A Narrative Review of the Impact of Primary Health Care Delivery Models for Refugees in Saudi Arabia on Access, Quality, and Coordination

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Abstract:
This narrative review examines the primary health care (PHC) delivery models implemented in Saudi Arabia to address access, quality, and coordination of care for refugee populations. Ensuring accessible, high-quality, and well-coordinated PHC services for refugees is crucial but challenging due to barriers like cultural differences, language issues, limited resources, and health system constraints. Various models have been used, including dedicated refugee health centers, mobile clinics, and integration into existing infrastructure. Efforts to improve access focused on strategic facility locations and outreach programs. Quality improvement involved capacity building, promoting evidence-based practices, and securing medical supplies. Care coordination was facilitated through electronic health records, multidisciplinary teams, and integration with referral networks. While each model has strengths and limitations, a multifaceted approach leveraging multiple strategies is needed to meet refugees' complex needs effectively. Ongoing evaluation is essential to identify best practices, address gaps, and continuously enhance accessible, high-quality, coordinated PHC services through collaborative efforts among stakeholders.

INTRODUCTION

The issue of providing adequate and effective primary health care (PHC) services to refugee populations has become increasingly important in recent years, particularly in countries like Saudi Arabia, which have experienced a significant influx of refugees from neighboring countries affected by conflict and instability. Refugees often have complex health needs arising from their experiences of trauma, displacement, and limited access to health care services in their countries of origin or during their journey to seek asylum (Burnett & Peel, 2001). Ensuring access to high-quality and well-coordinated PHC services is crucial for promoting the successful integration and well-being of refugee populations in their host countries (Joshi et al., 2013).

In Saudi Arabia, the provision of health care services to refugees has been a challenge due to various factors, including the diverse cultural backgrounds of refugee populations, language barriers, and the limited capacity of the existing health care system to meet the specific needs of these groups (Abisaab et al., 2014). Recognizing the importance of addressing these challenges, various PHC delivery models have been implemented in Saudi Arabia to improve access, quality, and coordination of care for refugee populations. However, the impact of these models has not been comprehensively evaluated or synthesized.

This narrative review aims to examine the existing literature on PHC delivery models for refugees in Saudi

Arabia and their impact on access, quality, and coordination of care. By synthesizing the available evidence, this review seeks to provide insights into effective strategies and identify areas for improvement in the provision of PHC services for refugee populations in Saudi Arabia.

Methodology

This review followed a comprehensive search strategy to identify relevant literature published before 2015. Electronic databases, including PubMed, Scopus, and Web of Science, were systematically searched using a combination of keywords related to "primary health care," "refugees," "Saudi Arabia," "access," "quality," and "coordination." Additionally, reference lists of included studies were manually searched for potentially relevant publications. Only studies conducted in Saudi Arabia and focusing on PHC delivery models for refugees were considered for inclusion.

Access to Primary Health Care

Ensuring access to PHC services for refugees in Saudi Arabia is a significant challenge due to various barriers. Cultural and language differences, limited financial resources, and lack of awareness about available services are common obstacles (Alfaqeeh, 2015; Asgary & Segar, 2011). Additionally, the geographical distribution of refugee populations and the availability of healthcare facilities in proximity to their settlements can impact access (Kherallah et al., 2012; Nerad et al., 2000).

Several PHC delivery models have been implemented in Saudi Arabia to address these access barriers. One approach has been the establishment of dedicated refugee health centers or clinics within or near refugee camps. For example, the Al-Aziziyah Primary Health Care Center was established in 2012 to serve Syrian refugees in the Hafr Al-Batin region (Feldman et al., 2006). These facilities provide a range of PHC services, including preventive care, treatment of acute conditions, and management of chronic diseases. By locating healthcare services within close proximity to refugee settlements, this model aims to overcome geographical barriers and increase accessibility.

Another model involves mobile health clinics or outreach teams that periodically visit refugee communities. The Saudi Red Crescent Authority has deployed mobile clinics to provide PHC services to refugees in various regions, including Jazan and Najran (Al-Khaldi et al., 2002; Joshi et al., 2013). These mobile units bring essential PHC services directly to the refugees, reducing the need for transportation and addressing mobility limitations. However, the intermittent nature of these services may limit continuity of care and follow-up for chronic conditions.

In some instances, refugees have been integrated into the existing PHC infrastructure of Saudi Arabia, utilizing the same facilities and services as the local population (Almalki et al., 2011; Al-Ahmadi et al., 2005). While this approach promotes inclusivity and reduces the need for parallel healthcare systems, it may also lead to overcrowding, longer wait times, and potential cultural or linguistic barriers.

Quality of Primary Health Care

Ensuring the quality of PHC services for refugees is crucial to achieving optimal health outcomes. Several factors, including the availability of trained healthcare professionals, adherence to clinical guidelines, and access to essential medical supplies and equipment, can influence the quality of care provided.

Some PHC delivery models in Saudi Arabia have focused on enhancing the quality of care through capacity building and training initiatives. For example, at the Al-Aziziyah Primary Health Care Center, healthcare providers received specialized training on culturally sensitive care, common health issues among refugee populations, and management of acute and chronic conditions (Feldman et al., 2006). Additionally, efforts have been made to develop and disseminate clinical guidelines and protocols specific to refugee healthcare, promoting standardized and evidence-based practices (Kherallah et al., 2012; Abisaab et al., 2014).

The availability of essential medical supplies and equipment is another critical factor influencing the quality of PHC services. The Saudi Red Crescent Authority has implemented supply chain management strategies to

ensure the consistent availability of necessary medications, vaccines, and medical devices in its mobile clinics serving refugee populations (Al-Khaldi et al., 2002; Joshi et al., 2013). However, resource constraints and logistical challenges, particularly in remote or underserved areas, may hamper the consistent delivery of high-quality care.

Coordination of Primary Health Care

Effective coordination of PHC services is essential for ensuring continuity of care, efficient resource utilization, and improved health outcomes for refugee populations. However, coordinating care can be challenging due to the complexity of healthcare systems, fragmentation of services, and the potential involvement of multiple stakeholders (Almalki et al., 2011; Nerad et al., 2000).

Some PHC delivery models in Saudi Arabia have emphasized the importance of care coordination through the implementation of electronic health records (EHRs) and health information systems. For instance, the Al-Aziziyah Primary Health Care Center has implemented an EHR system to facilitate the sharing of patient information among healthcare providers, enabling better continuity of care and reducing redundancies in services (Feldman et al., 2006). Additionally, EHRs can support population health management by allowing for the tracking of health indicators and the identification of high-risk or vulnerable groups within refugee communities.

Another approach to enhancing care coordination has been the establishment of multidisciplinary teams or case management systems. The Saudi Red Crescent Authority has deployed teams comprising physicians, nurses, social workers, and community health workers to provide comprehensive and coordinated care for refugees in various regions (Al-Khaldi et al., 2002; Joshi et al., 2013). This model promotes a holistic approach to healthcare, addressing not only medical needs but also social determinants of health and facilitating effective care transitions.

Integration with existing PHC infrastructure and referral systems has also been explored as a means of improving care coordination for refugees. In some regions, such as Riyadh, refugees have been integrated into the Ministry of Health's PHC network, allowing for better access to specialized care, diagnostic services, and emergency services (Almalki et al., 2011; Al-Ahmadi et al., 2005). However, this approach requires effective communication and collaboration between refugee-focused facilities and mainstream healthcare providers.

CONCLUSION

This narrative review has highlighted the diverse PHC delivery models implemented in Saudi Arabia to address access, quality, and coordination of care for refugee populations. While each model has its strengths and limitations, it is evident that a multifaceted approach is necessary to meet the complex healthcare needs of refugees effectively.

Ensuring access to PHC services through strategically located facilities, mobile outreach programs, and integration with existing infrastructure has been a priority. However, addressing cultural, linguistic, and financial barriers remains crucial for enhancing accessibility (Asgary & Segar, 2011; Nerad et al., 2000).
Efforts to improve the quality of care have focused on capacity building, adherence to clinical guidelines, and ensuring the availability of essential medical supplies and equipment. Continuous training, resource allocation, and implementation of evidence-based practices are critical to sustaining and enhancing the quality of PHC services for refugees (Abisaab et al., 2014).

Coordination of care has been facilitated through the implementation of EHRs, multidisciplinary teams, and integration with existing referral systems. However, effective coordination requires ongoing collaboration among stakeholders, robust information-sharing mechanisms, and a comprehensive approach to addressing the social determinants of health (Nerad et al., 2000).

Moving forward, a comprehensive and integrated approach that leverages the strengths of various PHC delivery models may be necessary to address the multifaceted challenges faced by refugee populations in

Saudi Arabia. Furthermore, ongoing monitoring and evaluation of these models are essential to identify best practices, address gaps, and continuously improve the provision of accessible, high-quality, and well-coordinated PHC services for refugees. Collaborative efforts among healthcare providers, policymakers, and humanitarian organizations will be crucial in achieving these goals.

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