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Barriers to Health Care Accessibility for People Living with HIV/Aids (Plwhas) in Ghana: A Case Study of Agomanya and Effiduase

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Abstract

Access to healthcare services for people living with HIV/AIDS (PLWHAs) remains a significant public health challenge, especially in developing countries, such as Ghana. This study investigated the barriers to accessing health care for PLWHA in Agomanya and Effiduase, Ghana, offset by the availability of antiretroviral treatment. While ARV treatment has had a positive impact on the life span and health of PLWHAs, social, economic, and systemic barriers continue to impede PLWHAs from accessing required medical services. Stigma and discrimination are identified to be hindering patients in obtaining treatment. PLWHAs are afraid of being publicly shunned or their confidentiality breached; this fear has caused many to delay health treatment. Economic factors, including means of transportation and lack of financial resources for medication and services, aggravate pre-existing problems. Further, weaknesses in healthcare infrastructure, including a lack of human resources, long waiting times, and erratic drug supplies, have become serious impediments to treatment adherence. The authors refer to "positive prevention" as a potential intervention for reducing the transmission risks and reinfection rates among PLWHAs. Positive prevention promotes safer sexual practices, positions people in regular medical appointments, and provides psychological support for enhanced wellbeing. Nevertheless, such interventions have variable success due to barriers that interfere with access to health care that continues to exist. It is therefore suggested that a far broader array of policy interventions be put in place to achieve this, including strengthening health facilities, guaranteeing patient confidentiality, establishing financial support, and sending out community sensitization campaigns to curtail stigma. A synergy of effort among health personnel, policymakers, and civil society organizations would facilitate the attainment of equitable healthcare access for PLWHAs in Ghana. This research adds to the growing discourse on HIV/AIDS healthcare accessibility with calls for COVID-oriented interventions with socioeconomic variables in the governance of PLWHAs.

Keywords: HIV/AIDS, Healthcare Access, Antiretroviral Treatment (ARV), Stigma And Discrimination, Economic Barriers, Healthcare Infrastructure, Treatment Adherence, Positive Prevention, Ghana, PLWHA, Financial Support, Policy Interventions, Community Sensitization, Equitable Healthcare, Systemic Barriers, Public Health Education

Introduction

With an increased availability of antiretroviral (ARV) treatment, persons living with HIV/AIDS (PLWHAs) can live longer, healthier lives. At the same time, however, extended life expectancy creates an urgent need for behaviour modification programs geared to PLWHAs, the practice known as "positive prevention." Positive prevention aims at lowering the risk of transmission and reinfection, thus addressing the continued transmission of HIV among those already infected. This approach is increasingly being employed in the public health field to promote safer behaviours and improve general wellbeing among PLWHAs (Wolitski, Janssen, Onorato, Purcell, & Crepaz, 2005).

Although the ARV treatment has helped to curtail morbidity and mortality from this illness, the falling rates of illness are matched by rising HIV infection rates, indicating that prevention programs targeting only HIV-negative individuals may not be sufficient in controlling the epidemic (Colfax, 2004). Tailored HIV prevention programs aimed at certain behaviors and needs of people with HIV infection are imperative to curtailing further transmission and endorsing positive health behavior practice.

Positive prevention became the standard of HIV prevention programs in the United States and has demonstrated success in altering risky behaviours. Now the attention of international authorities has been attracted, and the programs are being replicated in South Africa, one of the countries with the largest populations of PLWHA in the world (Wolitski et al., 2005). It is particularly important for South Africa, where some studies show that a large proportion continues with high-risk activities despite their knowledge and availability of treatment, that the prevention needs of PLWHA be catered to. Thus, addressing the positive prevention approach becomes a priority for public health in itself (Wolitski et al., 2005).

Looking at barriers and facilitators to adopting safer behaviours, this study will seek to place positive prevention among PLWHA. By attempting to explore the existing interventions and identify gaps, the study will advance the cause of addressing the peculiar prevention needs of PLWHA in different situations, mainly through promoting a more inclusive behaviour-cum-healthcare system. Research reveals the many impediments to healthcare for PLWHAs in Ghana that are almost confounding the situation. Some major barriers include poverty, long waiting times, unavailability of drugs, and stigma (Ankomah et al., 2016; Badu et al., 2016). Discrimination against PLWHAs in health care settings and communities, on the other hand, entails social isolation and unemployment for them (Opoku et al., 2021). Moreover, harrowing housing conditions related to HIV status aggravate physical health and mental well-being (Tenkorang et al., 2017; Teye-Kau et al., 2018). The situation becomes desperate when family support is almost non-existent and dependency burdens are extremely high (Owusu, 2019).The challenges that PLWHAs face are very complex, with personal, community, and national factors acting as facilitators to their vulnerability (Owusu & Laar, 2018).To advance health access and discover health outcomes essentially one way recommended by experts is to create more awareness on HIV, train health care providers better, ensure confidentiality for the patients, and create better social support systems (Asghari et al., 2018; Owusu, 2019).

Statement of the Problem

Although some measures have been put in place to assist PLHIV in Ghana in accessing health services, including ART, such services remain largely inaccessible for most. Several studies have documented the existence of hindrances to easy utilization of health services by PLHIV. For instance, Ankomah (2016) noted that exorbitant costs, long distances to service points, unavailability of essential drugs, and stigma affect the utilization of ART.

Likewise, stigma and discrimination have been found to further engender social isolation, resulting in low service uptake by Opoku (2021). Ogunbajo (2018) stated that fear of being seen at an HIV facility, along with financial strain, dissuades many, especially from marginalised groups, to access care.

Such studies definitely shed light on issues of interest but tend to look at the narrow perspectives of particular regions or subgroups. Hence, an understanding of the broader context gets compromised, especially in communities like Agomanya and Effiduase in the Eastern Region of Ghana. Moreover, although the existing literature tends to stress stigmatization and logistical constraints, not much is said about intersecting factors related to organizational support and health-care delivery models, especially in rural or semi-urban areas. Factors such as social cohesion, community dynamics, and healthcare disparities in different precincts have received little attention.

There will be enormous gaps in understanding the peculiar problems of PLWHAs in Agomanya and Effiduase, without this study. Such gaps in service provision and policy could hinder access to healthcare services, fostering health inequalities and threatening national and global HIV treatment targets. This study must draw out such factors affecting healthcare access and use in these areas. The findings will be used to inform targeted interventions to improve healthcare delivery, treatment outcomes, and eventually quality of life for PLWHAs in these communities.

Specific Objectives of the Study

1. An attempt to study the geographical, social, and financial barriers affecting access to healthcare for the people living with HIV/AIDS (PLWHAs) in Agomanya and Effiduase.
2. Assess the role of organizational interventions in dealing with these barriers so as to improve health utilization among the PLWHAs.

Theoretical Framework

The HBM provides a very good and very pertinent framework for this study on barriers to healthcare access and utilization among the people living with HIV/AIDS (PLWHAs) in Ghana. The HBM is a psychological model that explains health-related behaviour and predicts that behaviour from the analysis of attitudes and beliefs of individual persons. The implication is that behaviour is influenced by an individual's perception of the threat of a health problem (perceived susceptibility and severity), the perceived benefit of taking preventive or remedial action, and the perceived barrier (or cost) to taking that action. Cues to action (In this context, cues to action could be defined as both internal and external triggers that halt the decision-making processes) and self-efficacy would be ingredients of the model. Self-efficacy is defined here as the confidence in oneself in carrying out the desired health behaviour.

The reason HBM relates to this study is that it provides a framework to understand why PLWHAs might or might not seek care, even when treatment options like antiretroviral therapy (ART) are available. Putting this aside, the reason for choosing this model is logical because it specifically addresses the complex interaction between your own personal beliefs and societal barriers in determining health behaviors. Under the HBM, factors that have been established by previous research as some of the major obstacles are stigma, money, fear of side effects, and perceived discrimination.

The relevance of the HBM lies in its ability to contextualize these barriers within a larger arena of behavioural motivation. This will permit the identification of specific points of intervention that will cause more frequent use of health services by PLWHAs. In applying the HBM, this study intends to explore how perceived threat, benefit, and barriers influence healthcare-seeking behaviour. The application of this insight will be paramount in informing the design of effective health interventions to promote HIV care access and adherence in the area.

Literature Review

The literature review engages research that has looked into barriers to access and use in health care in Ghana affecting persons living with HIV/AIDS. This review targets the understanding of structural, social, and individual-level barriers that relate to the study objectives.

Empirical Review

An exhaustive review of literature on barriers to healthcare access for people living with HIV/AIDS (PLWHAs) in Ghana reveals a staggering array of challenges that range from structural impediments to social and individual-level constraints. Here, some key studies are presented to highlight a constellation of barriers: We now discuss these studies concerning their adverse effect on healthcare utilization and ART adherence.

Ankomah (2016) conducted an investigation using a mixed-method design that encompasses cross-sectional surveys and qualitative interviews into barriers to ART access among HIV-positive persons in southern Ghana. A vast majority, comprising 63.3 percent of participants, were noted to face extreme obstacles such as cost-related factors, long waiting periods, shortage of drugs, stigma, fear of side effects, insecurity of job, long distances to health facilities, etc. With this, structural and individualized interventions so greatly needed to enhance access to healthcare for PLWHAs.

Just as in Opoku's 2021 research, which examined how PLWHAs cope in Ghana; his study surveyed stigma and discrimination as the negative effects in the lives of his respondents. Semi-structured interviews were held with 35 individuals, and the outcome showed that stigma from both the communities and health institutions led to social alienation, unemployment, or deteriorating relationships. This points to the need for stigma reduction programs, which could improve healthcare participation as well as quality of life for people with HIV/AIDS. In the same vein, Ogunbajo (2018) highlighted the barriers to and facilitators of care engagement among Ghanaian MSM.

The qualitative study elucidated barriers which included fears of being known at the HIV clinics, financial constraints, and health system challenges; alongside supporting factors such as social support and awareness.

Dako-Gyeke (2015), similarly, studied PLWHAs in Ghana for stigmatisation and discrimination using focus-group discussions and in-depth interviews. The study revealed that stigma, whether enacted, anticipated, or internalized, had a significant adverse effect on healthcare utilizations. Except for a few exceptions from Korle-Bu Teaching Hospital, the stigma had run rife in other health facilities. This suggests that some policies and interventions from social work should be implemented that focus on the reduction of stigma and improving access to care.

Asghari (2018) presented a scoping review examining various barriers faced by people living with HIV accessing different types of healthcare services. Typical challenges included negative interactions with healthcare staff, long wait times, scarce resources, and fears about the disclosure of HIV status. The review recommends that better training of health staff be introduced while raising awareness of HIV to improve communication between the patients and providers in the interests of equitable access to healthcare for all such PLHIV.

Adjetey (2019) investigated the acceptability of applying community-based health service models among people living with human immunodeficiency virus (HIV). Though the facility-based services were preferred because of thorough health checks offered at the facility, another reason that hindered acceptability of community-based models was the stigma. The study highlights the need to address stigma for the components to work and be acceptable in the alternative health service delivery system.

Ayiigah (2024) looked at the stigma against ART clients in the Upper East Region of Ghana identifying that culture, ignorance, and a poor enabling environment were major factors for this. The study showed that public and self-stigmatization was common, expressed as social isolation, mockery, and discriminatory practices that obstructed access to healthcare. Recommendations included culturally-sensitive educational interventions and strict enforcement of anti-stigma policies.

Nutor (2024) looked into the association between HIV-related stigma and treatment outcomes in the Volta Region, where significant internalized and anticipated stigma were being shown with likely worst psychosocial consequences and lesser treatment adherence. This calls for a comprehensive intervention strategy geared toward stigma reduction for better engagement of PLHIV into healthcare.

In the end, Boakye (2023) examined Ghana's progress in attaining the UNAIDS 95-95-95 targets for treatment and put stigma, limited access to health care, and funding constraints on the map as the major barriers. The researchers sought to bring to light the challenge that while the goals may be attained, much more will be required if the stigma and ART uptake hitches are to be eradicated as these issues raise more general concerns of health service access among PLWHA.

These two papers bring out the complex nature of the relations among the policy setting, social relations and individual behaviours that influence access to health care among people living with HIV/AIDS in Ghana. How people living with HIV view treatment, stigma and support from family and friends, cost of receiving treatment and taking drugs and actually moving from ART services to other care services are all interrelated because they all prompt poor healthcare seeking behaviour. It is necessary to combine the interactions into the formulation of tailored interventions to make a change in the lifestyle of PLWHAs in Ghana.

Conceptual Review

The most common barriers to good health outcomes and quality of life among persons living with HIV/AIDS, or PLWHA, are barriers that restrict their access to health services through government bureaucratic structures. Studies have often pointed to three main types of barriers-the structural, provider-related, and community-level barriers.

Structural and Systemic Barriers

Other constraints are structural and system factors of access to health care for persons living with HIV and AIDS. One of the noteworthy factors is the distance of rural areas to medical units where patients have to travel for long distances at high levels of cost to reach the services. Doing so impedes patients from coming back for regular appointments and as a result PLWHAs find it hard to continuously receive care. Sometimes people may have to travel to some other town or even a region to get quality services on HIV, therefore ruining their chances again for timely treatment. Bajunirwe et al. (2018), Tafuma et al. (2018), Otara et al. (2024), and Sawe et al. (2016) were those who supported the study and observation.

Financial constraints also weigh heavily in this regard. Many PLWHAs are impoverished, and the costs of treatment—be it transport, food, or sometimes medication—can be overwhelming. Such financial burden looms larger in settings where out-of-pocket payments are required from patients for services rendered or restricted insurance coverage (Bajunirwe et al., 2018; Tafuma et al., 2018).

Another barrier pertains to the structure of the healthcare service delivery. In many healthcare systems, HIV care is divided from care for other conditions like diabetes and hypertension. Such fragmentation leads to poor continuity in care and an increased burden on patients who are required to keep track of separate appointments and facilities (Gooden et al., 2023). Some healthcare facilities also have inconvenient working hours or lengthy waiting periods that dissuade PLWHAs from putting themselves forward for care (Bajunirwe et al., 2018; Tafuma et al., 2018).

Healthcare Provider-Related Barriers

There is no doubt that the behavior of healthcare providers and the overall service delivery are dominant factors influencing PLWHA’s access to treatment. Unfortunately, such challenges have been noted in some cultures which can be due to the stereotypes health providers possess (Nair et al., 2017; Jaafari et al., 2022; Tafuma et al., 2019). The patients are also subjected to this kind of discrimination since they are for example discriminated against by health providers because of transmission of HIV and AIDS.

Even confidentiality problems can be a barrier of great magnitude. When health workers narrates the HIV status as a rag concurrently leading to the next day HIV related discrimination prediction, patients are less willing to be treated in these future occasions. And such breaches of the privacy of HIV status would have enduring implications on people's health-seeking behavior, as fear of exposure of their HIV status can become a barrier in accessing crucial services.

Individual and Community-Level Barriers

A fear of disclosure of one's HIV status is an individual constraint most often cited as preventing access to health care (Jaafari et al., 2022). Treatment avoidance by many PLWHAs is partly attributable to a fear of identification at the hands of health facilities or if others might have their HIV status disclosed. These types of continuous fears have always been linked with the stigma attached to such people in the society. People tend consider HIV as a “dirty” or even “wrong” disease.

The other side of the barriers we presumed is that there may be some ignorance which may affect peoples’ healthcare access services. Some PLWHAs may not consider any need for seeking regular medical attention or may even be hesitant on the treatment’s capability to work (Ai et al., 2023). In addition, mental health issues, and self-stigmatization are some of the reasons for which some individuals do not access the required care (Gilje, 2012; Soundar et al., 2020).

Facilitators of Healthcare Access and Utilization

Contemporary study recognizes varied interferences that keep people living with HIV/AIDS (PLWHAs) from accessing healthcare. However, there are other determinants which foster access. In such instances, social services or even familial care are encouraging and supply the tools needed for the person to make use of the healthcare (Otara et al., 2024). Moreover, high Retention to Care rates have been connected with requirements of the HIV infected individual and the caregiver as well as the caregiver’s service availability.

Anxiety about healthcare and appropriate communication among PLWHAs and their care providers are crucial factors in the process of care acceptance and retention (Jaafari et al., 2022). It prevents loss of patients, who readily present for care, into such programs. Sympathy and assistance play a huge role in the patients' decisions to return for their treatment, rather than just sitting and waiting for the patients to come.

Conceptual Review

The individuals suffering from HIV—AIDS bear certain limitations that may expose the patients to obstacles when in need of healthcare, hence affecting their institutions and well being. Consequently, the emphasis of the discussion is placed on the main problems raised by different studies approaches, the division of these impediments into three classes is provided: system-imposed, healthcare professional-centered, and individual or community focused blocks.

Structural and Systemic Barriers

The structural and systemic factors are the greatest hindrance to access to healthcare for PLWHA (Park is particularly of that distance to health facilities which put them at high financial and time costs as patients reside in the rural area). Thus, they may have problems with the feasible regular visit (Robleda et al., 1997).

Treatment becomes even more confusing when they have to travel to other towns or regions where better specialty HIV services exist (Levesque et al., 2009). With such studies it is expected that coexistence of such factors in majority of its prevalence of healthcare access in most regions where the people have got infections. Thus, it may be that 99% of most health care is related to the above two barriers; this is how we derived the following: HIV specifically and other blocking factors like distance and poverty, and more (Fox et al., 2005, Turinawe et al., 2009; Otara et al., 2024).

Economic hardship is the great one in having incurred high costs, in addition to transportation and feeding, at times, even medicine. Poverty has clipped many PWLHAs so much so that they are merely high cost-driven out of treatment. This thought conveys a similar meaning by another researcher. For instance, it is affecting people like in the following description as he uses other words that mean the similar thing: Finding of Tafuma et al. (2018) was echoed by this: totally unable to be paid by the affected community bilaterally or with support from the federations.

Another major one comes in regard to health-care service provision. HIV care exists as a separate service in many health-care systems from other services like the treatment for diabetes and hypertension. This actually amounts to ineffective continuity of care that then is burdened on the patient who has to do the maze of bookings and premises (Gooden et al., 2023; Park et al., 2015). As another effect to that, with part of such facilities working for a few hours or so are waiting for opening at 0800hours, provide prevention and treatment services to PLWHAs.

Healthcare Provider-Related Barriers

In health service accessibility, indeed, the attitudes and behavior of health care providers in healthcare facilities may be vital for the determination of the willingness and ability of PLWHAs to seek health services. Stigma and discrimination from health workers are common barriers. It is not uncommon to hear that patients are pushed away or out of doors by health workers who regard them as being positive with HIV (Nair et al., 2019; Jaafari et al., 2022; Tafuma et al., 2018). Ignorance of ways through which HIV can be transmitted by health care providers is the reason behind this behavior, making them dread HIV and in turn become stigmatized.

Another critical barrier is the secrecy in patient-provider discussions. Secret disclosures by health workers with HIV-positive patients then, inadvertently, trigger the actual stigma of such patients, making them more unwilling to visit healthcare centers in the future (Nair et al., 2019). HIV fear is going to deter access to life-saving medical health services if confidentiality is breached-now once you are afraid of HIV exposure, you will go delirious on your own skin for ages because such people will not go voluntarily to learn to save their lives.

Individual and Community-Level Barriers

The leading obstacle noted by Jaafari et al. (2022) is the fear that arises when those living with the virus expose their health-related information. Indeed, most PLWHA in the area do not access services of health for fear of being recognized within the health facility or public disclosure of their HIV status. The fear emanating from stigma and discrimination associated with HIV occurs at a community level where HIV is generally viewed as filthy or unscrupulous.

Fulfilling the whole need of seeking facilities for healthcare is further problematic due to the low level of awareness about HIV as well as the kind of medical services that are on offer. For some persons living with HIV/AIDS, it is poor in the understanding on why continuous service check-up serves them or for imposition of wrong beliefs on the effectiveness of medications. With regards to health care, different mental health problems and internalized stigma also triggers health care's lack of seeking behavior. But even after taking into consideration such abstract discussions-what forms it ultimately takes on-the process by which actual praxis occurs must in turn be transformed into a practice; precise primary work can renew science and remove its ideological stains.

Facilitators of Healthcare Access and Utilization

Others underscored the significance of various buffer facilitators that have been beset with challenges; such items are social services and the family members, and how they become motivators and resource bears in health seeking among the health-seeking needing PLWHA (Otara et al., 2024).

Furthermore, easy availability of information on HIV services and frequent availability of services are associated with increased rates of healthcare utilization. Involved in encouraging PLWHA into care and retention is: trust in the health system and positive interactions with healthcare providers (Jaafari et al., 2022). A patient who feels respected and supported is likely to keep appointments with the healthcare provider and follow their treatment plan.

Barriers to healthcare access for PLWHAs are complex and interconnected at the levels of structure, healthcare provider, and individual/community. The challenges require a multilevel strategy of improving healthcare infrastructure, upgrading provider education, combating stigma, and equipping and supporting PLWHAs for the struggle. Interventions in the future will emphasize the integration of HIV services with other healthcare needs, strengthening of confidentiality processes, and addressing social-economic determinants limiting care access. Accordingly, in order for healthcare systems to promote equitable access by reducing health barriers to PLWHAs, it is important to address these barriers comprehensively.

Conceptual Framework

Computation Theory for Barriers to Healthcare Access and Utilization among PLHAs A basis for an exhaustive conceptual framework for the study of barriers to healthcare access and utilization for HIV/AIDS must bear upon the socio-ecological model. The framework conceived will encompass different levels of influence and their interplay as described in the studies. The socio-ecological framework for barriers and facilitators to progression in HIV care is based on a socio-ecological conceptual framework developed by Roura and others in 2009.

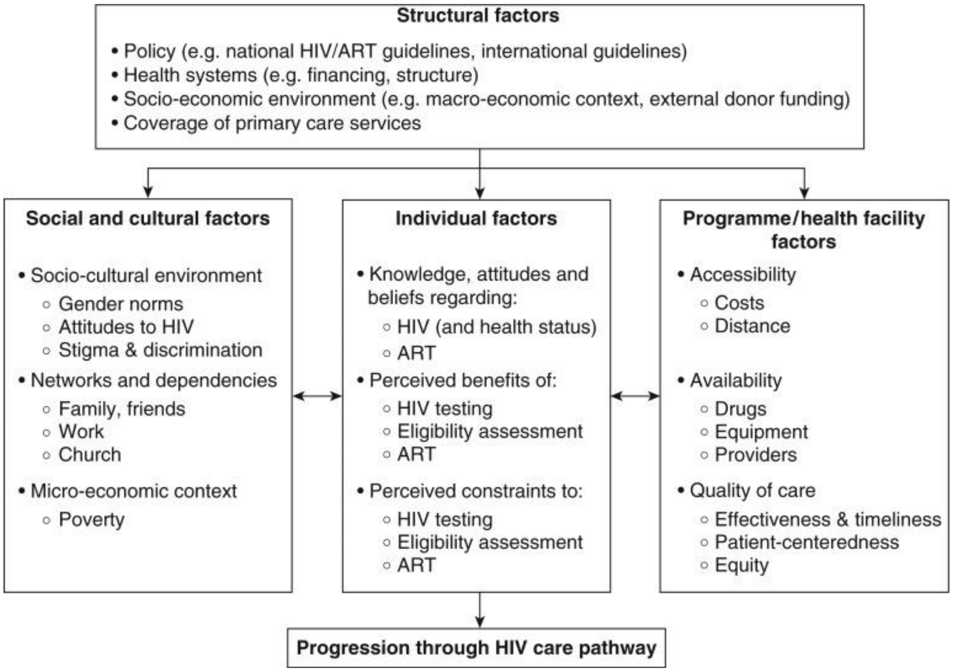


Figure 1: Conceptual Framework for Barriers to Healthcare Accessibility and Utilization Among PLWHAs

Source: Roura et al. (2009)

Levels of the Conceptual Framework 1. Individual-level factors at the very core of the framework would directly impact the ability and willingness of a PLWHA to access and utilize health care services: Knowledge and awareness: Knowledge of HIV/AIDS and available services. Personal beliefs and attitudes: Points of view regarding HIV treatment and health care Mental health: Including depression, anxiety, and internalized stigma Financial status: Individual poverty and ability to pay for healthcare costs Health status:

Including CD4 count and presence of comorbidities 2. Interpersonal Level It includes PLWHAs' immediate social network: Family support: Acceptance and assistance from family members Peer pressure: Influence from the experiences and attitudes of fellow PLWHAs Health care provider relationships: Quality of interactions with health care staff 3. Healthcare System Level This level concerns the structure and functioning of healthcare services: Availability of services: Availability of HIV-specific and general healthcare services Organization of services: Integration or fragmentation of HIV and other health services Healthcare provider factors: Knowledge, attitudes, and practice of healthcare workers Confidentiality procedures: Measures for patient privacy Protection Waiting times and facility hours: Convenience to access services 4. Community Level This area focuses greater attention on broad social and cultural factors such as stigma and discrimination: Community attitudes towards persons living with HIV/AIDS Cultural beliefs: Local perceptions about HIV/AIDS and health care systems Social support systems: The very existence of support groups and community organizations 5. Structural Level This is the farthest level in the outer region for broader societal and policy factors: Geographic accessibility: Distance to healthcare facilities and the infrastructure for transportation Economic factors: Poverty and economic opportunities in the region Health policy: Policies governing HIV/AIDS care, both at the national and local scales Resources for the healthcare system: Availability of equipment, medications, and trained personnel Interplay Between Levels The framework puts an emphasis on the interconnectedness of these levels and how they influence one another. For instance, Structural factors such as geographic accessibility directly alter Individual Level factors like the ability to reach the healthcare facilities. Community stigma affects the level of Individual fear of disclosure and healthcare-seeking behaviour. System factors such as confidentiality affect the trust relationship in Interpersonal levels with providers. Use of the Framework This conceptual framework is a comprehensive structure for: 1. Research design: In guiding the formulation of research questions and methodologies that recognize all relevant levels of influence. 2. Data analysis is the process of organizing and interpreting findings with a holistic view of barriers. Interventions will be planned by identifying sites of potential interventions for improving healthcare accessibility and utilization of services among Persons Living With HIV/AIDS (PLWHAs) at different levels. Policy development entails developing overarching policies that will assist in addressing barriers at each level of the socio-ecological model. As a guiding framework, researchers and policymakers will gain a richer and more holistic understanding of the complexity surrounding all factors affording or hindering health access and utilization among PLWHAs. Therefore, the framework becomes an avenue through which effective approaches would be devised to improve health outcomes among this group.

Study Area/Setting

This study was conducted in New Juaben and Manya Krobo Districts in the Eastern Region of Ghana, such areas are characterized by a high prevalence rate of people living with HIV/AIDS. In these areas, HIV prevalence has been on the rise since the 1970s, with New Juaben, specifically Koforidua, recording an 8.5% rate which is among the highest in the country.

New Juaben District

New Juaben is a municipality in the Eastern Region with Koforidua as its capital. It is the smallest district in the region by land area. Still, it hosts important national health facilities like the Regional Hospital, which serves patients suffering from HIV/AIDS from surrounding areas due to excellent medical services. The district has four health subdistricts and features a varied ethnic composition, mainly comprised of the Akan group and smaller populations of Ga-Adangme and Ewe. The area's topography includes flat plains and some hills, while a tropical rainforest setting provides a backdrop for agriculture, timber processing, commerce, and public service as the mainstays of the economic sectors.

Manya Krobo District

The town of Manya Krobo is in the eastern area of the Eastern Region along the banks of the Volta, and with a total area of approximately some 1,476 km2. It has a fairly homogenous topography consisting of open flat land interspersed with isolated hills, with its numerous streams emptying into the Volta Lake. The district embraces twelve area councils, the majority of which are composed of a kombination of Krobo folks, thereby fostering high levels of social cohesion, resulting in Krobo cultural values being respected. Three major hospitals—Atua, St. Martin's, and Akuse Hospitals—are situated in Lower Manya.

Spatial Dimensions of the Study Area

Healthcare provision in the two districts is affected in varied ways due to the geographical and social variations of the areas. Effiduase is far more accessible with greater cultural interaction because it is along a major route linking Accra to Kumasi. In contrast, Agomanya is more rural, thus giving it the social cohesiveness and family relationships that shape the dynamics of patient care.

Antiretroviral drug pilot programs being conducted in Agomanya serve to set the community apart from Effiduase, which only treats opportunistic infections with standard medications while the other one focuses on ARV. These rural settings offer Agomanya residents fairly good interrelationships, almost in contrast with that township setting, which is cosmopolitan due to its New Juaben metropolitan area. This area has a wide population of migrants.

The health delivery systems in the two districts are thus made considerably different due to these spatial and social factors, which have a cascading effect on the overall care programs designed for PLHAs.

Methodology

Study Area

The study was conducted at Agomanya and Effiduase in the Eastern Region, Ghana. These two communities were selected for having a fairly large population of people living with HIV/AIDS and hosting key healthcare facilities offering treatment and support services for PLWHAs. The two key main primary care centers where PLWHAs access services are St. Joseph's Hospital in New Juaben and St. Martin's Hospital in Manya Krobo. The selection of these venues enabled the researcher to conduct an in-depth analysis of the local context and probe the specific challenges that the PLWHAs faced in accessing health care.

Research Design

The study adopted a descriptive cross-sectional research design. This design allowed data collection to be done at one particular point in time and thus provided a snapshot of barriers to the access and utilization of healthcare among PLWHAs. The design combined both qualitative and quantitative methodologies, ensuring a full comprehension of the factors affecting access to healthcare. The structured questionnaires captured numeric data, while the focus group discussions and interviews provided richer qualitative information. Target populations in this study included:

PLWHAs who are currently receiving treatment at selected care centres

Healthcare personnel working in HIV/AIDS care units at the selected facilities.

Government and NGOs' activities involved in offering care and support services for PLWHAs.

The people staying in Agomanya and Effiduase fall under the communities where care services are provided.

Sample and Sampling

The total sample size for this study was 202, distributed as described below:

i. *100 PLWHAs from the identified care centres*
ii. *90 community residents from the catchment areas where health services are rendered*
iii. *4 health personnel, that is 2 from each of the care centres*

iv. *4 members of the DHMT*
v. *1 Regional AIDS Coordinator*
vi. *1 officer from the Disease Control Unit in the Eastern Region*
vii. *2 representatives from NGOs directly involved in supporting PLWHAs.*

To get a representative sample, proportionate stratified sampling was used in the selection of respondents, especially the PLWHA ones. Because there are unequal numbers of PLWHAs at the two care centers, 47 respondents were selected from St. Joseph's Hospital, while 53 were selected from St. Martin's Hospital. For the community residents, 38 respondents were sampled from Effiduase, while 52 were from Agomanya, based on population sizes. The subjects in this study were selected using a simple random sampling technique to minimize bias in the selection of individual respondents for interviews and the administration of questionnaires.

Instrumentation

Instruments for data collection included a structured questionnaire and interview schedules suitable for the objectives outlined in the research. The structured questionnaire comprises both open-ended and closed-ended questions to adapt to the quantitative analysis. Some of the key variables assessed include the respondents' demographic characteristics, barriers to health services access, and perceived care services. Focus group discussions were conducted to diversify perspectives and enhance the qualitative aspect of the research.

Reliability and Validity

To ensure that the instruments were valid, the questionnaire and interview guide underwent expert reviews by experts in HIV/AIDS research and public health for validation to ensure that all had adequately addressed the objectives of the study. A pilot test with a small sample of PLWHAs and healthcare personnel was conducted to establish the reliability and clarity of the questions. The outcomes of the pilot test were used to refine the instruments, ensuring that they captured the intended data without ambiguity.

Data Collection

The collection of primary data was through fieldwork by the researcher and trained assistants. Structured questionnaires were administered personally to each respondent to make sure that questions were understood and answered. Interviews with health personnel and NGO representatives were held to get an in-depth understanding of the organizational challenges as well as support systems that PLWHAs faced. In this regard, Focus Group

Discussions were also conducted to engage community members in a discussion format to elicit varied perspectives on issues impinging on access to health care.

Data Analysis

Data analysis was done using SPSS version 24. Further, descriptive statistics were used to summarize demographic information and quantify responses to closed-ended questions. Qualitative data from open-ended questions and focus group discussions were categorized into thematic areas to identify main patterns and trends. Such results were then presented in charts, tables, and bar graphs so that the data was clear and easy to compare.

Results

Results on Accessibility to Care Centers

Distance to healthcare facilities is a critical factor influencing the utilization of healthcare services. According to Dutton (1986), structural barriers such as the time spent travelling to a facility and the duration spent receiving treatment can deter individuals from accessing healthcare. This study aimed to assess the impact of distance on care delivery for people living with HIV/AIDS (PLWHAs) in the communities, considering factors like geographical location, community status, social cohesion, and variations in care delivery.

Effiduase, located within the New Juaben Metropolitan area, benefits from the socio-economic activities of Koforidua, the regional capital. The survey indicated that the care centre in Effiduase serves not only PLWHAs from the metropolis but also those from other parts of the region and beyond. Data from the study revealed that 81% of PLWHAs travelled to the care centres by vehicle, while 19% walked (Table 4.2.1). The need for transport imposes a financial burden on many patients, exacerbating their struggle, especially considering that the average treatment cost is 50,000 cedis per month, which many patients find unaffordable.

In contrast, Agomanya, though a district capital with active business activities, exhibits more rural characteristics and stronger social cohesion than Effiduase. Despite the closer community ties, 19% of respondents also walked to the care centres, while the majority relied on vehicles, similar to Effiduase. This indicates that the care centres serve residents and PLWHAs who travel from up to 30 km away, highlighting the extended reach of these facilities beyond their immediate communities.

When asked if they would prefer the care centres to be relocated closer to their homes, 73% of respondents declined (Table 4.2.2), contradicting Dutton's (1986) assertion that distance is a primary barrier to healthcare utilization. The primary reason for this preference was the fear of stigmatization and discrimination. Patients preferred travelling to distant centres to maintain privacy about their HIV status, even if it meant increased financial and logistical burdens. The reservation regarding establishing care sites in closer proximity underscores the severe effects of social stigma on healthcare-seeking behavior whereby PLWHAs appear to prioritize anonymity over convenience. The distance may be a logistical issue, but this social issue involving stigma and discrimination would appear to be the clincher in determining healthcare accessibility for PLWHAs in this context.

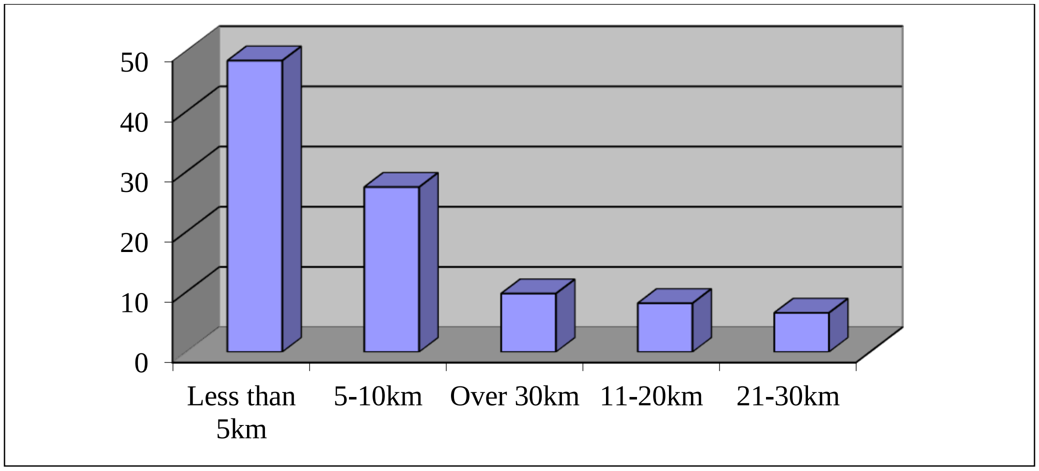
Factors

The Factors Affecting Accessibility and Utilization of Healthcare Facilities Results Section: A Comparative Study of Agomanya and Effiduase. This section presents the findings of the comparative research between Agomanya and Effiduase based on a number of factors affecting accessibility and utilization of healthcare facilities by persons living with HIV/AIDS (PLWHAs). The key factors studied were distance from the care centre, availability at the facility of antiretrovirals, actions of organizations, length of time spent in the health facility, knowledge of another person's HIV status, relationships with persons living with HIV/AIDS, and the knowledge of the respondent with regard to their own HIV status.

Distances to Care Centres

Agomanya: The study revealed that 60.6% of Agomanya respondents lived within a 5 km radius of the care centre, indicating that most PLWHAs are either locals or residents of nearby communities. Another 33.3% lived within a distance of 5 to 10 km from such towns as Atua, Somanya, and Odumase, while only 6.1% lived beyond the distance of 10 km. This shows that the care centre mainly serves clients who are within a relatively short distance.

Effiduase: In contrast, 34.5% of respondents in Effiduase lived within 5 km, a figure significantly lower than in Agomanya. An additional 20.7% lived within 5 to 10 km, and 55.2% resided within 10 km of the facility. A notable difference is that 10.3% lived between 11 and 20 km, and 13.8% lived between 21 and 30 km, with 20.7% residing beyond 30 km, including some who travelled from as far as Kumasi. This wider geographical spread may be attributed to Effiduase's accessibility along significant travel routes like Accra-Kumasi.



DISTANCE-km

Figure 2: Distances from PLWHAs' House to Care Centre

Source: Field data from Manya Krobo and New Juaben Districts (2003)

Provision of Antiretrovirals

Agomanya: Providing antiretrovirals (ARVs) is a major differentiating factor between the two areas. St. Martin's de Porres Hospital in Manya Krobo District offers ARV treatment with drugs like Combivir and Efavirenz, although patients pay monthly fees. This facility undertakes initiatives to cater to orphans and other vulnerable children, thereby demonstrating a holistic approach to care.

Effiduase, unlike Agomanya, does not provide any Anti-retrovirals but does provide treatment for opportunistic infections such as tuberculosis and other common sicknesses. This limitation greatly hinders the accessibility and effectiveness of care provided to PLWHAs in Effiduase.

Interventions from Organizations

The FHI Health Systems project, with other organizations, subsidized drug costs for People Living With HIV/AIDS, gave financial support for health workers, and trained for home-based care. Such interventions are crucial in increasing the access to health facilities.

In contrast, while Effiduase benefits from some organizational support, it does not have the richness in depth and breadth of interventions seen in Agomanya, especially in the direct support of ARV provision and comprehensive care services.

Length of Time Spent at Facility

Both Agomanya and Effiduase stated that this set of people spent long hours in the centres being involved in various activities such as talks, socialization, and treatment. Contrary to popular belief, the patients considered this prolonged stay beneficial because of the bestowed attention and a sense of belonging which encouraged them to continue using health care services.

Knowledge of Other People's HIV Status

Agomanya and Effiduase: Typically, most respondents (about 72.5%) had knowledge of another person's HIV status, mainly among their families and friends. This knowledge had mixed impacts—while it sometimes fostered support, it also led to stigma and discrimination, influencing some PLWHAs to seek care in less familiar environments to avoid social judgment.

Relationship with People Living with HIV/AIDS

Relationships between respondents and PLWHAs were reported differently in the two communities. In Manya Krobo, more respondents indicated having family members living with HIV/AIDS, which influenced their attitudes and interactions positively. In Effiduase, the connections were less pronounced but still significant in shaping social attitudes towards healthcare utilization.

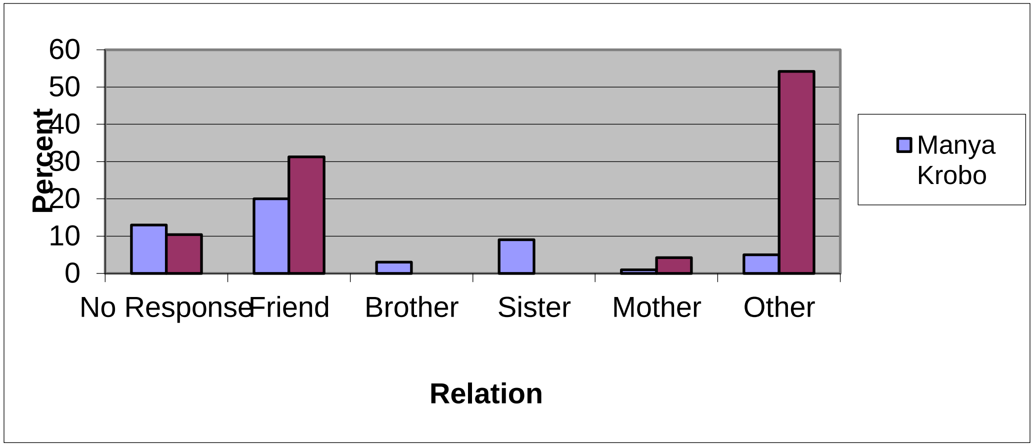


Figure 3: Respondents' Relationship with PLWHAs

Source: Field data from Manya Krobo and New Juaben Districts (2003)

Respondents' Knowledge of Their HIV Status

Slightly more than one-fifth of respondents, or approximately 23.6%, were aware of their HIV-positive status, while mere 76.4% claimed not to have known. On one hand, a significantly larger proportion of those surveyed were aware of their HIV status than was the case in national surveys; on the other hand, a considerable number of them did not see themselves as being at risk, indicating a breach in the self-appraisal of whatever personal risk may avert them from being proactive in seeking healthcare.

Conclusion

The study continues to take on the logistical difficulties in seeking healthcare and appropriate treatment for PLWHA in Agomanya and Effiduase and finds that physical distance alone does not account for the complexity surrounding healthcare-seeking behaviour. Logistical impediments such as distance to the care centre or availability of antiretrovirals do matter, but social factors especially stigma and discrimination outweigh them with respect to access to health care. The act of PLWHAs not wanting care centres near their homes even at the cost of financial and logistical burdens bears testament to a social stigma so far-reaching that it convinces patients to place privacy above convenience. Further variability includes the nature of support from the aid organisations, availability or lack of antiretroviral treatments, and social ties within these communities, all of which further complicate access to consistent and effective care. These findings signify that schemes to enhance accessibility must, therefore, consider a range of barriers rather than only a few physical or structural ones; the stigma and discrimination that the community members with HIV/AIDS have to contend with in seeking and using some of these health services must be addressed as well.

Recommendations

To improve healthcare accessibility and uptake of PLWHAs in Agomanya and Effiduase, the community, local health authorities, and NGOs are encouraged to take steps toward reducing stigma through educational and sensitization programmes that create an understanding of HIV/AIDS as a manageable condition, thus creating an environment of support for care-seeking. Facility managers and service providers need to strengthen privacy and confidentiality measures to minimize fear and stigma, e.g., discreet registration, private consultations, etc. The Ministry of Health and the regional health directorates must increase access to ARVs in underserved areas by increasing their availability and strengthening supply chains to ease the financial and logistical burden on PLWHAs. The government must work with NGOs to strengthen economic support systems through expanding health insurance coverage, transport subsidy systems, and direct cash transfer systems to overcome economic barriers to healthcare access. Finally, targeted interventions like mobile clinics and outreach activities can bring ART and primary health care closer to patients, reducing travel burdens and ensuring continuity of care. The implementation of these activities will address structural and social barriers, promoting better health outcomes for PLWHAs in these communities.

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