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## Perceived barriers to accessing health services among people with disabilities in rural northern Namibia

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People living with disabilities (PWD) face unique problems in dealing with conventional healthcare facilities. We investigate the experiences of PWD as they access healthcare facilities in rural Namibia. More specifically, we investigate structural–environmental and process barriers to accessing health facilities. The study relied on semi-structured interviews and purposive sampling. The results showed PWD find it difficult to walk to health centers for treatment due to lack of transport, money to pay for treatment and toilet facilities and the distance is too far for people with lower-limb disabilities. There is a need to consider the unique issues affecting access to healthcare for people living with disabilities to achieve equitable access to healthcare services.

**Keywords:** disability; barriers; Namibia

### Points of interest

- This article looks in detail at problems of cost, transport, language and non-friendly facilities in rural northern Namibia.
- The cost of transportation is high, clinics are located far from houses and there is lack of transportation; thus many people with disabilities cannot visit clinics.
- Clinics are available in villages but people in wheelchairs find it difficult to enter facilities.
- People with disabilities want providers who can understand their language, who are sensitive to their needs and who show respect.

### Introduction

The Namibian government's Vision 2030 aims to achieve equity in healthcare for all Namibians including those living with disabilities, who must be treated with

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dignity, honor and respect. It indicates that economic and social structures will be in place to eliminate marginalization as people with disabilities will be given the necessary assistance to enable them to participate effectively in education and employment opportunities. The barriers to achieving Vision 2030 may be particularly acute in rural regions because of long distances, poverty and lack of transportation. The vision is that:

people living with disabilities (temporary or permanent) and other disadvantaged persons, are well integrated into the main stream of society, and have equal rights under the law. They are encouraged and supported to participate actively in the economy and society. (Government of the Republic of Namibia [GRN] 2004, 119)

The Vision 2030 policy is consistent with one goal in the program of action arising from the International Conference on Population and Development in 1994. This is the goal of universal access to healthcare by 2015. People with disabilities were identified as particularly vulnerable, with a need for recognition of their reproductive health needs, and elimination of discrimination with regard to their reproductive rights. According to United Nations estimates, one person in 20 has a moderate or severe disability, and three-quarters of these people live in developing countries. However, it is reported that the reproductive health needs of women with disabilities are often not met or recognized (Smith et al. 2004).

People living with disabilities face unique problems with conventional healthcare facilities and the healthcare system. For example, in many instances rural clinics lack toilets and a proper ramp to access facilities. This is important because people living with disabilities might be discouraged from visiting clinics, thereby defeating the goal of equal access to healthcare. The implementation of Vision 2030 objectives for people living with disabilities faces several structural and delivery process barriers. Structural barriers include insufficient space for wheelchairs, long distances to clinic, and lack of accessible medical treatment. Process barriers include long waiting hours, lack of sign-language interpreters and insufficient health personnel. Lack of understanding of the extent to which these barriers are operative in Namibia will reduce the potential for Vision 2030 to be achieved.

This paper investigates the experiences of people living with disabilities as they try to access healthcare facilities and services in rural Namibia. More specifically, we investigate structural–environmental barriers to accessing health facilities (i.e. transportation, physical barriers, facility accessibility, cost of services) and health service delivery process barriers (i.e. timeliness of services scheduling of appointments, language, feeling respected and health provider knowledge). Given that Namibia is largely rural, addressing rural urban health disparity is necessary to ensure health for all citizens. This requires identifying barriers faced by rural residents. Although research in other countries show insights into barriers that rural people face, there has been no such study in Namibia and there is need for greater specificity about perceptions of healthcare by people living with disabilities in rural Namibia. The rationale for the paper is that knowing the barriers people living with disabilities face in accessing the healthcare system may contribute to policy formulation that allows greater access to health for all. Moreover, ‘evidence is building that shows that lack of access affects individual’s health status’ (Turner Goins et al. 2001).

### **The healthcare system in Namibia**

The Namibian health system was fractioned after independence from South Africa in 1990. Gaps in access to healthcare existed not only between rural and urban dwellers but also between rich and poor and white and black populations. Nevertheless, in the last two decades there has been improvement in access to healthcare facilities. A strong political commitment to upgrade the primary healthcare system has slowly made health services more responsive to the needs of the population (Gustafsson-Wright et al. 2011). In terms of health expenditures, Namibia is among the better-off African countries. The country has one of the highest total expenditures on health at 7% of Gross Domestic Product and only 30% of total health expenditures are private expenditures. Out-of-pocket expenditures as a proportion of private health expenditure are only 18%, the second lowest among African countries, surpassed only by South Africa. The overall orientation of public health services is towards primary healthcare, where the focus is on community health, preventative measures and treatment that can be provided relatively easily, cheaply and quickly. Most of these services are provided through public clinics, outreach points and district public hospitals. Medicines are generally affordable due to highly subsidized flat user fees. Nonetheless, there is a critical shortage of health professionals, in particular outside the urban areas, and the public sector suffers from long waiting times. In 2003, in the public sector there were an average of over 7000 patients per registered doctor and 947 patients per registered nurse. The doctor patient ratio is lowest in the Khomas region with an average 3129 people per doctor, and highest in the Ohangwena region with 22,144 people per doctor. The Caprivi strip, which has the highest HIV prevalence in Namibia, has one doctor per 12,000 people and one nurse for every 2400 people (Gustafsson-Wright et al. 2011).

### **Review of related literature**

In Africa – where rural urban disparities loom large and where services are in short supply as a result of geographic isolation – poverty illiteracy, distances, transportation difficulties and related factors make delivery of healthcare for people living with disabilities challenging. This reinforces the statement by Brems et al. that:

Optimal healthcare delivery, regardless of location, is technology-demanding, costly without economies of scale, and dependent upon a skilled workforce. These features of healthcare systems are difficult to satisfy, even in urban areas. In rural areas, these features, in combination with rural limitations, make development and maintenance of efficient and effective healthcare delivery difficult. (2006, 114)

In this section we review previous research concerning structural and physical barriers to healthcare delivery to rural people living with disabilities.

### ***Geography, distance and transportation***

Geographical challenges such as mountains, gullies, rivers, unpaved roads, and so forth, present physical barriers to accessing healthcare. ‘Due to these geographic challenges, some rural residents make trade-offs between their safe travel in incremental weather and accessing health care in a timely manner’ (Chipp et al. 2010,

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 et al. 1996, 48). Brem 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 difficulty of travel as well as availability of specialized services that is a problem in Namibia's rural areas.

Among the attributes of rural areas influencing healthcare 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 and Regan 2009):

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, and Powers 2005)

Minden et al. (2007) agree by arguing that transportation is critical for rural patients' ability to receive care and maintain their health and functional status. Similarly, Caldwell (2008) found for families with developmental disabilities that the greatest out-of-pocket costs included transportation. Lack of transportation options presents 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 was reported overwhelmingly more by rural than urban providers. In this context, Green-Hernandez 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. (2006, 10)

### ***Health costs***

According to Etowa et al. (2007), 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 traveling to regional centers to receive healthcare because such care does not exist in their local community and/or facilities. In the Etowa et al. (2007) study, 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 et al. (2005, 210) found that 'financial constraints posed considerable barriers to accessing needed health care among study participants, including issues related to

health care expense, inadequate health care coverage'. Hwang et al. (2009) demonstrated that people living with disabilities need a wider range and depth of services and this resulted in higher costs of healthcare for them. In Namibia, where most people with disabilities are not employed (and do not have insurance coverage of any kind), the costs of transportation, medicine and other services can be prohibitively high.

### ***Language and attitudes***

Communication differences pose an impediment to effective and ethical rural healthcare. Rural residents reported having greater difficulty with labeling of medication and interpreting written information and instructions (Chipp et al. 2010; Hamrosi, Taylor, and Aslani 2006). Further, Hwang et al. (2009) report that people living with disabilities experience insufficient communication with providers. 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. 2007, 68).

### ***Knowledge***

Some facilities lack knowledge. This is brought about by insufficient training and limited numbers of healthcare workers. This problem is not only limited to poor countries but also affects rural places in developed countries. For example, Turner Goins et al. found that for 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. (2005, 210)

In Namibia most rural residents are dependent on healthcare provided by nurses rather than doctors and other specialized personnel. The limited number of even nurses means that rural residents are subject to few competent personnel. In this context, Hwang et al. (2009) concluded that whereas most individuals tend to be satisfied with the overall competence of physicians, many believe that providers need to know more when it comes to dealing with people living with disabilities.

### ***Methodology***

The methodology was designed to elicit perceptions of healthcare delivery held by persons with disabilities living in rural Namibia. This study relied on semi-structured interviews. Examples of items used in the interview schedule were, to mention but a few: what is your understanding of health and health-related issues, what are your health needs, do you access healthcare in the same way as everyone else in your family and community, according to you what factors make it difficult for a person to access healthcare, what are the obstacles you face in accessing healthcare?

### ***Sample and site selection***

Purposive sampling was utilized in choosing the respondents and the three research sites in Namibia.

The selection of the sites was primarily based on the objective of the broader study. We included the following criteria:

- Must have a health clinic or healthcare center, which in Namibia is the first entry point for seeking healthcare.
- Health service must be provided to the public by the Ministry of Health – or by a non-governmental organization subsidized by the government.

The regions selected were: Caprivi (Chetto, Kabbe and Sibbinda Clinics), Kunene (Etanga, Okongwati and Opuwo Clinics), and Omusati (Tsandi, Omagalanga and Anamulenge Clinics).

Research assistants were social science graduates with some experience in data collection for the Multi-Disciplinary Research Centre, University of Namibia. They were brought together in Windhoek for a one-week training workshop. All questions were translated into Oshiwambo (the language of the Omusati region), Otjiherero (the language of the Kunene region) and Silozi (the most widely spoken language of the Caprivi region).

### ***Research measures***

Interviews were conducted with 25 respondents living with disabilities.

### ***Research procedures and assistants***

Three teams were involved in this research. Each team consisted of a research site coordinator (from the Multi-Disciplinary Research Centre), a research assistant and three interviewers who were temporarily employed by the Multi-Disciplinary Research Centre. Owing to the sensitive nature of the topic as well as linguistic considerations, it was decided to use Oshiwambo-speaking research assistants and interviewers in the Omusati region, Silozi-speaking assistants in the Caprivi region and Otjiherero-speaking assistants in the Kunene region. The sex of the interviewers was varied to match that of the respondents.

### ***Data analysis***

Interviews were scanned for comments, themes were established, and data were systematically examined to see ways in which these themes were portrayed. In the findings section, illustrative comments are presented in quotes for the various themes in order to gain a sense of what respondents actually believed.

## **Findings**

### ***Characteristics of the respondents***

Most of the respondents were female and had low formal education (see Table 1).

Table 1. Characteristics of the respondents according to region.

	Caprivi region		Kunene region		Omusati region	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Sex						
Female	40	54.1	43	63.2	39	60.9
Male	34	45.9	25	36.8	25	39.1
Education						
No education	16	21.9	47	71.2	3	4.8
Some primary	12	16.4	8	12.1	21	33.3
Complete primary	4	5.5	2	3.0	12	19
Secondary school but not Grade 12	27	37	4	6.1	20	31.7
Grade 12	12	16.4	3	4.5	6	9.5
1–3 years tertiary education	2	2.7	1	1.5	0	.0
>3 years tertiary education	0	.0	1	1.5	1	1.6

Note: Percentages may not add up to 100% due to rounding.

### *Structural–environmental barriers to accessing health facilities*

Structural–environmental barriers are conditions in the physical and social environment in which healthcare services are delivered (Kroll et al. 2006). These typically consist of a lack of access ramps at health centers, difficult-to-access rooms and equipment (e.g. height of tables, scales that accommodate wheelchairs, inaccessible washrooms), and the unavailability of needed transportation services to medical appointments (Hwang et al. 2009). According to the Namibian Demographic and Health Survey (GRN 2006), access to healthcare facilities, in terms of distance, time and costs, is a very useful indicator of the quality of life in Namibia.

### *Distance*

The Namibian Demographic and Health Survey (GRN 2006) found that rural households are more likely to be nearest to a clinic than urban households, and urban households are more likely to be nearest to a government hospital than rural households. Two in three households in this study accessed the nearest government health facility by foot. In the Caprivi region, 2.7% of households access a government hospital by car or motorcycle, 8.2% by bus or taxi, 1.8% use animals or animal cart, and the overwhelming majority (87.3%) walk. In the Omusati region, 5.5% of households access a government hospital by car or motorcycle, 22.6% by bus or taxi, 0.5% use animals or animal cart, and the overwhelming majority (71.5%) walk. In the Kunene region, 28.1% of households access a government hospital by car or motorcycle, 12.5% by bus or taxi, 14.6% use animals or animal cart, and a majority (44.8%) walk. Thus, in these rural areas the overwhelming majority depends on walking and this is where distance matters as the average time it takes for an individual to reach a health facility by walking is estimated as 59.9 minutes (GRN 2006, 291).

Respondents in our sample readily acknowledged that they walk to access healthcare:



yes, for example if I don't have money for transport to the clinic, I have to wake up at 5am and walk 2 hours and 30 minutes to get to the clinic, and sometimes when I get there its already full. I have to wait in that long queue to get help and when I am done with the whole process I have to walk back home. The next morning I still feel sick and tired because of the distance I walked. (Amputated arm, Tsandi Clinic)

Another respondent noted:

When the children are at school, I find it difficult to access health facilities as there is no one to assist me to get there. I wait for them to come back and since they come back late, the clinic is closed. (Visually impaired, Omagalanga Clinic)

### *Transportation costs*

In rural areas there are many strategies people with disabilities use to go to health-care facilities. They include private car or donkey cart, walking (the majority), taxis (where available) and in a minority of cases homemade sledges. Most facilities do not have transport and do not arrange transport unless somebody is very sick (or in case of referrals); then the nurse will call the ambulance from a more central health facility such as a hospital. This, however, 'can take up to 2 hours to get to the clinic' (Omagalanga, visually impaired). Transportation is one of the most worrisome problems people with disabilities face, as noted here:

From my village to the facility I pay N\$40.00 [Namibian dollars] and walk almost 2 hrs but if I get a lift it is only 12 to 20 minutes. I am not happy, because I walk long distances while sick, and when they arrange transport it only arrives in the evening. The Ministry must see to it that every clinic has its own car to help patients that are vulnerable and have disabilities in villages and deliver medicine in time at the clinic. (Disability not specified, Chetto Clinic)

The main obstacle I face when seeking for health care is transport money. It's really a big problem because at times I don't come to the clinic just because of transport money. (Amputated arm, Tsandi Clinic)

Costs escalate for those individuals that choose to hire private cars to go to clinics:

I use private car that takes me to the clinic and back home and I pay N\$50, sometimes I think I need a wheelchair to use for long distance as this leg starts to itch especially in the hot weather. (Paraplegic disability, Tsandi Clinic)

This is also the case for individuals that are referred for specialized treatment at regional centers:

If you ask for a donkey cart you pay N\$40.00 to the owner plus N\$4.00 consultation fee, and if you are referred to the hospital and there is no ambulance you pay N \$100.00 and it takes an hour and a half. (Paraplegic disability, Chetto Clinic)

Individuals that have lower-limb disability particularly find it hard to walk to healthcare centers:

If there is no car or donkey cart to transport me then I do not go for treatment. I cannot walk as I stay far from the clinic and with my leg I cannot walk as I will not be

able to reach. In the rainy season I have to wait until the water subsides because nurses cannot come to villages to treat us there (Paraplegic disability, Tsandi Clinic)

Physical barriers include paths: 'I usually use my wheelchair but foot path which I always use, is full of sand and it takes time to reach the tarred road' (paraplegic disability, Omagalanga Clinic).

### *Poverty*

The cost of services extends to cost of consultancy, drugs and medicine. Poverty underlies the difficulties that many rural people face in Namibia. Unemployment is another indicator of health status (Etowa et al. 2007). 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. Unemployment statistics for Namibia show that 51.3% of people are unemployed. The rural unemployment rate (64.9%) is higher than the urban one (36.4%). The number of the unemployed that have been looking for work in the past two years is 84.8% in the Caprivi region, 77.9% in the Kunene region and 87.2% in the Omusati region (GRN 2008a). This means that the majority of the people in these regions are in poverty. A recent study confirms most people living with disabilities are in poverty (GRN 2008b). Thus many people living with disabilities struggle to pay for services, and therefore cost constitutes a barrier to care. This is well recognized by the respondents in this sample:

Money is a big source of everything and without money you cannot access health care, without money you cannot eat anything or wear clothes. (Disability not specified, Chetto Clinic)

My parents are very old and they never worked in their life. They are just getting pension from the government and since we are more than 10 we cannot afford to pay money to visit the clinic or hospital – something must be done. (Disability not specified, Chetto Clinic)

It seems that most people manage to pay the N\$4 required to get service from a public health facility:

We only pay N\$4.00 for consultation fee. We don't pay for the care given and no there are no bribes or hidden costs. For the consultation N\$4.00 is fine no problem, but the problem is with the transport money. It is expensive to access because of the transport, if four of you are sick in the family the cost is  $4 \times 40.00 = \text{N\$}160.00$ . This is too much for me as a disabled person to pay, I cannot afford it. (Paraplegic disability, Chetto Clinic)

In cases where people with disabilities do not have money, the N\$4 is sometimes waived: 'I used to pay a consultation fee of \$4-00, but now I get treated for free. I don't understand why I had to pay the consultation fee' (visually impaired, Chetto Clinic). Sometimes villagers help each other to raise the required consultation fee: 'I do not experience these problems, because in our village we help each other as group' (amputated leg and visually impaired, Omagalanga Clinic).

Poverty means that some rural people living with disabilities cannot pay for health services, although the consultation fee is only N\$4.

### ***Health service delivery process barriers***

According to Kroll et al. (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: scheduling of appointments and timeliness of services, language and attitudes, provider knowledge, drugs and medicine, physical access and rehabilitation.

#### *Experiences of accessing healthcare services*

These experiences 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: 'In fact I did not make an appointment' (paraplegic disability, Kabbe Clinic) and 'I think the service I received was good as I recovered quickly and did not have to make an appointment' (amputated legs, Sibbinda Clinic). Where appointments are made 'they are not always followed' (disability not specified, Sibbinda Clinic).

Health facilities manage patients through use of queues: 'Everybody [regardless of disability status] joins the queue if you find the queue and if not, you just go in straight to the nurses to be treated (visually impaired, Omagalanga Clinic). Most patients, however, 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 the queues for treatment' (paraplegic disability, Sibbinda Clinic). The service is 'bad as patients wait a long time in the queue and when they get treatment it is almost an hour' (disability not specified, Chetto Clinic). What makes things worse is that there are no 'special queues for people living with disabilities' (paraplegic disability, Tsandi Clinic). Many of those living with disabilities find it difficult to cope:

I went to take my high blood pressure medication. It was overcrowded and there is no place to buy refreshment. The waiting time is very long because nurses are few and they work very slowly and take their time with patients. Their attitude is not good towards patients. (Paraplegic disability, Opuwo Clinic)

#### *Language barriers*

Language barriers were experienced only in the Caprivi region where there is a large group of minority San people. These occupy the lowest level of Namibia's groups in poverty (with the lowest education, social economic status and life expectancy). What this translates to is that there are few San-speaking healthcare workers. Most of the health workers are from other ethnic groups and they do not care to learn the local language. This was interpreted as a problem of attitude among San people living with disabilities in that area: 'The attitudes of the nurses are bad, the nurse does not want to speak our language and she is not friendly to us' (disability not specified, Chetto Clinic). 'My other obstacle is language barrier, we don't speak the same language with the nurse, therefore we talk through the translator, and sometimes the translator doesn't say exactly what the patient is complaining of' (visually impaired, Chetto Clinic). 'Some patients hide their sickness, and tell the

nurses that it is a headache. They fear to tell the truth to the nurse due to the language problem' (paraplegic, Sibbinda Clinic).

#### *Health provider attitudes*

Nurses are considered rude but this does not exclusively apply to people living with disabilities:

Nurses are very rude with patients. They do not give proper explanation to patients. If you ask pharmacists to elaborate on the prescription they tell you that it is written on the medicine. No, I do not ask questions because they might give me answers that are not good and give me stress. The medication I am getting is for long term treatment. After the car accident I went through a counselling process, it really helped me to win my confidence back. I realized that if you do not accept that you have become disabled you will suffer your whole life. (Paraplegic disability, Opuwo Clinic)

#### *Health provider knowledge*

Most people living with disabilities praise health workers for their skills: 'The nurse is qualified and well trained together with HIV counselors they were trained to do their work' (disability not specified, Chetto Clinic). One person living with disability was quite elaborate in praising health providers:

I use modern health care because long time we San people were using traditional herbs but we were dying. Now we have changed to modern health care, because doctors and nurses are qualified and they know what they are doing. If you tell them all about your sickness they will diagnose and look for medication that goes hand in hand with your disease. They use modern equipment and it's cheap. It is not like traditional healers where you pay cattle for nothing. They treat you the way you want and give medicine to cure people's disease and to help them to recover, and enjoy good health again. (Disability not specified, Chetto Clinic)

There were complaints, however, on the healthcare system: 'nurses forget about how to treat patients and further training for them is needed. There are no interpreters for the deaf' (amputated legs, Tsandi Clinic).

The main complaint is that there are not enough health workers to do the job. For instance, at Chetto Clinic the research team waited for three days before they saw the nurse. She had gone to Katima Mulilo (the regional center) 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' (visually impaired, Chetto Clinic). At the same clinic others complained of:

no 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 (for network coverage) almost 3 kilometres away. Absenteeism 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. (Disability not specified, Chetto Clinic)

#### *Lack of drugs and ambulance service*

People with disabilities complained that 'There are not enough medicines for everyone. There are so many people who use this health centre' (paraplegic disability, Sibbinda Clinic). Among the problems are:

Lack of drugs on a continuing basis because they arrive late, lack of equipment like scales for people living with disabilities, lack of experienced workers that execute the work properly, and no timeous delivery of drugs. (Paraplegic disability, Kabbe Clinic)

The only thing the clinic can give is eye drops. It does not really meet my on-going health needs because I need regular check-ups but there is no Doctor to do that. (Visually impaired, Chetto Clinic)

They [government] must recruit more nurses and build a big pharmacy so that we can have all types of medicines. (Disability not specified, Etanga Clinic)

### *Rehabilitation*

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 normal daily functions. In almost all of the rural clinics and regardless of type of disability, people living with disabilities complained of lack of rehabilitation:

Normally I go to Katima Mulilo. But there are times when I go there but nothing happens because they also don't have equipment. Rehabilitation centre is also not available. (Paraplegic disability, Sibbinda Clinic)

Since I became disabled, I never received any rehabilitation. I need spectacles to assist me, when it becomes dark and when I am reading my bible. I also need education for the blind because I am not far from becoming blind. I want to obtain knowledge while I have one eye that is able to see. (Multiple disabilities, Omagalanga Clinic)

### *Physical difficulties*

Physical accessibility depended on the type of disability suffered and the clinic. Those in wheelchairs have problems of entrance, while the visually impaired and those with upper limb disability do manage:

While the clinic has a disability toilet, there is no examination room, no pharmacy, no special investigation and I do not know if there is privacy room where blind people can explain their problems. We have our disabled people toilet, it is clean and the examination room is also clean. The toilet is available for us and the examination room is fine and one can talk freely with nurses – no disturbance and no one can hear what you discuss. The pharmacy is here for storing medication and consultation room is where you can get your medicine. (Multiple disabilities, Omagalanga Clinic)

The entrance is fine, toilet is available, examination room fine, privacy is there. No interpreter for those with speech problems. (Paraplegic disability, Tsandi Clinic)

At Omagalanga clinic, the entrance is not friendly for those using wheel chairs. (Visually impaired, Omagalanga Clinic)

These views are quite different from the ones in the Kunene region:

The facilities do not have enough equipment and nurses are very few. (Paraplegic, Opuwo Clinic)

We have only one nurse and sometimes the facility is overcrowded and it's a lot of work for one person. (Disability not specified, Etanga Clinic)

The place is very dirty; walls are red and needs painting. Toilets are not user friendly especially to people living with disabilities. There are not enough wards: people with new-born babies are sleeping with sick people no matter how sick the patient is. (Physically disabled paraplegic, Opuwo Clinic)

Reflecting on all this, one contributor said:

It is accessible for us the disabled people but for the ones that are using wheel chairs it is not that accessible when it comes to entering the waiting room, because the entrance point is not that flat. The waiting room is also small; as a result a person with a wheel chair will not be able to move freely, because the space is not enough. There are no toilets at this clinic; we are helping ourselves in the bushes. There is no pharmacy, the pills and medicines are being kept in the consultation room. There is no special investigation that is done to the disabled people that are visiting this clinic. They are all being referred to Opuwo hospital, when they need special investigation. (Disability not specified, Etanga Clinic)

One person was philosophical: 'If you concentrate on obstacles you will never go wherever you want to go so I will say there are no obstacles' (disability not specified, Etanga Clinic).

For some, location provides another physical barrier to accessing health facilities. During the rainy season, flooding presents a challenge for those that have problems with legs and walking: 'water [floods], it's also a problem to cross when going to the clinic' (multiple disabilities, Omagalanga Clinic). For others it is not so problematic:

to me, I see no difficulties as the clinic is located at the centre and everyone is able to access it when necessary. Even during the rainy season when it is surrounded by water, we can still access it as there is another entrance to access the clinic. (Visually impaired, Omagalanga Clinic)

Location of the facility is fine but I think it is only for those without disabilities. (Paraplegic disability, Sibbinda Clinic)

### *Lack of toilets*

Toilets presented particular problems for people living with disabilities:

provision of toilets for people living with disabilities at Sibbinda health centre is problematic. People with disabilities cannot really access the toilet without the help of relatives and most of the time, people are forced to use the bush as there is always lack of water at the facility. (Paraplegic disability, Sibbinda Clinic)

There are no toilets for people living with disabilities and the cashier counter is also very high for people in wheel chairs. (Paraplegic disability, Okongwati Clinic)

### **Discussion and conclusions**

The major aim of this study was to investigate the structural and physical barriers that people living with disabilities face as they try to access healthcare facilities and services in rural Namibia.

More specifically, we investigated structural–environmental barriers to accessing health facilities (i.e. transportation, physical barriers, facility accessibility, cost of services) and health service delivery process barriers (i.e. timeliness of services scheduling of appointments, language, feeling respected and health provider knowledge). This research largely confirms research in other countries showing that people living with disabilities have a whole host of barriers pertaining to both service delivery process and structural environment. There are several things that we feel may be unique to Namibia. These are the fact that many people living with disabilities are unemployed and therefore have little means to afford transportation and healthcare services. What this means is that while many rural people experience the costs of transportation, medicines and other services as high, for people living with disabilities this can be prohibitively high. Most people living with disabilities walk to health centers, as indeed do most rural Namibians; however, for those living with disabilities this is an odious task. Not all disabilities are the same and this affects how respondents experience the problem of transportation. Among those with lower-limb disabilities, walking to healthcare centers can in itself threaten their health. Similarly, those with lower-limb disability and in wheelchairs have more difficulties accessing narrow pathways in health centers. Toilets seem to be a huge problem for many people living with disabilities. For minorities, lack of communication in local languages comes across as an issue of attitude. Namibia's Vision 2030 talks of integrating people with disabilities in mainstream society by treating them with respect and honor. This can only be achieved if the problems that people living with disabilities in rural areas face in accessing healthcare are dealt with.

In conclusion, the findings of this study are based on a small sample and therefore may not be generalized. Nevertheless, within the context of qualitative studies the findings of the study point to the need to take problems of people living with disabilities in rural Namibia more seriously. There is a need for health workers to have more training (and respect) for problems of people living with disabilities. There is need for health authorities to consider the unique issues affecting access to healthcare for people living with disabilities.

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