

Augsburg University

Idun

Theses and Graduate Projects

2022

What Are Barriers and Contributing Factors Limiting Healthcare Access in Southern Africa?

Ron Chitekwe

Follow this and additional works at: <https://idun.augsburg.edu/etd>

What Are Barriers and Contributing Factors Limiting Healthcare Access in Southern Africa?

By:

Ron Chitekwe, PA-S

Masters Advisor: Kristen Lindvall, PA-C

Paper Submitted in Partial Fulfillment
of the Requirements for the Degree of
Master of Science in Physician Assistant Studies

Augsburg University

07/25/2022

Table of Contents

Abstract.....	3
Introduction.....	4-6
Methods.....	6
Review of the Literature.....	6-18
Discussion.....	19-21
Conclusions.....	22-23
References.....	24-25

Abstract:

Introduction: Equitable access to timely and basic health care is an intrinsic component of overall equity in health and lack of it may be both an indicator and “contributory cause” of a population’s health inequalities, especially in developing countries.¹ Therefore it is important to find the root causes that are causing the barriers and those contributing to people not being able to access healthcare when they need it and in a timely manner.

Purpose: The purpose of the study is to review barriers and contributing factors that are limiting access to healthcare in Southern Africa.

Methods: A comprehensive literature review was conducted using MEDLINE, Google Scholar, PubMed, and the Lindell Library using the search terms healthcare access in southern Africa/Africa, barriers to healthcare in Southern Africa/Africa. Inclusion criteria were studies from 2015 to present and exclusion criteria were studies that were older than 2015.

Conclusions: In Southern Africa, socioeconomic factors, stigma, disabilities and transport, all pose barriers to timely access of healthcare.

Key Words: Southern Africa, barriers, socioeconomic, transport, disabilities, stigma. What are Barriers and Contributing Factors Limiting Healthcare Access in Southern Africa?

.

Introduction:

Access to care sets the baseline for all patient encounters within the healthcare industry. Despite its importance, healthcare access is not a reality for most individuals in many parts of the world. This is especially true for low-income countries such as those in Southern Africa.

Equity in healthcare requires that all individuals and groups have access to health services of excellent quality, and that services are provided according to individual needs. However, there is an increasing awareness that marginalized and vulnerable groups may face problems in accessing healthcare. The purpose of this research paper is to identify the barriers and contributing factors facing people living in Southern Africa and review interventions that will be helpful to improve access to healthcare there.

There are many barriers that contribute to low healthcare access, it usually comes to cost, those who can pay are able to access healthcare services at a higher rate than those who cannot afford it. This is true especially in many developing countries where, unlike in the Western world, they face additional barriers beyond the cost of healthcare. In addition to the barriers, contributing factors, and the required interventions needed to improve healthcare access in Southern Africa, I will compare those interventions to other parts of Africa. It is also important to try to understand what kind of interventions were done in the whole African continent and the main reasons those interventions worked and what kind of lessons we can learn from those when we are trying to come up with interventions for Southern Africa, specifically.

Equitable access to timely and basic health care is an intrinsic component of overall equity in health and lack of it may be both an indicator and “contributory cause” of a population’s health inequalities.¹ People should be able to seek care when they need it, they should be able to reach clinics or hospitals, they should be able to engage with their providers,

they should be able to trust they will receive the best care possible and be able to afford the care they need regardless of financial situation.

Southern Africa is comprised of ten countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe.² Southern Africa has vast mineral resources and comprises as one of the wealthiest regions in Africa, yet it is also one of the worst and poorer regions in relationship to the vast mineral stores it has. Even though there have been some improvements in the economies of these countries, the number of people living in poverty has continued to increase, leading to high numbers of income inequality over the last three decades. Income inequality, bad leadership, corruption, and in some cases, economic policies that aim to keep many African countries donor reliant by western countries have contributed greatly to poor economic outcomes in Africa, especially in Southern Africa. Poor economies have led to poor healthcare systems in these countries, except for South Africa which has a decent health care system as compared to the other countries in the southern hemisphere. Despite having a higher functioning healthcare system as compared to the other Southern African countries, many people in South Africa are still not able to access healthcare because of cost, distance to hospitals, low numbers of providers and facilities, and availability of basic healthcare supplies such as medicine, wound care tools, diagnostic equipment, such as MRI, CT scan, and x-ray machines. In Southern Africa, the majority of the population lives in low-income rural settings or in the outskirts slums of major cities, such as Johannesburg, Maputo, and Lilongwe with those living with poor and low income are exacerbated by restricted healthcare access.

Most of the studies reviewed were from South Africa and Malawi, with South Africa being the richest country in Southern Africa and Malawi being the poorest and these were

applied to review the barriers Southern Africa is currently facing when it comes to healthcare. Studies from Zimbabwe, Zambia, and Angola were also reviewed to try and paint a holistic picture as to what the healthcare system is like in Southern Africa.

Methods:

Research was conducted using the following search engines, MEDLINE, PubMed, Google Scholar, and Lindell Library source database, to identify studies for barriers and contributing factors to limiting healthcare access. Studies that included details of intervention conducted were compared to others focused on the rest of the African continent. Results were limited to direct studies and those only in the English language that have been published the last five to seven years. The search options only included published articles that consisted of randomized control trials, clinical trials, observational studies, meta-analyses.

Review of the Literature:

Socio-economic Factors:

Socioeconomic factors play an important role in our daily lives, it determines where we live, our life expectancy, access to food, access to medicine, and most important of all, whether we have access to healthcare. In some Southern African countries they have free government hospitals where the original goal was to provide free healthcare to those who cannot afford it, but due to lack of financial investment and resources, these hospitals have become nothing but a shell of their former and no more than a good feeling for those going to these hospitals to feel like they are at least doing something as they cannot even get the basic healthcare treatment and in most cases, they lack medicine and equipment for treatment.

The Southern African region appears to be the epicenter of the HIV epidemic, accounting for 54.5% of the 38 million people living with HIV (PLHIV), 43.0% of all new HIV infections

and 43.0% of all AIDS-related deaths worldwide.³ These are considered very high numbers when compared to other countries in the Africa and considering the population of southern countries as compared to the rest of Africa. Nine of the ten countries with the highest prevalence rates of HIV worldwide are located in this region in descending order: Eswatini (Swaziland), Lesotho, Botswana, South Africa, Zimbabwe, Mozambique, Namibia, Zambia and Malawi, with prevalence rates ranging from 27.0% to 8.9%.³

In the study by Ekholuenetale et al., the association between socio-economic factors and HIV self-testing knowledge amongst South African women is reviewed. The average educational level of women, household wealth, and residential and employment status were selected as the socio-economic factors in this study.³ HIV self-testing (HIVST) is considered to be one of the most important factors in the fight against HIV in the region, it has the potential to complement traditional HIV counseling and testing and to reach hard to access populations in the rural areas or those afraid to come forward because they are scared of the stigma associated with HIV counseling and testing. The study found that women with tertiary education were 3.93 times more likely to have HIVST knowledge when compared with those with no formal education.³ In another study by Faturiyele et al. that reviewed access to HIV care and treatment for migrants between Lesotho and South Africa, socioeconomic factors played an important role for the migrants to access their Antiretroviral Treatment (ART) medications, with a considerable amount of people stopped taking the medication. The study used a cross-sectional survey design to assess needs, preferences and barriers to HIV care and treatment among HIV-infected migrants from fifteen facilities in Lesotho.⁴ HIV treatment requires strict adherence to prevent drug resistance and treatment failure. However, migrants often default in their treatment, due to factors such as legal and administrative issues limiting access to treatment for foreign nationals,

language and cultural barriers, failure to afford transport costs to collect medications, discrimination from healthcare providers in foreign countries, and the lack of protocols that allow continuity of HIV care across borders of neighboring countries.⁴ Out of the 517 HIV-infected migrants for which defaulting status was known, 126 (24.4%) had defaulted on their treatment, the barriers to getting ART while in South Africa ranged from failing to get to Lesotho, not affording transport costs, not knowing where to get treatment, not being legally registered in South Africa, Antiretrovirals (ARV) regimen not being available at facility, and being discriminated against by healthcare providers because they were foreigners.⁴ All these plays a role in socioeconomic barriers to accessing healthcare when treatment is needed.

In the study conducted by Caviglia et. al., the role of the newly developed national emergency medical service that was established to improve healthcare access in Sierra Leone was reviewed. To tackle the high rates of maternal and neonatal mortality reported in its territory, in 2010, the Sierra Leone government launched the Free Health Care Initiative (FHCI), which waived all medical-related fees for pregnant and breastfeeding women, children under the age of 5 years, and Ebola survivors.⁵ Although the FHCI was effective in curbing financial barriers to accessing care, leading to an overall improvement in the utilization rates of healthcare services, wealth-related health inequalities remained prevalent, and people residing in rural areas, accounting for 59% of the total population, were still left underserved.⁵

Pedro et al. reviewed prevalence, awareness, treatment, and control of hypertension, diabetes, and hypercholesterolemia among adults in Angola and found that although, despite being a growing economy, Angola's primary health system may not be currently able to provide an adequate answer to the changing health needs of its population.⁶ In a comparison, Makaula et al, found that Community-Directed Interventions (CDI) is a participatory approach for delivery

of essential healthcare services at community level and since most health systems in Sub-Saharan Africa are weak and lack mechanisms of delivering essential health services to those who are most in need, community participation increases service delivery and enhance sustainability.⁷ In a different study, Chimatilo et al found that social-economic factors have an effect on the time for starting antenatal care (ANC) as many of women don't start ANC early because they are waiting for new clothes, this is so due to poor socio-economic status of most families in the area.⁸ Some women preferred going for business rather than starting ANC when they had less than 5 months pregnancy in order to provide for their families.⁸ This was also reported in other studies done in South Africa and Nigeria where women were reported to start ANC late because they needed to find money for transport and new clothes.⁸

Transportation:

Inadequate road infrastructure, finances, ambulance services and expensive private transport all play a role as transportation barriers to access a health facility. This is in line with findings from a Malawian study by Abihiro et al. that people from rural areas spend more time traveling than those in urban regions, and that lack of transport, inadequate financial resources and poor road conditions limit the possibilities of people in rural communities to access health facilities.⁹ Other reviews on the barriers to surgical health care encountered by patients in rural sub-Saharan Africa have identified cultural, structural, and financial constraints as barriers and concluded that patient and community education and transport needs should be made available.⁹ Punchak et al. reported on the inadequacy of neurosurgical service in sub-Saharan Africa. The average percentage of the population with access to neurosurgery within a two-hour window was shown to be 25.26% in sub-Saharan Africa, while it was 93.3% in Eastern Europe and Central Asia.¹⁰ This was attributed to low numbers of neurosurgery providers, equipment challenges and

unreliable access to transportation to neurosurgical centers in low- and middle-income countries, including the sub-Saharan region.¹¹ In general, district hospitals provide less surgical care than central hospitals. Galukande et al. reported relatively low rates of major surgery at district hospitals in Eastern Africa, ranging from 50 to 450 surgical procedures per 100,000 population.¹¹ More than 95% of the population in South Asia and Central, Eastern and Western sub-Saharan Africa do not have access to surgical care, whereas less than 5% of the population in Australia, high-income America and Western Europe lack access.¹¹ This demonstrates the unmet surgical need and confirms the barriers to access to essential surgery in rural districts in sub-Saharan Africa.¹¹ 50% of the Malawian population live within five kilometers from their health center, a walkable distance for a healthy person, though not necessarily for someone seeking health care.¹¹ Accordingly, it is surprising that only 1.8% of the respondents stated that travel on foot was the main way for their household members to go to a primary health facility, reflecting mostly the use of bicycles and Oxcarts for traveling short distances.¹¹ Secondary level and tertiary level health facilities, however, are often far from people's homes.¹¹ District hospitals support health centers with ambulance services to ferry sick people from the health center to the district hospital, and on to the tertiary central hospitals if needed.¹¹ This hospital ambulance transport support system usually gives priority to maternity patients, especially urgent obstetric complications. Each district hospital has a minimum of fifteen health centers to support within its catchment area and may have only two or three ambulances.¹¹ Unfortunately, these may also be off the road due to lack of fuel or vehicle spare parts, and they often fail to go to health centers to fetch patients and eventually, communities must find alternative transportation from home to the health center, and from the health center to a district hospital.¹¹ Elderly people may carry children on their back over considerable distances just to seek surgical health care. Sometimes

when they get to a health center, they are informed that the facility does not have resources for surgical treatment e.g. sutures for closing wounds or plaster of Paris (POP) for treating fractures, hence they have to wait for an ambulance coming for obstetric emergency patient to come and collect them together to go to the district hospital.¹¹ Otherwise, they should be prepared to find and pay for alternative means of transportation to travel to the district hospital.¹¹ This time-consuming activity contributes to the delay in presentation to health facilities as another barrier.¹¹ Central hospitals offer tertiary surgical services for emergency and elective conditions but are located in the big cities far from most rural areas.¹¹ These central hospitals serve as both secondary and tertiary level facilities due to inadequate surgical services at the secondary level.¹¹ Sometimes resources are so limited that health service seekers must bypass the district hospitals and travel directly to the central hospital in order to be assisted accordingly.¹¹ When patients get to a district hospital, they get referred to a central hospital, and usually the mode of transport is by public hospital ambulance which sometimes delays time of travel because they have to wait to fill it up with more patients, hence posing as another barrier.¹¹

Caviglia et al, found that similar to most of the other African countries, Sierra Leone has been long devoid of any formalized prehospital care system and since the limited number of ambulances available in the country were associated with high transport-related fees, the majority of patients used to reach hospital facilities either using private vehicles or public services, therefore bearing the costs of transport fare and often being subjected to delays in care.⁵ A government-backed joint venture comprising Doctors with Africa (CUAMM, Padua, Italy), the Regional Government of Veneto (Italy), the Research Center in Emergency and Disaster Medicine (CRIMEDIM, Università del Piemonte Orientale, Italy), and the Sierra Leone Ministry of Health and Sanitation (MOHS), designed the first National Emergency Medical Service

(NEMS) in Sierra Leone, one of the very few coordinated, structured, and fully equipped prehospital emergency medical services (EMS) in the African continent.⁵ The goal of this newly developed entity is to provide a free-of-charge prehospital service coordinated by a centralized operation center (OC), using part of the ambulances donated to the country during the Ebola outbreak.⁵ NEMS in Sierra Leone was associated with an overall increase in access to hospitals and the rise in hospital admissions was observed not only among individuals with free access to healthcare services, but also among those not exempted from payment, suggesting that prior to NEMS inception, geographical and transportation barriers played an important role in limiting the access to the country's healthcare services, irrespective of the possible financial constraints of subjects.⁵

Disabilities:

An array of diverse barriers, occurring at various points along the pathways to care, restricts health care accessibility for many individuals and groups globally. Especially disproportionate though, is the extent and impact of the barriers encountered by the world's largest minority group: people with disabilities.¹ This research addresses three disabilities that plays an important role in limiting access to healthcare in Southern Africa, they are physical, hearing/speech, and mental disability.

Harrison et al reviews the access to health care for people with disabilities in Malawi and the kind of barriers they face to access healthcare. The study identified three main barriers the population in Malawi face to timely and adequate healthcare access, those were: 1) Cost of transport, drugs and services, 2) Insufficient health care resources, and 3) dependence on others¹ Malawi being a poor country, with the majority of the population living in poverty, the health system is significantly limited in its number of facilities, provision of drugs, medical personnel

and amount of funding. Given that 85% of the country's population live in rural communities, the impact of this on the accessibility of health care, for many, is further restricted by lack of physical infrastructure and financial means.¹ Among those living rurally, people with disabilities are especially vulnerable to health care access barriers.¹

In another study by Wilbur et al. that was conducted in Thyolo District, a poor rural district of Southern Malawi, with a population of approximately 500,000,¹² discovered key barriers to accessing healthcare included fear and uncertainty about the referral hospital, procedural problems within the camps leading to lack of understanding about the referral, distance to the hospital, low awareness and understanding of hearing loss, and lack of and cost of transport. The study aimed to develop an intervention to improve uptake of referral for children with ear and hearing conditions in Thyolo, because previous evidence from other LMICs had shown poor uptake of referral for children with disabilities.¹² A review was conducted on improving access to health services for children in LMICs, in order to understand what works elsewhere.¹²

With consideration of costs, feasibility, acceptability, and sustainability, a consensus was reached to focus on interventions on those that address fear about the hospital, awareness and understanding about ear and hearing health, and information about the referral, provision of transportation was not considered to be a sustainable due to the high perceived long-term costs, despite transportation being a key barrier.¹² Based on the recommendation the following interventions were implemented: A photograph/pictorial information booklet providing information about the process of going to the hospital for ear and hearing services, counselors trained to deliver information booklet in camp settings, including one "expert" mother (i.e., mother of a child with ear and/or hearing issue who has attended QECH for referral previously)

who would provide peer support and a community health worker, and text message reminders for caregivers who had been referred to QECH.¹² The goal of the outcome of these proposed interventions were to reduce fear about hospitals, provide sufficient information about children referrals, and improve awareness and understanding about ear and hearing health.

People with severe mental disorders may experience specific barriers to accessing care, even when locally available, due to lack of autonomy, stigma, impoverishment, discrimination and disempowerment related to long-term illness.¹³ Hailemariam et al. reviews access to mental healthcare integrated in primary care for people with severe mental disorders in rural Ethiopia. The study found that contact coverage with a new service which integrated mental healthcare into primary care was high (81.3%) and equitable with respect to gender, physical and sensory impairment, and socio-economic status, but rural residents had lower odds of accessing the service.¹³ The most frequently endorsed barriers to attending primary healthcare (PHC) for mental healthcare were the belief that the condition would get better without intervention (44.6%), concerns about the cost of treatment (44.6%) and transport (37.0%), and believing no treatment was available.¹³ McKinney et al, found that lack of accessible transportation is a significant barrier in accessing healthcare services for people with disabilities in South Africa.¹⁴ Railway networks are not accessible to wheelchair users, no assistance is provided to assist disabled passengers in accessing and using trains, and disabled passengers feel vulnerable because of safety concerns.¹⁴ In addition, there are no telecoil (TTY) facilities available for passengers using hearing aids, and many stations have poor signage and unclear loudspeaker systems.¹⁴

Intellectual disability (ID) is more common in low- and middle-income countries than in wealthier countries, largely because of the association of ID with the consequences of poverty,

including malnutrition, increased exposure to toxins and higher rates of interpersonal violence.¹⁵ Parents of children with ID in these countries face the additional challenge of a relative lack of services, with services, where they do exist, tending to be clustered in urban centers.¹⁵ In the study by Mkabile et al. it found that, the main service parents accessed was the outpatient specialized ID services (IDS) at the hospital and despite the proximity of Khayelitsha to IDS, getting to the service presented major challenges.¹⁵ The hospital itself, in keeping with all other hospitals in the area, does not provide transport, nor, despite its being a free service for those who cannot afford to pay, does it provide financial support for transport for impoverished services users.¹⁵ The access issues faced by people trying to use the hospital services may at times be exacerbated by the behavior of the child with ID or where transport is available, it is expensive for these impoverished parents.¹⁵

In a different study by Chauke et al. the study found, caring challenges experienced by the parents of adolescents with intellectual disability were coupled with a lack of resources.¹⁶ Participants faced the challenge of a lack of physical resources to support their adolescent with intellectual disability and some of the adolescents needed accessories such as wheelchairs that parents could not afford, so they ended up carrying the adolescent on their backs or in their arms, which could be heavy for them and strained their body.¹⁶

Stigma:

Stigma associated with certain diseases or conditions prevents people from seeking care. Mental health literacy is an important component of health literacy and is essential for improving access to mental health care and reducing stigma related to mental illness.¹⁷ These challenges are significant barriers to accessing mental health care for depression, soon to be the largest single contributor to the global burden of disease.¹⁷

Addressing depression in young people is a health-care policy need in Southern Africa. There exists poor mental health literacy, high levels of stigma, and weak capacity at the community level to address this health-care need.¹⁷ These challenges are significant barriers to accessing mental health care for depression, soon to be the largest single contributor to the global burden of disease.¹⁷

The study by Kutcher et al. applies a horizontal integrated approach to address the issue of youth depression in Malawi and Tanzania, which was designed to be applied in low settings. The study describes an innovative approach that addresses these issues simultaneously while concurrently strengthening key mental health components in existing education and health-care systems as successfully applied in Malawi and replicated in Tanzania.¹⁷ With the use of interactive, youth-informed weekly radio programs, mental health curriculum training for teachers and peer educators in secondary schools, and a clinical competency training program for community-based health workers, the innovation created a “hub and spoke” model for improving mental health care for young people.¹⁷ The interventions that were applied were able to produce positive results that can be used for policy implementations. A further set of challenges will be related to the need for Ministries of Health and Education to collaborate in the application of this innovation—at both policy and implementation levels.¹⁷

In the study by Hunt et al., it details the difficulty and stigma LGBTI and sex workers experience in Zimbabwe to access healthcare services they desperately need. Three distinct main themes emerged from the data: Illnesses have been caused by ‘bad behavior’ and deserve blame, discouraging key populations from seeking health support, equal access to healthcare is conditional on conforming to sexual norms receive the same access to health and palliative care services as the health workers resulted in experiences of poor support and provision of care

during chronic illness, significantly increasing morbidity and mortality, and perceptions that healthcare workers were ill-informed about needs of key populations, and personal attitudes impacted on their care delivery.¹⁸ The study was helpful to support and show how stigma of sex workers and LGTBI community is part of the barrier and contributing factor limiting access to health care. In another study that was conducted Folayan et al. that reviewed the barriers and challenges to HIV preexposure prophylaxis access by men who have sex with men and female sex workers in Nigeria. Qualitative and quantitative data were collected through a cross-sectional study and the study found that barriers to receiving preexposure prophylaxis were stigma and discrimination.¹⁹ One of the reasons proffered was that use of an antiretrovirals implies being HIV infected.¹⁹ This misconception may result from poor public awareness that antiretrovirals are now being used for the prevention of HIV infection as well as for treatment of infection and second, stigma and discrimination could result from drugs used for PrEP being labeled as drugs “for use by people with high HIV sexual risk behaviors.”¹⁹

In a different study from Abousi et al. that was conducted in Ghana that mainly focused on providing evidence-based information for planning adolescent healthcare interventions. In their quest to improve access to and use of adolescent health services, Ghana Health Services in collaboration with the Ministry of Health Ghana integrated adolescent health services into primary health care.²⁰ Despite the government efforts adolescent’s ability to access healthcare has slightly improved and utilization of healthcare access remains low. Both the grey literature and anecdotal evidence show that unplanned pregnancies leading to school drop-out, childbirth complications and illegal abortions remains high among adolescents in Ghana.²⁰ The increase was mainly due to lack or shortage of basic medical supplies, inconvenient operating hours, long patient wait times, negative perceptions, provider-level barriers, fear, lack of information, and

the main one was lack financial information.²⁰ All these combined made the intervention by the government not work. This study provides useful information for health policymakers and practitioners, especially those whose remit includes adolescent health.²⁰

In contrast to the above, a study by Hayes et al reports, “A universal testing and treatment intervention to improve HIV control: one-year results from intervention communities in Zambia in the HPTN 071 (PopART) cluster-randomized trial”, that reviewed interventions that increased access to HIV testing²¹. Epidemiological and modeling studies have shown that universal testing and treatment (UTT) for HIV, whereby everyone in the community should know their HIV status and all HIV-infected individuals should be offered immediate antiretroviral therapy (ART), may steeply reduce the incidence of new HIV infections in generalized epidemics in sub-Saharan Africa.¹⁰ Uptake of HIV testing with the lay health workers was high, and we found that after one year, an estimated 78% of men and 87% women who were HIV-positive knew their HIV status.²¹ Among known HIV-positive adults, around 73% were on ART by the end of the annual round and an estimated overall proportion of HIV-positive adults on ART, irrespective of whether they knew their status, increased from 44% to 61% following the intervention.²¹

Socioeconomic factors, transportation, disabilities, and stigma all pose as barriers that are limiting a majority of people in Southern Africa from accessing necessary health care. As the rate of poverty is increasing especially for those in the rural areas, this poses a threat on mortality rates. If people are not able to access healthcare, a basic need, because of these barriers then this poses as an infringement of their human rights. Patients should be able to access healthcare regardless of what role they play in society, their social class, where they stay, or what they identify as.

Discussion:

This paper investigated the barriers and contributing factors that limit healthcare access to people in Southern Africa, and some of the interventions that has been done and whether those interventions have worked or not. Current research identified socioeconomic, transportation, disabilities, and stigma as the main barriers to limiting healthcare access to people in developing countries and the study included in this paper had the common objective to find whether this was indeed supported by research.

Socioeconomic is the most significant barrier to healthcare. Apart from the cost of healthcare, it covers a wider area than the research covered from poverty, individual/household wealth, employment, and education. Due to poor economies, most Southern African countries do not have a well-functioning and reliable public healthcare system. Even with increasing awareness of the barriers socioeconomic factors play in healthcare, poor socioeconomic conditions are associated with overall poor treatment outcomes and increased risk of not getting or accessing care. There are also concerns raised about access to PrEP to reduce the number of people being infected by HIV, but the cost is a significant barrier for the population in Africa to access PrEP as it is too expensive or not readily available. Kenya and South Africa are the only African countries that support access to PrEP by communities at risk for HIV infection, which they do through donor-funded projects. More efforts are needed to provide the drug at a cheaper cost to developing countries, where the number of HIV infections are higher.

Countries' infrastructures play a crucial role as well, and lack of healthcare facilities in rural areas with people traveling long distances to urban areas to find care. In Southern Africa where you live matters and rural people are more likely to be underserved with healthcare services and to experience barriers in access to health information.³ Giving people access to

transportation resulted in overall increase of people being able to access clinics and hospitals, the increase was observed in almost all populations, including those who did not get free access to healthcare or transportation. Moreover, the observation that underserved rural communities benefited the most from the activation of the free ambulance service in terms of ability to reach hospital care suggests that NEMS was effective in reducing health inequalities between urban and rural areas in Sierra Leone.³ A relevant aspect that arose from the implementation of NEMS in Sierra Leone was the importance of developing a robust and reliable patient referral network, featuring an efficient communication network and well-defined standard operating procedures.³ These results show that poor economic conditions is not simply about the cost or ability to pay for healthcare treatment, but other financial factors as well that limit access to healthcare.

The research also was able to show how cultural stigma plays a major role in limiting access to healthcare, resulting in people who need care the most not being able to access it because of what people might say or what the community might think of them. For example, the use of contraceptives among teens or adolescents is more controversial in many African countries and culture, as a result it limits adolescents being able to access contraceptives. Adolescents are mostly not independent, and therefore may require the approval or consent of their guardians or parents before they can access health services and studies have confirmed disapproval by parents and community members as a barrier to adolescents' access to reproductive health services.²⁰ When it comes to antenatal care, cultural practices can play an important role in when women can start taking it. The study established that that some women do not start ANC early as they wait for marriage counselors or their mother in-laws to come and give them advice especially if it is the first pregnancy and this leads to the pregnancy being kept secret until it reaches 3 to 4 months,⁸ and at this point it is a late to start prenatal care.

The research shows how hard it is for people with physical disabilities to have access to healthcare, this can be due to lack facilities, lack of transportation, dependence on others, discrimination, and insufficient health care resources. As hard as it is in developed countries, it can be almost impossible in developing countries. These challenges are compounded in low- and middle-income countries (LMICs) where factors such as poverty, poverty-related diseases, inefficient healthcare systems, training and equipment, inaccessible transportation systems, corruption, political instability, and negative attitudes towards disability occur.¹⁴ Despite the substantial prevalence of mental and neurological disorders in most low and middle-income countries (LMICs), mental health services remain numerically limited, geographically centralized and structurally hospital-based. Sometimes even though there may be facilities available locally, people with disabilities might have limited access due to discrimination, stigma, and poverty.

To decrease these barriers that limit healthcare access, important steps need to be taken. Transport should be made accommodative to the communities that are not within reach. With the appropriate funding towards roads, communities should have local clinics that can help eradicate transport as a barrier to access to healthcare. Healthcare workers should be ethically responsible to provide access to health care regardless of who they are, their sexual orientation, status in society. Eradication of socioeconomic barriers by increasing healthcare funding in both urban and rural areas, so people can access healthcare without worrying about cost. Increase in health education, so people are able to understand the care and treatment they are receiving, and it also helps to reduce stigma associated with certain diseases, conditions, and sexual orientation.

Conclusion:

The current data demonstrates that healthcare, a basic human necessity and right, has proved to be a privilege in most parts of Southern Africa. In Southern Africa, socioeconomic factors, stigma, disabilities and transport, all pose barriers to timely access of healthcare. Improving the availability of free transport for patients between rural health centers and district hospitals, and between the district and central hospitals, could help overcome some of the most pronounced barriers to health care experienced by people in rural Southern Africa. Governments should have strategic implementation plans and funding towards health care facilities within their reach.

By oath, healthcare workers in Southern Africa should be able to provide the necessary care to all patients without stigmatizing them. Frequently, health care workers have biases towards patients, especially if they are part of the LGBTQI community, are HIV positive, or sex workers to name a few. Resolving these biases can be done through collaborative learning between the Ministry of Justice and the Ministry of Health where healthcare workers will be taught about the biases they may bare. Through this, a workplace educational intervention can be set up focused on developing sustainable leadership and work team practices designed to support team relational capacity and compassionate health care delivery.

Governments, through their respective Ministries of Health and Ministry of Transport, should be held accountable for the lack of access of healthcare facilities. They should introduce sustainable interventions and health care audit tools with feedback systems which are able to identify and improve patient accessibility to health care. Road networks should be a priority in rural areas so that it eases the time taken to travel to health facilities. Health care facilities should also have ample ambulance and emergency transportation services within their. In communities

which are hard to reach and are too far from main hospitals, the Ministry of Health should build secondary or waiting health care facilities that are equipped with medical personal who will be able to diagnose any sickness before referring the patients to the district hospitals.

References

1. Harrison, J.A.K., Thomson, R., Banda, H.T. *et al.* Access to health care for people with disabilities in rural Malawi: what are the barriers?. *BMC Public Health* **20**, 833 (2020). <https://doi.org/10.1186/s12889-020-08691-9>
2. Marks, Shula E.. "Southern Africa". Encyclopedia Britannica, 30 Sep. 2020, <https://www.britannica.com/place/Southern-Africa>. Accessed 20 July 2022.
3. Ekholuenetale M, Nzopotam CI, Okonji OC. Association between socio-economic factors and HIV self-testing knowledge amongst South African women. *South Afr J HIV Med.* 2022;23(1):1347. Published 2022 Mar 24. doi:10.4102/sajhivmed.v23i1.1347
4. Faturiyele, I., Karletsos, D., Ntene-Sealiete, K. *et al.* Access to HIV care and treatment for migrants between Lesotho and South Africa: a mixed methods study. *BMC Public Health* **18**, 668 (2018). <https://doi.org/10.1186/s12889-018-5594-3>
5. Caviglia M, Dell'Aringa M, Putoto G, et al. Improving Access to Healthcare in Sierra Leone: The Role of the Newly Developed National Emergency Medical Service. *Int J Environ Res Public Health.* 2021;18(18):9546. Published 2021 Sep 10. doi:10.3390/ijerph18189546
6. Pedro JM, Brito M, Barros H. Prevalence, awareness, treatment and control of hypertension, diabetes and hypercholesterolaemia among adults in Dande municipality, Angola. *Cardiovasc J Afr.* 2018;29(2):73-81. doi:10.5830/CVJA-2017-04
7. Makaula, P., Funsanani, M., Mamba, K.C. *et al.* Strengthening primary health care at district-level in Malawi - determining the coverage, costs and benefits of community-directed interventions. *BMC Health Serv Res* **19**, 509 (2019). <https://doi.org/10.1186/s12913-019-4341-5>
8. Chimatiro, C.S., Hajison, P., Chipeta, E. *et al.* Understanding barriers preventing pregnant women from starting antenatal clinic in the first trimester of pregnancy in Ntcheu District-Malawi. *Reprod Health* **15**, 158 (2018). <https://doi.org/10.1186/s12978-018-0605-5>
9. Abiuro, G.A., Mbera, G.B. & De Allegri, M. Gaps in universal health coverage in Malawi: A qualitative study in rural communities. *BMC Health Serv Res* **14**, 234 (2014). <https://doi.org/10.1186/1472-6963-14-234>
10. Punchak M, Mukhopadhyay S, Sachdev S, et al. Neurosurgical Care: Availability and Access in Low-Income and Middle-Income Countries. *World Neurosurg.* 2018;112:e240-e254. doi:10.1016/j.wneu.2018.01.029
11. Varela C, Young S, Mkandawire N, Groen RS, Banza L, Viste A. TRANSPORTATION BARRIERS TO ACCESS HEALTH CARE FOR SURGICAL CONDITIONS IN MALAWI a cross sectional nationwide household survey. *BMC Public Health.* 2019;19(1):264. Published 2019 Mar 5. doi:10.1186/s12889-019-6577-8
12. Wilbur J, Bright T, Mahon T, et al. Developing Behaviour Change Interventions for Improving Access to Health and Hygiene for People with Disabilities: Two Case Studies

- from Nepal and Malawi. *Int J Environ Res Public Health*. 2018;15(12):2746. Published 2018 Dec 5. doi:10.3390/ijerph15122746
13. Hailemariam, M., Fekadu, A., Medhin, G. *et al.* Equitable access to mental healthcare integrated in primary care for people with severe mental disorders in rural Ethiopia: a community-based cross-sectional study. *Int J Ment Health Syst* **13**, 78 (2019). <https://doi.org/10.1186/s13033-019-0332-5>
 14. McKinney EL, McKinney V, Swartz L. Access to healthcare for people with disabilities in South Africa: Bad at any time, worse during COVID-19?. *S Afr Fam Pract* (2004). 2021;63(1):e1-e5. Published 2021 Jul 19. doi:10.4102/safp.v63i1.5226
 15. Mkabile S, Swartz L. Putting cultural difference in its place: Barriers to access to health services for parents of children with intellectual disability in an urban African setting [published online ahead of print, 2021 Aug 31]. *Int J Soc Psychiatry*. 2021;207640211043150. doi:10.1177/00207640211043150
 16. Chauke T, Poggenpoel M, Myburgh CPH, Ntshingila N. Experiences of parents of an adolescent with intellectual disability in Giyani, Limpopo province, South Africa. *Health SA Gesondheid*. 2021;26. doi:10.4102/hsag.v26i0.1538
 17. Kutcher S, Perkins K, Gilberds H, et al. Creating Evidence-Based Youth Mental Health Policy in Sub-Saharan Africa: A Description of the Integrated Approach to Addressing the Issue of Youth Depression in Malawi and Tanzania. *Front Psychiatry*. 2019;10:542. Published 2019 Aug 28. doi:10.3389/fpsy.2019.00542
 18. Hunt J, Bristowe K, Chidyamatatare S, Harding R. 'They will be afraid to touch you': LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe-an in-depth qualitative study. *BMJ Glob Health*. 2017 Apr 13;2(2):e000168. doi: 10.1136/bmjgh-2016-000168. PMID: 28589012; PMCID: PMC5435254.
 19. Emmanuel, G., Folayan, M., Undelikwe, G. *et al.* Community perspectives on barriers and challenges to HIV pre-exposure prophylaxis access by men who have sex with men and female sex workers access in Nigeria. *BMC Public Health* **20**, 69 (2020). <https://doi.org/10.1186/s12889-020-8195-x>
 20. Abuosi, A.A. and Anaba, E.A. (2019), "Barriers on access to and use of adolescent health services in Ghana", *Journal of Health Research*, Vol. 33 No. 3, pp. 197-207. <https://doi.org/10.1108/JHR-10-2018-0119>
 21. Hayes R, Floyd S, Schaap A, et al. A universal testing and treatment intervention to improve HIV control: One-year results from intervention communities in Zambia in the HPTN 071 (PopART) cluster-randomised trial. *PLoS Med*. 2017;14(5):e1002292. Published 2017 May 2. doi:10.1371/journal.pmed.1002292



Augsburg University Institutional Repository Deposit Agreement

By depositing this Content ("Content") in the Augsburg University Institutional Repository known as Idun, I agree that I am solely responsible for any consequences of uploading this Content to Idun and making it publicly available, and I represent and warrant that:

- I am *either* the sole creator or the owner of the copyrights in the Content; or, without obtaining another's permission, I have the right to deposit the Content in an archive such as Idun.
- To the extent that any portions of the Content are not my own creation, they are used with the copyright holder's expressed permission or as permitted by law. Additionally, the Content does not infringe the copyrights or other intellectual property rights of another, nor does the Content violate any laws or another's right of privacy or publicity.
- The Content contains no restricted, private, confidential, or otherwise protected data or information that should not be publicly shared.

I understand that Augsburg University will do its best to provide perpetual access to my Content. To support these efforts, I grant the Board of Regents of Augsburg University, through its library, the following non-exclusive, perpetual, royalty free, worldwide rights and licenses:

- To access, reproduce, distribute and publicly display the Content, in whole or in part, to secure, preserve and make it publicly available
- To make derivative works based upon the Content in order to migrate to other media or formats, or to preserve its public access.

These terms do not transfer ownership of the copyright(s) in the Content. These terms only grant to Augsburg University the limited license outlined above.

Initial one:

I agree and I wish this Content to be Open Access.

I agree, but I wish to restrict access of this Content to the Augsburg University network.

Work (s) to be deposited

Title: What Are Barriers and Contributing Factors Limiting Health Access in Southern Africa?

Author(s) of Work(s): Ron C Chitekwel

Depositor's Name (Please Print): _____

Author's Signature:  Date: 8/5/2022

If the Deposit Agreement is executed by the Author's Representative, the Representative shall separately execute the Following representation.

I represent that I am authorized by the Author to execute this Deposit Agreement on the behalf of the Author.

Author's Representative Signature: _____ Date: _____