ACCESS TO HEALTHCARE IN RURAL COMMUNITIES IN GHANA: A STUDY OF SOME SELECTED COMMUNITIES IN THE PRU DISTRICT

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ABSTRACT

Good health contributes greatly to achieving national goals and objectives and consequently, international goals such as the Millennium Development Goals. It is, therefore, required that facilities and services are provided to enhance access to healthcare services in order to ensure that all individuals irrespective of their location benefit in developing countries. The Government of Ghanaian has, over the years, made efforts to achieve 'Health for All' through various programmes which include the Village Health Workers Initiative, Primary Health Care and the National Health Insurance Scheme. The focus of this paper is on the assessment of access to healthcare among rural dwellers; the challenges encountered; coping strategies; and recommendations towards overcoming such challenges in Ghana through a case study of the Pru District. Qualitative and quantitative data were collected through household survey, key informant interviews, focus group discussions, observation and review of relevant literature on the subject matter. Data collection instruments employed included questionnaire, interview guide and checklist. A sample size of 200 households was selected for the household survey in 7 rural communities. The revelation is that the rural dwellers are highly disadvantaged in terms of physical accessibility to healthcare facilities. Factors accounting for this included: unavailability of healthcare facilities in the rural communities, poor transportation systems, unavailability of equipment for Traditional Birth Attendants (TBAs), long travel distances, and low income levels. The situation results in high mortality rates and teenage pregnancies. It is recommended that the district authorities, community leaders and other stakeholders make efforts to provide health facilities, build the capacity of TBAs to properly manage cases, improve road conditions and intensify community health education.

Keywords: Access, Healthcare, Rural, Communities.

INTRODUCTION

Improved health is intrinsic in the achievement of the Millennium Development Goals (MDGs) particularly in Reducing Child Mortality, Improving Maternal Health and Combating HIV & AIDS, Malaria and other diseases. Health and development are inextricably linked and this makes it necessary for governments and various development partners to invest resources in the health sector. In the year 2010, 12.1 percent of the total expenditure for the Ghanaian government was invested in the health and as high as 5.1 percent of Gross Domestic Product was for the same sector (World Health Organisation, 2013).

Globally, the rural population is almost 50 percent of the total human population as available data provides that by the middle of 2009, the number of people living in rural areas was 3.41 billion and urban areas 3.42 billion (United Nations, 2009). The Ghanaian context presents a similar case as 49.1 percent of the population lives in the rural areas (Ghana Statistical Service, 2012). A recent United Nations report indicated that if the MDG4: Target 4.a (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) is to be met, efforts must concentrate on those countries and regions where child death rates are highest. Such places were identified as the developing regions and rural areas (United Nations, 2013). Also, access to health services is inadequate and poor in deprived and rural areas consequently, the poor suffer from the appalling cost of ill health from two perspectives: from the cost of accessing services and from productive days lost (Ministry of Health, 2007). Achieving a decent health status among the populace and realizing the MDGs requires that access to good quality healthcare is improved significantly in the countryside however, this has been horrendous to many governments particularly, the developing world.

Lu et al (2010) identified inadequate health facilities, long distances to health facilities, lack of effective and efficient transportation systems, inadequate health personnel and inability to afford the cost of health services as major hurdles constraining rural people from accessing health services. In a study undertaken by Adam W., et al (2004), similar factors were identified as hinderingchild health among the poor especially rural dwellers and these consequently had effects on the gap in mortality rates between rural and urban areas. This is worse among rural dwellers that live along water bodies that access health services from district capitals as transportation is a critical issue to accessing health services.

As a matter of importance, the Ghanaian government has not lent deaf ears to the situation as some efforts have been made by the government to enhance access to quality health care among rural dwellers. Unfortunately, efforts by the government to achieve a close-to-client service delivery which is mostly a step to reaching the rural populace have not achieved its objectives over the years (Ministry of Health, 1979; 1998). Village Health Workers (VHW) were suggested as the way forward to developing a reasonably priced health services to the rural poorand to enhance access since earlier efforts have not yielded the needed results though some successes were made (Neumann et al. 1974;Lamptey et al. 1980, 1984 in Nyonator et al, 2005). This was successful but when it was scaled up, it faced some challenges and hence, could not survive. Cole-King et al. (1979) identified some of the challenges to be organizational, resource, training, monitoring and supervisionproblems hence, the VHW system was abandoned in the 1980s.

Regardless of the variousstrategies for achieving 'Health for All' in the 1980s, in 1990 more than 70% of all Ghanaiansstill lived over 8 km from the nearest health care provider(Ministry of Health 1998) and rural infant mortality rates weredouble the corresponding urban rates. Improving access tohealth care delivery therefore remained a central goal of healthsector and till date, rural dwellers are constrained (Nyonator et al, 2005). Other policies and strategies such as the Community-based Health Planning and Services (CHPS) was introduced in 1999 and the National Health Insurance Scheme (NHIS) in 2004 to help achieve health for all irrespective of the economic and geographical conditions of individuals.

In recent times, there have been little research to ascertain barriers to geographical access to healthcare particularly, in rural areas. This paper assesses the state of healthcare access among

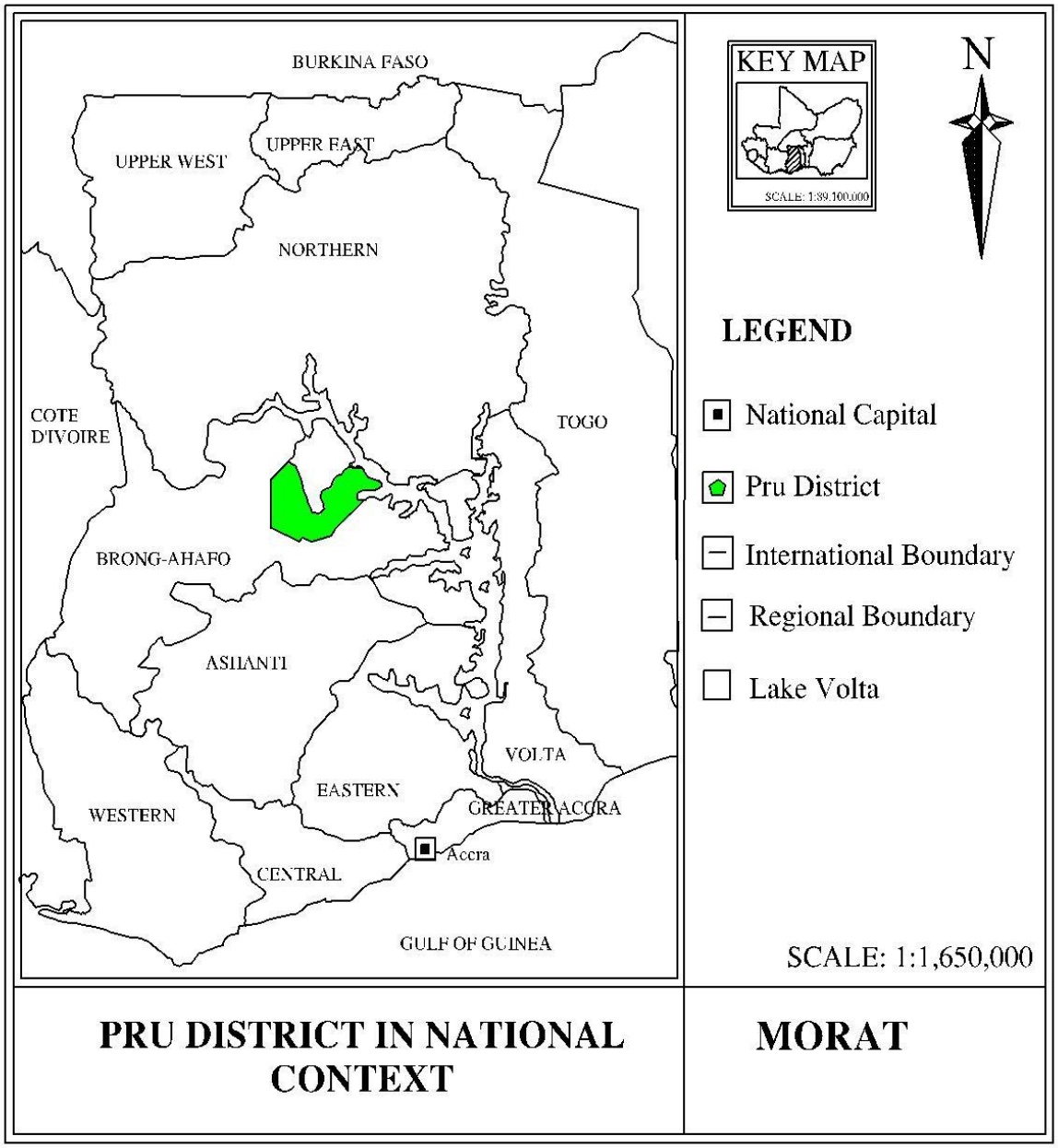
rural dwellers, the challenges encountered and the coping strategies, and to recommend the way forward to overcoming such challenges. The paper has analyzed the effects of poor access to healthcare on maternal and child mortality and recommend ways to improving access to healthcare in rural communities.

MATERIALS AND METHODS

The Pru District has 10 health care facilities made up of one (1) mission hospital at the district capital (Yeji), three Health Centres, One Rural Clinic, three Maternity Homes and 2 other clinics one of which is privately managed. This presents a major problem of inadequate health infrastructure in the area as a result, efforts have been made by the Assembly to identify and train a total of about 56 Traditional Birth Attendants to support. The district has a major health challenge and this is manifested in the quantitative and qualitative health needs as data shows that as at 2009, the District had Four (4) Doctors, 68 Nurses, 2 Dispensing professionals, 8 Laboratory Technicians, 5 Medical Record Technician and 6 Disease Control Officers. The Doctor patient ratio for the District is therefore 1:30,854 as compared to the national ratio of 1: 925. The Nurse patient ratio is however 1: 1,815 and poor for rural dwellers due to challenges in the form of physical and economic accessibility.

The existing number of facilities in the District clearly indicates that some communities have low access to health care facilities. According to data from the 2003 Core Welfare Indicators Questionnaire survey, about 32.3percent of households are within the reach to the nearest health facility as compared to the regional average of 53.85percent (Pru District Assembly, 2010). The situation is worse for rural dwellers as these facilities are somewhat distributed among the major centres such as Yeji, Zabrama, Abease, Prang, Parambo. In terms of distance from nearest health facility to localities, 92.7percent of the localities in the District have traditional healers, thus seek treatment from them whereas 2.8percent of the population have clinics within their locality, compared 0.7percent to hospitals(Pru District Assembly, 2010). Rural dwellers are therefore faced with several healthcare problems and in some cases rely on traditional healers and other unqualified personnel. Figure 1 presents the location of the district in the National context.Figure 1 presents the location of the district in the national context.

Fig 1: Pru District in National Context



Source: Adapted from PruDisctrict Assembly, 2010

A preliminary survey was carried out through which relevant institutions such as the District Health Directorate (DHD), Non-Governmental Organizations, and other local authorities were identified and consulted for background information on health and health related issues. The research topic was discussed with the identified institutions and this was followed by pretesting the institutional questionnaires. The area was visited and a meeting held with the community leaders such as the Assemblyman, unit committee members, youth leaders and some traditional leaders.

Seven (7) communities were selected for the survey. The household survey involved 200 households who were selected randomly with the help of the Assemblymen, unit committee members and youth leaders. A Focus Group Discussion was held in all communities and key informants such as the chiefs, Assemblymen, unit committee members, teachers, and youth leaders were interviewed to help collect valid information.

Information was also collected from the District Health Directorate precisely the Primary Health Unit, Disease Control Office, Family Planning Unit, and some healthcare providers such as Bernice Clinic, St. Mathias Hospital and two TBAs. Data from the Key Informants and Focus Group Discussions were collated on a sheet and the household survey in Statistical Package for Social Science (SPSS) for further analysis.

RESULTS AND DISCUSSION

Availability and Utilization of Health Facilities

Results show health facilities were not available in all sampled communities however, some of the communities had Traditional Birth Attendants (TBAs). Access to healthcare is therefore a major challenge for the inhabitants of these communities. Over 70 percent of respondents however indicated that they have accessed at least one of the following health facilities: Health Centres, Clinics and hospitals located in the urban areas particularly the district capital. As a result of the long distances (at least 20 kilometers) and the ineffective transport systems, accessing these health facilities is discouraging hence, one accesses these facilities when the health condition is severely bad and also in emergency situations. This results in increased health cost as a result of high cost of transportation to the district capital and in some cases, loss of lives. The survey revealed that during emergencies, the only means of transportation available to inhabitants is to hire the services of a tricycle operator and sometimes a boat which are relatively expensive (about GH₵15.00≈US$4.95) for the rural dwellers with an average annual income of GH₵3,655.00≈US$1,205.28). The situation is even worse due to the seasonal nature of the income earned by the rural dwellers.

Family Planning Services

Although family planning to a large extent helps in reducing the burden of parents (by reducing family/household sizes), prevent unwanted pregnancies and reduce infant and maternal mortality, some respondents (45 percent) do not see it as being relevant. Seventy three(73)percent of respondents indicated that they have practiced some form of family planning mainly; condom use, injectable (Depo Provera) and implants (Norplant) and Intra-Uterine Device (IUD).

Although the patronage was high, it was sad to find that only 21 percent of family planning users showed a positive attitude towards the practice as the majority (79 percent) were inconsistent in terms of usage and did not follow the routine visits as prescribed by the service providers. Such respondents were mainly from communities such as Korancha,

Pajero-kura, Asemka and Kajaiand were mainly individuals who used depoprovera (injectable). The reasons assigned to such inconsistencies were basically long distances, unavailability of readily available transport means which invariably results in high transport costs hence discouraging clients from accessing such services from the district capital. A female respondent stated that *"I do not see why I should travel over 30 kilometers and pay for a transport fare of about GH₵15 just to access family planning service. My husband will not even give me the money"*.

During an interview session with the staff of the most patronized health facilities; St. Mathias Hospital and Bernice Clinic, it was revealed that family planning clients from the rural areas rarely comply with the required dates of visit and they come on market days sometimes 3 to 5 days late and in rare cases, over a week. Some have also attributed it to lack of education and hence, cannot read the inscriptions and instructions provided. This to some extent is valid as the study found that less than 30 percent of family planning users have received some level of formal education with the majority (over 75percent) having no form of education particularly the females. This has resulted in unwanted pregnancies and contributed to the high rate of teenage pregnancy in the district as 14.1 percent of registered antenatal cases were teenagers (Pru District Assembly, 2010) and some do not register for antenatal services but the community gets to know when such girls drop out of school and during birthing. The situation also has effects on household size as the average household size was as high as 8.1 persons and some respondents attributed the high household size to lack of proper parental care, poor attitude towards family planning and the need for larger family sizes for fishing activities.

In effect, access to family planning services is poor due to the lack of health facilities, long travel distances, low income levels among inhabitants and the low level of education and knowledge among inhabitants. Interventions will therefore be required in provision of the required facilities and intensive family planning education to influence the attitude and behavioral pattern of inhabitants.

Antenatal and Post natal Services

All (100 percent of respondents) indicated their awareness of the benefits of regular antenatal and postnatal care visits to the health of the child and the mother. In all, only 12 percent of female respondents indicated that they do not visit any health facility for such services making the picture an impressive one. However,for those who accessed such services, only 8 percent visited the facilities regularly. Interacting with two sonographers in the two major health facilities in the district capital, it was revealed that pregnant women are expected to visit any health facility at least 3 times for gynecological examinations before delivery. However, clients often come once with a small proportion (less than 20 percent) visiting twice.

The sonographers indicated that clients do well to come once because their focus is to know the sex of the unborn child after which they ignore the other germane medical issues such as the positioning of the fetus in the right state within the uterus. Consequently, many (about 40 percent) of them faced complications during childbirth or delivery as some fetus may be positioned wrongly within the uterus. Other effects mentioned included high medical cost as complicated deliveries require surgical operations; which is not available in the rural areas hence, calling for transport cost and operational cost. In some cases, complicated deliveries have resulted in the loss of the mother or the child.

Also, for the rural dwellers, their major point of delivery was the services of the Traditional Birth Attendants who in this context lack a facility for operations or activities. The situation is exacerbated by the lack of the required materials and equipment such as Apron, goggle, face mask and gown, sterile gloves, sterilized scissorsfor aiding delivery and this exposes the TBA, the mother as well as the child to health risks (See Box 1 for the checklist). Due to the lack of a health facility for the TBAs, services are provided in the homes of clients. The two TBAs interviewed indicated that they travel to surrounding communities to provide healthcare services to clients during emergency circumstances. TBAs do not provide services to the following group of clients:

- Individuals are who giving birth for the first time in their lives. Such clients are likely to face difficulties as a first time experience in delivery. They therefore require the services of a trained midwife and in a facility with the required equipment.
- Individuals who have giving birth for more than 5 times. These clients have weak uterus and may end up requiring surgical operations for help them deliver.
- Individuals who face complications during delivery.

Such clients therefore require the services of a higher level health facility however, these are lacking in the rural areas making access a difficult issue. When pregnant women are referred to health facilities in the district capital, they face a major challenge with transportation as there are no readily available means of transport. As a result, the TBA helps in calling some individuals who own tricycles in the district capital to come to their aid. This is worsened by the poor communication services in the rural areas as respondents indicated that there is only one point where they are able to make phone calls and even with that, the place is not reliable. In a Focus Group Discussion in Kajai, the members indicated that about 4 women lost their children during such emergencies in the year 2014 (in a period of 5 months).

Access to antenatal and postnatal services are generally poor in the sampled communities as a result of unavailability of health facilities, human resource and equipment, poor communication services and the lack of effective and efficient transport systems. This results in increasing infant and maternal mortality and this makes the realization of the MDG 3 a dream than a reality.

Box 1: Checklist of Child Birth Equipment

- Clean water, soap and hand towel.
- Apron, goggle, face mask and gown.
- Sterile gloves.
- New razor blade or sterilised scissors.
- Sterile or very clean new string to tie the cord.
- New razor blade or sterilised scissors.
- Antiseptic solution for cleaning the mother's perineum and genital area.
- 10 IU (international units) of the injectable drug called oxytocin, or 600 µg (microgram) tablets of misoprostol.
- Tetracycline eye ointment
- Three buckets or small bowls each with 0.5 percent chlorine solution, or soap solution and clean water.
- Plastic bowl to receive the placenta.
- Two sterile clamp forceps.
- Sterile gauze, cotton swab and sanitary pad for the mother.
- Two dry, clean baby towels and two drapes.

- Blood pressure cuff and stethoscope.
- Antiseptic solution for cleaning the mother's perineum and genital area.
- Three buckets or small bowls each with 0.5 percent chlorine solution, or soap solution and clean water.
- Plastic bowl to receive the placenta.

Researchers' Field Survey, 2014

Common Diseases

From the study, the major diseases identified included endemic diseases such as Malaria and chronic diseases such as diabetes and hypertension. About 63 percent of respondents indicated that at least a member of their households were attacked by malaria at the time of the survey. For hypertension and diabetes, 17 percent and 6 percent of respondents stated that some of their household members were attacked by the diseases. It must be emphasized that some respondents highlighted that they had a perception that some individuals have contracted the diseases but have not been diagnosed because they have not visited any health facility for examinations. By implication, a larger number might be suffering from such diseases and therefore require regular visits to health facilities for monitoring however, such individuals do not access any healthcare services due to lack of health facilities in their area and the long distances required to cover in other to access such services.

Snake bite was identified as one of the major causes of mortality in the sampled communities. Some key informants such as the Assemblyman, unit committee leaders and the chiefs indicated that about 10 people had died by from January to June, 2014 as a result of snake bites. During the focus group discussion, about 74 percent of participants pointed out that snake bites are among the major health issues in their area as many people die due to lack of health facility to respond to such emergencies, poor transport systems and the inability of individuals to afford the healthcare cost. Although about 63 percent of the population were registered with insurance, access to healthcare has been poor and respondents indicated that they will not register again. Their reason was that due the unavailability of health facilities, registered beneficiaries of the National Health Insurance Scheme (NHIS) do not access health facilities except in emergency situations which in their context is mainly snake bites which is not covered by the NHIS.

Attitude towards Expanded Programme on Immunization (EPI)

EPI is employed to work against the six diseases namely Tuberculosis, Poliomyelitis, Diphtheria, Whooping cough, Neonatal Tetanus and Measles. 86 percent reported that the EPI health workers have visited their villages and have vaccinated their children against the six deadly diseases. However, parents do not take their children to the health facilities for other primary healthcare services due to long distances and long waiting time as there is so much pressure on the health facility in the district capital. Only 13 percent indicated that they visit the Primary Healthcare Unit (PHC) regularly. This might have effects on the growth of their children and sometimes results in deformity and forfeiture of children.

Coping Strategies:

- ***Saving for Delivery/Birth***

Access to healthcare is very important especially for birth. In the midst of the serious challenges of accessing healthcare, the rural people save some money for birthing as a coping strategy. About 70 percent of households indicate that their way of coping with the situation is to keep some money with friends and relatives when their wives get pregnant to ensure that they get money for transport and other healthcare expenditure required.

On the average, an amount of (GH₵400.00≈US$131.90)is saved. Although this approach has been helpful, it had a major weaknesses; unreliability of the individuals who keep the money as some of them spend the money and when it was required, such individuals could not provide. As a result, inhabitants prefer to save with financial institutions however, these are not available in the rural areas and the problem would exist during emergencies.

- **Staying with Relatives in the District Capital**

Another major strategy adopted by these rural dwellers is to take their pregnant wives to the district capital to stay with their relatives. This is usually done when the pregnancy is over 6 months old. This gives them the opportunity to access any health facility as the physical accessibility has been improved due to proximity to the health facilities. The weakness with this strategy is that for those (some 57 percent of respondents) who do not have relatives in the district capital, they cannot employ such a strategy. However, some members of a FGD indicated that though they do not have relatives in the district capital, they employed the strategy because they had rented rooms in the district capital. It must also be noted that renting is an extra cost to the expenditure of the households and not all households could afford such services. The average annual rent for a single room was (GH₵240.00≈US$79.14)in which 73 percent of respondents were not willing to pay due to low income levels (Researchers' Field Survey, 2014).

RECOMMENDATIONS

- **Provide health facility**

In the short to medium term, the District Assembly, community leaders and other Non-Governmental Organizations should provide the communities with a health post, CHPS Compound or community clinic which is expected to be located in the Kajai community to serve the surrounding communities as it is the central community. An ambulance should be provided to these communities to help carry clients to the hospitals and other higher level health facilities in the district capital when the need arises. Also, motorcycles retrofitted with sidecars to take residents to clinics in the district capital.

- **Capacity Building**

The district authorities and other stakeholders should also build the capacity of the TBAs through constant training and the supply of required equipment to help them carry out their roles as expected.

- **Intensify Community Health Education**

Also, the District Health Directorate should ensure that health education is intensified in these rural areas to help change the perceptions and negative attitudes of these people towards

family planning and the Expanded Programme on Immunization. Education can be done at least once in every month.

- **Improve road Conditions**

Efforts should be made to improve the road conditions especially the Abease-Zabrama road as this is the major access routefor the surrounding communities. Although some efforts have been made in this direction, some pot holes exist and community efforts will be required to completely resolve such a problem.

- **Communication Services**

In the long term, the District Authorities and other stakeholders are expected to collaborate with the private sector (Network Service Providers such as Vodafone, MTN, among others) to provide better network services to such communities to improve the communication services.

CONCLUSION

Access to health facilities and services is prudent to ensuring high living standards among the population hence, irrespective of one's geographical and socio-economic circumstances, access to health must be a basic service. However, the situation has been poor in the Ghanaian context, particularly for the rural dwellers.

The study found that the factors inhibiting access to health facilities and services by the rural populace are multidimensional and somewhat related ranging from physical accessibility problems, low income levels, low technological issues, high illiteracy, among other factors. The effects of the situation are numerous including complications during birthing, increased infant and maternal mortality, teenage pregnancies and high rate of social vices. If the situation persists, the realization of the MDGs particularly MDGs 1, 4, 5 and 6 will be far from reach hence requiring urgent intervention by all stakeholders to attack the situation holistically.

REFERENCES

Adam W., et al (2004). Child Health: Reaching the Poor.America Journal of Public Health.2004 May; 94(5): 726–736.

GSS (2012).2010 Population and Housing Census.Ghana Statistical Service. Accra, Ghana.

Lu N., Samuels M. E., Kletke P. R., &Whitler E. T. (2010).Rural-Urban Differences in Health Insurance Coverage and Patterns among Working-Age Adults in Kentucky. Journal of Rural Health, 26: 129 – 138.

Ministry of Health of the Republic of Ghana.(1979).Primary Health CareStrategy.Ministry of Health. Accra, Ghana.

Ministry of Health of the Republic of Ghana.(1998).A profile of healthinequities in Ghana.Ministry of Health. Accra, Ghana.

Nyonator, F.K., et al (2005). The Ghana Community-based Health Planning and Services Initiative for scaling up service delivery innovation. Health Policy and Planning; 20 (1): 25–34. Oxford University Press.

Pru District Assembly (2010).Medium Term Development Plan (2010-2013) under Ghana Share Growth and Development Agenda, District Planning Coordinating Unit.Yeji, Ghana.

United Nations (2009).Monitoring Global Population Trends.

http://www.un.org/en/development/desa/population/publications/urbanization/urban-rural.shtml Accessed 18/05/2014.

United Nations, Department of Economic and Social Affairs, Population Division (2007). World Population Prospects: The 2006 Revision. CD-ROM Edition - Extended Dataset in Excel and ASCII formats (United Nations publications, ST/ESA/ SER.A/266).

United Nations (2013). The Millennium Development Goals Report: 2013. United Nations, New York.

WHO (2013).Country Cooperation Strategy at a Glance. Available at http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_gha_en.pdf