

**BARRIERS TO ACCESSING HEALTH CARE FOR THE PHYSICALLY  
IMPAIRED POPULATION IN NAMIBIA**

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## Abstract

People with physical impairments are entitled to using health facilities at least as much as the general population if not more. Inadequate health services coupled with the absence of a physical impairment-friendly health care system social environment in the developing nations make it difficult for them to access basic medical services. The study uses a qualitative research methodology to describe and understand rather than to explain and predict access to health facilities. The objective is to understand the current situation on access to health care for the physically impaired. The rationale for the paper is to assist in understanding barriers to access health care services for people with disabilities and to promote equity for all groups in society.

The study was conducted in Khomas and Caprivi Regions of Namibia. It found that there were problems related to lack of transportation. Either there was no transportation at clinics, from home to the clinic or if transportation was available it was unreliable. The physical environment was not accommodating to the physically impaired individuals because most individuals could not drive through the sandy ground with their wheel chairs and therefore could not access health care services easily. Communication with providers was also an issue when it came to individuals with hearing impairment because they found it hard to communicate their health conditions to providers (and vice versa) if they did not have interpreters of their own. Study records that rising to the challenge of providing excellent and accessible health care to persons with impairments is imperative as a matter of equity and recommends

health professionals to go beyond minimum requirements set by law to make facilities and services usable to the greatest extent possible.

**Keywords:** Barriers, Health services, Physical Impairments, Access

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## **Declarations**

I, Elina M. Amadhila, declare hereby that this study is a true reflection of my own research, and that this work or part thereof, has not been submitted for a degree in any other institution of higher education.

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## CHAPTER 1: INTRODUCTION

### 1.1 Orientation of the study

People with physical impairments remain at the margins of society as one of the most impoverished groups. Disability is considered not just as a problem for people with physical impairments, individuals and their families but also an economic liability for nations (Hosain & Chaterjee 1998). According to Hosain and Chaterjee (1998: p.1), “nothing is costlier to a nation than to allow a child to be exposed (before, during or after birth) to the risk of physical or other impairment. Let it escalate to an irreversible disability, then to look for rehabilitation that can never be adequate”. Thus it becomes imperative that disability be addressed at a national level.

The purpose of this thesis is to add to the limited knowledge on those with physical impairments in Namibia. It looks at how people with physical impairments access health care by providing descriptive information on the population - who they are, what types of services they use, and their satisfaction with the health care they receive. Identification of barriers to healthcare access for people with physical impairments is important because it can help to test and validate measures to improve equitable access to health services.

To understand what physical impairments are, one should understand what the term ‘disability’ means. The South African Revenue Service (2009), defines **disability**” as, a moderate to severe limitation of a person’s ability to function or perform daily activities

as a result of a physical, sensory, communication, intellectual or mental impairment, if the limitation has lasted or has a prognosis of lasting more than a year; and is diagnosed by a duly registered medical practitioner in accordance with criteria prescribed by the commissioner. The World Health Organization (WHO) and World Bank (WB) (2011), on the other hand, defined **disability** as:

“Difficulties encountered in any or all three areas of functioning. These are:

- **Impairment:** problems in body function or alterations in body structure; for example, paralysis or blindness;
- **Activity limitations:** difficulties in executing activities; for example, walking or eating;
- **Participation restrictions:** problems with involvement in any area of life; for example, face discrimination in employment or transportation”.

Furthermore, “The International Classification of Functioning (ICF) model can also be used to understand and measure the positive aspects of functioning such as body functions, activities, participation and environmental facilitation. The ICF adopts neutral language and does not distinguish between the type and cause of disability – for instance, between “physical” and “mental” health. “**Health conditions**” are diseases, injuries, and disorders, while “impairments” are specific decrements in body functions and structures, often identified as symptoms or signs of health conditions. **Disability** arises from the interaction of health conditions with contextual factors – environmental and personal factors” (WHO & World Bank, 2011).

The SARS (2009: p1) defines what physical impairments are. It said:

Disability that is less restraining than a disability as defined. This means the restriction on the person's ability to function or perform daily activities after maximum correction is less than a moderate to severe limitation. Maximum correction in this context means appropriate therapy, medication and use of devices.

With nearly every region of the Namibian population having an impairment of more than 5% there is a great need to address the barriers that prevent this particular population from accessing health care services, such as medical services, that they require [Government of the Republic of Namibia (GRN) 2003]. Individuals with physical impairments tend to have more health care access problems, secondary health conditions, unmet health care needs, and are less likely to be satisfied with medical care than those without physical difficulties/impairments (Hagglund, Clark, Conforti, & Shigaki 1999). Becker, Stuijbergen and Tinkle (1997) identified five commonly recognized reasons for inadequate health care services for people with physical impairments:

- i) Transportation problems – inadequate public transportation and also inaccessible transportation can be a problem for people with physical impairments to get to health care facilities.
- ii) Inaccessible offices – when offices are inaccessible, relying on patient's personal assistants to lift them onto examination tables can potentially

breach important privacy boundaries (Iezzoni, Davis, Soukup, & O'Day, 2002).

- iii) Inadequate knowledge among health care providers and provider attitudes – personal and cultural barriers related to the care given by the provider include providers' insufficient knowledge (Drainoni, Lee Hood, Bachman, Andrew, & Maisels, 2006).
- iv) Inadequate insurance coverage – financial barriers emerge from the lack of sufficient supplementary insurance and out of pocket expenses for prescription of drugs (Loue & Sajatovic, 2008).

Inadequate services coupled with the absence of a friendly social environment towards physical impairment in developing countries make it difficult for people with physical impairments to access health care systems for even basic medical needs (Hosain & Chaterjee, 1998).

Gold (1998) has argued that an improved understanding of how consumers with impairments experience barriers is a first step toward eradicating access disparities between people with physical impairments and their non-physically impaired counterparts in the current health-care environment. Fiedler (1981), on the other hand, reasoned that in order to fully understand the problem of access in any particular geographical region, it is very important to be aware of the 'macro' parameters that influence the nature and design of the local health delivery system. This means that individuals in society need to pay close attention to what influences decision-making

and who the target audiences for the clinic or health care centre are. However, Price (1988) has maintained that because of relatively scarce resources, all needs can never be met and, therefore, health care has to be rationed.

Policy makers and researchers pay little attention to ways of minimizing effects of barriers to access health care yet barriers experienced by those with physical impairments may be as important as supply factors in deterring patients from obtaining treatment (Ensor & Cooper, 2004). Currently, delivery of essential services in Namibia and worldwide concentrate on improving the quality of staff skills, protocols of treatment, availability of supplies and environment of health facilities. While these interventions are important, they do not address many of the barriers to accessing services faced by a person with physical impairment. Differences in health care can have far -reaching consequences. Those denied access to basic health care may live shorter and more constrained lives.

“Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential; more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided” (Whitehead, 1985: 7). In addition, the physically impaired are a vulnerable group, having very complex medical and health conditions. Given their typically low health and functional status, persons with disabilities are heavy users of health care and thus are costly to serve. The nature of the

investigation of this study is an enquiry into the lives of people with physical impairments who have recently come into contact with difficulties to access health care services. Disability has moved from an issue of the family alone to a public issue and it is for this reason that this study will address access issues to health care services for those that are physically challenged. The rationale is to help policy makers with formulating health policies that are equitable. The National Disability Council Act in Namibia states that:

As part of the process of equal opportunities, provision should be made to assist people with physical impairments to assume a more complete responsibility as members of society. Thus they should receive the support they need within the ordinary structures of society in areas such as health, employment, education and social services (GRN, 2004).

## **1.2 Statement of the research problem**

While considerable research has been done on health care access, use and satisfaction among those with physical impairments worldwide, (Obrist et al., 2007; Oliver & Mossialos, 2004) there is very little work done on access barriers for people with physical impairments in Namibia (Bell & Iithindi, 2002) and this study hopes to fill the gap in literature. Recent work in the health sciences field has shown that more than 70% of regions in Namibia provide orthopaedic services either in the form of outreach or permanent facility services (GRN, 2005). Over the five year period from 2000 to 2005, the number of patients provided services and treatment grew steadily to more than 90% (GRN, 2005). Despite the increase in the number of services provided and the country's

commitment to equal health care access for all by the year 2030 (GRN, 2008), those with physical challenges still find it difficult to access healthcare facilities.

### **1.3 Objectives of the Study**

The broad aim of this study is to understand the current situation on access to health care for the physically impaired in Namibia. Specifically, the study aims to:

1. Identify the Structural-Environmental (financial, geographical, technological and locational) barriers that the physically impaired experience in accessing health care.
2. Identify the process (accessibility, communication and knowledge) barriers that physically impaired experience in accessing health care.
3. Investigate how physically impaired people experience and cope with financial, geographical, locational, political and communication problems.

### **1.4 Significance of the Study**

The government's Vision 2030 aims at achieving equity in health care for all Namibians. The significance of the study lies in its potential to help policy makers formulate policies that are more inclusive of people with physical impairments in society and thereby realize this particular goal of Vision 2030. The study is also important to help government streamline services needed for the City of Windhoek in Khomas and other regions in Namibia when constructing hospitals and clinics. Finally, the study will assist in filling a gap and adding to the few current literature in Namibia by focusing access barriers to health care for people with physical impairments. There is currently only two

studies that we came across dealing with the provision of health care to improve equity in Namibia Bell & Iithindi (2002) and access to orthopaedic workshops (Ministry of health and social services, 2009)

### **1.5 Limitations of the study**

Most of the limitations of the current study are related to the method used in recruiting respondents. First, because I mainly recruited respondents who visited health facilities, I may have introduced selection bias into the results as individuals not able to attend clinics may perceive their access to and quality of healthcare differently. I also need to acknowledge that this study dealt only with patient perceptions of access to and quality of primary healthcare. Thus, I have no confirmation or detail about why a particular service was not provided by a primary care medical doctor (e.g. time allocation, patient preference, high table access problem) or a particular office was not accessible (e.g. parking, door width and rugs). Because of time and lack of financial resources, the study is only limited to Khomas and Caprivi regions. Because the focus was on those visiting health care facilities, the very young children, the institutionalized (like people in prisons) and those at home were excluded.

### **1.6 Organization of the study**

This study looks at the current literature on the topic, the methodology employed; results found, discussions and conclusions and then makes recommendations.

## **CHAPTER 2: LITERATURE REVIEW**

In the United States of America USA, people with physical impairments presently constitute one of the most disadvantaged minority groups in society and regularly encounter discrimination in critical areas of their lives, such as health care (Hwang et al. 2009). In Bangladesh, social and cultural barriers prevent certain groups including those with physical impairments from accessing health care (Hosain & Chaterjee, 1998). According to the Ministry of health and Social services (2009), in Namibia the element of discrimination against people with disabilities (PWDs) is 4.4%. However the study could not show whether these were positive or negative types of discrimination. The Ministry of Health and Social Services (2009) further reveals that the distances to health facilities providing orthopaedic technical services for people with physical impairments were too long. There was also insufficient transport facility at hospital level for people

with disabilities. In addition to these challenges, there was scarcity and insufficiency of rehabilitation professionals

## **2.1 Barriers:**

Barriers to access are those factors that contribute to preventing a person from utilizing a service when needed (Scheer, Kroll, Neri, & Beatty, 2003). Scheer et al. (2003) identified two broad categories of barriers to health care services: structural environmental barriers and process barriers. Structural environmental barriers are impediments to medical care directly related to the number, type, concentration, location, or organizational configuration of health providers. They include issues of accessibility, geography, technology and location and doctor's offices. Process barriers relate to the delivery of service. For example, lack of provider knowledge, bad attitudes and lack of timeliness of service from providers are issues frequently reported by patients. Barriers to services by people with disabilities may vary considerably according to the type of impairment they experience. This study did not explore all the specific barriers and it would have been impossible to do this justice in one qualitative study. The inclusion criterion was, therefore, limited to a specific group; those where the disability arose from impairments in movement related functions, and/or body structures relating to movement.

In Africa rural/urban disparities loom large and services are in short supply as a result of geographic isolation, poverty, illiteracy, distances, transportation difficulties and related factors, all of which make delivery of health care for people living with impairments

challenging. This reinforces the statement by Brems, Johnson, Warner and Roberts (2006: p.1) that:

Optimal healthcare delivery, regardless of location, is technology-demanding, costly without economies of scale, and dependent upon availability of skilled workforce. These features of healthcare systems are difficult to satisfy, even in urban areas. In rural areas, the health care system features of optimal health care delivery, in combination with rural limitations, make development and maintenance of efficient and effective healthcare delivery difficult.

A study by Veltman, Stewart, Tardif and Branigan (2001) showed that people with disabilities often lack opportunities to engage in preventive healthcare activities and do not have adequate access to primary healthcare, hospital care, and long-term care. People with physical disabilities often report that they must spend considerable effort educating their primary care providers about their disability and they feel that doctors sometimes focus inappropriately on the disability itself rather than on the health problems with which they present. Factors that impede adequate primary healthcare have been well demonstrated to include: unmet transportation needs, lack of provider knowledge regarding disabilities, refusal of medical treatment by a doctor because of a disability, architectural barriers such as lack of adequate ramps into healthcare facilities and inaccessible examining tables, poor coordination of healthcare services, and negative attitudes of healthcare providers toward people with disabilities (Veltman, et al, 2001). Goudge, Gilson, Russell, Gumede and Mills (2009) argue that key barriers to care are unaffordable costs to households, weak availability of inputs and services, and

poor acceptability (the appropriateness of the social interaction that accompanies care), collectively referred to as the access framework. In low and middle income countries, patients often either do not seek care, or do so only when they have access to funds, thus affecting continuity of care. Shortage of health service inputs (staff, drugs, and equipment) often mean that appropriate care is not available.

### **2.1.1 Structural/Environmental Barriers**

This section will look at different forms of structural barriers. These include the following:

#### **Accessibility:**

In Zimbabwe, Choruma (2007), reports that although most new buildings have ramps with rails, in many cases the recommended gradient of the ramps is not adhered to. The buildings may also lack signs to indicate where the physically impaired entrance, elevators or toilets are located. In urban areas, a door to an office or toilet is heavy and handles placed too high making it difficult for a person in a wheelchair to enter. Consumer satisfaction refers to attitudes toward the medical care system of those who have experienced contact with health facilities. Iezzoni, et al (2002) mentioned that the structure of the health care delivery system could affect satisfaction for persons with disabling conditions. Managed care health plans, which limit access to certain providers, pose logistical barriers to obtaining care. For example, since they cannot drive, some blind persons rely on public transport to move about their communities. If plans do not include providers on convenient bus or underground train routes, this could impede the

physical ability of some visually impaired persons to reach care. Thiede and McIntyre (2008) argue that social exclusion may result from a lack of mobility aids, or inaccessible built environment. Kroll, Jones, Kehn, and Neri, (2006) argue that it is of utmost importance that facilities at health centres are user-friendly. The term user-friendly means that service providers should not make it difficult for the patient to get the treatment that they are looking for at the clinic. They should accommodate those in wheelchairs especially by building of stairs and toilets. Shelf heights should be convenient for both standing and seated users

### **Provider's Offices:**

Doctors' offices have been said to lack equipment and space essential for treatment of patients using wheelchairs. Medical equipment is often not accessible for people with disabilities, particularly those with mobility impairments. The WHO and the World Bank (2011) state that men with disabilities reported health service provider's equipment (including medication) to be inadequate across income settings (22.4% compared with 7.7% for men without disabilities); women with disabilities reported similar difficulties. For example, many women with mobility impairments are unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand (World Health Organization & World Bank, 2011).

### **Health Costs:**

According to Etowa, Wiens, Bernard and Clow (2007b) poverty is a determinant of health because it restricts access to health services and treatment. Chipp et al. (2010) showed that rural residents incur more expenses travelling to regional centres to receive healthcare because such care does not exist in their local community and/or facilities. In the study by Etowa et al. (2007b) about 57% of the respondents reported that they did not have enough money for medication. Furthermore, women failed to seek medical attention because they could not pay for travel to the clinic. Similarly, Turner Goins, Hays, Landerman, & Hobbs, (2001:p. 210) found that “financial constraints posed considerable barriers to accessing needed health care among study participants, including issues related to health care expense, and inadequate health care coverage”. The research of Hwang et al. (2009) demonstrated that people living with disabilities need a wider range and depth of services than other patients and this resulted in higher costs of health care for them. In Namibia where most people with disabilities are not employed (and do not have insurance coverage of any kind) the costs of transport, medicine and other services can be prohibitively high. According to the WHO and World Bank (2011: p. 66):

The rate at which people with disabilities pay with current income or savings is roughly the same as for people without disabilities, but paying with personal means varies between groups: paying with insurance is more common in high-income countries, while selling items and relying on friends and family is more common in low income countries, and people with disabilities are more likely to

sell items, borrow money, or rely on a family member. People with disabilities experience lower rates of employment, are more likely to be economically disadvantaged, and are therefore less likely to afford private health insurance. Employed people with disabilities may be excluded from private health insurance because of pre-existing conditions or be “underinsured” because they have been denied coverage for a long period, or are excluded from claiming for treatment related to a pre-existing condition, or must pay higher premiums and out-of-pocket expenses.

Financial barriers may restrict access either by inhibiting the ability of patients to pay for needed medical services or by discouraging physicians and hospitals from treating patients of limited means (Drainoni, et al, 2006).

**Geography, Distance and Transportation:**

Geographical conditions greatly affect access to health services. In general, people in mountainous areas (regardless of economic status) access health services less frequently than people in delta regions. Geographical access is measured in distance and time to health facility and these indicators are worst in the North West Mountains and Central Highlands in Vietnam (Oanh, 2009)

Geographical challenges such as mountains, gullies, rivers, unpaved roads etc. present physical barriers to accessing healthcare. “Due to these geographic challenges, some rural residents make trade-offs between their safe travel in inclement weather and

accessing health care in a timely manner” (Chipp et al. 2010: p. 8). “Generally, the more remote the area in question, the greater the problems of access to medical care due to geographic distances, transportation problems, lack of insurance, and an inadequate supply of local providers” (Lishner, Richardson, Levine & Patrick, 1996). Brems et al. (2006) argue that travel distance negatively affects access to health services for rural more than urban patients. Moreover, due to distance and access restrictions, rural residents with a chronic illness may not receive information on new treatment strategies (Chipp et al. 2010). Rural residents also have very “limited access to specialized providers and consultants (i.e. cardiologists, oncologists, psychiatrists), and additional resources due to the rural geography” (Chipp et al. 2010: 2). It is not just mere distance, but it is also the difficulty of travel as well as availability of specialized services which is a problem in Namibia’s rural areas.

Among the attributes of rural areas which influence health care utilization is low population density, isolation, and lack of services. These geographic attributes present major challenges related to travel that rural residents encounter (Chipp et al. 2010; Wong & Regan, 2009) such challenges are summed up as follows:

“The ability to transverse these distances becomes imperative in obtaining health care. Without transportation, even a short distance to care can become an insurmountable problem. The opportunity for health care consumers to have a vehicle to transport them to a practitioner or facility is especially important in rural settings where distances are relatively great, roads may be of poor quality,

and public transportation is seldom available” (Arcury Presser, Gessler & Powers, 2005).

Minden, Frankel, Hadden and Hoaglin (2007) agree by arguing that transport is critical for rural patients’ ability to receive care and maintain their health and functional status. Similarly, Caldwell (2008) found that for families with developmental disabilities, the greatest out-of-pocket costs included transport. Lack of transportation options present an additional obstacle to rural dwellers accessing healthcare (Lishner et al. 1996). Brems et al. (2006) found that lack of access to services due to transportation difficulties were reported overwhelmingly more by rural than urban providers. In this context, Green-Hernandez (2006, p. 10) states that,

Residents of rural areas who are elderly, poor, or have handicaps have even more of a disadvantage than their urban and suburban counterparts. For instance, poor residents of urban and suburban areas can reach clinics through a combination of public transportation and walking. An urban resident with a handicap can often find accommodation on public transportation equipped with special devices. This is not an option for rural residents with handicaps, or who do not have their own transportation or support from family or friends.

Because public transport is not always an option for those who use wheeled mobility devices, access to health-care services by people with disabilities, as well as their ability to participate in other community settings, is not equal to that of the general population. Even those who can use public transport often have providers or durable medical

equipment vendors with offices that are not close to public transport (Scheer et al., 2003).

### **2.1.2 Process Barriers**

Process barriers are difficulties in the course of delivery of service (Scheer et al. 2003) . For example, lack of provider knowledge, communication and attitudes, acceptability, availability and quality of health are issues frequently reported by patients. Financial barriers may restrict access either by inhibiting the ability of patients to pay for needed medical services or by discouraging doctors and hospitals from treating patients of limited means. Personal and cultural barriers may inhibit people who need medical attention from seeking it or, once they obtain care, from following recommended post treatment guidelines. The following are different forms of process barriers.

Communication, Attitudes and Knowledge

#### **Communication and Attitudes:**

Communication difficulties between people with disabilities and service providers are regularly cited as an area of concern (Smith, 2009; Ubido, Huntington & Warburton, 2002). Communication differences pose an impediment to effective and ethical rural health care. Rural residents report having greater difficulty with labeling of medication and interpreting written information and instructions (Chipp et al., 2010; Hamrosi, Taylor & Aslani, 2006). More nurses/doctors who understand sign language should be trained and employed in the health sector in order to be able to communicate with those who are deaf (Kroll et al. 2006). The Ministry of Health and Social Services in Namibia approved a pocket guide for health care providers to learn sign language so that there is

effective communication between the health care providers and people with hearing impairments. Barriers, such as an inability to provide health information in plain text or sign language, constitute violations of rights to equal treatment and equal opportunities (Tomlinson et al., 2009). Hwang et al. (2009) report that people living with disabilities experience insufficient communication with providers. People with severe learning and communication difficulties may not be able to express discomfort or pain in usual ways. Carers must be aware of this and sensitive to changes in behaviour or well-being that indicate pain, illness or unhappiness (Lindsey, 2002). Hence, access reflects the interplay between the supply side and the demand side in health care. Issues of language seem to be related to issues of ethnicity. “Racist attitudes of health-care providers present an obvious barrier, the lack of diversity among health-care personnel also makes it difficult for some women to access suitable health-care providers” (Etowa et al. 2007b: 68). In this context, the WHO and World Bank (2011) argue that “Negative attitudes and behaviours have an adverse effect on children and adults with disabilities, leading to negative consequences such as low self-esteem and reduced participation. People who feel harassed because of their disability sometimes avoid going to places, changing their routines, or even moving from their homes” (WHO & WB, 2011).

### **Knowledge:**

Some facilities lack knowledge. This is brought about by insufficient training and limited number of health care workers. This problem is not only limited to poor countries but also affects rural places in developed countries. For example, Turner,

Williams, Carter, Spencer & Solovieva (2005: p.210r) found that in Canada there were “Concerns about the limited number of physicians and long-term care options. Discussions about the limited number of physicians included difficulty with recruitment and retention, need for more specialists, overall limited choice of physicians, and aging of local doctors”.

In a study by Becker et al (1997) women described providers as insensitive or lacking awareness of disability issues as they impact reproductive health care. Veltman et al. (2001) found that many patients felt they had unmet primary healthcare needs because their family doctors lacked education regarding physical impairments. Doctors, families and society as a whole do not understand or know much about physical impairments. Those who have physical impairments within societies find it hard to have their health care needs taken care of because those who are supposed to take care of them do not understand their problems. Neri and Kroll (2003) found that relationships with family and friends had been affected as a result of not getting access to needed primary care services or durable medical equipment. The WHO and WB (2011) concluded that generally, a better knowledge base is required on the prevalence, nature, and extent of disability - both at a national level where policies are designed and implemented, but also at global level with changes monitored over time.

While some authors have classified barriers as above, Carrillo (2005) has classified barriers according to Primary Access Barriers, Secondary Access Barriers and Tertiary

Access Barriers. Primary access barriers include health insurance which comprises lack of insurance, underinsurance, and inability to pay for care or treatments. Secondary Access Barriers comprise organizational and systems of care. These are all barriers encountered between home and providers' office: availability of care, transportation, childcare, waiting times, etc. He identified the problem under secondary access barriers to be that patients at risk who access the health care system face organizational and structural barriers (organizational related to leadership/workforce and structural related to systems of care). This result in decreased medical screening, late stage of presentation, and insufficient treatment resulting in more costs for the consumer. Tertiary access barriers are the communication problems between the provider and patient when language and culture hinder provider-patient communication. In the tertiary barriers, there are socio-cultural differences which lead to less effective care due to poor communication, different beliefs about illness and treatment, poor adherence to therapeutic plan, limited health education, provider bias and stereotypes. Rogers (1973, cited in Loue, 1998), on the other hand, identified barriers to access as the shortage of primary care doctors in the inner city and rural areas. Other studies considered the consumers' willingness to seek care (Mechanic 1972) and financing or reimbursements (Fox 1972).

In Namibia, most rural residents are dependent on healthcare provided by nurses rather than by doctors and other specialized personnel. The limited number of even nurses means that rural residents are subject to few competent medical staff. In this context,

Hwang et al. (2009) concluded that whereas most individuals tend to be satisfied with the overall competence of doctors, many believe that providers need to know more when it comes to dealing with people living with disabilities.

## 2.2 Access to Health Care:

Aday's (1975) study (as, cited in Scheer et al., 2003) defined access as the use of services relative to the actual need for care; lack of access occurs when there is need for services but those services are not utilized. According to Loue (1998, p. 102):

In the early 1970s there were several schools of thought in health services research. One group of researchers viewed access according to characteristics of the population such as family income, insurance coverage and attitudes towards the health care system. A second group depicted access as characteristics of the delivery system or system-specific attributes. Yet a third group viewed access as a consumer's experience with the health care system which included utilization of services and satisfaction with the organization and delivery of health care.

According to Millman (1993), because of difficulties in defining and measuring the concept of access, people equate access with insurance coverage or with having sufficient doctors and hospitals in the area in which they live, but having insurance or nearby health care providers is no guarantee that people who need services will get them. He, therefore, defined access as the timely use of personal health services to achieve the best possible health outcome. This is very important to consider when it

comes to developing countries because most of the time clinics are built, nurses are provided, free treatment is given but the needs of those with physical impairments are left out, leaving a very wide gap between access, satisfaction and barrier-free community.

Freeborn & Greenlick's (1973) study (as cited in Loue, 1998) found that in the early years of investigating access, researchers assumed that accessible care was care that was available whenever the patient was in need, that the point of entry into the health care system was well defined, and that individuals used services according to their need for care. Smith, Murray, Yousafzai and Kasonka (2004) revealed that factors defining access can be captured by the three dimensions of availability, affordability, and acceptability. The *availability* of health care captures all factors that relate to the actual existence of a specific service within reach of the client as well as aspects of user-friendliness, e.g. the existence of appointment systems and the convenience of opening hours. The distance to a facility is one of the indicators of access under this dimension that are easily measured. *Affordability* refers to the direct and indirect costs of care relative to the client's ability to pay. Health care financing arrangements strongly affect the affordability dimension. Lastly, *acceptability* covers many of the subjective, social, and cultural factors, such as the degree to which a certain service is culturally secure.

For access to be non-discriminatory, health care needs should be treated similarly, without regard to the patient's age, gender, race, religion, national origin, education,

place of residency, sexual orientation, ability to pay, or presumed social worth (Priester, 1992). Thiede (2005) argued that health services need to be such that they are not only medically secure but also culturally secure, i.e. they do not just fulfil the proper criteria of medical quality but they also incorporate expectations towards the health system that people have on the grounds of their culture. Access to health products and services depends on many factors. One key factor is the successful innovation of new technologies, either as new drugs, vaccines, treatment services, or as adaptations of existing products to the contexts and frameworks of low and middle income countries (Krattiger, 2007). Disability advocates point out that technology is often created without regard to people with impairments, creating unnecessary barriers to millions of people. According to Salinas (2007) in order to achieve desired outcomes in health care, not only is careful use of technologies that are applied by health professionals and provided by health services needed, but also there is need for an accountable decision-making process leading to the prescription of a particular procedure for a particular process. This decision-making process, to be considered a high quality one, needs timely access to adequate appropriate information on the safety, efficacy and effectiveness of the whole menu of technologies that are available to be prescribed for different conditions to different people.

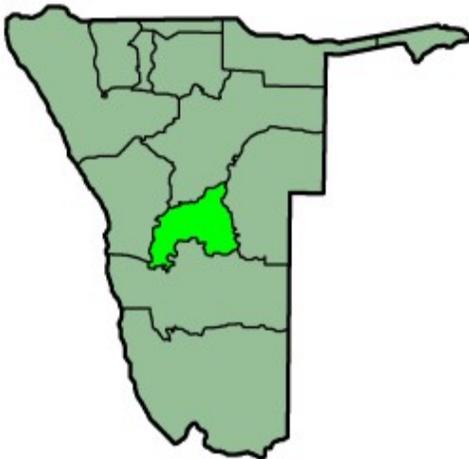
## CHAPTER 3: METHODOLOGY

This chapter briefly gives an introduction of the study sites, the research design employed, methods of data collection, selection of cases, sampling and then finally it concludes with how data was analysed.

### **3.1 Description of the Study Sites**

Two regions namely Khomas situated in the central part of Namibia and Caprivi situated in the north-eastern part of Namibia were chosen for data collection. A brief description of the each study region follows.

Figure Map of Namibia highlighting the research sites



#### **Khomas Region**

Khomas is one of the thirteen regions of Namibia. It has the capital city Windhoek and provides superior transportation infrastructure. It has well-developed economic, financial, and trade sectors. Khomas Region occupies 4.5% of the land area of Namibia and has the highest population of any of its regions (15%). According to the GRN (2005)

Khomas had a population of 250,262 (123,613 females and 126,648 males or 102 males for every 100 females) and was growing at an annual rate of 4%.

For this study, Khomas region was chosen because it is an urban area compared to the rural nature of the Caprivi Region. It represents the central part of the country, has abundance of health care facilities compared to other regions. In addition, Khomas has reasonably good infrastructure and because of this reason, there was a need to conduct research in this area to find out if people who were staying in Windhoek also experienced the same barriers in accessing health care services and if so, how different they were from the other regions (in this case the Caprivi region).

### **Caprivi Region**

The Caprivi region is a tropical area, with high temperatures and much rainfall during the December-to-March rainy season, making it the wettest region of Namibia. The terrain is mostly made up of swamps, floodplains, wetlands and woodland.

In addition to the Zambezi River, the Caprivi strip also contains the Kwando River and Chobe river, which marks the border with Botswana. Like many borders in Africa, Caprivi's boundaries either follow the midstream of rivers or run along straight lines. In broad terms the Caprivi stretches 450 kilometres from east to west and ranges between 32 and 100 kilometres in width from north to south.

Clinics and primary health care facilities are found at 34 places throughout Caprivi. Katima Mulilo is the largest town in the region, with other notable settlements including Kongola, Chinchimane, Bukalo, Sibbinda, and Impalila. (Mendelsohn & Roberts, 1998). About 80,000 people live in Caprivi and that is about 4% of Namibia's population. The Caprivi region was chosen because it is a rural area in contrast to the Khomas region. It is an area prone to flooding which can contribute to various forms of vulnerabilities. The two regions (Khomas and Caprivi) were chosen simply for the sake of comparison.

See tables 1, 2, 3 and 4 for a closer look to the number of people physically impaired in the two regions under study.

### **Khomas region**

Table Proportion of Disabled Population by area and sex

Area disabled	Population			Number of disabled			Per cent		
	Total	Females	Males	Total	Females	Males	Total	Females	Males
Khomas	248 688	122 950	125 738	9 150	4 524	4 626	3.7	3.7	3.7
Urban	232 362	115 685	116 677	8 495	4 274	4 221	3.7	3.7	3.6
Rural	16326	7265	9061	655	250	405	4.0	3.4	4.5

Source: (GRN 2005, Namibia 2001 Population and Housing Census Khomas Region

Table Type of Disability by sex in Khomas region

Type of disability	Number			Per cent		
	Total	Females	Males	Total	Females	males
Blind	4044	2231	1813	44.2	49.3	39.2
Deaf	2025	1017	1008	22.1	22.5	21.8

Impaired speech	1020	465	555	11.1	10.3	12.0
Impairment of hands	837	324	513	9.1	7.2	11.1
Impairment of legs	1365	586	779	14.9	13.0	16.8
Mentally disabled/ill	321	126	195	3.5	2.8	4.2
Other	332	173	159	3.6	3.8	3.4
Total*	9 150	4 524	4 626			

(Source: GRN 2005, Namibia 2001 Population and Housing Census Khomas region)

### Caprivi Region

Table Proportion of Disabled population by area and sex

Area disabled	Population			Number of disabled			Per cent		
	Total	Females	Males	Total	Females	Males	Total	Females	Males
Caprivi	79 652	40 677	28 859	3 495	1 822	1 673	4.4	4.5	4.3
Urban	22 047	11 818	10 229	433	229	204	2.0	1.9	2.0

Rural	57 605	28 859	28 746	3 062	1 593	1 469	5.3	5.5	5.1
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Source: (GRN 2003, Namibia 2001 Population and Housing Census Caprivi Region)

Table Type of disability by sex in Caprivi region

Type of disability	Number			Per cent		
	Total	Females	Males	Total	Females	Males
Blind	1218	717	501	34.8	39.4	29.9
Deaf	836	429	407	23.9	23.5	24.3
Impaired speech	359	169	190	10.3	9.3	11.4
Impairment of hands	452	232	220	12.9	12.7	13.2
Impairment of legs	918	477	441	26.3	26.2	26.4
Mentally disabled/ill	363	188	175	10.4	10.3	10.5
Other	127	64	63	3.6	3.5	3.8
Not stated	326	166	160	9.3	9.1	9.6
Total*	3495	1822	1673			

Source: (GRN 2003, Namibia 2001 Population and Housing Census Caprivi Region)

**Note:** \* The total is the number of persons with a disability. This is not the total in the column as some persons have multiple disabilities

As evident from Tables 2 to 5, there are more people with physical impairments in the rural areas in the Caprivi region as compared to the urban areas and the opposite is true for the Khomas region. In both Khomas and Caprivi regions, more people suffer from visual impairments than other types of impairment.

Physical impairments are either brought about by injuries or inadequate health care. It is often argued that inadequate health care may be brought about by inadequate medication, unavailability of specialised health service providers, and unavailability of transportation to take patients from clinics to hospitals when there is a need, etc. This study investigated the barriers people with physical impairments experience in accessing needed health care as well as their coping strategies to deal with those barriers (GRN, 2006).

### **3.2 Research Design**

This study uses a qualitative research design. There is agreement that good qualitative studies answer clearly stated, important research questions (Frankel & Devers, 2000). According to Babbie and Mouton (2001), qualitative research is defined as describing and understanding rather than the explaining and predicting human behaviour. Sarantakos (2005) has argued that there is not one but many qualitative methodologies; thus the need to make it clear on the type of qualitative methodology one uses. This study used semi-structured interviews and focus groups discussion. Sarantakos (2005) went on to say that the central principles of the qualitative methodology are taken from a relativist orientation, constructivist ontology and an interpretive epistemology.

The reasons why this methodology was considered to be appropriate for this study include the following:

- 1) The theoretical foundation of this study is constructionism. This theory focuses on the firm belief that there is in practice neither objective reality nor objective truth.

The construction of reality is an active process of creating a world. The reality people experience in everyday life is a constructed reality – their reality – based on *their* interpretation. “Impressions of reality gained by researchers who listen to respondents talking about their lives are construction of the constructed reality of the respondents; they are impressions of the reconstructed reality” (Sarantakos, 2005). To link this to the topic, the incidences that happen to people with impairments as they access health care services are their realities. The impressions created by a researcher who listens to people with physical impairments talking about the barriers (reality) they have in accessing health care services are reconstructions of that reality.

2. The key process that facilitates construction and reconstruction is interpretation. According to Sarantakos (2005), interpretation has its roots in the works of Max Weber (1864-1920) which was concerned with *Verstehen* (understanding) of social life. Understanding relates to the views, opinions and perceptions of people as they are experienced and expressed in everyday life. The study is interested in the subjective meaning, namely the way in which people make sense of their world and how they assign meanings to it i.e. how they perceive their impairments, what impairments mean to them and what difficulties they experience when they access health care facilities. This question measures people’s subjective appreciation of health, and is used to demarcate people with impairments from others:

As noted earlier, qualitative research is diverse, and this is evident not only in the ways in which research is conducted but also in the variety of paradigms that are associated with this particular research strategy. According to Babbie (2001, cited in De Vos, Strydom, Fouche and Delport, 2005) a paradigm is the fundamental model or frame of reference we use to organise our observations and reasoning. “Although a paradigm does not necessarily answer important research questions, it can tell us where to look for the answers” (De Vos et al., 2005). Symbolic interactionism is the paradigm that this research followed. The main tenets of this paradigm, as summarised by Sarantakos (2005), are: social life and objects become significant when they are assigned meanings; language is the most important symbolic system.

The most appropriate method of research is the naturalistic method which incorporates two major procedures: exploration and inspection. I believe these methods are appropriate for this study because the aim of the study is to explore the barriers people with physical impairments experience in accessing health care services. The aim is to interact with people in their natural settings using a language that they understand and then find out what meanings they attach to barriers that they experience. “Meanings are used and revised as instruments for the guidance and formation of the action” (Sarantakos, 2005).

### **3.3 Selection of Cases**

Following approval by the ethics committee of the Ministry of Health and Social Services, qualitative in-depth semi-structured questionnaires were administered and focus groups interviews were conducted with thirty purposively sampled individuals in Okuryangava clinic, Katutura health centre and Dordabis clinic in Khomas Region and Kabbe, Sibbinda and Chetto clinics in Caprivi Region. Fifteen individuals were interviewed in the Khomas region and fifteen in the Caprivi Region.

Purposive sampling was used to select people with differing impairments, ages, socio-economic status in order to obtain data on a wide range of experiences. The inclusion criteria of people with impairments were limited to a specific group as follows: the disability arose from impairments listed in the International Classification of Function disability and Health (ICF) domains of upper limb(s) disability, lower limb(s) disability, manual dexterity and movement-related functions that result in limitation of mobility. Those with learning and communication impairments were not included in this study because it needs special knowledge to communicate with these people and the researcher was not proficient in this.

### **3.4 Methods of Data Collection**

The study formed part of a bigger project titled “Enabling universal and equitable access to healthcare services for vulnerable groups in resource poor settings in Africa”. The project looked at health policies and did an analysis in selected countries (Sudan,

Namibia, South Africa and Malawi). The analysis mainly relates to whether health care policies are inclusive of vulnerable groups and whether what is in the policies is practised on the ground. From the policies, there was a need to find out what and how disability is talked about, which model of disability is referred to and what that means for individuals and their families. The practice part of the policy analysis was tested on collection of data in different regions that was Khomas, Kunene, Hardap, Caprivi and Omusati and this is where barriers to access to health care services were investigated. Ten enumerators were recruited for collection of data and the criteria used was that they should be able to speak the languages commonly spoken in regions selected. For example Caprivians went to collect data in Caprivi, Ovambos went to Ovambo speaking communities such as Omusati region and so forth.

The evidence reported is drawn from semi-structured interviews and focus groups conducted as part of an exploratory research project and a six page interview guide was devised. According to Babbie and Mouton (2001), focus groups discussions (FGDs) are important to find information you would not otherwise be able to access from an individual. Focus groups are useful because they tend to allow a space in which people may get together and create meaning among themselves rather than individually. The reason for using the semi-structured interviews is that the study aims to do an in-depth inquiry to explore issues and aims to probe to get more information. Semi-structured interviews and focus groups were appropriate for the study because the aim of the study is to explore and investigate. Given that the degree to which questions are structured

depended on the type of impairment suffered by the respondent; it is the respondent's history and experience that decided which topics were important in the various interviews. The semi-structured interviews are important as they help to give exact information that the researcher is looking for in the study. Both focus group discussions and in-depth interviews were captured through tape recordings.

Focus group discussants were selected at the clinic provided that they suffered some type of impairment and they were between the ages of fifteen and sixty-five. Some had been individually interviewed before and some only took part in the focus group discussions. Each group comprised of a maximum of ten discussants. The emphasis was not on having equal numbers of males and females in a focus group but merely having a mixture of both. A suitable venue and time was chosen by the discussants themselves and there were about seven discussants in each group in the two regions. Two focus groups were conducted in total and the participants participated voluntarily. The Focus group in Khomas region was conducted at the disability resource centre in Okuryangava area while the focus group in Caprivi region was conducted at Sibbinda clinic. The main points discussed were issues of accessibility, finance, language, communication with providers, transportation, distance, knowledge of providers, to mention a few.

The perspectives of people with impairments and of health service staff were sought in order to identify whether there are currently any physical, social and/or attitudinal barriers to the former group's use of health services within Namibia. The questions and

prompts used in the interviews were formulated by using background information obtained from existing literature and from physically impaired people's organizations at the outset of the study. The purpose of the discussion was to gain an overview of issues that were of concern to people with impairments in relation to their access to health care services. Some of the research questions asked were: what are the obstacles you face when you are seeking health care? What is the cost of health care and other costs you experience? What mode of transport do you use to get to the health facility? (See the full interview schedule in annexure 1)

Interviews were also conducted with six providers (as key informants) of health services whereby *two* providers were purposively chosen from each clinic. Providers were selected if they worked in a chosen health care facility and if they gave treatment or any other service to people with impairments. The providers were either nurses, doctors, community counselors or security guards. It was found suitable to interview these people as providers because they provide services to patients at the clinics and all deal with them in different ways.

The interviews with people with impairments were conducted in the organizations of physically impaired people, health centres such as Okuryangava, Katutura and Dordabis clinics in Khomas region and Kabbe, Sibbinda, and Chetto clinics in Caprivi or at home according to the preferences of the interviewee found at the clinic. Owing to the sensitive nature of the topic as well as linguistic considerations, it was decided to use local languages. Silozi was used in Caprivi as it is the most widely spoken language in

the Caprivi region and other different languages were spoken in Khomas depending on which language the respondent was comfortable with.

Table Summary of data collection tools and number of interviews conducted

<b>Data collection methods</b>	<b>Number of Interviews in Caprivi</b>	<b>Caprivi totals</b>	<b>Number of Interviews in Khomas</b>	<b>Khomas totals</b>
FGDs	1	1	1	1
Semi-structured interviews	Kabbe -5 Sibbinda -5 Chetto -5	15	Katutura -5 Okuryangava-5 Dordabis -5	15
Key informants	Kabbe -2 Sibbinda -2 Chetto -2	6	Katutura -2 Okuryangava-2 Dordabis -2	6

### 3.5 Techniques of Data Analysis

All interviews were audio-taped and transcribed in full. Three speakers of indigenous languages translated the local language texts independently. The transcribed interviews were given unique identifier codes. All interview transcripts were analyzed using *the qualitative data analysis software Atlas ti*.

After reviewing the interview transcriptions, analysis of interview data began with coding into broad categories dictated by the interview questions. Emerging issues and themes were coded using open coding in Atlas ti. (See appendix 3). The categories were refined through repetitive scanning of the data. During this process subcategories or new

categories were identified and analysis continued until no new categories emerged. For example, after all the interviews were coded, codes were examined in order to identify related concepts and families of related themes were formed, creating a structure of issues that had a common theme. Content and thematic analyses were the main techniques for data analysis.

## **CHAPTER 4: RESULTS**

### **4.1 Introduction**

The aim of the study was to identify financial, geographical, technological, locational, access and communication barriers that are experienced in accessing health care services and also to investigate how the physically impaired population cope with these barriers. This chapter attempts to answer the research questions, based on the findings that emerged from the analysis of the interview data.

More males i.e. 60% were interviewed in the Khomas region than females and the opposite is true for the Caprivi Region where 20% less were interviewed. People suffering from visual impairments were mostly in the age category of 35-49. Nine out of the fifteen people interviewed in the Khomas region were unemployed and with only six being employed. The figures tell us that the unemployed respondents amongst the physically impaired in the Khomas region were mostly in the age category of 20-34 (see table 6). In the Caprivi region, 40% of the respondents suffered from lower limb disability and visual impairments. Only three respondents out of the fifteen were employed, the rest were unemployed. Those who were unemployed fell into the age category of 50-64, as this category also included pensioners from the age of 60. (see table 7). The highest education qualification category was in the Grade 12 qualification category with 40 % in Khomas region and the highest in Caprivi was in the no formal education category with 33%.

Table Characteristics of the Respondents in Khomas region

	Katutura		Okuryangava		Dordabis		Totals	
	Number	%	Number	%	Number	%	Number	%
<b>Gender</b>								
Female	2	40%	1	20%	1	20%	4	27%
Male	3	60%	4	80%	4	80%	11	73%
<b>Age categories</b>								
15-19	2	40%	2	40%	0	0	4	27%
20-34	2	40%	2	40%	2	40%	6	40%
35-49	1	20%	1	20%	2	40%	4	27%
50-64	0	0%	0	0%	1	20%	1	7%
<b>Employment</b>								

Employed	2	40%	3	60%	1	20%	6	40%
Unemployed	3	60%	2	40%	4	80%	9	60%
<b>Type of Impairments suffered</b>								
Paraplegic	1	20%	0	0%	2	40%	3	20%
Amputated leg	3	60%	2	40%	0	0%	5	33%
Amputated arm	0	0	0	0	1	20%		
Hearing Impaired	1	20%	1	20%	0	0	2	13%
Visually impaired	0	0	2	40%	2	40%	4	27%
<b>Education</b>								
Some primary school education	2	40%	0	0	1	20%	3	20%
Secondary school education but not grade 12	2	40%	2	40%	0	0%	4	27%
Grade 12	1	20%	2	40%	3	60%	6	40%
Tertiary education	0	0%	1	20%	1	20%	2	13%

Table Characteristics of the respondents in Caprivi region

	Kabbe		Sibbinda		Chetto		Totals	
	Number	%	Number	%	Number	%	Number	%
<b>Gender</b>								
Female	3	60%	2	40%	3	60%	8	54%
Male	2	40%	3	60%	2	40%	7	47%
<b>Age categories</b>								
15-19	0	0%	0	0%	0	0%	0	0%
20-34	1	20%	2	40%	2	40%	5	33%
35-49	3	60%	1	20%	0	0%	4	27%
50-64	1	20%	2	40%	3	60%	6	40%
<b>Employment</b>								
Employed	2	40%	1	20%	1	20%	4	27%
Unemployed	2	40%	4	80%	4	80%	10	67%
Missing	1	20%	0	0%	0	0%	1	7%
<b>Type of Impairments suffered</b>								
Paraplegic	1	20%	0	0%	1	20%	2	13%
Amputated leg	1	20%	2	40%	0	0%	3	20%
Amputated arm	1	20%	0	0%	1	20%	2	13%
Hearing Impaired	1	20%	0	0%	1	20%	2	13%
Visually impaired	0	0%	1	20%	2	40%	3	20%
Disability not specified	1	20%	2	40%			3	20%
<b>Education</b>								
No formal education	0	0%	2	40%	3	60%	5	33%
Some primary school education	1	20%	1	20%	2	40%	4	27%

Complete primary school education	1	20%	0	0%			1	7%
Secondary school education but not grade 12	2	40%	1	20%	0	0%	3	20%
Grade 12	0	0%	0	0%	0	0%	0	%
Tertiary education	0	0%	1	20%	0	0%	1	7%
Missing	1	20%	0	0%	0	0%	1	7%

## 4.2 Structural Barriers to Health Service Delivery

Structural-environmental barriers are conditions in the physical and social environment in which health care services are delivered (Kroll, et al, 2006). Such barriers typically consist of a lack of access ramps at health centres, difficult to access rooms and equipment (e.g. height of tables, scales that do not accommodate wheelchairs, inaccessible washrooms), and the unavailability of needed transportation services to medical appointments (Kroll et al., 2006 & Hwang et al., 2009). According to the Namibian Demographic and Health survey (NDHS) (GRN, 2006) access to health care facilities, in terms of distance, time, and cost is a very useful indicator of the quality of life of the population in Namibia. Forms of structural barriers are as follows:

### 4.2.1 Physical Difficulties

Physical accessibility depends on the type of disability suffered and the design of the clinic. For example, those in wheelchairs have problems of access buildings while the visually impaired and those with upper limbs disability do manage to access easily. This was not so much of a big issue to a lot of people in the sites studied. However one respondent in Khomas reported that:

*“It is difficult for me to access this facility because the stairs are too high”*  
(Female, health service user, legs amputated - Khomas/Okuryangava)

In Caprivi another respondent put it this way,

*“The facility is not accessible to me as a physically impaired person and there are no porters who can help us at this clinic. No toilets for physically impaired people and no path entrance for us. Examination room is not accessible unless someone lifts me - that is when I go in the examination room”* (Male, Health service user, legs amputated – Caprivi/Sibbinda).

#### 4.2.2 Distance/ Geography

The NDHS (GRN 2006, p.2) found that rural households are more likely to be nearer to a clinic than urban households, and urban households are more likely to be nearer to a government hospital than rural households. For Khomas region the percent distribution of households by the nearest government health facility, according to residence and region is 20.5% for a hospital, 3.2% for a health centre and 65.6% for a clinic. For Caprivi region, the per cent distribution of households by the nearest government health facility according to residence and region is 7.3% for a hospital, 14.9% for a health centre and 77.3% for a clinic. This is to be expected because there are more clinics in the country than any other type of facility (GRN 2008, p.:269). There are however

implications, it means that most people attend clinics than hospitals because they are the nearest type of health facilities.

The mean time to reach a government hospital is 99 minutes; with 14 per cent of households being three or more hours travelling time from the nearest hospital. The NDHS was very general when it comes to the mean time to reach a government hospital. It only classified areas according to rural and urban and, therefore, this study could not determine the specific mean times for Caprivi and Khomas regions. Because government health facilities tend to be concentrated in cities and towns, urban households are closer to hospitals than rural households and travel times vary substantially. The mean time to the nearest government hospital is 37 minutes for urban households, compared with 150 minutes for rural households (GRN 2006: 271). Respondents in the two regions, especially those living in Caprivi/Sibbinda area complained of the long distance to the nearest clinic since it is situated far from their villages. For those in Chetto area, distance was not a problem for many respondents; the problem only came if the person was physically impaired and had to walk to the clinic. This means that without transportation even a short distance to care facilities can become an insurmountable problem. The following excerpts from Chetto, Sibbinda, Katutura and Okuryangava are illustrative:

*“It took about half an hour to get to the clinic. The village is not far but because we both can't see, we walk slowly just to make sure there is nothing on the way and find footpath using a stick”. (Female, Health service user, visually impaired, Caprivi/Chetto)*

*“I am also not happy with the location of the facility because my village is too far and it's bushy so it is scary. When you walk it takes more than 1 hour 30 minutes to*

*get to the health facility” (Female, Health service user, paralysed body, Caprivi / Sibbinda).*

*“Windhoek is a big place and distances also play a role as most suburbs are far from the clinic” (Female, Health service user, visually impaired – Khomas/Katutura).*

*“Long distances also play a role in people not accessing health care as they cannot walk a long distance” (Male, Health service user, legs amputated Khomas/Okuryangava).*

It is acknowledged that access is a problem for the poor and other vulnerable groups but people with physical impairments have a double burden. A number of people in the focus group highlighted distance as a major barrier to access health care services. The excerpt below shows.

*“Long distances are the major problem for us to access health care and again at the hospitals the security guards do not allow taxis to enter the facility even if the taxi is carrying a physically impaired person” (Okuryangava FGD, Khomas region).*

*“I live about 10kms from the clinic and I cannot walk properly. My leg and arm were broken few years ago in an accident. We should be provided with a mobile clinic that must be treating physically impaired people who cannot walk to access health care. The fact that there are no staff members who are physically impaired like us shows that they must employ people who are also physically impaired because they will know how we feel (Sibbinda FGD, Caprivi region).*

Those living in Khomas /Dordabis had also a problem with bad road infrastructure.

*“The road is very bad and it takes us about 3 hours to get to the clinic” (Female, Health service user, physically impaired - Khomas/Dordabis).*

In the Caprivi region, the constituencies traversed by the Zambezi and Chobe rivers, namely the Kabbe and Katima Rural constituencies, experience high water inflows from the northern parts of the rivers (from Zambia) causing severe flooding every year since 2009. Whilst the 2009 floods were slow to take effect, the 2010 floods were rapid thus causing panic among the communities in these flood prone areas. Caprivi/Kabbe

residents had problems accessing health care facilities because of flooded footpaths. During the rainy season flooding presents a challenge for those that have problems with leg amputations. Many respondents alluded to problems caused or compounded by floods as evident from the examples presented below:

*“During floods like this it is very difficult to access the clinic because all shortcuts/ footpaths are usually flooded. Therefore people use canoes to travel to the clinic. If you don’t know how to use a canoe you will be forced to stay at home and this becomes a barrier for a particular person to access the health care at the right time” (Female, health service user, arm amputated – Caprivi/Kabbe).*

*“Water (floods), it’s also a problem to cross when going to the clinic. I usually use my wheelchair but the thing is, in my foot path which I always use, it is full of sand it takes me time to reach the tarred road” (Female, Health Service User, legs amputated – Caprivi/Kabbe).*

There were no problems of floods reported in the Khomas region.

#### 4.2.3 Transportation

Transportation is one of the most worrisome problems people with disabilities face. The Central Bureau of Statistics (2008) reported that on average, in Khomas region, it takes 11.3 kilometres to reach a hospital or clinic. Two in three households access the nearest government health facility on foot. In the Khomas Region, 28.9% of households access a government hospital by car or motor cycle, 21.6% by bus or taxi, 0.8% use animals or animal carts, while 48.7.% walk. For some, location provides another physical barrier to accessing health facilities as comments under the distance theme have shown. According to the NDHS GRN (2006), the overall mean time required to reach the nearest facility is 74 minutes reflecting on the dispersed population of Namibia.

Form of transport to/from facility is important in any consideration of transport. In rural areas there are many strategies people with disabilities employ to get to healthcare

facilities. They include private car or walking (the majority), taxis (where available) and in a minority of cases homemade sledges. Access to transportation is the same for all groups of people in society; it does not matter if one is male or female. In Khomas region (Katutura and Okuryangava) access to public transportation is easy but in Dordabis getting transport to go to the clinic is very difficult because Dordabis is in a rural area. In Caprivi region, getting transport is also extremely difficult most of the time because of the floods and so people make their own means of transportation like sledges or call the ambulance from the hospital but it takes hours to get to them. For the few who stay close to clinics, getting there is not difficult. This is supported by the following excerpts:

*“I usually use a taxi. No transport is arranged unless you are referred to the hospital. The taxi fee is N\$16.00, 8.00 for coming and 8 for going back. For accessing of health care you pay N\$8.00 for consultation and N\$16.00 for transport. (Female, Health service user, mentally disturbed – Khomas/Katutura)*

*“If I am critically ill, then I will be loaded on anything with wheels, it could be a wheelbarrow or a donkey cart. They will even carry me to the facility if any of the things mentioned are not available” (Male, Health service user, Paralysed body – Khomas/Dordabis).*

*“They always refer me to central hospital and they call the ambulance to come pick me. We do not pay for that” (Female, Health service user, visually impaired – Khomas/Okuryangava)*

In the rural areas of Caprivi transport can take extreme forms. Thus a few respondents elaborated that;

*“When I am sick, my family pans oxens and I am put on a sledge and they take me immediately to the clinic for medication” (Female, Health Service User, Physically impaired (paraplegic) – Caprivi/Kabbe).*

*“The good thing with the clinic is if the illness is very serious they will call an ambulance for you but it delays a bit”* (Male, Health service user, leg amputated -Caprivi/Chetto)

*“I stay close to the health centre so I only walked a short distance. The facility is said to have an ambulance but I have not seen it help anyone. I like the location of my village and health centre”.* (Male, health service user, leg amputated – Caprivi/Sibbinda).

A notable difference between the three site areas chosen in Khomas region in terms of transportation is that people in the Khomas region who live in towns (Okuryangava and Katutura) use public transportation to get to health care facilities and those in the rural areas (Dordabis) make use of sledges. In the Caprivi region, on the other hand, people either use sledges or walk to health care facilities if they are not referred by nurses to be able to use ambulances.

Individuals, who have lower limbs disability in particular, find it hard to walk to healthcare centres and some physically impaired people with amputated arms and the visually impaired could not access health centres because there was no one to assist them push their wheel chairs. One person had a problem with unavailability of people to assist with moving her from one point to another. This is evident in the following excerpt:

*“I am transported by the wheelbarrow and the community assists to push me when I am going to the hospital, but I must pay \$2 or \$3 dollars. If there is no one to assist with pushing, I stay at home. It does not take too long to reach the clinic as it’s not far from the house”* (Male, Health service user, visually impaired – Khomas/Dordabis).

#### 4.2.4 Costs

The lack of financial resources is a barrier to access health care for many Namibians, because the impact it has appears to be greater for vulnerable groups including people with physical impairments. There are two types of costs that one has to consider when it comes to access health care services. These are cost of transportation and cost of services.

**Cost of services** extends beyond costs of transportation to cost of consultancy and drugs. Poverty underlies the difficulties that many rural people face in Namibia.

People with disabilities have fewer economic resources compared to their non-disabled counterparts. Most of the time it is difficult for them to get jobs to be able to sustain themselves and if they get these jobs, it is usually difficult for them keep it thus they remain in poverty. Unemployment is another indicator of health status (Etowa, Keddy, Egbeyemi & Eghan, 2007a).

Rural areas in Namibia are by definition in remote areas and they are in places that lack access to resources; consequently there is very little employment available. Most people who live in the capital city of Windhoek which forms part of the Khomas region (where this study is done) are from different parts of the country and they are in Khomas for greener pastures. According to Smith and Callaghan (1989) unemployment is defined, as distinct from non-employment, as being without paid work, seeking work, and in a position to accept a job if one is offered. Unemployment statistics for Namibia show that 51.3% of people are unemployed. According to the National Employment Policy, high levels of unemployment have serious economic, social and political implications for

Namibian society (GRN 1997). The rural unemployment rate of 46.6% is higher than the urban one 30.6%. According to the Central Bureau of Statistics (2008), most people in Namibia live in poverty. More females 30.4% than males 25.8% are impoverished. These figures are inclusive of people with impairments. In 2010 at the time when this study was conducted the Ministry of Health and Social Services (MoHSS) announced free access to health care services for all vulnerable groups in Namibia including people with physical impairments in addition to the disability grant that physically impaired individuals receive already because of their disability status. This was met with so much satisfaction and happiness from the group under discussion. The excerpts below supports:

*“I am thankful that I do not pay at the clinic because of the government fund that I receive”* (Female, Health service user, physically impaired – Khomas/Okuryangava)

*“I do not pay any cents to the clinic. I am treated for free”.* (Female, Health Service User, Physically impaired (paraplegic) – Caprivi/Kabbe)

Free access to health facilities seem not to be universally applied in Namibia because some health facilities in Caprivi are not implementing the law set by the Ministry of Health and Social Services (MoHSS), so the cost of treatment remains one of the barriers to access health care for the physically impaired. This is well recognized by the respondents in this sample in the Caprivi region:

*“I pay N\$ 8.00, for treatment but I have heard of new policies that exempt people with impairments from paying. I don't think it has been implemented here though”* (Male, Health service user, visually impaired, Caprivi/Sibbinda)

Respondents in Khomas did not complain about implementation problems when it comes to exemption of physically impaired patients from payment.

While getting treatment may be for free for people with disabilities, **cost of transport** to the health centre remains a problem especially to those who are unemployed either because of lack of education or the type of impairment they suffer or other reasons. . Both males and females in both regions experience the same difficulties when it comes to access to finance to pay for travel costs to the clinic or to pay for cost of services. In Khomas region in Katutura and Okuryangava areas, transport is widely available but money to pay for it becomes the problem.

*“I usually use a taxi. No transport is arranged unless referred to the hospital. The taxi fee is N\$16.00, 8.00 for coming and 8 for going back. For the accessing of health care you pay N\$8.00 and N\$16.00 for transport. The total cost is N\$24; it’s expensive and not acceptable. I cannot afford to pay this every time because I need drugs all the time and then, I will spend more money on medication and nothing for food so how will I survive. My parents are also not working so we cannot afford this cost; it’s too much”* (Female, Health service user mentally disturbed – Khomas/Katutura)

*If I am referred to hospital I look for transport or money for taxi so that I can go to the other clinics as they are far. If I do not get money or transport then I go back home as I cannot walk to other clinics because walking is a problem to me* (Male, health service user, amputated legs, Khomas/Okuryangava).

*The main factor that keeps people away is money to pay for the transportation fee* (Male, health service user, mentally challenged, Khomas/Dordabis)

In the Caprivi region, public transport is not widely available like in the Khomas region.

People make use of private transportation which is very expensive. Accordingly,

*Financial problems - there is no money to pay for the services* (Male, health service user, amputated arms, Caprivi/Chetto)

*“The transport cost is N\$ 150.00, which is very expensive for me and my family to pay for the patient and the caregiver going to the hospital. We cannot afford it. Then you just die at home because you are unable to pay it”* (Female, Health service user, arm amputated – Caprivi /Kabbe)

### **4.3 Process Barriers to Health Service delivery**

According to Kroll, Jones, Kehn & Neri (2006) and Hwang et al. (2009) process barriers refer to difficulties experienced by people in the course of service delivery. Examples of such difficulties include convenience of care, receipt of preventive teaching, and aspects of communication between providers and consumers. Here we consider the experiences of people living with disabilities with regard to: language and health provider attitudes, provider knowledge, drugs and medicine, physical access and rehabilitation. Fiedler (1981) found that among the factors that affect access and utilization are the hours that the care is available. Because service hours are determined by providers and not patients, the most convenient time for patients to obtain care may be very different from the time that is acceptable to providers. A common primary care story is that revealed by Fiedler's (1981) study of North Carolina in the USA where only one-fifth of the residents felt that medical care was available when it was needed and less than one seventh felt that they could see a doctor or a nurse on weekends

### 4.3.1 Health Provider Attitudes

Some health care providers' attitudes at some facilities are said to be unbearable. Providers at some health facilities, either unconsciously or consciously, treat certain groups of people in society differently from other patients. This is what I call discrimination. In some rural places patients say that nurses are rude, they insult patients and do not observe privacy as they are supposed to but this does not exclusively apply to people living with disabilities. Two female health care users complained about the attitudes of the nurses by saying the following:

*“The attitude of the two nurses from Kenya is bad. They do not even greet patients. The male nurse cannot even put on his uniform, he just works like a doctor” (Female, Health service user, amputated legs-Caprivi/Sibbinda)*

*“You would stop coming at the health centre and rather use traditional health care to avoid insults from nurses” (Female, Health service user, arm amputated – Caprivi /Sibbinda)*

One respondent thought that health providers have negative attitudes towards people with physical impairments and deliberately distinguish between real and non-real (i.e. disability) health problems. Another respondent complained that health care providers do not practise privacy. They put it this way respectively:

*“It's difficult to continue asking a question when nurses already think it's a disability problem instead of a real health problem although it's something that happens to everyone (Female, pregnant women with legs amputated, Caprivi/Kabbe)*

*The health workers insult us when we don't come to the clinic on given dates. Community health counsellor is from the village and discusses patients' health reports with other people, e.g. discuss people's status at shebeens (Male, health service user, amputated legs, Khomas/Dordabis).*

Most of the patients getting treatment at Sibbinda Clinic in the Caprivi region complained of very bad mannered and rude providers who like to do things their own way. This was an issue for one focus group participant. She said:

*“You can see how I am, I cannot access health care at Sibbinda again because the way I was treated, I thought that maybe I am not a Namibian, one morning I went to the clinic with my baby at the back, reaching there I found a long queue and I had to follow the queue. During that time waiting, my baby urinated on the floor; when the cleaner came and asked whose baby urinated and was told it was my baby she came to me and pushed me very bad in my head and telling me to go and look for the mop. She talked in a rude manner and I was even told to pay consultation fees, I told them I am a physically impaired person but the lady insisted although she later understood and stamped my health passport. I took the health passport to the nurse on duty; the nurse was a foreigner from Kenya. When I gave him the health passport he asked if I paid and then I said I did not pay, he just threw the book to my face and told me to go and look for money to pay for the consultation.”* (Sibbinda FGD, Caprivi region)

*“I do access health care at this health centre but I am disabled and us who are disabled are not always treated in a good manner and the staff do not even bother to assist patients who have impairments”* (Sibbinda, FGD, Caprivi region).

#### **4.3.2 Language**

*The language barrier was a main concern in the Caprivi region where there is a large group of the minority San people. San people occupy the lowest level of Namibia’s ethnic hierarchy (with the lowest education, socio-economic status and life expectancy).*

*What this translates to is that there are hardly any health workers in Namibia who are San. Most of the health workers are from other ethnic groups and they probably do not care to learn the local language. A case in point is at Chetto clinic in Caprivi region. This was interpreted as a problem of attitude among San people living with disabilities in that area. The excerpt below explains the problem of language:*

*“Explanation on procedures, conditions and management strategies, prognosis, prevention, medication use and answering questions are not done in our language. This is bad because all these are done by counsellors, the nurse cannot explain in our language” (Male, Health service user, Disability (not specified) – Caprivi/Chetto)*

One particular individual who had problems with hearing at the time gave his story of how he found it difficult to get treatment because he could not communicate with the providers who do not know sign language.

*“The problem again is when coming to the health facility, there are no interpreters and the communication with the doctor was difficult. Sometimes the doctor will not get what you are saying and may end up not treating you as well as it should be and may even prescribe you wrong medications” (Male, Health service user, hearing impaired - Khomas/Okuryangava)*

#### **4.3.3 Quality of Health Service**

Quality of health care is easily defined as doing the right thing, at the right time, in the right way, to achieve the best possible results (“What does quality in health care mean?” 2010). Quality of health service aspect is important in measuring barriers to access health care services because, for example, if a clinic does not have enough providers, the quality is compromised as this means the health service user will not be able to get treatment when they need it. Some people have to travel long distances from their catchment area clinics to clinics in other areas to get doctors. Sometimes this means the health service user will have to wait until they have enough financial resources to be able to move from one clinic to another and this then results in not getting the treatment at the right time. To support this, Quality of health care was, therefore, measured under the availability and acceptability concepts and the excerpts that follow give examples.

#### 4.3.4 Availability

Ricketts & Goldsmith (2005) defined availability as the volume of physician and other health care services. Low number of providers can affect quality of health care services. In this study the problem of lack of providers that results in patients not getting treatment when they need it was pointed out as follows:

*“I stay in Otjomuise and there is also a clinic there but without any doctors so you are referred here to Katutura” (male, arm amputated, Khomas/Katutura).*

*“We need a doctor at this facility. We are poor and cannot afford going to Windhoek every time as this requires extra spending money” (female, leg amputated, Khomas/Dordabis).*

*“There are no doctors at Sibbinda but we prefer to see doctors” (female, visually impaired, Caprivi/Sibbinda).*

The majority of people with physical impairments reported that there is also a lack of information regarding HIV/AIDS and they were more vulnerable to contracting HIV/AIDS. The following excerpt from the focus group is illustrative:

*“Health issues where people with disabilities are left out is the area of HIV/AIDS, we get information about HIV/AIDS awareness through television but not all of us can listen to what is being said on news, for example, people with hearing impairments. People with visual impairments cannot read if the condom has expired because the information is not written in braille that we can read. The attitude of nurses is not good too when it comes to intimate relationships and we see this as violation of our rights because they think we are not the same as other people” (Okuryangava FGD, Khomas region).*

When there is unavailability of providers or other services needed by a patient, it results in self-care for the patient.

#### 4.3.5 Self-Care

*Self-care involves the attitudes and techniques by which individuals assume responsibility for maintaining health and treating illness (Bailey, 1987). When all things fail, patients go to look for their own medication somewhere else. In Namibia, this is mostly caused by difficulties of accessing clinics/health centres because of unavailability of medication at health facilities and lack of financial resources as evident from the examples below.*

*“I buy pain killers and other simple medications from the shops.” (Female, visually impaired, Khomas/Dordabis).*

*“Sometimes if there is no medicine at the clinic and we have money then we have to buy the medicine at the shops, otherwise there is nothing we can do if we don't have money” (Female, pregnant woman with legs amputated, Caprivi/Kabbe).*

*“I use traditional health care and self-care because it is easy to access, easy to use and is free. As I am unable to go to the clinic where they demand money I just serve myself” (Male, hearing impaired, Caprivi/Sibbinda).*

Other experiences of accessing health care services were considered in terms of scheduling of appointments and timeliness of services. It seems that appointments are not utilized in scheduling services. Health service consumers are expected to come to health facilities whenever they can and that is what they do.

Most consumers complained about the timeliness of services, their main complaint being queuing and the time it takes for them to get service. Many people with disabilities described the service as bad because of the time spent in queues. Many of those living

with disabilities find it difficult to cope especially in the Khomas region as explained below by one respondent

*“This clinic is always crowded, that is the reason most people stay away from the clinic, but I don’t have any other choice. I have to come every day”* (Male, health service user, amputated legs, Khomas/Katutura).

*“We spend most of the time in the queue without help* (Female, Health service user, Physically impaired (Polio) – Khomas/Katutura).

#### **4.3.6** Health Provider Knowledge

Most people living with disabilities praise health workers for their skills. They say:

*“The nurse is qualified and well trained together with HIV counsellors they were trained to do their work. Although she is a well-qualified nurse, she is not friendly”* (Male, amputated arm, Caprivi/Chetto).

*“The nurses are skilful because they work fast and also explain the medication”* (Male, paralysed body, Khomas/Dordabis).

One person living with disabilities was quite detailed in praising health providers when it comes to collecting medications from the clinic:

*“There is always shortage of medicine and if they are out of stock then they will tell you to go home and come after a day or two. The best about the nurses is that they will send somebody to tell us to go collect our medication”* (Female, Health service user, visually impaired – Khomas/Dordabis).

The main complaint was that there are not enough health workers to do the job. For instance, at Chetto as a researcher I waited for three days before I saw the nurse. She had gone to Katima Mulilo (the regional centre) for a workshop and since she was the only one at the clinic there was no service for the four days (she took an extra day for shopping) she was away. It was in this context that one person complained, *“One nurse*

*cannot cater for all the people's needs (female, Paralysed body, Caprivi/Chetto)."* At the same clinic others complained of:

*"Communication, no access to phones - if a patient is very ill the nurse has to use her own cell phone to call the ambulance. If there's no network she sends another person again to go to the hill almost 3 kilometres away. Non-availability of the nurse is a problem - if they were at least two- if one goes for the workshop at least the other one must remain"* (Male, disability not specified, Caprivi/Chetto)

#### **4.3.7 Acceptability**

**Donabedian (1990) defined acceptability as conformity to patient preferences regarding accessibility, the patient-practitioner relations, the amenities, the effects of care and the cost of care. In Khomas region the issue of discrimination and acceptability of persons with disabilities is a problem and keeps people with disabilities away from accessing health care services. One respondent alluded to the following:**

*"In our culture people hate physically impaired persons, so if you don't see for yourself you will remain like that whether dirty, untidy place, rotten food etc; they don't take care about you"* (Female, paralysed body, Khomas/Katutura).

People who have hearing impairments cannot access health care services because they cannot understand the providers and, therefore, the effects of treatment are sometimes not effective. This is a sign of unacceptability and unconformity to patient-provider relations.

*"I once met a lady at the day of national HIV testing day. What happened was that people did not help her just because she could not talk and then when she asked me to help her officials also objected because I am not her family member"* (Male, hearing impaired, Khomas/Okuryangava)

*Nurses discriminate against us, e.g., they ask why do we get babies when we are impaired (female, visually impaired, Khomas/Katutura).*

People with physical impairments feel that they are not considered when government make decisions, information is not provided and no money is put aside for them so that they can assist themselves. The excerpt below from a focus group discussion is illustrative:

*“Information is not provided to physically impaired people by the Ministry of Health for example information on where to get equipment. There is also an issue of budget from the Ministry that they do not include the disability centre in their budget because we never get any money from government as a centre. Also, one day at this clinic, a hearing impaired patient came to the clinic and she put her health passport in the box where other patients put their passport and the nurse started calling the names of the patients reading the health passports. The hearing impaired patient stayed at the clinic for the whole day as she could not hear when her name was called and the nurses did not ask if she was treated or not. Another issue is that there are lots of decisions made on disability policy but then people are not aware of this circular and even the service providers are not aware of it. The policy is not implemented because of financial reasons” (Okuryangava FGD, Khomas region).*

One respondent in the focus group gave a solution by saying

*“The issue of interpretation for people with hearing impairments should be addressed by the government. Courses in sign language should be given because this problem does not only occur at health facilities but also in the public service” (Okuryangava FGD, Khomas region).*

#### 4.3.8 Social context

There is very thin literature or none I have come across that defines what social context is but generally social context is a term used to refer to the social environment of an individual. It can also refer to the culture that he or she was educated and/or lives in, and the people and institutions with whom the person interacts. The social context in which an individual lives plays a big role in how they access health care, where they access, why they access wherever they access. The contributing factors to the social context are

the household in which the person lives, the community, his/her government and others. The term 'social context' was not used directly in the interviews but rather 'household support' was used as a proxy for social context.

#### 4.3.9 Household Support:

**Household is defined as a group of persons who carry out domestic functions together. It implies common residence, economic cooperation and socialisation of children (Bender, 1967). Respondents from Khomas region gave examples of not having support at home and the consequences thereof.**

*"I don't know where my rights start and where they end because, if I say something at home, my young sister and brothers do not consider it to be a point, I am impaired. The same applies when I come to visit the facility, now where will I go?"*(Female, Paralysed, Khomas/Katutura)

*"I understand that the main problem why people do not sometimes access health care is that people whom we stay with do not care about us and do not support us to get to the clinic. So we end up being home while we are sick."* (Male, leg amputated, Khomas/Okuryangava).

Comparing Khomas to Caprivi region, users in Caprivi did not complain about lack of household support since they had people who assisted them. They talked of people who helped them out:

*"How to take medication I am helped by my brother who is my caregiver, because my mother is old and my sister is also physically impaired"* (Female, paraplegic disability, Caprivi/Kabbe).

#### 4.3.10 Rehabilitation

Anthony, Cohen, Farkas & Gagne (2002: 3) defined rehabilitation as, “an attempt to open doors of the community and help people figuratively develop a prescription for their lives.” Rehabilitation is extremely important for people living with disabilities as it utilizes strategies and techniques focused on restoring the useful life of people. Rehabilitation helps the body achieve the normal daily functions. In almost all the rural clinics and regardless of type of disability, people living with disabilities complained of lack of rehabilitation. One respondent from Okuryangava said: *“I registered in Okuryangava rehabilitation school but up to now nothing has happened”* (Female, Health service user, physically impaired (Polio) – Khomas/Katutura)

*“They never receive rehabilitation ever since birth; they never received any assistive devices. They need assistance in any form regarding their disability. Only one of them receives a disability grant; I tried many times for him to get assistance”* (Female, care taker of two physically impaired men, paralysed – Khomas/Dordabis)

Among the suggestions for improvement put forward by the health users/respondents were that health facilities should accommodate those in wheelchairs especially by building ramps up stairs and toilets. Shelf heights should be convenient for both standing and seated users and more nurses/doctors who understand sign language should be trained and employed in the health sector in order to communicate with those who are deaf (process barriers) otherwise equality in accessing health care would become an impossible mission for Namibia.

Most recommendations also related to facilities and personnel. Among the notable recommendations from various sites were the following:

*“They must build the clinics for people with physical impairments only, and employ physically impaired nurses and doctors to treat them the way they want”* (Female Health service user physical impaired (polio) -Khomas/Katutura)

*“I think it will be a good idea if all people with disabilities have their specific hospitals and doctors trained to work on their special needs”*. (Male, hearing impaired, Khomas/Okuryangava)

#### **4.4 Health Provider Views:**

There is hardly any literature that defines who a health care provider is but generally a health provider is an individual who provides health services to health care consumers (patients). Provider’s views (this included nurses, doctors, social workers, community counselors, security guards etc.) were also needed to find out what barriers they see people with physical impairments encounter. One community counsellor at Kabbe clinic in the Caprivi Region made it clear that hearing impaired people are difficult to treat because there are no providers at the clinic who can do sign language.

*“People who are difficult are the physically impaired people. For example, if he is a sign language patient (mute) and no one can translate what he is talking about, you will find that he might get different medication than the one that is suitable for his illness”* (Female, community counsellor, Kabbe).

*“I treated physically impaired persons such as mentally challenged and deaf people but experienced a problem when it comes to interpretation”* (Female nurse, Okuryangava).

It was surprising to know that most providers are not aware of the disability policy in the country and what it says about those with disabilities. One provider explains from Caprivi:

*“I know nothing about the policy, but I do have knowledge about disabilities. We do handle them and support them like other people”*(Female community counsellor, Kabbe).

The nurse at Chetto clinic admitted to not communicating with patients and her supervisors because of the language problem and not knowing what type of medication to give to patients.

*“I am not very happy with my supervisors. There is no communication between me and the supervisors. Especially in cases of emergencies, it’s not easy to call an ambulance, there is no network. I am not very close to the community. I am still new and communicating with them is not easy since I do not speak their language. The counsellors and cleaners are the ones who help with translations. I find it difficult to treat patients with HIV/AIDS and Tuberculosis because I was not trained in these areas. I find it very challenging to issue medicines and sometimes it could be dangerous because I do not really know”* (Female, nurse, Chetto).

*“Language barrier is also a problem as some patients cannot speak English and the nurse cannot speak the vernacular language with the patient, so it ends up being a problem as the communication is not good, it ruins the treatment process.”* (Female, nurse, Okuryangava clinic).

One security guard at Kabbe clinic in the Caprivi region made it clear that those with lower limbs impairments find it difficult to access the clinic because they do not have wheelchairs and the clinic itself also does not have a ramp. He gave an example that:

*“People with impairments usually struggle to access the health services at the clinic, because, because there is no ramp at the entrance of the clinic and once the patients are inside the clinic they would be crawling around the clinic because there are no wheelchairs to help those with physical impairments ”* (Male, security guard, Kabbe)

On the other hand at Sibbinda clinic providers complained of there not being enough equipment available that is needed to treat patients. A nurse explains as follows:

*“We do not have much equipment here at the facility; the ones we have are old”* (Female, nurse, Sibbinda).

At Dordabis there were complaints about medication as follows;

*“More equipment is definitely needed at our clinic, I would say and more mobile clinics. Because the ones available are only for the rural areas, but it would be*

*good if the mobile clinics are also there in the local community. Last but not least we need medications for our patients” (Female, nurse, Khomas/Dordabis).*

There are, however, some providers who are very happy with what they do and do not have problems preventing them from providing good services at their facilities. They indicated that they would still appreciate management visiting them at their hospitals to see progress.

*“I am really happy here, I love my job very much and I also know that there is a crown waiting for me up in the heaven. I am quite privileged to help those in need although I think that our superiors should pass by once in a while to see how we perform because it is rarely done. I wish that there was a programme every quarter to sit together and have discussions relating to health issues and our work” (Female, nurse, Khomas/Katutura).*

The same nurse from Katutura clinic feels that there is nothing special about people with impairments and they should be treated like anyone else.

*“People with impairments are followed up liked any other patients. They usually come with their supporters anyway; there is nothing special about them” (Female nurse, Khomas/Katutura).*

Quite surprising is that these types of comments only came from Khomas region specifically the Katutura clinic and not the Caprivi Region.

## **CHAPTER 5: DISCUSSION AND CONCLUSIONS**

### **5.1 Summary of the Findings**

Transportation issues were concerned with either the lack of transportation or unreliable transportation if it is available. The physical environment was not accommodating to the physically impaired individuals because most of them could not move through the sandy ground with their wheelchairs and, therefore, could not access health care services easily this constituted structural-environmental barriers among others Health service delivery process barriers encompassed among others communication with providers. This was an issue, especially when it came to the hearing impaired individuals because they found it hard to communicate their health conditions to providers (and vice versa) if they did not have interpreters of their own. For many respondents, a visit to the clinic was considered a waste of time and money because of the lack of availability of medication and equipment. Some individuals felt excluded in decision-making because their needs and wants were not met. For some people, the type of attitude and lack of respect they received from providers kept them away, although they did not find any difficulty reaching the clinic. Many respondents coped with barriers either by buying their own medications, making their own form of transportation when there was none or going to traditional healers as a way to get treatment.

## **5.2 Discussion of Findings**

The aim of this study was to investigate barriers that the physically impaired individuals experience in accessing health care services. The identified access barriers to health-care services were grouped into two categories: structural barriers and delivery process

barriers. Structural barriers encompassed issues of finance, geography, location and transportation. Process barriers included communication with patients and providers and accessibility of the facility.

The results of the study conducted among individuals representing different forms of impairments indicate that despite regulations by the Namibian government to allow people with impairments to access health care services for free, people with impairments continue to face significant barriers to health care access. Consistent with the findings of other research on health care access for people living with impairments, a wide range of barriers were reported (Drainoni et al., 2006).

Structural barriers included challenges and restrictions posed by policies and procedures. Many of the findings e.g. lack of transportation and inadequate specialised health care providers largely confirm research in other countries like Zimbabwe (Choruma 2007) and United States of America (Scheer et al., 2003) among others. There were still those barriers that are unique to Namibia, for example, the employment of foreign nurses who may not understand local languages, and people that have a unique language not spoken by most health providers. Although many of these barriers (e.g., long distance to facilities, unavailability of transportation, unavailability of medication and lack of financial resources to pay for transportation among others) are not necessarily unique to people with impairments, their consequences tend to be more severe for people with impairments. People in wheelchairs have problems getting over rocky terrain and

making their way through narrow clinic paths. Someone with a lower limb problem who does not have a wheelchair but walks to the facility may damage his/her health further. Because public transportation is not always an option for those who use wheeled mobility devices, access to health care services by people with impairments as well as their ability to participate in their community settings, is not equal to that of the general population (Scheer et al 2003).

Communication problems between the hearing impaired and the providers and lack of toilets for the physically impaired come across as issues of unequal access to health care. Kroll et al. (2006) argue that it is of utmost importance that facilities at health centres are user-friendly. This term means that health centres should not make it difficult for one to get treatment and other services that they are looking for there. Hosain & Chaterjee, (1998) argued that where prevention of disability is not possible, the process of development of permanent disability or handicap can be halted by offering appropriate treatment at an early stage. This will in turn reduce the social and economic burden of poor countries where usually a meagre amount is spent on health and social welfare.

Transportation was another multifaceted access problem where if public transportation was available to the individual, it did not conveniently reach health-care provision. In Khomas region public transportation was a method of transport used to get to health facilities while in the Caprivi region people relied on their own form of transport which was very expensive. This is the situation because Khomas is an urban area while the Caprivi region is rural. If health care providers were available at the clinic in both

regions, there were not of much assistance to physically impaired individuals especially to those who have hearing impairments. If the clinic did not have sufficient medication (as two respondents reported from the two regions under self-care theme) patients had to purchase medication from their own pocket. Many individuals reported that for reasons of cost, they had been unable to access health care services. Many individuals also expressed feelings of frustration and anger resulting from the misunderstandings on the part of some providers. This confirms the process barriers, specifically attitude and communication barriers that this study aimed to investigate. According to Fitzpatrick, Powe, Cooper, Ives, & Robbins (2004), perceptions of physicians' attitudes toward a patient's health and personal needs, as perhaps measured by time spent with a patient and level of response to concerns, may also act as a barrier to obtaining necessary treatment and preventive care which then forms part of the process barriers.

At the time of the interviews, approximately 80% of the respondents were unemployed and therefore had no medical aid which leads us to believe that they experienced significant economic hardship, which may have further restricted their access to the needed health care services. In both two regions lower limbs and visual impairments were the highest recorded forms of disability. There were more people with lower limbs disability followed by visual impairments. This implies that care should be taken to ensure that mobile clinics are available because the category of the highest number of people with impairments is that of people who cannot (in most cases) walk without the assistance of someone else.

The researcher is of the opinion that the experiences surrounding access to health care as reported by the respondents in both Khomas and Caprivi can reasonably be promulgated to experiences of people with disabilities who did not form part of the study in the two regions. However, despite the severity of the barriers faced in the two regions under study, it is believed that individuals with impairments in other parts of the country may face even greater challenges than those reported here, in view of the highly dispersed population found in Namibia where people are dispersed far from established towns/homelands and towns are also far away from one another.

### **5.3 Conclusions**

While a small exploratory study is hardly definitive, our results reinforce and expand on previously reported difficulties faced by people with disabilities when they attempt to access health care services. Hopefully, future research will include people with disabilities as an integral part of the research team in addressing these issues. Future researchers can look at similar studies with control groups so as to compare perceptions of access to and quality of the services provided by primary care doctors.

Although the failure to adequately address the health needs of people with impairments may seem inevitable given limited resources and spiralling health-care costs, it is also not clear whether the current approach is the best one in the long run given the barriers discussed in this study. In my opinion, to eliminate access barriers and meet the needs of people with physical impairments in an effective and sustainable manner will require

innovative thinking and input from those intimately familiar with and affected by current barriers. It will also require input from health care providers who are familiar with the structural, process and environmental challenges of providing accessible and high quality care to members of this population.

#### **5.4 Recommendations**

Based on the present findings and analysis, the following recommendations are aimed at improving health care access for persons with physical impairments.

- Interventions should be directed at enhancing providers' understanding of how to work effectively with people with physical impairments for example providers should be able to determine real health issues from disability issues.
- Linking of rehabilitation specialists as consultants to group practices or community clinics should be done so that the specialists' expertise would be available to primary care providers in community settings.
- Provisions of timely access to treatment
- Making mobile clinics available in villages so that long distances will not become a major factor preventing people who cannot walk from accessing health care services.

To date, the Ministry of Health and Social Services has built clinics, provided health care providers and medications, and also has introduced free access to health care services for people with disabilities and a lot more but there are still those critical factors related to

the needs of those with physical impairments that the Ministry still needs to consider. These are: provisions of trained sign language interpreters, accessible health care physical infrastructure for people in wheel chairs, constructing more clinics in communities for those who cannot walk etc. The overall objective of the National Policy on Disability in Namibia is to “ensure that all disabled people are able to participate in mainstream contemporary society, by providing adequate services” (Ministry of Land Resources and Rehabilitation, 1997). In order for people with physical impairments to participate in the main-stream economy, adequate services such as those mentioned above need to be met.

Rising to the challenge of providing excellent and accessible health care to persons with impairments is imperative as a matter of equity. This study hopefully will motivate health professionals to go beyond the minimum requirements set by law in order to make facilities and services usable to the physically impaired patient as much as possible. By meeting the needs of people with physical impairments, one will also be providing enhanced facilities and services to other health consumers because people with impairments are frequent users of health care services and will provide a good measure of the overall performance of the health care system.

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## **Appendices**

### **Appendix 1 – Interview guide with health care users**

**Participant nr**

**Study site nr**

**Investigator code**

**Date of interview**

**Demographic information**

1. Gender:

Male	Female
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2. Age group:

0 – 4	5- 14	15 - 19	20 -34	35 - 49	50 -64	65 -79	80 and older
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3. Educational status

No formal education	
Some primary school education	
Complete primary school education	
Secondary school education., but not grade 12	
Grade 12	
1 – 3 years tertiary education	
> 3 years tertiary education	

4. Current employment status

Self –Employed	Employed	Home- maker	Scholar / student	Unemployed
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5. Income of family unit

No income	
R1 – R1000	
R1001 – R2000	
R2001 – R5000	
R5001 – R10 000	
R10 001- R15 000	
R15 000+	

6. Number of people in family unit

1	2	3	4	5	6	7	8	9	10 or more
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7. What type of dwelling do you stay in?

House or separate stand	
Traditional dwelling	
Flat, town, cluster, semi detached house	
Informal dwelling/shack	
House, flat, room in backyard	
Institution	
Other	

If other please specify

8. Do you have the following inside the house?

	Yes	No
Electricity / other source of power		
Toilet		
Bathroom		
Running water		

9. If physically impaired, can you tell me about your impairment-what happened to you and how did you become impaired

(ask about types of activities that are difficult for the person to do in addition to their classification of their disability type)

The relevance of the topics for each specific interview will vary from one interview to another. It is the informant's history and experience that will decide which topics are important in the various interviews.

Explain to respondents the nature and purpose of the study, why they were specifically asked to participate and gain informed consent.

Guiding questions:

1. What is your understanding of health and health related issues?

- Hygiene
- Nutrition
- Medication
- Training
- Related to the disability

2. What are your health needs?

- Hygiene
- Nutrition
- Medication
- Training

Do you access health care in the same way as everyone else?

3. a) In your family      b) in your community?

What factors/problems according to you make it more difficult for a person to access health care (vulnerability factors) and why?

Do you experience any of these factors? If yes ask person to explain (with examples) and also to relate how this affects his/her health care access.

4. Please describe reasons that lead to vulnerability, how you are adapting to it and what strategies you are using.
5. Please describe the different kinds of health service and/or medical care you know about or have accessed/received? This can include modern health care (professional sector), traditional health care (healers and indigenous practices) and self care in the family. What are your feelings about each of these services and why do you have these feelings?
6. Which of these types of services do you personally use and why do you choose to use them?
7. Tell me about your general health status. How would you describe your health today- excellent, good, poor, very poor? Do you have any specific health needs and if yes what are they? How are these needs catered for?
8. Please discuss your use of health care services and experiences while accessing these in the past six months (or further back if they want, but focus on past six months)
  - Why did you need health care?
  - What services did you access and receive?

- How did you experience the service? Was it 1) excellent 2) good 3)neither good nor bad 4) bad 5) very bad

With regards to:

- Making and getting an appointment
- Convenience of the services hours
- The physical surroundings
- Accessibility
- Crowding, availability of seats, water and other refreshments, restrooms, cleanliness
- Registration procedures
- Security
- Privacy
- Status of the equipment
- Availability of your medical records
- Number of staff
- Attitude of staff
- Support received when needed
- Skills of staff
- Waiting times
- Length of consultation

- Explanation on procedures, condition and management strategies, prognosis, prevention, medication use and your questions answered
- Equal treatment, exceptions
- Confidentiality
- Autonomy and informed consent
- Treated in an acceptable manner
- Drug dispensing: Availability of drugs, asked about – allergies, side effects, use of other drugs, Verbal and written directions given – dosage, frequency and route, follow-up

9. Were you satisfied with the service? Why / why not

10. How did the care impact on your health status and quality of life? Did you feel better after the health care?

11. Tell me about any other obstacles you face when you are seeking health care/accessing health services

12. What mode of transport do you use to get to the health care facility (Walking, Private car – own or rented, horse cart, wheelchair, bicycle, bus, taxi, train, ambulance)?

- Does the facility assist with transport or arranging transport?

- Cost of transport, time it takes
- How happy are you with the location of the facility and your travel arrangements?
- Other issues around transport that the person would like to mention

13. Cost of health care and other costs (Care, medication, bribes, loss of income, hidden costs)

- What are all the costs you have to bear in order to access health care?
- In your opinion is this cost acceptable
- How do you finance these costs/ could you afford it?
- How does it impact on your and the families general financial status

14. What happens if the facility you usually access cannot perform the services that you need?

15. What in your opinion are the main difficulties these services experience if any?

16. Do you have any ideas on how these challenges can be addressed?

**Additional questions if participant is physical impaired:**

17. Tell me about the physical accessibility of the point of service delivery. Include toilets examination rooms, pharmacy, special investigations etc.

18. Were information / explanations on procedures, your condition, and medication given in an adequate, understandable way? Do you understand what is wrong with you and how to take your medication? Are you able to ask questions and , if yes, are you happy with the explanations and answers you get?
19. To what extent does the service meet your ongoing health needs?
20. Tell me about the rehabilitation you received?
21. Tell me about any assistive devices you might need or have received – waiting times, fit, usefulness, cost, education and training, follow up

Closing the interview: Acknowledge the informant's cooperation, time spent and information shared and ask whether any other information that they want to give that they feel was not covered adequately.

## **Appendix 2 – Interview guide for interviews with health service providers**

**Participant nr**

**Study site nr**

**Investigator code**

**Date of interview**

**Demographic information**

1. Gender:

Male	Female
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2. Age group:

<34	34 - 49	50 -64	65 -79	80 and older
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6. Educational status

No formal education	
Some primary school education	
Complete primary school education	
Secondary school education., but not grade 12	
Grade 12	
1- 3 years tertiary education	
> 3 years tertiary education	

1. Could you explain to me what your understanding of equitable health care access is
2. What factors according to you increase people's vulnerability to poor health care access / which patients struggle to access the services at the facility?
3. How accessible is the facility where you work for patients (physical, costs, time, type of services, equipment, number of health care workers)
4. What is your understanding of vulnerability? Name possible groups.
5. What in your opinion can be done to improve access to health services if improvement is needed?
6. Tell me about how patients are treated in general in the facility (fairness, equality, respectfully, patiently)

7. How satisfied are you with your job and the service you deliver?
8. Are there any challenges in this facility that prevents you from performing your duties as you would like to perform them?
9. How satisfied are you with the support you receive from your employers and superiors?
10. Tell me about the general morale at the facility that you work?
11. What is your relationship with the community that you work for?
12. Can you tell me about your experiences (stories & examples) of providing health services at this facility (Have there been situations/ people/ cases that have been particularly challenging/ difficult/ positive/ successful?) Can you give an example of patients that are easy to treat and others that are difficult?
13. How do you understand disability?
14. Have you any experience of treating people with disabilities? Can you tell me about that? (physical/ emotional/ intellectual/ sensory/ epilepsy/ albinism) (Do you find them more challenging than other patients?).

15. Are physically impaired people frequently seen? Which categories of impairment do people who come have?

16. How does follow-up of people with impairments take place?

17. Knowledge about disability policy?

18. Knowledge about disability in health policy and legislation and how this is implemented at the particular health service

19. Do you want to share any additional information with me?

Acknowledge the informant's cooperation, time spent and information shared and ask whether any other information that they want to give that they feel was not covered adequately.

### Appendix 3 – Emerging themes

When coding the data using ATLAS TI, the following themes emerged.

<b>Themes</b>	<b>Barriers to access health care</b>	<b>Quality of health service</b>	<b>Social context</b>
Sub-themes	Transport - Unavailability at clinics, Unavailability from home to clinic, Unreliable service and ineligibility	Quality of health care	Household
	Distance/geography – Long distance to facilities	Availability	National issues
	Physical access at facility - Inaccessible equipment	Acceptability - Insensitivity and disrespect from providers	Self Care
	Cost – lack of financial	Recommendation(s)	

	resources	for improvement	
	Language	Rehabilitation	
	Communication - Inadequate accommodations for deaf consumers, Office staff's impatience with speech difficulties		
	Information		

**Appendix 4 - Health Facility information**

<b>Name of health facility</b>	<b>Katutura Health Centre</b>	<b>Okuryangava Clinic</b>	<b>Dordabis Clinic</b>
<b>Type of facility</b>	Health centre	Health clinic	Health centre
<b>Name of health district</b>	Windhoek	Windhoek	Windhoek
<b>Name of region</b>	Khomas	Khomas	Khomas
<b>1. Number of wheelchair accessible toilets</b>	Toilet for physical impaired people is there but used by the cleaner (staff)	None	None
<b>Name of health facility</b>	<b>Katutura Health Centre</b>	<b>Okuryangava Clinic</b>	<b>Dordabis Clinic</b>
<b>2. Patients for which fee varies</b>	Patients who cannot afford the fees Patients suffering from long-standing illness Patients with disabilities Non-citizens Other: pensioners	Patients who cannot afford the fees Patients suffering from long-standing illness Patients with disabilities Non-citizens Other: pensioners	Patients who cannot afford the fees Patients with disabilities Non-citizens Other: pensioners



<b>Name of health facility</b>	<b>Katutura Health Centre</b>	<b>Okuryangava Clinic</b>	<b>Dordabis Clinic</b>
<b>3. Physical impaired parking bays?</b>	None	None	None
<b>4. Have an entrance ramp?</b>	Yes	Yes	No
<b>5. Flat landing at the door?</b>	Yes	Yes	No
<b>6. Entrance door automatic?</b>	No	No	No
<b>7. If not automatic does it have pull lever/type handles?</b>	Yes	No	No
<b>8. Dropped counter?</b>	Yes	No	Yes
<b>9. If building has more than one storey does it have lifts?</b>	No	Yes	No
<b>10. Lifts have Braille numbering?</b>	N.A.	No	No
<b>11. Staircases have handrails?</b>	N.A.	No	No
<b>12. Doorways at least 750mm wide?</b>	N.A.	Yes	No
<b>13. Thresholds not exceed 15mm height?</b>	N.A.	No	No
<b>14. Passages and stairs well lit at all times?</b>	N.A.	No	No

<b>15. Centre of public phone key pads</b>	Yes	No	No
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**FACILITY INFORMATION - CAPRIVI**

<b>Name of health facility</b>	<b>Kabbe Clinic</b>	<b>Sibbinda Health Centre</b>	<b>Chetto Health Centre</b>
<b>Type of facility</b>	Health clinic	Health Centre	Health Centre
<b>Name of health district</b>	Kabbe	Sibbinda	Chetto
<b>Name of region</b>	Caprivi	Caprivi	Caprivi

Size of fa

Name of health facility	Kabbe Clinic	Sibbinda Health Centre	Chetto Health Centre
<p><b>1. Number of wheelchair accessible toilets</b></p>	<p>There are no wheel chair accessible toilets at the facility. The way to the toilets is too sandy, making it difficult to be accessed by a wheel chair. The physical structure of the toilets is also a barrier for physical impaired users. The step at the entrance is very high for a wheel chair to roll over. Alternatively, physical impaired patients are referred to other toilets which are about 30 metres away from the clinic. These toilets are only accessed by permission because they belong to the Adult Education office.</p>	<p>There are no wheel chair accessible toilets available at the facility but the entrance to the Health centre and the counter for payments are the only things that can be accessed by a physical impaired person.</p>	<p>The Clinic does not have any wheel chair accessible toilets.</p>
<p><b>2. Physical impaired parking bays?</b></p>	<p>No parking bays available.</p>	<p>No parking bays available.</p>	<p>No parking bays available.</p>
<p><b>3. Have an entrance ramp?</b></p>	<p>No</p>	<p>No</p>	<p>Yes</p>
<p><b>4. Flat landing at the door?</b></p>	<p>No</p>	<p>No</p>	<p>Yes</p>

<b>5. Entrance door automatic?</b>	No	No	No
<b>6. If not automatic does it have pull lever/type handles?</b>	No	Yes	Yes
<b>7. Dropped counter?</b>	No counter but there is a removable table in the open space of the waiting room, which is accessible by both physical impaired people and non-physical impaired patients.	Yes	No
<b>8. If building has more than one storey does it have lifts?</b>	No, only one storey	No	No
<b>9. Lifts have Braille numbering?</b>	N.A.	No	No
<b>10. Staircases have handrails?</b>	N.A.	No	No
<b>11. Doorways at least 750mm wide?</b>	No	No	No
<b>12. Thresholds not exceed 15mm height?</b>	No	No	No

<b>13. Passages and stairs well lit at all times?</b>	No	No	No
<b>14. All signs on high contrasting backgrounds?</b>	No	No	No
<b>15. Centre of public phone key pads</b>	No	No	No

