Addressing access barriers faced by rural communities in the Americas through participatory mixed methods analyses

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Objectives

To identify the main barriers to access faced by rural communities in the hinterlands of Guyana and Condorcanqui province of Peru

To inform and identify policy recommendations for addressing barriers that limit access to essential health services in those rural communities
### Country context

#### Guyana
- Guyana has placed great focus on health sector reform, policy development, and other actions aimed at improving access to MCH and other essential health services:
- Most Guyanese (~90%) live in the coastal area, while a smaller percentage inhabits the rural interior, or hinterland.
- The community of Amerindian ancestry lives mostly in the hinterland. It is the most vulnerable social group, with the country’s highest poverty levels and lowest health indicators.

#### Peru
- Peru has committed to protecting and guaranteeing the right to health for indigenous peoples.
- The indigenous people of Peru represent about 25% of the population. Most live in rural and hard-to-reach parts of the Andes and Amazon region. About 50% live in poverty.
- Condorcanqui is a difficult to access province of the Amazon, where 95% of the population is indigenous. The time to travel to one community to another can take between 10-12 hours and most health facilities (~88%) have inadequate infrastructure.
Framework of Analysis
The Tanahashi Model for evaluating equity in access and barriers to achieve universal health

**GOAL: COVERAGE AND UNIVERSAL HEALTH ACCESS**

**Quality access** (effective coverage; e.g., use, quality, adhere, financial protection)
“People who receive services in a timely manner and at a quality level”

**Contact** (e.g., health literacy and knowledge of services and entitlements)
“People who use services”

**Acceptability** (e.g., language, culture, gender norms and roles)
“People who are willing to use services”

**Accessibility** (e.g., financial, organizational/accommodation and geographic)
“People who can use services”

**Availability** (e.g., medical and human resources and treatments)
“People for whom services are available”

**TARGET POPULATION OR POPULATION GROUP**

Source: Adapted from “Handbook for conducting and adolescent health services barriers assessment (AHSBA) with a focus on disadvantage adolescents”, WHO, 2019
Methodology

Observational and cross-sectional analysis, with evidence triangulation for an integrated analysis with actors:

**Guyana**
- Specific focus on MCH services
- Emphasis on hinterland and rural interior

**Peru**
- Specific focus on mental health services
- Emphasis on youth and adolescents in rural areas of the Amazon, Condorcanqui Province

- Household survey data on unmet needs and barriers
- Workshops with stakeholders to validate, interpret policy options
- Literature review on access barriers
- Insight from health officials on policy implementation and barriers
Main barriers experienced by indigenous communities in the Peruvian Amazon
The access barriers to health services that were identified for the indigenous population in Peru are mostly associated with acceptability, availability, and geographic accessibility.

<table>
<thead>
<tr>
<th>Acceptability</th>
<th>Availability</th>
<th>Geographic acc.</th>
<th>Effective cover.</th>
<th>Accommodation</th>
<th>Contact</th>
<th>Financial access.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care workers do not speak the local language in health centers</td>
<td>Mistreatment, bad attitude, stigmatization and discrimination of indigenous communities and low-income patients by health personnel</td>
<td>Long distance and time traveled for patients to arrive to consultations and health centers</td>
<td>Indigenous patients do not utilize treatments because they do not understand the written prescriptions, diagnosis and</td>
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<td>Lack of adaptation and a cultural sense of belonging in the different health services (i.e. traditional/alternative medicine, medicinal plants, families/spouses excluded from delivery rooms, inadequate structure for vertical delivery)</td>
<td>Feeling of shame, fear and lack of trust due to cultural beliefs of patients towards health providers and services provided</td>
<td>Limitations of health services on the part of health providers due to having to</td>
<td>Exam results are not received on time due to a lack of service coordination</td>
<td>Poor communication (due to language barriers)</td>
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<td>Lack of access to health services (regular/complex exams) and shortages of resources for diagnosis and treatment (tests, medications and materials) in regions where the indigenous population resides</td>
<td>Shortages of health personnel (overload and high turnover) designated to the indigenous population</td>
<td>Health care professional does not know about traditional medicine</td>
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<td>Lack of specialists, which limits the possibilities of referrals from the health</td>
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<td>Low availability of traditional therapists</td>
<td>Lack of knowledge among patients regarding diseases (infectious and non-infectious) keeps</td>
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<td>Low of knowledge about the benefits of the new comprehensive health system</td>
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</table>
Issues of acceptability, contact and accommodation are found to be the main reasons for which indigenous people do not seek care in Peruvian health facilities.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Indigenous</th>
<th>Non-indigenous</th>
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<tbody>
<tr>
<td>Acceptability (lack of trust in doctors)</td>
<td>28,5%</td>
<td>11,7%</td>
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<tr>
<td>Contact (does not consider it serious/necessary)</td>
<td>24,6%</td>
<td>24,3%</td>
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<td>Accommodation (lack of time) &amp; (long waiting time)</td>
<td>35,1%</td>
<td>16,9%</td>
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<tr>
<td>Effective coverage (automedication)</td>
<td>14,6%</td>
<td>9,4%</td>
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<tr>
<td>Geografic accessibility (long distances)</td>
<td>6,5%</td>
<td>6,1%</td>
</tr>
<tr>
<td>Financial accessibility (lack of money)</td>
<td>4,9%</td>
<td>1,9%</td>
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</table>

Reasons for which the population does not seek attention in a health establishment, according to ethnicity, Peru, 2017-2019

Source: Own elaboration from ENAHO data obtained from INEI.
There has been a reduction in equity gaps in favor of the indigenous population for financial barriers. However, the indigenous population reported most frequently barriers of acceptability, geographic accessibility, and contact.

Source: Own elaboration from ENAHO data obtained from INEI.
### Acceptability

Officials recognized lack of culturally-adapted health services and stigma, fear and shame as barriers.

- Main themes
  - Preference for medicinal plants
  - Health professionals rarely know indigenous languages
  - Cultural beliefs (among parents and community) that only “crazy” people or those with disabilities need mental health care

### Availability

Another relevant obstacle was the lack of human resources and inputs/services needed to provide care.

- Main themes
  - Lack of psychologists in indigenous communities
  - Lack of services such as tele-consultations due to lack of electricity and internet

### Geographic accessibility

The nearest health center tends to be too far from where the population resides.

- Main themes
  - Long travel distance
  - Poor road conditions

### Financial accessibility

The main financial barrier faced by rural populations is inability to afford costs associated with transportation.

- Main themes
  - Costs associated with transportation are too high
  - Health centers lack financial resources needed to pay for travel expenses
Main access barriers to maternal and child health services experienced by women living in the hinterlands and rural coastal areas of Guyana.
The main barriers to MCH services as identified by the literature are related to acceptability, availability, and effective coverage.
Health officials reported issues due to geographic accessibility and acceptability more frequently than any other access dimension.
Women who live in rural areas report geographic, financial, and gender-based barriers more frequently than their urban-based counterparts.

Women that report access barriers to health care when they are sick, by residence, wealth status, marital status, and participation in household decision-making

Source: own calculations based on the Demographic Health Survey 2009
Note: 95% confidence intervals indicated.
Note: Data represents the percentage of women (ages 15-49 who were replied "yes" to a particular access barrier during the interview.
Policy Recommendations

Health officials in both countries recognized the need to strengthen PHC to improve access in rural communities

Guyana

- Expand the resolutive capacity of the first level of care within the context of integrated health delivery networks
- Utilize health prevention and promotion to boost access to health services
- Invest in human resources for health and work to develop and improve working conditions
- Invest in technologies, including communication and transportation infrastructure
- Increase and prioritize public expenditure in primary health care

Peru

- Guarantee intercultural adaptation of health services and their integration into the community model of mental health
- Ensure the availability of personnel with intercultural and community mental health capacities.
- Ensure an active role for indigenous peoples, families and communities in Condorcanqui
- Adopt a holistic, intercultural approach to health promotion, with a particular attention to the life course
- Improve investment to strengthen the first level of care and community services.
DIRESA Amazonas and PAHO inter-programmatic team (HSS, EGC, NMH)
Thank you