Health Systems

Mayeh A. Omar

Health care for nomads too, please

Pastoral nomadism, a way of life in many developing countries, especially in Africa, has received little attention from planners, economists and governments, partly because the communities in question present what are perceived as difficult logistical problems. Yet it is incumbent on the authorities to develop practical and feasible approaches to the delivery of primary health care for nomadic populations.

There is a growing recognition that pastoral nomadism is an efficient low-cost method of animal production based on a profound understanding of ecology and the use of natural forage on marginal land, and that tribal societies make a significant contribution to national income and foreign exchange earnings. Nevertheless, these groups continue to be neglected.

What is nomadism?

Pastoral nomads do not, as a rule, practise agriculture, but rear livestock for their own use and for barter. They do not have permanent places of abode but migrate in a seasonal manner. Semi-nomads, on the other hand, engage in unspecialized herding and farming, a mixed form of subsistence.

Transhumance, a more highly developed form of pastoralism, is practised by sedentary people whose main economic activity is farming; seasonal pastoral movements are limited in scale, involving only cowherds, shepherds or goatherds. Depending on the definition employed there are 50–100 million nomads in the world, most of them in the nomad belt stretching from the Western Sahara to Outer Mongolia.

Because of their isolation and ecological situation, nomads have developed special cultural and social patterns and, in the main, they have completely self-sufficient domestic economies. Circumstances have made them independent of the outside world and of their own countrymen and government, and the authorities may have no control over them.

In general, nomads have a system of collective ownership in the clan or tribe. Today's nomads are the caretakers of the...
Health Systems

clan’s inherited livestock. They take only as much food and hides from the herds as is needed for subsistence, the aim being to hand them over to the next generation in improved condition and increased numbers. The strong bonds that exist within the clans tend to induce a reluctance to accept development, including the introduction of health services.

| The migrations of nomads are predictable and the watering places around which they congregate are well known; these factors are conducive to the delivery of effective services. |

In Africa, low rainfall is the principal factor explaining why certain areas are inhabited by pastoral nomads. An annual rainfall below 250 mm is about the lower limit for cereal-growing; however, agriculture is unprofitable where the annual rainfall is less than 700 mm. Cultivation may also be hindered by extremes of wind speed, temperature and altitude. Where such conditions prevail, people are obliged to rear livestock. Wide areas are required for grazing, and the people consequently become nomadic. The search for water is the main reason given by nomads for migration; the second most important reason is the need for grazing. Both, of course, go together, as water is a prerequisite for grazing. In essence, the animals migrate and the owners follow them.

**Health problems and services**

The harsh way of life usually leads to a high tolerance of suffering in nomads. They are well adapted to the extreme climate and have a slow, swinging gait that is energy-saving and does not cause overheating. A considerable capacity for resisting flies and disease has also evolved.

Infant and child mortality, and accidental deaths associated with herding, tend to be high in nomadic communities. General health is comparatively good, thanks to satisfactory nutrition and an existence close to nature, but some diseases, for instance trachoma, may occur frequently because of ecological and climatic factors.

Although the use of latrines, and conventional washing with soap and water, are abhorrent to traditional nomads, it would appear that they are more interested in personal hygiene than are settled people (1). Furthermore, their migratory life favours hygiene, as they move periodically away from accumulated dirt and rubbish, leaving the natural processes of cleansing to take effect before the same places are revisited. The portable dwellings used by nomads favour the maintenance of cleanliness, whereas there is a tendency for slum conditions to develop if nomads settle in fixed houses.

Nomadic people are independent and self-sufficient in most fields. They have developed health services in which traditional healers and birth attendants are prominent. Certain treatments performed by highly trusted native doctors are undoubtedly beneficial. However, the main therapeutic effects are psychological. Where no help from outside can be obtained and transport facilities are inefficient, traditional healers come into their own. Their practices undoubtedly have some value, but on occasions serious consequences arise, such as infection and septicaemia.
No sense in neglect

Planners usually concentrate on investment in densely populated areas where economic viability is demonstrable. Conversely, sparsely populated areas tend to be neglected. The provision of health care for nomads needs commitment together with human and material resources on a scale lacking in most developing countries.

There is a widely held belief that nomads, like other traditional groups, resist modern medical care, and that in any case it is impossible to provide social services for them because they are frequently on the move. Planners, however, especially those involved in health and other development programmes in countries where pastoral nomadism is a way of life, need to understand that the goal of health for all cannot be achieved without taking nomads into account. Misconceptions and prejudices about nomads have to be overcome, and ways have to be found to incorporate them into development activities.

Nomadic people are self-reliant, independent-minded, and have a highly developed sense of identity and community. Their migrations are predictable and the watering places around which they congregate are well known; these factors are conducive to the delivery of effective services.

The extent to which a country has developed its national health programme can often be judged by the services it provides for underprivileged groups. The quality of front-line services can be used as an indicator of health development (2).

Public health programmes directed against prevalent diseases often fail to reach migratory populations. A disease thought to be under control may remain in inaccessible pockets of infection among nomads. During their migrations they may carry the disease over great distances. This happens, for example, with malaria (3).

It is surely unacceptable that a segment of the population in some countries should be neglected by planners just because they live in extreme conditions. Indeed, these very conditions warrant radical solutions. Nomads need services that are designed specifically for them so that resources can be used in the most appropriate and effective ways.

There is a need for operational research in order to select the best approaches in terms of appropriateness, practicality and cost-effectiveness.

The per capita cost of a satisfactory health service in scattered communities is bound to be high because, at any given time, the number of patients is likely to be small, and because of the need for special facilities, such as mobile clinics. There is a need for operational research in order to select the best approaches in terms of appropriateness, practicality and cost-effectiveness.
Health planners in developing countries with limited resources and large nomadic populations should set up primary health care systems responsive to the needs of these people. It should be possible to avoid pitfalls already experienced in some countries, such as the undue proliferation of institutions, excessive centralization, and harmful professional rivalries.

Acknowledgements

I am extremely grateful to Dr Ranieri Guerra and Dr Maymuna Omar for reviewing the present article and providing useful suggestions.

Assessing community risk factors

Health workers should periodically ask the question “What kind of care is the community receiving in relation to its needs?”, rather than the more usual “What health services am I providing?” To answer the first question, it is necessary to know both the actual and the felt needs of the people, the proportion of these needs that is being taken care of, and the means by which this is being done. Only a part of the current health problems will be presented at the clinic, since some people will fail to attend, perhaps because they do not feel it can deal with their particular problems, or because they find the distance or cost too much, or for some other reason. Community health workers are an important source of information on additional needs that are not being met.

References


