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Universal health care? The views of Negev Bedouin Arabs on health services

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Background: This study examines health and health care attitudes, practices and utilization patterns among the Bedouin Arab minority in the south of Israel. Particular attention is given to the effects of the new National Insurance Law that provides universal coverage for the first time, and to the identification of critical issues for further research.

Methods: Focus groups, adapted to Bedouin culture, were the primary method of data collection. Twelve groups (158 participants) from throughout the Negev met for 3–7 sessions each, using specially trained local moderators and observers. Issues discussed and analyzed included experience and satisfaction with the current health system (both modern and traditional), health service availability/barriers, health care needs, influences of social change, and the National Insurance Law.

Results: Participants voice dissatisfaction with modern health services in the Bedouin sector and the state of health of Negev Bedouin. They place great emphasis on the connection between health and the rapid social and economic changes, which this traditionally nomadic group is undergoing. Traditional health care is felt to still exist, but its importance is waning. The National Insurance law is having a major impact on the Bedouin, particularly because it provides universal health insurance coverage where only partial coverage had been in effect.

Conclusions: This study, one of the first of its kind in the Bedouin sector, showed that the focus group method, if properly modified to cultural norms, can be a valuable research tool in traditional communities and in health service research. The findings from this research can be used to direct efforts to improve health policy and health services for this group, as well as preparing the way for further qualitative or quantitative studies.

Introduction

Bedouin Arab semi-nomads have lived in the Negev, the desert south of what is now Israel, at least since the fifth century AD. Israeli Bedouin society is in major social, economic, and cultural transition as a result of rapid semi-urbanization and sedentarization (Meir 1997). In recent years, the government-initiated process of settlement has advanced rapidly with the movement of 55% of the population from a semi-nomadic existence to settlement in eight permanent towns and villages. An additional 35–40% of the population now lives in unplanned settlements and encampments surrounding the permanent sites. Only approximately 4000 Negev Bedouin remain truly semi-nomadic. The process of urbanization that is currently underway includes the partial or complete breakdown of the tribal social structure and the transition to social individualism. In addition, the first indications of urban social strata have emerged and consumption of consumer goods and modern services has greatly increased – including health care.

After a major exodus to other countries during the Arab-Israeli War (1947–49), the numbers of Negev Bedouin have increased from 12 000 in 1948 to more than 100 000 today, forming 24% of the Beer Sheva District by the end of 1995 (Center for Regional Development 1997). This dramatic natural growth, among the highest in the world, is due to rapid increases in life expectancy and in the birth rate (44.3/1000 live births annually, compared with 16–22/1000 among Jews in the Negev) and rapid declines in infant mortality (Center for Regional Development 1997; Central Bureau of Statistics 1997). Bedouin society has traditionally favoured large families (Meir 1997). Almost 60% of the Bedouin population are under the age of 15 years compared with 35–37% of the Jewish population in the Negev. Only 10% of the Bedouins are above 65, compared with 14–17% among the Israeli Jews (Center for Regional Development 1997; Central Bureau of Statistics 1997).

The Negev Bedouin have the lowest overall socioeconomic status of any social or ethnic group in Israel (Lewando-Hundt

and Abu Saad 1993; Center for Regional Development 1997). They have half the per capita income, twice as many children and half the living space compared with the average Israeli. Rates of unemployment and welfare support are among the highest in Israel. Educational achievement is also problematic. Negev Bedouin students complete the secondary school matriculation exams at less than half the rate of their Jewish neighbours in the Negev or Israeli Arabs in general (Center for Regional Development 1997). Polygamy is frequent among Bedouins in the Negev, featuring in 20% of marriages (Morad et al. 1997), a rate similar to that in the Arabic Gulf countries (Chaleby 1985).

Health status of Bedouins

With the rapid movement of the Negev Bedouin Arabs to permanent settlements and urbanization, the appearance of diseases of civilization have begun to appear alongside the pre-existing infectious diseases, problems of nutrition and environmental exposures. The rates of preventable diseases such as anaemia, diarrhoea and accidents in children are higher than the average for Israelis. The infant mortality rate, though low compared with other countries in the region, is estimated to be 1.5–2 times higher for Bedouins than for Israeli Jews (National Council for Child Welfare 1998). The high frequency of birth defects among Bedouin children is a particularly serious problem among this group (National Council for Child Welfare 1998).

Health services for the Bedouin

The health care services available to the Bedouin Arab community in the Negev have also undergone great change in the last few decades. Until the 1960s, local traditional healers, including herbalists, bone setters, dervishes and others, provided nearly all of the health care for this group. Midwives in the tribal setting traditionally managed births independently from distant hospitals and clinics. During the Ottoman Period, ending in 1917, modern medical services for the rural population were rare and inaccessible, except for occasional infrequent, unscheduled physician visits (Reiss 1991). Although the British made some limited efforts to introduce Western health care to the Negev Bedouin during the Mandate Period (1917–48), their efforts were largely confined to preventive services and hygiene. However, by the mid-1930s, there was a small eight-bed hospital in Beer Sheva and four clinics in the Negev region (El-Aref 1937). Nonetheless, these limited services and even more limited personnel were far from able to provide for the health needs of the Bedouin population, the majority of whom were still in the periphery (Tal 1993; Shvartz and Morad 1996).

After the establishment of the State of Israel in 1948, the Israeli Government saw fit to relate specifically and separately to the health needs of its entire Arab population. For that reason, a special Minority Department was established at the Ministry of Health. However, in the 1950s this Department was dissolved, since it was claimed that the Arab community had merged into the social structure of the general population. The new approach was to deal with the Israeli Arab population in a manner that was consistent with long range planning for the general population (Israeli Ministry of Health 1968). For example, the same health services model used for Israeli Jews, whereby preventive and curative health services were provided by different organizational structures, was applied to the Israeli Arabs.

The situation of the Negev Bedouin was more complicated, however. During the first two decades of Israeli rule (1948–66) they were governed by a military administration which significantly restricted the geographical mobility of this previously semi-nomadic people, while providing only rudimentary local services, including health services. Only one physician, Dr Henry Koslovksy, served the Negev Bedouin between 1949–55, supported initially by a voluntary Jewish organization and later by the Minority Department at the Ministry of Health (Grushka 1968; Shvartz and Morad 1996). After the Minority Department was dissolved, there was little or no support for Bedouin *curative* health services or mobile units. Beginning in 1955, the Ministry of Health began providing child and maternal *preventive* health services as well as rudimentary curative services. These services were provided free or at low cost to the Negev Bedouin from a few sites, but the services were limited by geographic access and the small staff – one physician and one nurse (Shvartz and Morad 1996). Throughout the late 1960s and 1970s the Ministry of Health's maternal and child preventive health services expanded in planned towns, as did access to the growing Beer Sheva hospital and associated medical services. By the mid-1980s, over 90% of Negev Bedouin births occurred in hospitals in the large cities.

After the dissolution of the military administration in 1966, *curative* care for Negev Bedouins was put in the hands of the largest Israeli health maintenance organization (HMO), the General Sick Fund of the Histadrut of Labor, with the later entrance of other Sick Funds. However, the use of curative health services, particularly primary care, remained partial with 40% of the population being without insurance coverage as late as 1994. In addition, there were often gaps in the relationship between the location of the Negev Bedouin and the location of the clinics designed to serve them. For example, Government policy decreed that any permanent clinics be set up in the permanent towns and villages or in Beer Sheva. People from the unplanned settlements and encampments, where the majority of the population lived until recently, had to travel to these sites, seek care from the few mobile services, or do without conventional health care.

Most researchers point out the inadequate allocation of health-related resources and manpower in both the permanently settled centres and in the unplanned encampments (Schreibman 1984; Rafiq 1985; Meir 1987, 1997). In their opinion, a tremendous gap exists between actual and desired performance. This is even truer for the small semi-nomadic Bedouin community, which does not enjoy the benefit of any services provided by municipal or civil institutions.

The movement towards uniformity in health services across ethnic groups and geographic regions in Israel was intensified with the passage of the 1995 National Health Insurance Law. This law, which guarantees an equal 'basket' of health services

to all citizens of the State of Israel, provides universal coverage without any special provisos or preparations for groups with special needs. Overnight, all Bedouin became eligible for curative health care services, the details of which were unspecified in the law. Planning for the special needs of the Bedouin minority was not done prior to the passage of the law, nor were any surveillance or evaluation mechanisms put in place to gauge the short or long-term consequences on this population.

No comprehensive study has yet been undertaken which examines the Bedouins' satisfaction with the health service system as compared with the policy of State and municipal agents in the matter. With very few exceptions, health and health policy studies of the Bedouin have paid little or no attention to their preferences, beliefs, and satisfaction (Lewando-Hundt 1988; Beckerleg et al. 1997).

The present study was undertaken to investigate the Negev Bedouins' experience with and evaluation of the health services and health policies that have been applied to their communities. This was designed to include such issues as the health status of the Negev Bedouins; patterns of health service utilization; health beliefs and health expectations; and satisfaction with the health system. It also focuses on the community's assessments of health service needs and the suitability of the existing framework to the different demographic demands of this population. Particular emphasis was given to attitudes and awareness among the Negev Bedouin community regarding the National Health Insurance Law one year after its inauguration.

This investigation was also designed to test the utility of a method of data collection specially adapted to this traditional society and to identify critical issues for further study. The acceptance and reliability of conventional survey methods in traditional communities, such as the Bedouin, is often quite limited, due to language and conceptual barriers. In this study, a qualitative investigator model of participatory research was incorporated.

Methodology

Data collection

This study utilizes an adaptation of a type of group interview, called *focus groups*, as a data collection technique. These are meetings of individuals to discuss a topic in which a moderator uses well-defined prearranged guidelines to facilitate group discussion and interaction. An observer is utilized to take notes and comment on group dynamics. Generally such group interviews are recorded on audio or videotape for later analysis of themes.

Focus groups were chosen as the data collection technique, rather than long interviews or participant observation, due to their suitability in initial explorations of a new area, their ability to collect rich and diverse experiences, and their relative economy in time and money. They can quickly orient a research group to a problem, generate hypotheses based on informative insights, and help define variables (Patton 1987; Borkan 1993). The meetings combine elements of ethnographic and survey research and can provide insights into the perceptions and experiences of target populations (Morgan 1988). Focus groups provide an enjoyable forum for interaction among participants and allow a certain level of data quality control, since extreme views are often muted or marginalized by the majority. In addition, they provide participants with the opportunity for interaction and the ongoing development of views during sessions, something not possible in individual interviews.

Although a relatively new phenomenon to health care research, focus groups have been used extensively in marketing (Morgan 1988). In medicine they have been employed to clarify perceptions of risk factors and risk-related behaviour (Basch 1987; Bernard 1989). They have also been used to evaluate the efficacy of low back pain treatments provided by physicians or chiropractors (Cherkin et al. 1988; Borkan et al. 1995), and to gain access to attitudes and perspectives of participants with backgrounds and experiences very different to those of the investigators. More recently they have been utilized in international public health and health services assessment. For example, focus groups have been used in places as disparate as the Philippines, to tap into local knowledge about malaria (Miguel et al. 1999), Borno State, Nigeria, to examine perceived causes of eclampsia (El-Nafaty and Omotara 1998), and Adelaide, South Australia, to identify environmental barriers to breastfeeding (McIntrye et al. 1999).

The choice of the focus group method for this study was based on both the standard reasons, noted above, as well the similarity of this experience to native Bedouin patterns of socialization. Tribal members, generally divided by gender, will frequently meet for leisure and discussion in homes, tents, or designated structures (*shieg*). However, applying Western research techniques of data collection directly to traditional societies is fraught with difficulties. In this study, the classic focus group format was adapted for Bedouin culture. For example, participants in focus groups are generally strangers, both to each other and to the professional moderator and observer (Morgan 1988; Krueger 1994). Such prerequisites arise out of the cultural assumptions present in Western societies regarding individualism and autonomy. However, in tightly knit traditional tribal societies in which social interaction and settlement patterns are strictly regulated, disclosure to strangers, and in some cases even interaction, is unacceptable, even forbidden. For instance, a moderator from a particular Bedouin tribe might find it difficult to elicit a free flow of information from members of another clan, while participation of men and women in the same group would generally be expected to result in the muting of the voice of the latter. Due to the limited size of the community and the network of affiliations to extended families, true anonymity is limited. Finally, because of fears about the use and misuse of information, audio and video recording is generally not permitted.

To overcome these barriers it was decided to modify the focus group technique in the following ways:

(1) In place of outside professional moderators and observers, a cadre of Bedouin from within the various communities

was trained using a didactic course on anthropological methods with demonstrations and role-playing. One of the chief investigators (MM) contacted a wide range of individuals from a variety of Bedouin towns and tribes. Those who took part in the training included 47 men and 12 women from throughout the Negev. Although the occupations of trainees varied, the major professional groups represented were teachers and students. At the end of the training, certificates were awarded and those who appeared to be the best suited were then asked to conduct focus groups in their community, either as moderators or observer-recorders.

(2) Focus group participants were invited from a single settlement location, either in a town or in the periphery, generally from the same tribe and always with a moderator and observer from their community. Purposeful sampling (Patton 1987) attempted to get a wide spectrum of individuals who were willing to participate and share in a group setting. We avoided inviting formal, informal, or traditional leaders such as sheiks, politicians, local council members or health care professionals, due to concerns about their possible domination of the discussion.
(3) Separate groups were organized for men and women with same-sex moderators and observers.
(4) The observer recorded the data using handwritten notes that were later reviewed for accuracy with the moderator. No audio- or video-recording methods were utilized. (See note-taker guide in appendix.)
(5) Focus groups, lasting from one to several hours, met on more than one occasion, and records were kept both of participation patterns and individual involvement in the discussions. In some cases, different members of the same household switched.
(6) The moderator guide developed for this study was discussed, piloted, and revised with the cadre of Bedouin from within the various communities as part of the training course. (See moderator guide in appendix.) This allowed for refinement of the guide, checks for cultural appropriateness, and trainees' involvement in the research design.

Sites and subjects

Twelve focus groups were conducted with an average of five meetings per group (range 3–7) (see Table 1). Locations included planned cities and towns (permanent sites and settlements) and spontaneous settlements (encampments outside the towns and cities). A total of 158 individuals or households participated in the groups, with a median attendance rate of those invited of 86%, mean 78%. Ten groups were male only, two were female only. Groups were stratified by gender and residency (i.e. no one from outside a particular town or settlement was invited to attend). The sampling criteria were designed to provide representation by various sub-clans and occupational groups within the towns and settlements and the composition of groups reflected this strategy. Oral consent was obtained prior to each group. Quality control was maintained through intermittent observations of the group process by one of the Principle Investigators (MM) and by the review of field notes soon after groups were conducted.

The original design called for equal numbers of male and female groups; however, several logistical barriers arose in executing this plan:

- Fewer Bedouin women than men came to the training sessions for leaders, and fewer yet finished the course, in part reflecting the smaller percentage of educated females in this population.
- Those women who completed the course reported difficulties in organizing groups of women in their communities, due to a variety of logistical and cultural barriers.
- Repeated attempts at drafting additional female moderators and observers, though successful in part, did not result in the desired number of groups.

Data analysis

The analytic core of this study is a qualitative iterative cycle of data collection, analysis, refinement of the research questions

Table 1. Characteristics of the focus groups

Focus groups – location sites and gender of participants	No. of sessions	No. of participants (participating households)	% of those invited who attended groups
Inside planned towns and cities			
Settlement 1: males	4	8	67
Settlement 2: males	5	13	68
Settlement 3: males	6	15	86
Settlement 4: males	4	11	74
Settlement 4: females	6	15	89
Settlement 5: males	5	18	92
Settlement 5: females	6	14	93
Settlement 6: males	3	10	30
Settlement 7: males	4	16	83
Outside planned settlements			
Encampment 1: males	5	13	78
Encampment 2: males	7	14	90
Encampment 3: males	6	11	93

leading to further data collection. This cycle was repeated until interpretations were formulated and verified. The analysis was mainly conducted by a team of three native Arabic speakers who were instructed by one of the chief investigators in a technique known as 'Immersion/crystallization'. This involves, 'the analyst's prolonged immersion into and experience of the text and then emerging, after concerned reflection, with an intuitive crystallization of the text' (Miller and Crabtree 1992, p. 19). Searches for alternative interpretations and negative cases were also stressed as part of the analytic process. Specifically, the analysis team repeatedly reviewed all observers notes in several systematic passes:

(1) Extract key sentences and central concepts from individual focus groups (codebook formation).
(2) Check if such concepts are present in other groups.
(3) Extract minority views from individual focus groups (alternative interpretations and negative cases).
(4) Check if such concepts are present in other groups.

To provide quality control, several sets of observer notes were translated into Hebrew for review by other members of the research team.

An additional element of this study was the formation of a community advisory group. Due to the absence of universally recognized leaders in the Bedouin community, the advisory group was composed of individuals from a variety of backgrounds. Many attended the training sessions at the onset of the research and met on a few occasions, particularly prior to the onset of the study. They were also informed of the study results and were provided with the data prior to publication.

Results

Participants uniformly displayed great interest in discussing health issues in this type of forum, as reflected by lively discussion, dynamic interaction, and frequent second, third and fourth meetings, all with high rates of attendance. The modified focus group method appeared to succeed in creating a data collection milieu compatible with cultural norms. The content of discussion in the groups centred on the following issues:

(1) the health status and life expectancy of the Bedouin population and recent changes brought on by sedentarization;
(2) health service utilization;
(3) dissatisfaction with the modern curative and preventive health services, particularly inequities, availability, staffing and barriers;
(4) expectations of involvement in planning;
(5) health beliefs;
(6) the new National Insurance Law.

During the focus group discussions at different localities, dissatisfaction with the health status of the Negev Bedouin was repeatedly voiced. Every group felt that there was a strong relationship between the decline in the overall health status of their community and the changes from migratory to settled existence. Many of the participants from both the planned and unplanned settlements agreed that the nomadic lifestyle is healthier and less stressful than the modern one. Participants were convinced that changes engendered by the sedentarization process, such as a greater dependency on modern food technologies, are negatively affecting their individual and communal health. Although in the settled towns they could now get access to reliable sources of food and water, modern housing (with its inherent protection from the harsh desert elements), as well as schools and medical facilities, they were cut off from their traditional 'healthy' way of life. According to reports from focus groups, the diseases that Bedouins in the Negev face today are more 'severe', more 'deadly', than problems they faced in the nomadic period. In addition, there was great concern that they were starting to suffer from the diseases of civilization. Participants believed that diseases such as Diabetes mellitus, hypertension and stroke are new to the Bedouin community, and they are shocked by the rapid and aggressive 'invasion' of these diseases into their localities.

Participants in the focus groups were certain that the life expectancy of the average Negev Bedouin is better than 3–4 decades ago, but this is attributed neither to changes in the quality of life nor to the benefits of Western health services. First and foremost, focus group members attributed the improvement to 'God's will', stating that, 'Only God can prolong or shorten life'. As one participant noted, matters of life and death are not human business: 'everything is from Allah, the doctor only assists'. The actions of medical professionals are seen as having a marginal effect. For instance, Negev Bedouin were reported to generally avoid blaming doctors when their loved ones died, only wanting to be sure that efforts were made to avoid suffering. A member of the Hawashli tribe in one group spoke in regard to a young man who died unexpectedly, 'Everything the doctor could do was done, the rest is Allah's business.'

Health service utilization was a topic of discussion in all groups. In addition to the use of maternal and child preventive health services provided by the Ministry of Health and curative services administered by the four Israeli Sick Funds, participants in the groups mentioned a wide variety of health care options and utilization patterns. After use of the Sick Funds, non-affiliated or private Western medical practitioners appeared to be the most popular choice. Such services were sought in the larger Bedouin and Jewish towns, Occupied West Bank and Gaza; first aid stations (Magen David/Red Crescent); emergency and specialty departments at hospitals in major Israeli cities. As one participant noted, '[When I am sick] I take my car to Dimona [a small Jewish city] to visit my doctor there.'

Traditional Bedouin healers were also consulted frequently. Participants voiced their belief that traditional medicine is still practised within the Bedouin community, but all agreed that the use and importance of these healing arts seem to be waning. Nonetheless, there was wide personal knowledge of traditional treatment modalities, as well as where to find healers – two good markers of current relevance and use. A participant in one group offered this personal narrative:

> 'We went with a [female member of my family] to the Darvish and he said that the girl was bewitched by a dybuk (spirit possession). He read a few passages of the Koran and held the head of the patient in his hands. Since then the girl has not required any medications.'

Opinions as to the patterns of resort varied but there appeared to be general agreement that Negev Bedouin patients went first to conventional Western medical practitioners, and only when treatment was not successful or service not accessible, did they turn to traditional healers.

Participants voiced dissatisfaction with the Sick Fund's curative health services in the Bedouin sector. They claimed that inadequate health care planning and provision were having a major impact on their health and welfare, particularly in comparison to the Israeli Jewish sector. The problems ranged from insufficient numbers of clinics, to inadequate services, to multiple barriers to access and utilization – from communication, to transportation, to language, to costs. The few services that existed were understaffed and located almost solely in the planned towns. In addition, basic medications were often not present at the HMO clinics. For example, a member of one group spoke:

> 'We come to the clinic and the staff tells us, "We don't have this medication here, go bring it from Beer Sheva [the nearest major city]." Why don't they bring it here, if they bring it to Yerocham and Dimona [nearby Jewish towns]?'

The situation in the periphery was even more severe. Participants voiced their concern that the current medical service model effectively excluded Negev Bedouin in the periphery from receiving health care

One participant noted that when such issues were raised with the staff at the Sick Fund clinics, they tended to get answers such as, 'This is what comes to you [the Bedouin], there aren't any more funds or budgets.' However, as a participant in the same group noted, 'Only we [the actual patients] pay the price!' Another noted that, 'If this happened in another sector, like the Jewish sector, they certainly would receive all they asked for.'

Although there was greater satisfaction with maternal and child preventive health services provided by the Ministry of Health in the Bedouin sector than with the HMOs, complaints were frequent. All planned Bedouin towns are served by maternal and child health clinics, but they were felt to be over-crowded and short of staff and did not serve the needs of Bedouin in spontaneous settlements or in semi-nomadic lifestyles. In all clinics, waits were long, hours of service were short, and no evening appointments were offered – something said to be routine in many Jewish areas. The clinic buildings were often wholly inadequate to the numbers and types of patients served. Enclosed waiting areas, if they existed, were often not air-conditioned or heated, while the majority of sites required patients to wait outside, exposed to the elements in both summer heat and winter. Some clinics were just converted caravans (mobile homes) or private homes. The latter often had steps, making access for the infirm or disabled difficult or impossible.

As identified by the focus groups, health professional staffing in the Negev Bedouin sector is a particular problem for both the Sick Funds and the Ministry of Health maternal and child preventive health services. The clinics serving their communities are felt to suffer from both inadequate numbers of Bedouin nurses and physicians and an accompanying lack of cultural sensitivity to Bedouin society. Many of the practitioners, whether family, general, or paediatric, were thought to be less qualified than in the Jewish sector, while examinations were felt to be cursory and treatments poor. Doctors, often immigrants from the former Soviet Union, rarely speak Arabic and problems of communication are acute, particularly for the elderly Bedouin, many of whom do not speak Hebrew. Not only are difficulties in explaining their problems common, the elderly frequently have difficulty understanding the staff's advice and explanations. One participant summed up the situation, putting the blame squarely on the Sick Fund:

> 'From where did they bring us these Russian doctors? We can't understand them and they can't understand us, but it's not [the doctors'] fault.'

Participants in the group ascribed this cultural and linguistic divide as the main reason for the lack of compliance frequently claimed by doctors in the Bedouin sector. Many of the physicians and staff are felt to be ignorant of traditional Bedouin culture. For example, there was little understanding of the cultural requirement for some of the women to have an adult male relative chaperone them during visits.

Issues regarding barriers to accessing health services were repeatedly raised in the focus groups. For instance, it was often remarked, 'How is it possible to get to a clinic outside [in a city or town] when there are no roads?' In the unplanned settlements and peripheral encampments, men generally use the limited numbers of cars and trucks to go to work. This often forces the women and children to walk long distances to access health care. Participants wanted clinics built where their people live, and not just in the planned towns. As mentioned in one of the focus groups:

> 'Most of the problems [with access] involved our women. They can't get to the clinics when there is no arranged transport and thus must travel far by foot. Only Allah knows who will meet the woman on the road and convince her [to go with him] or to take her.'

Even if people could reach the clinics, they could not always afford the services. Until the 1995 National Insurance Law made curative services a universal right for every citizen, health insurance through the Sick Funds had previously been prohibitively expensive for a large portion of Negev Bedouin. Many participants also voiced concern about the continued biannual fees levied by the Ministry of Health for maternal and child health services. The participants agreed that the Bedouin standard of living is very low, with multiple economic pressures on families – aggravated by the young ages of many couples and the large number of children. Pooling of

resources from the extended family, frequently available in the past, is not as prevalent today and most couples have to manage alone.

Even with the current limitations, focus group members agreed that Western medicine and modern health care services are essential to the health of the Bedouin community. Most groups had more faith in the secondary or tertiary care they received at the regional hospital (Soroka Hospital in Beer Sheva) than in primary care, despite difficulties in accessing services.

There was much discussion of the issue of who was responsible for the current situation. Blame for the present and past inequities and insufficiencies were laid on both regional and national governmental structures. The participants were particularly vexed by the lack of involvement of the local community in the planning of their health services. They felt strongly that there should be a partnership between health planners and representatives of the Bedouin community in the Negev. Young participants, particularly those from the unplanned settlements, often saw this lack of consideration for local views on health care needs and expectations as part of general discrimination of the Arab minority in Israel and the neglect of Bedouin human rights. 'Nobody asks us what we want, nobody asks how we can participate, and nobody asks how do we feel about it,' said one participant. The policy of placing clinics only in the planned settlements was felt to be disrespectful to the uniqueness of this formerly seminomadic people and part of the governmental effort to move Bedouins to planned towns.

The dissatisfaction with health care services is not an isolated phenomenon. A few participants mentioned that the Negev Bedouin face similar problems in the educational system. The planning, provision and evaluation of services were felt to be executed by bureaucracies external to the community with no room for input by local Bedouin or their leaders.

Familiarity with National Insurance Law, which was passed by the Israeli Knesset (Parliament) in 1994 and came into effect in 1995, was generally superficial. Some claimed that they had never heard of the law, while misinformation or partial information was rampant. For example, some participants mentioned that they now felt free to use any of the Sick Fund clinics, while others said that they could not move from one Sick Fund to another. The right to curative services, as instituted under the Law, was not universally known in the Bedouin community, and focus group participants noted that this was causing some to avoid attending clinics due to fears of incurring debts.

Nonetheless, although participants often did not have concrete knowledge regarding the specific content of the Law, they saw it as an important advance. This became apparent during the focus group discussions, which helped to bring participants' 'databases' on the subject into par with one another. Participants, even those who were unfamiliar initially, became advocates for the law because it provided universal health insurance coverage for the Bedouin, where only partial coverage had been in effect. The extension of coverage to such a large group of previously uninsured and unaffiliated was seen as enticing the whole range of Israeli Sick Funds to compete for providing health services. Such competition was a first for the Negev Bedouin and provided a new possibility of choice, where none had existed before. Participants also voiced optimism that the Law would have an important role in ensuring the right of the Bedouin to receive health services comparable with their Jewish neighbours and erasing some of the current inequities.

Discussion

The value of modified focus groups in traditional societies

This study, one of the first of its kind in the Bedouin sector, showed that the focus group method can be a valuable research tool in traditional minority communities if it is properly modified to cultural norms. Not only was the research team successful in bypassing trust and communication barriers present between members of different tribes, we were also able to encourage broad and consistent participation in both initial and repeat meetings. This success may be due to the choice of a format generally felt to be consistent with the established social norms of Bedouin interaction and which provided a comfortable setting for the sharing of views.

The most serious limitation of this study was the method of participant recruitment and selection. Invitations to participate in a particular focus group were limited to individuals or households from a certain town, village or encampment. Given the size of most Bedouin villages and towns, and their composition on the basis of tribal, sub-tribal, or extended allegiances, such selection necessarily involves the inclusion of participants who know one another and who are tied into pre-existing social structures. Most methodological discussions on focus groups suggest that participants should be strangers so as to limit deference or concealment which might occur among family, friends or co-workers (Morgan 1988; Krueger 1994). There is a consensus that one must be wary with interviews among pre-existing groups, since members may have formal or informal ways of relating to each other that can influence their responses in a variety of implicit or explicit manners, confounding interpretations. Such confounding influences may include hierarchical ties (superior–subordinate), bonds of friendship or loyalty, familial ties or economic links.

However, there is support and precedent for our recruitment strategy. It should be remembered that, 'The driving force in participant selection is the purpose of the study' (Krueger 1994). In this investigation, the goal was to elicit views on a number of subjects connected to health and health care services. The reserve that might have been present if participants and moderators/observers had been from a variety of tribes and locations would have made open and free disclosure impossible. In addition, rarely, if ever, are focus groups composed of random samples of a target population. Such randomization may be neither necessary nor desirable since the goal of focus groups is 'not to infer but to understand, not to generalize but to determine the range, not to make statements about the population but provide insights about how people perceive a situation' (Krueger 1994).

Finally, it should be noted that the proposition that impersonal selection of focus group participants who are strangers to one another facilitates the sharing of information is rooted in Western cultural assumptions. Fuller et al. (1993) conducted focus groups among individuals living in poor, crowded housing conditions in Bangkok. In this study, each group was composed of participants from a single neighbourhood who were likely to know each other beforehand. The researchers felt that this was acceptable because the bustling conditions and norms of interaction in the local Thai context already involved a high level of mutual information sharing. The neighbourhood groups were also a concession to local logistics, i.e. the lack of automobiles and telephones among the target population would have severely influenced participation. Jarrett (1993), who conducted focus groups among low-income minority populations in the United States, believes that impersonal selection strategies may be inappropriate for reaching minorities, where potential participants may have realistic concerns about taking part in such studies. For example, though not called focus groups, a study examining issues of child and maternal preventive health services (Beckerleg et al. 1998) used separate 'natural groups' of women and men where participants were generally well known to one another, often within the same family or subclan. The natural groups gathered in the home of a new mother or at men's meeting tents or shacks, presenting culturally sanctioned opportunities to interview using a focus group format.

A further limitation was the small number of focus groups, particularly women's groups. Women are critical in decision-making in matters of illness and resort to health care, and the paucity of groups is unfortunate. There are no strict criteria for the sampling size in qualitative research. Generally, one continues until the data become redundant and there are no further insights – something which may be achieved in three or four groups (Calder 1977; Morgan 1988). This was felt to occur within this study for both women and men, although more women's groups would certainly have been desirable.

Conclusions

The findings from this research will be used in three ways:

- to assist with the development of a survey instrument;
- to direct efforts to improve health policy and health services;
- to increase awareness of health issues among Negev Bedouin.

The use of focus groups to assist in the development of survey instruments is well established (Morgan 1993). Insights from this study have been utilized to construct a culturally compatible questionnaire for surveying the expectations, utilization and levels of satisfaction with health care services among a random sample of all Negev Bedouin.

Researchers in other countries have achieved success with intensive, selective intervention programmes for minority populations in improving economic, physical and mental well-being, and at the same time, bridging gaps of language and culture with the dominant society (Ghada Karmi 1993). The Bedouin community benefited from this research in two specific ways. First of all, a cadre of Bedouin research assistants was trained who will be able to take part in future studies, and some may be empowered to become independent researchers. This study also points out the need to involve the Bedouin in the planning of services for their communities and the need for greater public education on the National Insurance Law. Insights from the research are being returned to the Bedouin community through community education measures. Information is also being disseminated to the health planners who will be amending the national health care laws.

The investigators believe that studies such as these will bring new insights to the special needs of the Negev Bedouin and will help direct efforts to provide better and more culturally appropriate health care to this population. The understandings which arise from attempts to match data collection methods with cultural norms may contribute to the improvement of services, the betterment of the consumer's well-being, and a more economical use of resources.

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Appendix 1. Steps in note taking for observers

(1) Record and describe the site, record the date, names of moderator and note-taker, number of participants, demographic details, etc.
(2) Assign each participant a number which will be used throughout the transcript, or alternatively, use the first letter of the first name as a reminder.
(3) Record word for word as much as possible, according to the person who spoke. Also try to record some aspects of body language.
Tricks:
- try to get main ideas
- record the 'gems'
- make an outline when there is too much material
- avoid recording lengthy introductions to ideas (example: 'I mean I thought I heard that . . .')

(4) Review notes immediately at the end of the session with the moderator and fill in blanks.
(5) Add summary material from moderators and note-takers which includes your thoughts about the process of the focus group and your thoughts about the major concepts covered during the group.
(6) Rewrite or check to make sure that notes are legible.

Appendix 2. Moderator's guide

Could you please tell me where you and your family go to get health care, either when someone gets sick or to prevent illnesses?

Where have you gone in the last few months to receive care?
Probes:
- family member or neighbour
- traditional healer
- nurse, doctor
- clinic (sick fund, maternal and child health clinics, etc.)
- hospital (emergency room, inpatient or outpatient, etc.)
- other

Please tell us about your experiences, or those of your family and friends during your visits to the places where you receive care.

What do you like and dislike about each place? (positive aspects and negative aspects)

What makes it difficult (or easy) to get good health care?
Probes:
- distance/transportation
- cost
- language barriers
- relationships with nurses or doctors
- cultural differences
- other

What would be the 'ideal' health care system for the Bedouin population in your area?

Utilization
Where do you go if you get sick?

Where do you go for preventive care, like immunizations?

Do you and most of the people you know belong to one of the Sick Funds?
Probes: which ones, reasons, preferences, etc.

Do most of the mothers around you (in the extended family, in your area) go to a maternal and child health station with their children and if so, tell us about their experiences?

Relationships
How do the nurses and the doctors receive and treat you and your family in general?
Probes: with respect, friendly, hurriedly, etc.

Do the nurses and the doctors speak Arabic with you?
How well do you understand the nurses/doctors?
How well do they understand you?

Did the nurse/doctor answer your questions?

Do you generally understand their explanations?

Do the nurses and the doctors seem to understand Bedouin and respect their culture?

National health care law
What do you know about these laws and how do you think they will affect the health care of Bedouin in the Negev?

Improving the research
How did you feel about answering our questions today?

Do you have any suggestions on what we should do to get the opinions of the community?
Probes: What other questions would you ask?
Who else would you contact?

How could this research be used to help the community?