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Title

Access to healthcare facilities in remote rural and farming communities: challenges and options

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Abstract

Government of Zimbabwe policy proclaims that most health provision shall be free of charge in rural and farming communities. These free services include consultation, maternity, medicines among others. However, despite efforts to reach out to excluded communities with free and affordable healthcare systems, free medical service has only been on paper. On top of user fees still being charged, some health centres are charging a maintenance levy which may be paid as cash or in forms of materials like bricks. The most expensive 'charge' is inaccessibility of health care services by some rural and farming communities. Using interviews at 15 health centres from Zimbabwe's rural and farming communities, this research found out that the cost of travelling to health centres, sometimes with two or more other relatives; the cost of accommodation; the cost of food; and the cost of medicines make healthcare very expensive. Further to this, those who are referred from primary healthcare centres for secondary or tertiary healthcare face daunting challenges. Resultantly, they fail to access healthcare that is free to them because it becomes too expensive to access it. Based on these findings, this research recommends an enhanced free healthcare package which meets all the needs of disadvantaged patients from Zimbabwe's rural and farming communities.

Key words

health, remote, rural, farming community, Zimbabwe

Introduction

Health delivery is a crucial element that contributes significantly to human development. Thus, realising the importance of health care, the Government of Zimbabwe supports health for all its citizens. Cognisant of the fact that some of its citizens may be unable to meet the cost of health care, the government introduced policies to make health care available and affordable. Such policies also benefitted rural and farming communities which were provided with the infrastructure for health care among other health related services. Rising levels of health care has seen Zimbabwe being ranked one of the best in Africa in terms of health delivery. However, this trend waned during the last decade owing to a number of factors, among them economic collapse and sanctions imposed on the country. The broad objective of the study reported in this article was to explore reasons why people in rural and farming communities do not seek health care services in spite of these services being provided free of charge at public health institutions.

Health delivery in rural areas of Zimbabwe

Public health in rural Zimbabwe is coordinated by the Ministry of Health and Child Welfare (MHCW). At the grassroots level, the health system consists of village health workers who are part of the primary health care system. These workers work with a primary healthcare facility, normally a clinic run by a nurse in charge. At the clinic, a community health nurse working with an environment health technician coordinates community health efforts like awareness and surveillance (MHCW, 2010). Each clinic in Zimbabwe is expected to service 10 000 people within an 8km radius. However, this has not been achieved, some patients travel for more than 10km to get health care (MHCW, 2009). This situation has been made worse by the low numbers of village health workers and reduction in mobile clinics.

Each clinic reports to a District Hospital normally situated at a growth point. This is a referral centre at district level serving all clinics in the district. Each hospital is expected to cover 140 000 people. The district hospital refers patients to a provincial hospital which in turn refers to quaternary or national (sometimes referred to as central) hospitals. The provincial hospital is situated in the provincial capital, normally taking more than 4 hours of travelling on buses charging between $4 and $15 whilst national hospitals are found in Harare and Bulawayo and journey to these hospitals cost $10 on average. Journeys to national hospitals may take several hours, some close to a day. In rural areas, there are limited private health facilities normally situated at growth points. There are not normally accessible to rural people because of the costs involved. Alternative treatment in rural areas include faith based methods (praying, prophets and others), traditional based methods (exorcism, *n'anga*s, herbalists or others) and Chinese medicine (tiens, ceragem and others).

In the main, people in rural areas have poor access to health care because of a number of reasons. The basic reason is poverty. Poor people have several needs, and health care competes with the need to secure food, education and livelihoods (WHO, 2008; ZimStats, 2002). In this regard, the Government of Zimbabwe proclaims that health care services must be free of charge to poor people in Zimbabwe. This proclamation seeks to increase the number of rural people seeking health services. Free services include consultation, medication, specialist services where available, accommodation, counselling, tests, and home visits among others (MHCW, 2010).

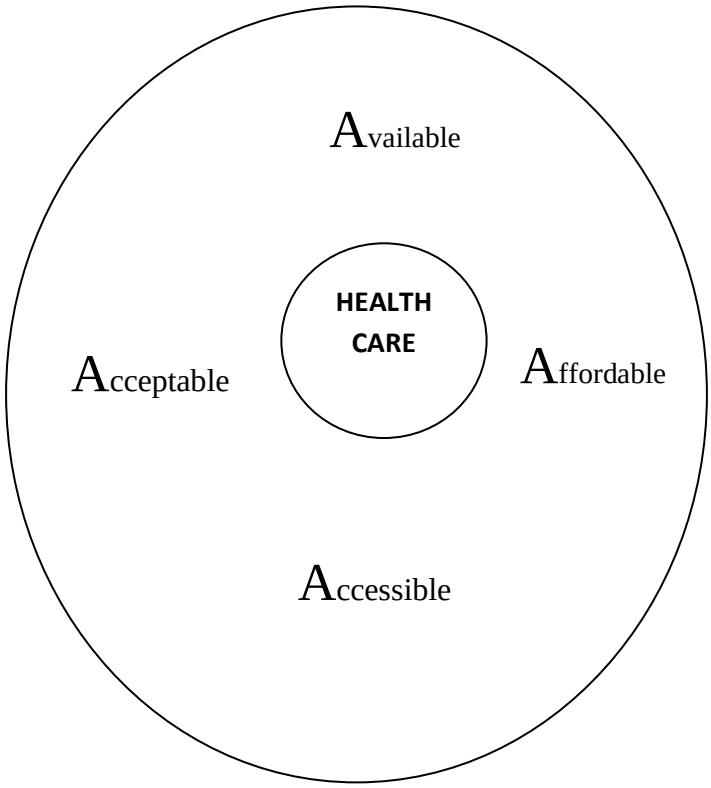
Other services provided by primary health care centres, according to MHCW are basic but comprehensive promotive, preventive, curative and rehabilitative care, concentrating on mother and child care including antenatal care, delivery of uncomplicated births, family planning, child health and nutrition, routine immunization for children and anti-tetanus immunization for child-bearing women, environmental sanitation, especially in relation to small-scale water supplies and excreta disposal systems, control of communicable diseases , other specified problems including mental illness, eye diseases and physical and mental handicap, and general curative care including oral health (MHCW, 2010).

However, besides being affordable, health care also has to be accessible, acceptable, appropriate and available (MHCW, 2008; WHO, 2008). Studies detailed here tended to focus on availability of healthcare services at the expense of other determinants. This study looked at neglected factors as they impact delivery of health services in rural areas. Such neglected factors may be better understood by looking at the Four A's Model that shows determinants of successful healthcare. The model is illustrated and described in the proceeding section.

Conceptual framework

This paper was informed by the Four A's Model of healthcare which was advanced by key stakeholders in heath, among them the World Health Organisation (2002). The Four A's Model is based on the assumption that success of health delivery strategies and innovations is determined by its acceptability, affordability, availability and accessibility.

Figure 1: Four A's Model of Healthcare



In line with this model, healthcare services can only be successful if they have all the four A's. The model has been equated to a wheel of life which should be balanced for any human being to achieve efficiency.

Methodology

The results of this research were derived from a three months study of health institutions in rural and farming communities. Fifteen primary and two secondary health care facilities formed part of the study and these were derived from Buhera and Hwedza Districts. Buhera is a largely rural district with an estimated total population of 218,570 people (Murambinda Mission Hospital, 2002) whilst Hwedza has a combined rural and farming area with an estimated population of 90 350 inhabitants (Hwedza Constituency Information Centre, 2008; 10). In total, Buhera has 30 primary health institutions whilst Hwedza has 10, five of them in farming or former commercial farming areas. Two district hospitals were included in this study. These were Murambinda Mission Hospital in Buhera and St Mary's Mission Hospital in Hwedza. These are all Catholic Mission Hospitals but designated government district hospitals. Rural inhabitants of study sites are poor people who struggle for a living through subsistence farming in Buhera and subsistence to commercial farming in Hwedza (Murambinda Mission Hospital, 2002; Hwedza Constituency Information Centre, 2008). Buhera, like the central part of Hwedza, is a dry area whilst the southern part of Hwedza, which used to be a large scale commercial farming area, receives favourable rainfalls.

Buhera and Hwedza districts were selected since they provided health facilities in rural (Buhera) and commercial farming areas (Hwedza). The two districts are adjacent and they are linked by a good road network. The two districts have a combined population of about 390 000 and a total 42 of health centres. Generally, the sample can represent the situation in most rural and farming communities of Zimbabwe but cannot be taken as representative of the whole country. Fifteen health centres took part in the study (Appendix 1). In Buhera, the researchers used simple random methods to select 10 health centres. In Hwedza, a total sample of health centres in commercial farming areas was achieved since all the five centres fitted this inclusion criterion. Each centre provided a single respondent, in all cases the most senior health worker. On top of these, three medical officers were interviewed (two from Buhera and one from Hwedza) based on availability. Resultantly, 18 respondents who included five environmental health workers, 10 nurses and three medical officers were interviewed.

This study relied on data gathered by the researchers from health workers. In-depth interviews were done with all the 18 respondents. An interview guide (Appendix 2) was used with all respondents. Eleven of the respondents were interviewed at the district hospital during their routine visits whilst seven were interviewed at their health centres. In applying this methodology, research ethics of confidentiality and informed consent were successfully applied. Respondents participated in the study after consenting. Before each interview, interviewers informed respondents about the purpose of the study, explained that participation was voluntary and that all data gathered was not going to be released to other parties. Data was analysed using themes corresponding to the Four A's model. However, some data remained unclassified under the four A's resulting in the authors classifying the extra data into two themes that were named appropriateness and alternativeness. Thus, two more A's were created resulting in adaptation of the Four A's model into a Six A's model.

The major limitation of this study is side-lining of quantitative techniques in data collection and analysis. This study could have been stronger had it increased the number of respondents and health institutions covered. It could also have improved results if it had included users of health services as respondents. These limitations were difficult to overcome given resource limitations at the time. To address shortcomings of this study, a follow up and complementary quantitative study targeting 200 rural households is ongoing. This study seeks to assess the Six A's model of health service delivery in these two study sites from the perspective of villagers and farmers who are the consumers of health services.

Results and discussion

The findings of this study are presented in seven sections: affordability of health services; availability of health services; accessibility of health services; appropriateness of health services; acceptability of health services; alternativeness of health services and summary of findings. After each result is presented, a discussion follows. At primary level, consultation was free of charge. However, 10 primary health care centres charged a levy of between $1 and $3 for construction, security and repairs. It was explained that such levies were not strictly on cash basis. Villagers could pay in forms of bricks or labour. Health workers agreed that although this was a community approach that induces participation, some households could not afford such levies and they end up not attending health centres for critical health services. This supports the views given by the researches on poverty and health delivery in Zimbabwe (MHCW, 2002, 2010).

Village heath work services were free of charge. This is in line with government policy (MHCW, 2010). However, respondents said village health workers normally seek various rewards for the health services they give. For example, one respondent reported to the clinic that they paid 'some few South African rands' to incentivise a VHW to give health information. Another nurse reported that VHW normally gain 'socially' that is they get certain favours in the community like free labour or free beer. Respondents concurred that VHW were not coercive in terms of seeking rewards but used their opportunity to increase their social capital or influence.

At District Hospital level, consultation was free of charge. The health workers explained that although at some district hospitals in Zimbabwe, there were some charges, at Murambinda and St Marys they were not charging because as mission hospitals, they receive donations from their churches and from other associations. The nurses interviewed pointed out that the major challenge at this level is accommodation of long term patients and those accompanying them. At times, the accompanying person sleeps in the open. When there are more patients at the hospital, some patients are forced to go home and attend treatment sessions as outpatients. This affects the treatment process and may promote not-compliance MPSLSW (2010). Whilst HIV/AIDS services were found to be affordable, they were affected by lack of funds for follow up visits to collect free ARVs. This reinforces earlier findings on lack of access to health care (WHO, 2008).

Availability of health services
VHWs were not active in most villages, although the number of villages was not established. Maternity nurses and environmental health technicians were available at 4 primary health centres. Doctors were in most cases overloaded with patients, concurring with previous researches (WHO, 2008).

All facilities lacked adequate supply of essential medicines. This resulted in patients seeking such medicines from private pharmacies where they are very expensive MPSLSW (2010). For example CPZ tablets were not available at Murambinda Hospital. Surrounding pharmacies had no stock too. It was available from Harare at a cost of between $3 and $6 for a month's supply (adult prescription of one tablet a day for a month). Resultantly, people defaulted taking their medicines or moved on to alternative treatments. One respondent gave a case of a sister who used to break tablet into four pieces so that she could give her brother for a lengthier period of time. This was attributable to the brother's relapse since he was a psychiatric patient.

Each health centre in Hwedza and Buhera served approximately 9000 and 10 000 people respectively. The district hospitals covered about less than 90 000 and less than 200 000 people respectively in Hwedza and Buhera. It should be noted Hwedza has a rural hospital at Hwedza whilst Buhera has two smaller hospitals, one at Buhera offices and another one at Birchnough Bridge. These small but extra hospitals reduce the catchment areas for the designated hospitals. In this case, the researchers reduced the total catchment for the designated hospitals. The Government of Zimbabwe anticipates that each primary care clinic must serve 10 000 people whilst a district hospital serves 140 000 people. It anticipates everyone to be within 8km, i.e. walking distance to a health facility. Respondents noted that whilst most residents live within this radius, there are other villages that are even over 15km away from a health centre. The Access to Health Care Services Study of 2008 found that most communities live within a 5km radius of their nearest health facilities, 23% between 5 to 10 km, and 17% over 10km from the nearest health centre.

Accessibility of health services
Respondents concurred that villagers who live in areas where they need to pay for bus fares to access health services, especially specialist services, normally end up not accessing such services or delaying accessing it. Areas with very poor transport networks were seriously affected since transporters charged exorbitant prices or were not available every day. This view has been put before and reduces uptake of health services and products (MHCW, 2002; 2010). The Maternal and Perinatal Mortality Study of 2007 noted that only 52% of rural women delivered in health facilities compared to 94% in urban areas. This difference was caused mainly by the difficulty rural women faced in reaching a health facility. Awareness about the availability of health services was said to be unavailable to some villagers. One nurse said some villagers did not know that there was medicine to treat conditions like epilepsy. One doctor argued that some villagers were unaware that family planning was free, a view supporting earlier findings and recommendations on the need for appropriate information and communication technology for health.

Acceptability of health services
Respondents agreed that some apostolic sects do not accept modern medical treatment. This was popular among the Johanne Marange sect. The disbelief in modern treatment is a doctrine that is supported by faith healing. It is also motivated by lack of confidence in modern treatment practices. Another example was given on condom use which was low and at times rejected by some villagers who argued that it shows elements of mistrust and infidelity in a relationship. Respondents agreed that condom use was not acceptable among adult populations. Yet another example was given by respondents on unacceptability of surgical treatment. Nurses interviewed agreed that among the rural people, surgical treatment is viewed with suspicion and some families opt not having it done on their family members. Health workers who were involved in immunisation strongly concurred that immunisation was not acceptable amongst some churches. This was so because of the belief that '*vana vanochengetwa namwari'.*

Appropriateness of health services
Village health work was rated as appropriate as it was promoted by people who already know about the beliefs and attitudes of the local people. One doctor said VHW are trusted and may provide acceptable services. He said they were using VHW to promote behaviour change. This strategy has also been recommended by another WHO and other researches on the uptake of health services in Zimbabwe (ZimStats, 2002). Some health workers questioned the appropriateness of doctors who do not speak or understand Shona but working with a Shona speaking population. Such doctors normally come to these hospitals on short to medium term basis and the local people at times find the communication barrier too huge. Suspected cases of misdiagnosis were reported. The appropriateness of current approaches of health care towards people who resist them e.g. Johanne Marange sects was questioned. Those interviewed had different views. Others said those who resist treatment for cholera and HIV/AIDS must be forced to receive it and laws must be put in place to make them comply. Other respondents

thought otherwise, arguing that there was need for dialogue. Dialogue has also been the focus of MHCW although it resorted to force in Buhera during previous cholera outbreaks (MHCW, 2010).

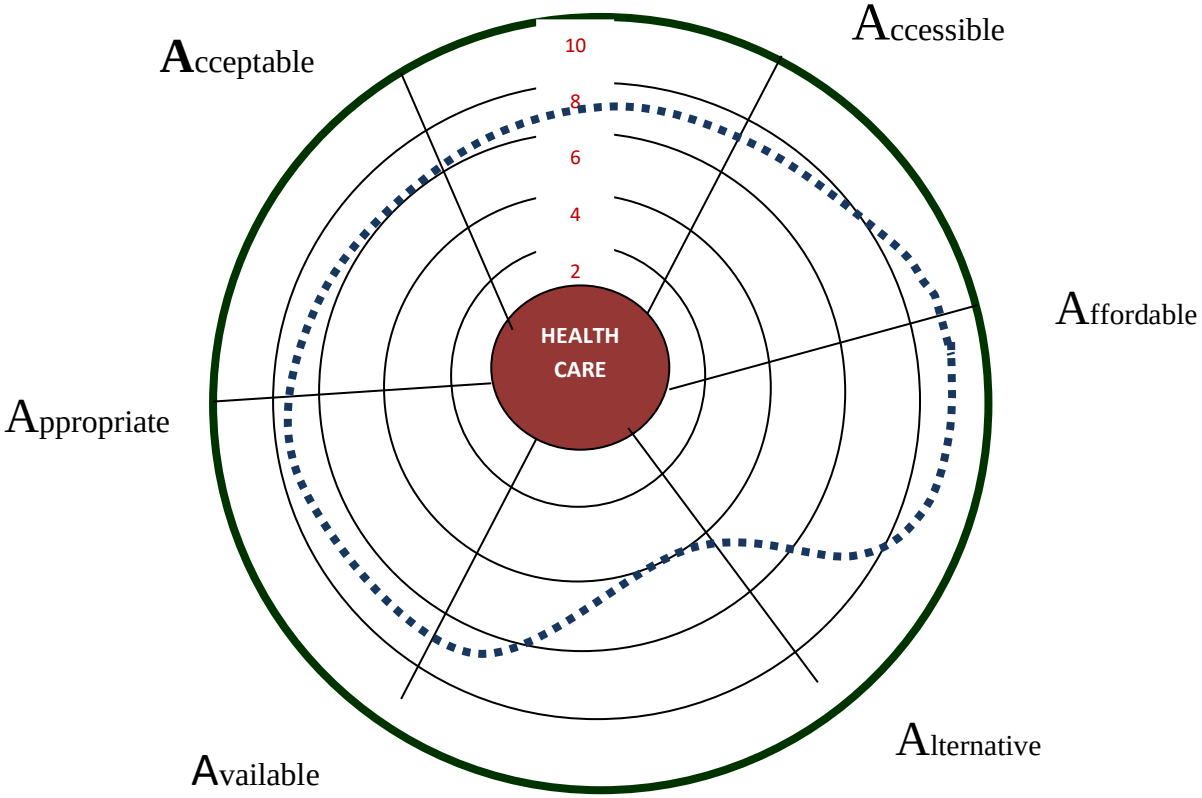
Alternativeness

Respondents said modern treatment presented no alternative methods of treatment to villagers. They argued that traditional methods were not accepted by the health system and that religious faith was also said to derail modern treatment for example it reduced health seeking behaviour. On the other hand, Chinese medicine was not accepted by health workers although the villagers flocked to Tiens Centres with some being referred to Harare at various Ceragem centres where they sleep in the open and queue to be attended. However, respondents agreed that whilst the system does not integrate with traditional methods, villagers use these alternatives on a daily basis. Thus, there is conflict between the system and the views of the villagers.

Summary of findings

After assessing health delivery in Buhera and Hwedza, researchers summarised results by adapting the initial 4 A's framework into a 6 A's wheel of healthcare presented on Figure 2.

Figure 2: 6 A's Wheel of Healthcare



This model is an improvement of the Four A's model. It includes two more A's and a scale to measure the level at which an A is considered to exist within a community. Though applicable in a more quantifying study, the scale is an approximation of the balance that exists in health care systems. Each A is quantified on a scale of 1-10 based on the recurrence of selected themes. The most desirable level of the wheel is shown by a green bold continuous line. The estimated level for studied communities is shown by a blue dotted line. The graphical presentation shows that wheel of healthcare in the studied communities was not balanced.

Options to improve access to health care

In light of these findings, authors would like to broadly recommend provision of comprehensive health services in rural and farming communities. Such service provides a balanced wheel of health delivery. Further recommendations are as follows:

- Provision of free accommodation at health centres to reduce costs.
- Resumption of mobile health services in villages.
- Facilitation of visiting doctors at rural health centres.
- Increasing the number of village health workers.
- Provision of incentives to village health workers.
- Reducing distance from health centres by increasing the number of health centres.
- Integrate churches and traditionalists who do not believe in modern treatment and improve health laws to ensure compliance and integration.
- Monitor Chinese medicines.
- Improving transportation and communication systems.
- Grassroots mobilisation and education to increase health seeking behaviour.
- The research recommends the following areas for further studies:
    - Examine the concept of *mapiritsi anaouraya* (modern treatment kills) and its effects towards health seeking behaviour.
    - Consider alternative strategies used by people in rural and farming communities to get health services.
    - Examine strategies of health promotion being used by public institutions in communities that have low health seeking behaviour.

Conclusion

Generally, public health services are affordable in rural and farming communities. However, for those who require extra resources to reach health facilities and to access them, health services become expensive. Primary and secondary health care services are not readily available to rural and farming communities. Major services lacking include doctor's consultation and specialist services. Health services are not readily accessible to residents of rural and farming communities. Health services are not all acceptable in rural and farming communities. Appropriateness of health services is an important factor which determines uptake of health services. Health services that are not appropriate were not readily consumed by people residing in rural and farming communities studied. Alternative methods of therapy are neglected. Alternative methods of managing ill health must be integrated into the health delivery system for them to improve instead of keeping them at the periphery of the system. In the main, the authors conclude that health services in rural and farming communities do not meet all the 6 A's required for successful health delivery. Health services that are only affordable, like those in Zimbabwe, and not accessible, available, acceptable and appropriate, are actually very expensive.

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