sitting in the shops, stalls and halls where it is sold.

A khat-chewing session can take 4 or 5 or 6 hours. Initially, there is a feeling of mild euphoria, which gives way to some hours of quiet contemplation. Susan says: “After you have been chewing for a while, anything seems possible and you feel quite perky—you start building castles in the air or, as they say in Swahili, ‘a big house of spit’.” Because khat is a stimulant, it can be difficult to sleep afterwards.

In traditional Yemeni society, khat chewing is acceptable to Muslims, and takes place mainly at home, often after a traditional meal of fermented fenugreek seeds made into a dip and eaten with bread. Men will gather together for a khat-chewing session and spend time talking or in quiet reflection, smoking tobacco with a shisha pipe. Many men discipline themselves to stop chewing and have a meal at around sunset, so that they are able to go to sleep later in the evening.

This pattern of usage persists in some parts of Ugandan society, where people chew khat accompanied by soft drinks, tobacco, tea or coffee, sitting around in small groups. The session often takes place in someone’s home or in the shops where users buy the khat. These consumers who use khat on its own are known as ‘maqatna’, a Yemeni term that denotes ‘khat enthusiast’—although the literal translation is ‘we-with-khat’.

Susan also identified a different pattern of usage, where people chew khat at the same time as smoking cannabis or drinking alcohol. She says: “I call these people ‘mixers’. I found that many young people in modern society in Uganda have started chewing khat in greater amounts, with fewer cultural checks on when they could use it, and they combine it with other drugs such as cannabis

“Almost everything about khat is disputed”

and alcohol—and, sometimes, with pills of some sort. Others take diazepam afterwards to come down. But if you mix drugs in this way, the effects become greater and it causes all sorts of economic and social problems for people.”

One way forward might be to regulate khat

Khat is only mildly physically addictive, she says, but it is habit-forming in that people adopt a rhythm of getting together with their friends each day for a session. Those who chew khat to this extent are spending long periods not working.

In Uganda, the sight of young men chewing khat, often coupled with alcohol and cannabis use, is against a deeply held ethic that values hard work and education. “People don’t like it because they see it as alien, having been introduced by migrants, and because it takes place during the day when people should be working,” Susan says.

To date, khat use remains legal in Uganda. Although some observers claim that it is associated with criminal behaviour, including rape and other violence, Susan says that many people confuse khat with cannabis. Other research she has conducted in Kenya and Uganda

found no evidence that khat use boosts levels of promiscuity, commercial sex, sexually transmitted diseases or rape. By contrast, she concludes that, for many people involved in the production and distribution of khat, this crop provides them with a much-welcomed income. One way forward, she suggests, might be to

regulate khat; this option could provide governments with taxation income.

Further Reading

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Beckerleg S. (2010) East African discourses on khat and sex. *Journal of Ethnopharmacology* **132**: 600-606.

Beckerleg S. (2010) *Ethnic Identity and Development: Khat and Social Change in Africa*. Basingstoke: Palgrave Macmillan.

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Fadia says: “Because King Abdullah is very responsive to Bedouin needs, he gave a decree to give all Bedouin access to the Royal Medical Services. Initially, there was a mobile clinic and now a fixed hospital is under construction. The public services are now provided by the Ministry of Health and the Royal Medical Services.”

Gillian adds: “The project has strengthened the ongoing dialogue between the army and the Ministry of Health, who are the key stakeholders in the Health Strategy in Jordan. They are both now more aware of what the other is doing, and there is an ongoing dialogue about implementing the main recommendations from the study.”

One part of the Bedouin Health Project examined the quality of nursing care provided at primary care clinics in the North-Eastern Badia. Fadia describes how there is little infrastructure in this region. Many women who need health care often cannot reach the clinics because they can only get there if a male relative takes them, or by community transport, or on foot.

Despite the distances involved, one of the key recommendations of the Bedouin Health Project is that the Ministry of Health should close down some of the small village health centres, as the available resources are spread too thinly among these facilities.

“By law, the Government is supposed to provide you with electricity and water if there are five households or 50

people in a settlement—and, after that, they are supposed to provide a school and a clinic,” says Fadia. “But the clinics might only be staffed for just a few hours a couple of days a week. This approach is diluting the resources because many of these settlements are very remote. It is true that people might then have to go a bit further to obtain health care but, when they arrive, the services provided will be better.”

Another problem for the Bedouin has been that, because of their nomadic lifestyle, they may be registered at one clinic but find themselves nearer another clinic at the time when they need care. After the Bedouin Health Project identified this system as a financial burden on the Bedouin, incurred as a result of their lifestyle, the Minister of Health abolished it, following a visit to the region.

There is now a move to allow midwives to insert intra-uterine devices for contraception. Up till now, only doctors have provided these services. But there is a shortage of doctors, and the project has suggested that giving midwives the legal authority to step in will help to meet the shortfall in provision. The Directors of Health in the governorates support this move as well.

A survey of Bedouin schoolchildren showed a high prevalence of untreated caries and gingivitis; educational sessions in schools, delivered in novel ways by clowns, project members and staff from Ministry of Health clinics, increased knowledge about oral hygiene. Six months after

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this intervention, an assessment showed that oral hygiene had improved. At one workshop, for dentists from the Ministry of Health, the project's dentist emphasised the need to shift the focus of care from treatment to prevention.

The main study findings found that the Bedouin felt discriminated against and that health workers from urban areas of Jordan expressed both ignorance and prejudice about the Bedouin way of life. This could also reduce the provision of accessible acceptable health care.

Fadia says: "Health care providers need to be sensitive to the Bedouin culture. Many health care staff don't understand their life style or traditions. To address this issue, we developed an intervention to teach nursing students and social work students about Bedouin life style and their traditional practices. It has been very well received both by students and the community. Some of the students have practised in the community and done some home visiting, to gain further insights into this culture."

The available resources are spread too thinly

The Ministry of Health in Jordan, which had signed a memorandum of agreement with the project's organisers, has recently welcomed the project's findings and recommendations. Fadia has met with the Deputy Minister of Health to discuss how to take forward the work on improving access to health care. Funds are also available for three scholarships for Bedouin students to study nursing.

Gillian suggests that it is important to address the lack of data. "I believe that there needs to be a health surveillance site, or a sentinel site for the regular collection of data on births, deaths and deliveries, to inform policy development," she says.

For example, in discussions, the Director of Field Medical Services in the Army said it could be theoretically possible to take women with complicated deliveries to hospital by helicopter, because of the huge distances involved. "But then he asked, how many women give birth at home and how many give birth on the road? We couldn't answer him—that data is completely lacking," Gillian says.

The study in Lebanon, carried out by a team at the American University of Beirut supported by Dr Dawn Chatty from the University of Oxford, also identified a lack of available accessible and acceptable health care for the Bedouin in the Bekaa valley.

References

Barbir F. (2010) Challenges in Planning and Implementing Community-based Health Interventions: Training Female Community Health Volunteers with the Bedouin

Communities in the Bekaa Valley of Lebanon. *International Journal of Migration, Health and Social Care* **6**(3): 36-40.

Chatty D. (2010) Bedouin in Lebanon: the Transformation of a Way of Life or an Attitude? *International Journal of Migration, Health and Social Care* **6**(3) 21-30.

Chatty D. (2010) Introduction: Bedouin in Lebanon: Migration, Settlement, Health Care and Policy. *International Journal of Migration, Health and Social Care* **6**(3): 19-20.

El-Kak F. (2010) Policy Makers and Bedouin Health Provision in Lebanon. *International Journal of Migration, Health and Social Care* **6**(3): 31-35.

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Mansour N. (2010) Gender at the margins: Bedouin Women's Perceptions of Lebanese Health Provision. *International Journal of Migration, Health and Social Care* **6**(3): 42-51.

Further papers for publication are in progress.

Information on the Bedouin Health Project can also be found on the following web pages:

Warwick

http://www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/currentfundedres/bedouin

Oxford

<http://www.rsc.ox.ac.uk/research/humanitarian-response/improving-healthcare-for-marginal-peoples>

Lebanon

<http://www.bedouinhealth.org/Content.aspx?id=4>

Jordan

<http://www.philadelphia.edu.jo/content/view/811/1054/>

The Learning Network: translating new knowledge into practice



“Knowledge is power.” But whose knowledge are we talking about? Is it the knowledge published in peer-reviewed journals and in academic textbooks? Is it the knowledge of someone who may have little formal education, who belongs to a community-based organisation?

These questions are pertinent for communities that are trying to translate their rights to health into practical action—especially those where people have experienced violation of their rights. In order to make the right to the highest attainable standard of health a reality, people need to act; in order to act, they need knowledge—the right sort of knowledge.

As part of the project, “Learning by Doing and Doing by Learning: a Civil Society Network to Realise the Right to Health”, Maria Stuttaford, Senior Research Fellow at the Institute of Health at the University of Warwick, with colleagues in Cape Town, is studying ways in which civil society organisations (CSOs) are learning from each other and with academics; and how this learning and new knowledge is translated into practice.

Maria says: “The theory of human rights, including the right to health, is dominated by Western theories of human rights. But as the sociologist Boaventura de Sousa Santos has observed, Western knowledge is only part of the picture—there is other knowledge, too, all adding up to what he calls a ‘constellation of knowledge.’”

In a chapter in the forthcoming book, *Knowledges, Frames and Locations—Explorations in Africa-Centred Epistemology*, Maria and her co-authors, Leslie London and Gabriela Glattstein-Young, argue that in order to translate the right to health into practice, it is important to accept that the existing ‘dominant’ knowledge may be incomplete. For example, the knowledge contained in an academic paper on a subject almost certainly fails to encompass much of the knowledge held by the people who were the subject of the research.

As a partial means of addressing this problem, Maria, together with Leslie London, Professor of Public Health at the University of Cape Town, and Nomafrench Mbombo, Professor of Nursing at the University of the Western Cape,

decided to set up the Learning Network in the Western Cape, South Africa. Maria says: “We realised that there were a multitude of CSOs out there, addressing human rights violations and fighting for the right to health. They have enormous expertise in how to do that and some of them just do it in their everyday lives without even thinking about it. But we knew that, if we want to roll out the right to health, we needed to find some way of sharing that expertise. The first thing we needed to do was to document that expertise, encourage people to talk about their expertise, to share examples, and to make their knowledge explicit, so that it can be captured, disseminated and shared more widely.”

The Learning Network has now been running since 2008, aided by grants from the South Africa Netherlands Research Programme on Alternatives in Development (SANPAD) and the Open Society Foundation (OSF). Maria says she and her academic colleagues initially conceptualised the Learning Network as a spiral (see Figure). “Our idea was to bring CSOs and academics together, identify common learning and

research goals, go off and collect data, do peer research, analyse the data and then come back together and disseminate the findings. Once we had reflected on the findings, that would allow us to reflect on practice, identify new learning goals and go round in a spiral of co-learning.”

She admits that the early days of the Learning Network had “a bit of a bumpy ride”. In the past year, however, the network has really taken off, she says. “Whereas before there was lots of engagement from academics to CSOs, now the CSOs are engaging directly with each other and not even going through the academic institutions any more. It really feels as though the network is working as a network of equal partners.”

The members of the network—six South African CSOs and three academic institutions—have been meeting regularly over the past three years. An Executive Committee has been formed, which meets monthly. During these meetings, a representative from each organisation provides an update about what that organisation is doing relating to the right to health—topics include running campaigns, sharing learning or addressing a particular violation of human rights. Four or five times a year, there are “review and reflection” meetings; at these, participants might report back on particular pieces of participatory peer research.

The members are starting to make links regionally

The network has recently secured a second cycle of funding from the South African National Research Foundation, and this coincides with the appointment of a new coordinator. This time, the coordinator will be located inside one of the CSOs. “It will be interesting to see how the Learning Network evolves and responds to having a coordinator based outside of a research-led institution and rather with a CSO,” Maria says.

What will the future hold? Maria hopes that, provided funds are available, it will be possible for the Learning Network to continue. “I think it has the potential to grow, once it is more established and feels more confident with the way it is working. The next step would be for the Learning Network to start making links with organisations in other parts of Africa,” Maria predicts.

There are already signs that this is starting to happen, she says. “We have already made links with Equinet, which is the South African Network on Equity and Health,

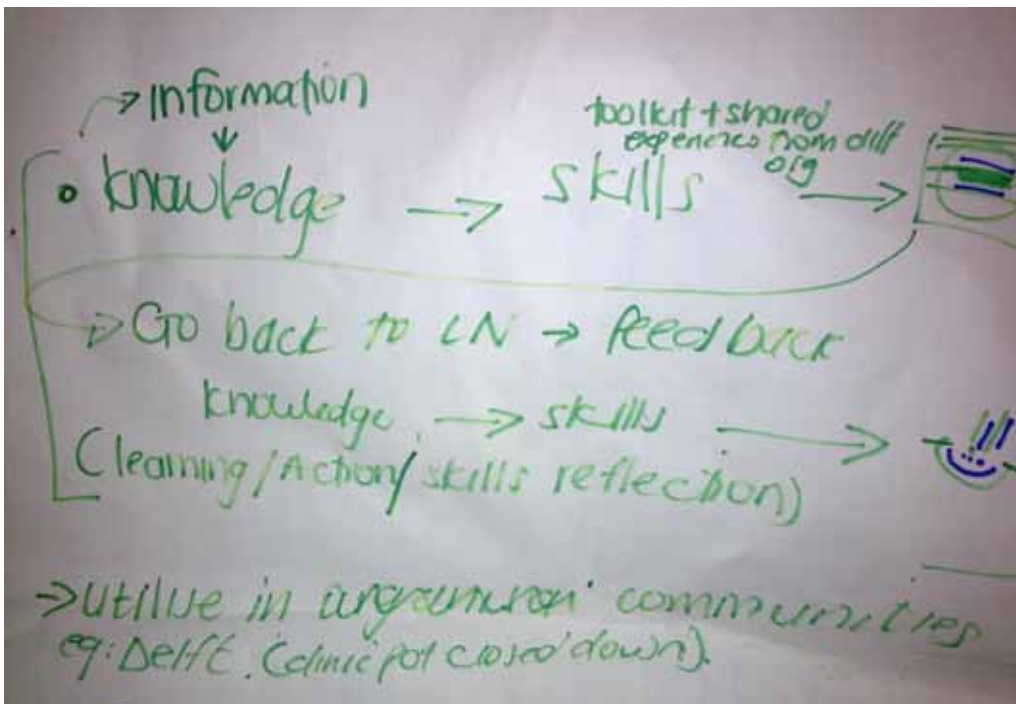
It now feels like a network of equal partners

and some of the members of the Learning Network have been to Uganda to present at the Equinet conference, so the members are starting to make links regionally.”

In the book, *Knowledges, Frames and Locations—Explorations in Africa-Centred Epistemology*, which will be edited by Brenda Cooper and Robert Morrell from the Project for the Enhancement of Research Capacity at the University of Cape Town, Maria and

her colleagues will be analysing some of the achievements and challenges of the Learning Network. “We will detail what the spiral of learning has achieved in terms of people’s learning, knowledge transfer and the translation of that knowledge into practice. For example, one CSO has decided to adopt a rights-based approach to developing a training programme about disability awareness in the workplace and this has, in turn, led to other CSOs requesting such training about disability awareness. We want to get to grips with whether we are surfacing new knowledge and the contributions this can make to theories of the right to health, including African theories, such as theories of collective rights,” Maria says.

The spiral of co-learning



It could all lead to a shift in emphasis from rights-based approaches based on purely Western notions of the right to health, to approaches that add to and draw on other knowledge in the constellation of knowledge, and thereby improve the practical implementation of the right to health at a local level.

Figure 1: “Information moves in a circular process of learning, action and reflection.” Illustration drawn by civil society organisations at Review and Reflection Workshop (29/06/10)

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