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A qualitative descriptive (QD) analysis of community-level experiences of healthcare delivery in rural, post-structural adjustment Ghana

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ABSTRACT

Structural adjustment programs (SAPs) imposed in Ghana during the 1970s intentionally stratified the country without recognition of the diverse methods of healing commonly relied on by communities. Development assistance programs forced the restructuring of all major institutions and especially the organization of health care. This restructuring changed the cost structure for health care and while intending to increase access and geographic availability, SAPs resulted in the further marginalization of rural communities—exacerbating existing circumstances and further stratifying this society. The focus of this study was to capture key aspects of different types of healthcare delivery in a rural community and to learn more about their disease or illness specialties and treatment approaches. With a qualitative design (QD) approach, and based on fourteen walking interviews, this paper offers insight into seven different ways by which members of otherwise marginalized communities may access healthcare.

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1. Introduction

Poor macroeconomic performance in Ghana, West Africa in the 1970s, in combination with political and civil instability and environmental degradation, forced Ghana to seek financial assistance. Under the advisement of international financial institutions (IFIs), Ghana participated in structural adjustment programs (SAPs) which resulted in the exacerbation of the existing circumstances, also resulting in hyperinflation, food shortages, unemployment, and the privatization of public enterprises including health care (Oppong, 2003; Oppong in Aryeetey-Attoh & Samuel, 2003). During this period, IFIs such as the International Monetary Fund (IMF) and the World Bank, overwhelmingly recommended fiscal reconstruction for countries to better concentrate efforts towards privatization to benefit business, investment, and trade. Yet, they consistently overlooked the myriad of socio-economic effects, which resulted in extensive and far-reaching consequences to services provided by the public sectors (Forster et al., 2019). In addition, given that government subsidies generally tend to concentrate efforts in urban areas, the period of post-structural adjustment reform in Ghana left many living in non-urban and rural areas without fair pricing of food and water, housing, and adequate access to medical care, resulting in disproportionally higher disease and death rates (Oppong in Aryeetey-Attoh & Samuel, 2003). Ultimately, greater than 6.5-million Ghanaians, or about 30% of the total population, lived in poverty after structural adjustment in 1997. Since this time, Ghana has made tremendous economic gains and shown significant growth, reducing extreme poverty from 16.6% to 8.4% by 2006 (Cooke et al., 2016). However, despite steady economic growth and reduction of extreme poverty, there is almost no change for those living at the poverty line, and inequality has increased, especially by region, and between the urban and rural areas. In fact, a panel analysis utilizing multivariate regression of 135 countries for the period of

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1980–2014 examined inequality after the period of reform. The primary pathways linking the adoption of structural adjustment programs to inequality are through four main areas of policy. These policy pathways include 1) governments adopting fiscal policies that restrict expenditures, 2) liberalizing external sectors including trade, 3) instituting financial sector reforms which include inflation-control measures 4) then, lastly, reforms that control external debt (Forster et al., 2019). Additional critics of SAPs cites examples of how these pathways manifest as cuts to health services, creating additional fee structures for health services; as well as cuts in other sectors such as public utilities, agriculture, and education which also alter labor markets and currency devaluation affecting prices especially for food and basic needs (Pfeiffer & Chapman, 2010).

Through the lens of critical theory, this study seeks to provide a qualitative descriptive (QD) analysis in a rural community in Ghana. Health system access is used to frame this analysis because it is one of the key determinants of equitable health outcomes (Forster et al., 2020). Critical theory was selected as the primary theoretical lens because of the known negative outcomes of polices mandated by IFIs on health equity (Forster et al., 2019; Forster et al., 2020). This paper explores community-level experiences of the impact of SAPs on the availability of health services for the rural poor in Ghana, West Africa, and provides a QD analysis of the continuum of alternatives that one might seek to get needed healthcare in the absence of formal delivery systems.

1.1. Background

The work of SAPs was made possible by the legacy of colonialism, then made necessary to respond to subsequent globalization and the need to modernize all major institutions, including the institution of health care. This initiative resulted in the Ghanaian health care system being organized at three levels: national, regional, and the district level, with five levels of providers: tertiary and regional hospitals, district hospitals, health centers and clinics, and health posts which serve as the first level of primary care for rural areas (ITA, 2020). Most health care in Ghana is administered by the Ministry of Health and Ghana Health Services, and now relies on the National Health Insurance Scheme (NHIS) to "provide wide coverage for a limited scope of health issues, primarily insuring for treatment against the most prevalent diseases" such as malaria (ITA, 2020), while supporting private sector development for health care. The health care system has transitioned from the initial fee-for-service model, instituted as a part of the SAPs, but considers the growing middle class as a health care market opportunity for non-state, privately funded health facilities (ITA, 2020).

Since the implementation of IMF policies cross-national studies have found that reforms have decreased overall health system access, and also led to an increase in neonatal mortality (Forster et al., 2020). What has emerged from this combination of events is a class-based health care system based on affordability (Oppong, 2003). For instance, the privatization of health care in Ghana, and the disproportionate investment in some communities, created a system that favored those who can afford to pay for health care and favored those with the resources to better navigate the health care system and even bypass local community resources in favor of the better equipped urban facilities.

In Ghana, the poor overwhelmingly reside in rural areas. While rural areas are primarily served by health posts and the NHIS, universal access remains largely regressive, in that, the poor still spend a disproportionate amount of their income on health care than those wealthier (Polychronis, n.d.). In addition to the actual cost of health care and the added costs associated with travel to a non-rural facility for more complex care, rural areas lack the capacity for improvements when considering the financing for infrastructure, transport improvements, and workforce development. Subsequently, the two wealthiest quintiles of the population account for almost half of the total healthcare benefits. This proportion increases when considering private sector health care as well (Polychronis, n.d.), thereby indicating that the poor received a smaller share of benefits of health care in Ghana.

It is anticipated that almost 43% of Ghanaians are considered rural poor (Cooke et al., 2016), living without practical and affordable access to health care. As measured inequality continues to increase for this group and health care infrastructure remains underdeveloped, the neo-liberal economic system affecting health care is also affecting urbanization, education, religion, and ultimately, health. This essentially creates a new social order of both physical and social distances between those who can afford to access the biomedical model of healthcare, and those who must resort to substandard and underdeveloped facilities, or remain vulnerable to alternative forms of care including relying on providers not trained for treating certain diseases, especially chronic disease, or resorting to itinerant drug vendors (IDVs) or drug peddlers "as a source of inexpensive, but frequently, questionable health care" (Oppong & Hodgson, 1998).

The combination of these factors has contributed to many rural Ghanaians remaining in poverty despite the decline of the overall poverty rate of the country. However, when considering the differences between urban and rural areas, urban poverty rates showed rapid decline, while rural poverty rates almost doubled over the same period. The poverty rates in rural areas are almost four times higher than urban poverty rates, which has doubled since the 1990s (Cooke et al., 2016). For instance, the contribution of poverty levels by the rural areas in the northern part of the country to overall national poverty levels increased from 37% to 49% between 1999 and 2006, and the depth of poverty for those living in the poorest region, Upper West, also increased during this same period. This outcome contributes toward Ghana having one of the fastest growing levels of inequality in Africa (Cooke et al., 2016), and indicates that despite the overall economic growth of the country, not enough is being done to improve the lives of the rural poor as this group is not seeing the benefits of the economic growth of the country, resulting in underinvestment in health care and health for a very significant portion of the population.

1.2. Setting of this study

The town of Asankrangwa is the capital of the Amenfi West District, in the Western Region of Ghana. The district area is 1448.56 square kilometers and is about 362 km away from the nation's capital city, Accra, in the Greater Accra Region. Travel, by car, could take up to 8 h between the two areas. The census population in 2010 was 92,152 with 59.72% of the population living in the rural areas (Ghana Statistical Service, 2014). The education level for the region remains low due to inadequate and unevenly distributed infrastructure and poorly trained professional teachers (Adjei, 2013). This region receives the highest levels of rainfall in the country and relies on the agricultural activities of cocoa, plantain, cocoyam, coffee, palm oil and rice for food and cash crops. Approximately 70% of the population, mostly rural, are engaged in agriculture, with 63.4% considered self-employed (Ghana Statistical Service, 2014). Despite producing 20% of the country's cocoa and having gold mines in the region, this district remains largely underdeveloped with less than one-third of the roads in the district paved, tarred, or connecting to larger roads. During the rainy season, the problem of unpaved roads is especially pronounced. There is a stated need to improve water supply and sanitation infrastructure as more than half of the households in the district utilize public dumps for the disposal of solid waste, or the street to dispose of liquid waste, contributing toward the overall health status of the area (Cooke et al., 2016; Ghana Statistical Service, 2014). The main sources for water in the district are rivers/streams, public boreholes, and wells (Ghana Statistical Service, 2014).

This largely rural area is also known as one of the poorer districts of the country. While the district has fourteen total health care facilities, 2 are privately-owned hospitals, and the remaining are public clinics and centers of the public health service. In this area, there are only 44 health professionals. Having only 2 medical doctors, the doctor-to-population ratio is three times the national average at 1:38,841 to 1:13,683

(Adjei, 2013), both well beyond the recommended standard for care. In addition, more than half of the residents of the district live between 6 km and 35 km away from health care facilities, needing to rely on the road system that is not paved or tarred, and almost unpassable during the rainy season (Adjei, 2013).

This district remains vulnerable to higher disease and death rates, primarily due to the underdevelopment of physical infrastructure and institutional health care, poor training of health professionals, and education of the people (Oppong in Aryeetey-Attoh & Samuel, 2003). In absence of the necessary infrastructure and capacity for a fully developed health care system in this rural area, many residents, instead, seek care in the community through a traditional healer, herbalist, occultist, or through self-care accessing medications through an itinerant drug vendor (IDV). Since, historically, communities have a very different relationship with health and illness that pre-dates and goes beyond the biomedical understanding of treating disease, the role of the healer is for facilitating the communication between themselves, and their ancestors to reach the Almighty God (Mokgobi, 2014). However, it is through this combination of factors that leaves communities unable to successfully adapt to threats of non-communicable diseases such as cardiovascular diseases, cancers, and diabetes (Ahlberg, 2017). Furthermore, this combination of factors establishes the gap in access to health care, and subsequent health outcomes that must be filled for affordable care and treatment of disease.

2. Materials and methods

Given the efforts by IFIs to privatize health care through SAPs, the transformation of the public health system, established inequality, and the social, economic, and epidemiological transitions of the past years, we must consider what access to healthcare looks like for the more than millions of people living out of reach of the medical resources, necessary to treat some of the more complex medical conditions of our time. A major objective of this study is to explore local narratives and practices for healthcare delivery around the rural community of Asankrangwa, Ghana.

As a part of the parent study, rural healthcare providers, in the village of Asankrangwa were identified through purposive sampling by asking residents of the village to identify what type of healer they would contact if they needed health or medical care. From this question, fourteen different types of healthcare providers were identified. Walking interview and observation methods were employed for each of the fourteen sites identified by members of the community which represented the different types of providers of health and wellness care in this region of Ghana. Standards for qualitative research note-taking were kept throughout observation and interview involvement. The combination of the walking narrative and participant observation were employed as a way of gaining a better understanding of the healthcare challenges in a rural and underserved area and provided a great opportunity for observation of the area and context instead of a traditional seated, structured, or semi-structured interview. Butler and Derrett (2014) indicate that walking interviews have the capacity to add a depth and richness to the information obtained. In addition, they state that walking also has a way of shifting power balances of the relationship (Butler & Derrett, 2014; Kinney, 2017) during the interview allowing for enhanced focus the explore the connection between self and place (Kinney, 2017).

Based on recommendations from a variety of members of the community, the parent study explored the experiences of: 1). occultist, female; 2–4). herbalists, 2 female, 1 male; 5). itinerant drug vendor (IDV), male; 6). chemist, male, from Asankrangwa; 7–8). pharmacist and, a pharmacy owner, both male, from Kumasi; 9–12). 4 total hospitals: a teaching hospital, in Accra; a rural hospital in the village of Asankrangwa; an herbalist healing camp outside of Asankrangwa; and an herbal clinic in the more urban, Tema community. Also interviewed as a part of the larger study, was 13). a representative from WHO Ghana and 14). a representative from the Ghana Pharmacy Council.

2.1. Data analysis

Secondary data analysis were performed of the original fourteen walking interviews that originated from a parent study. Goals of the original study were to better understand the community-level circumstances and conditions of the disproportionate and uneven investments made toward rural communities after a period of structural adjustment. This post-hoc analysis is intended to reveal new insights concerning the options and opportunities for access to healthcare in a rural area, and to describe the community-level experiences of the impact of SAPs on healthcare services for the rural poor. This approach is consistent with the objectives of this secondary analysis and the theoretical and philosophical framework of critical theory.

Using original fieldnotes and transcripts from the parent study, a qualitative descriptive (QD) (Kim et al., 2017) approach was conducted in order to obtain descriptive information about the contextual details for each site where the delivery of health care occurs. Primary data collection and the initial QD analysis were conducted by the primary investigator of the parent study, while the process of data cleaning for bias, errors, and relevance were performed by a secondary analyst familiar with the circumstances, however not present during data collection. These distinct steps were taken in order to preserve the integrity of the data creation, but especially to control for the bidirectional relationship between the primary investigator and the data inherent in design of the parent study.

Examples of seven providers, individuals providing direct care and also that of a hospital in the capital, were selected as a part of this QD study and were selected to best illustrate the continuum of healthcare that is available for someone living in the primarily poor and rural areas. These descriptions provide the first-hand account of the type of healing tradition from which they originate and also the types of ailments they treat. Participants residing or keeping practice in a rural area were considered for this study, and held in contrast to the QD analysis of two clinics near and in the capital, the primary area of benefit of structural adjustment programming and investment. All matters of IRB protocol were honored and all data remain de-identified throughout all phases of the process.

3. Theory

This exploration of the realities of healthcare delivery post-structural adjustment is grounded in critical theoretical framework of the political economy of health which, as a theoretical framework, is described as being:

> used to study health inequalities. It proposes that health disparities are determined by social structure and institutions that create, enforce, and perpetuate poverty and privilege. […] [Political economists of health – *AWM*] analyze the relationships between health status and political-economic institutions throughout the world, with particular emphasis on the detrimental health effects created by capitalist relations of production and sustained by specific political-economic arrangements (Witeska-Młynarczyk, 2015).

The research design, data collection, and analysis were all guided by the presuppositions of the political economy of health which supports the research question of 'Who and what is responsible for population patterns of health, disease, as manifested in present, past, and changing social inequalities in health?' (Witeska-Młynarczyk, 2015). This theoretical perspective lends well toward ethnographic approaches and for examining larger economic and political structures structural adjustment against the community-level experiences of access to healthcare. This is an essential tool for exploring the cultural histories of communities instead of placing the focus entirely on the individual for any decisions made with regard to health or healthcare. This study seeks to provide a descriptive analysis of the realities of where one may access healthcare

for certain ailments in a rural area locked out of healthcare investment during structural adjustment. The concern of critical theory as a lens for this study is to examine this uneven development primarily due to the more powerful structures of the IFIs that invested and guided government and political decision making that led to infrastructure development, uneven access to healthcare, and disease outcomes for the rural poor.

4. Results

4.1. Accessing healthcare utilizing an occultist

The occultist provides prayer services every three weeks on Friday. Area occultists come together on this Friday to perform rituals with drums, to sacrifice a goat, intended as an offering to the spirits. Upon consulting the spirits, those spirits will then direct the healer to the disease that will then be treated with herbs. The ceremony begins at 10:00 a.m. and usually lasts until 4:00 p.m. People come regularly for treatment to remedy such diseases as epilepsy, swollen abdomen, convulsions, sexually transmitted diseases, barrenness, and modern diseases. The occultist stated that AIDS cannot be treated with herbal medicine but can be detected by the spirits.

4.2. Accessing healthcare utilizing an herbalist

Participant 2, a Muslim woman in her 50s and has been an herbalist for about 20 years. She gathers and makes her own remedies. Her practices and treatments came to her in a dream. She currently supports her children but is not training them to follow in her family business. She is a member of the association of native healers that helps to establish, "or fix prices", but she does not provide any assistance or cooperative efforts for furthering the business goals of others. She has ambitions to start her own herbal center as many of her clients will come to stay with her until their treatment is completed. She solicits business from the market, as being an herbalist is how she supports her family.

She mainly treats women who cannot bear children or have defects of the womb. She treats this inability to have children with bark from different trees that she prepares herself as a remedy that is inserted into the vagina. This remedy is effective for treating women and also treating impotence in men. She stated that it usually takes three to four months to become pregnant after treatment.

Another condition in which this herbalist specializes is boils that ooze liquids. She treats these types of boils with another herb that she grinds into a smooth paste, which is then applied every three days.

As a part of her practice, she reveals that she sees more women than men, and that they resort to her once the hospital fails to provide relief.

4.3. Accessing healthcare at a rural healing camp

Further outside the rural village of Asankrangwa is a healing camp. Participant 3 is the owner and healer, has about fifty people living at her camp either receiving treatment or as a family member of a patient. The owner of the camp provides a very thorough tour of the camp including a sample of the dwellings and conditions of living when receiving treatment at the camp. She offered a description of every patient. Twenty-five years in the business herself, she learned from her grandmother and is also teaching her children. Her brother and sister also work with her. Together, they collect herbs from the forest grasses, leaves, barks, and roots. The healing camp treats male and female, any age for ailments such as broken bones to "madness", body pains or chest infections. She also works closely with hospitals to provide x-rays and anything she may need to aide in the treatment of her residents. For instance, nine people came to her with bullets in their bodies. Utilizing the x-rays from the hospital, she determined the fractures and was then able to treat the wounds with six different types of leaves. She also recommends joint procedures with hospitals to treat epilepsy. Typically, a resident will take the bark of a tree that is ground to be inhaled through the nose or taken as a drink, then go to the hospital.

Common remedies for this owner of the healing camp include using only one leaf of a certain type of tree to drink or use as an enema to treat a swollen abdomen. According to this respondent, jaundice can be treated and healed within a few weeks with a combination of leaves. In addition, women will come to her to give birth, and will stay to receive the necessary treatment once delivery is complete.

Lastly, she contends that the presence of evil spirits can cause diseases such as diarrhea or even barrenness. For such diseases, and what she referred to as "spiritual diarrheas", she suggests that these conditions require prayer and spiritual healing. She adds that going to church will help to remedy these problems.

4.4. Accessing healthcare utilizing an itinerant drug vendor (IDV)

Participant 4 incorporates his entrepreneurial skills with the practice of herbal healing. He travels at least 5 h by bus from Takoradi to Asankrangwa (a distance of about 187.4 km), peddling herbal medicines and drugs to patrons living along his route. He travels from town to town, treating chronic swelling, abscesses, boils, dislocations, fractures, rheumatic pains, asthma, and heart pains. He arranges with the bus drivers for a percentage of his sales as payment for transportation services, usually about 3–5000 (30-50Gp new currency) a week. Remedies are readily available, and he often sells in bulk.

Treatment for bone and body ailments consists of a dosage of one herb composed of the bark from three trees. Grinding the barks with lime juice forms this herb, and then the mixture is applied directly onto a wound. If a bone is fractured, then the remedy is applied with a bandage to cover, but only for a customer who experiences rheumatic pains, then the substance is applied without a bandage.

He contends that the herbal medicine that is used in the treatment for asthma, heart pains, and profuse coughing are typically are seasonal, and therefore more expensive. However, to preserve the remedies during the rainy season, a clear liquid is mixed with the barks, leaves, roots, and grass. Most of his clients are individuals who have had unsuccessful experiences with a doctor or at hospitals.

This participant sells a third remedy that does not require his preparation, but instead sells it for someone else. This remedy is also seasonal, and rare, and treats severe headaches, nosebleeds, or bad breath. It is prepared by adding water to the natural substance after grinding it on a stone. Once the mixture is made, it is inserted through the nose. This same remedy is also used to treat abdominal pains, however instead of water, lime juice is used to make the substance.

The profession of an IDV is the sole source of income for him. He works seven days a week, traveling and making herbal drugs. He currently also markets and sends three of his drugs to Côte d'Ivoire (Ivory Coast), West Africa for sale and aspires to develop and sell more and different kinds of drugs in the future.

4.5. Accessing healthcare at the local, rural hospital

Receiving treatment and procedures at the Asankrangwa Hospital are very dependent upon the intervening circumstances of the moment. The Ghanaian government supports the facility that was provided by the Spanish government. The head administrator of the hospital is a Chief from a neighboring community. He and two nurses are supported by the Ghanaian government to reside and work at the facility. None are from the area, but rather are there as a result of a program that supplies rural hospitals with staff.

Electricity is unreliable and unpredictable in this area, and blood is not widely available. Furthermore, and medical supplies and standard medications are in short, if not scarce supply. In addition, when supplies are donated or arrive, they are often impractical or unable to be utilized due to the lack of trained staff.

The hospital serves 250,000 people from the local and surrounding

area; however, a potential patient must bring their own blood supply. The capabilities for testing are completely absent due to the inability to culture, although a lab does exist, it is obsolete as long as conditions remain so. A birthing room and x-ray technology exist, though again, without electricity and clean or running water, these services are also obsolete. Many clients come to the hospital for diseases including, but not limited to typhoid, malaria, anemia, and urine retention in men.

4.6. Accessing healthcare at the Aponche Memorial Herbal Clinic Church Village, Tema

The urban Aponche Memorial Herbal Clinic Church Village, located in Tema, is outside of Accra, and is at least a 10-h drive (roughly 387.8 km) from the primary study site of the rural district of Asankrangwa. This clinic is a family business and relies on four-hundred-year-old remedies for healing. First established forty-five years ago in Kumasi, Ashanti Region, then moved to Tema in 1971, the family of all male healers provides an alternative to modern medicine. According to the leader, "Aponche" is one of the numerous arbitrary names given to first surviving children from mothers with chronic infant mortality. The Akan, Ghana's most populous ethnic group, use the names, "Kosanba" or "Donkor", meaning "has come back", to designate the surviving child from a mother that kept losing children. The great grandfather of this family was a Kosanba or Donkor, and was named Aponche, after the Akan for goat, as his mother was cleaning the goat pen when she gave birth.

The ten children, all males, provide services while the women prepare herbs on the premises. According to them, the men were better equipped to provide the services in this arrangement as the women were not bold enough to work with blood and bones. The emphasis on paternal transmission rests with the desire of the father. He asserts that male children are more committed to the course, as bringing in outsiders might not guarantee the same strong commitment. According to him, with three wives and twenty-eight total children, the ability to heal is in the blood of the family.

The clinic treats bone fractures, dislocations, piles (hemorrhoids), rheumatoid, infertility, impotence, barrenness, sores (chronic), diabetes, loss of appetite, skin diseases, and convulsions. Remedies are registered with the Food and Drugs Authority (FDA), Ghana's consumer protection agency, that is also allowed periodic inspections of the premises. The clinic seeks to incorporate practices of biomedicine, especially when determining appropriate dosages of medicine according to height, weight, and age. In addition, the clinic incorporates orthodox practices for such conditions that require an x-ray, additional blood, or a tetanus shot. The father recognizes the necessity of working hand-in-hand with western medicine but admits that professional superiority often gets in the way as the western practitioners are socialized differently than traditional healers. This discrepancy in understanding of healing practices often impedes the healing process.

Herbal medicines are prepared, as any other traditional healer does, by gathering, grinding, combining nature's resources, and applying, as necessary. The clinic produces and manufactures many remedies including De Porres Balm, Aponherb Bitters, Aponherb Tonic, Aponherb Anti-malaria, and Wonder One (registered with the FDA). The self-reported success rate for healing at the clinic is at 95%, though many people go elsewhere before seeking remedies from the clinic. In the situation of broken bones, immediate treatment is necessary before the bones sets on its own. According to the father, many times the hospital makes it worse, especially if the bone comes out of the skin. The final cost for receiving treatment and staying at the clinic typically ranges from 200–800,000 (GH 20–80 new currency). The clinic sees from eight to one-hundred twenty patients per day, with some coming from as far as Togo or the Ivory Coast, and even once, a child from the United States, for a skin disease. Like many traditional healing facilities, patients have attempted to other types of healing before seeking those methods.

The clinic is constantly improving, expanding, and is still under construction.

4.7. Accessing healthcare at Nyaho Medical Center, Accra

Considered the premier medical institution in Ghana, the Nyaho Medical Center is a private health clinic in Accra. Built in 1970 by a private donor from the Mayo Clinic, United States. The clinic is a thirty-one-bed facility with on-site X-ray and laboratory services, full inpatient services, and specialists in surgery, obstetrics, gynecology, and pediatrics to name a few. The Nyaho Clinic client base includes individual citizens and expatriates in the capital city. The clinic also serves corporations, embassies, and international organizations such as the WHO and the United Nations. Fees at the center cover treatment and include amenities and meals. This private hospital is approximately 9 h (a distance of about 361 km) from the primary study site.

5. Discussion

For the largely non-urban and rural population in Ghana, the delivery of health care in these areas is related to the broader social, economic, and political issues of societal transformation since colonialism, independence, and the adoption of structural adjustment programs. The disproportionate focus on urban communities as the primary beneficiaries of privatized health care left many communities without practical or affordable access to medical care. People in rural areas seek treatment for illness based on the services that are available and affordable to them. Furthermore, structural adjustment programs actively marginalized communities, and any subsequent reform exacerbated inequalities, producing a mass socioeconomic stratification.

Any type of meaningful reform moving forward must consider the valuable service and meaningful role that systems outside of the biomedical model have filled during this period of transformation. Health care choices are made according to the resources available (Crandon-Malamud & Libbet, 1991), and a diagnosis is also highly contingent upon these resources as well. In many ways, these choices were structured for people as the underinvestment and underdevelopment of the rural areas left the health needs of communities overlooked, poorer, sicker, and without alternatives. This type of active structuring by those in positions of power is the lead driver of the persistent inequalities experienced by the rural poor. To reduce the inequities in access to health systems, and the subsequent disproportionate health outcomes for these communities, an acknowledgment of the systematic patterns that have emerged as a result of larger social contexts, power structures. Corrective measures must be taken to ensure that rural communities are not disproportionately affected by the policies intended to improve lives. For instance, the devaluation of currency affects access and affordability of nutritious food, thereby also affecting health. In addition, higher income inequality affects labor markets, wages, while the elimination of food subsidies disproportionately affects poorer families, and thus, rural families by creating challenges for meeting basic nutritional needs for child health and nutrition (Forster et al., 2020).

At the crux of this study are the powerful community-level circumstances which illustrate the political and economic determinants of health, primarily access to the health system. Communities overlooked by structural adjustment still must meet basic needs, and these types of delivery modes for healthcare in rural communities is built and sustained because of the long history of trust, but also the gap that these roles filled to meet the social and spiritual needs of communities during this long period of transformation. Community healers have filled a valuable role that goes beyond biomedical care and the illness model of western medicine. The dialectic relationship between the two systems has forced entire communities to renegotiate identities, shift membership between groups, and recognize powers beyond simple treatment. Unfortunately, the integrated model as it stands does not account for these cultural complexities, nor does it account for the needs of communities beyond anything more than a medical diagnosis. The tradition of healing is "multiclass, multiethnic, and multireligious" (Crandon-Malamud & Libbet, 1991). It is medically plural, in that, to have a truly integrated model,

and in order to exist with differing medical traditions, biomedical knowledge must account for this holistic traditional medicine that is valued in communities. Without this integration, the more dominant western medical model will have not only lost opportunities, but deliberately stratified entire populations out of access to critical and valuable methods for healing.

With the insurgence of a health care marketplace, western medical practices, and structural readjustment programs, are also western pharmaceuticals. Physicians and specialists are concentrated in the capital city and with prescription drugs in the open market, a new business emerges. As with community healers, other business has also emerged included the business of itinerant drug vendors also fulfilling a very real function. Not necessarily in the business for healing, but rather for monetary gain, they fill a critical gap by offering distribution channels for medications to those who otherwise lacked access. The roles of itinerant drug vendors are a good example of the evolving system, the development of alternatives by the people to meet needs, and the ignorance of a very real problem. These changes in the structures of society are deserving of consideration. "As traditional healers practice as "unofficial" health workers in developing countries and are frequently consulted and trusted for their therapeutic methods, it is important to identify their strengths and weaknesses" (Asefzadeh & Sameefar, 2001). The registered pharmacist in Kumasi describes alternative healers and especially IDVs as self-motivated workers that are "going everywhere." IDVs are recognizing the village people, which are not commonly recognized by the Ministries, Councils, and the capital city as worthy, contributing members of society. However, limitations do exist to the role of the drug vendors: they are not healers, there are problems with dosages of medicine, IDVs are businessmen and women; business is conducted in the informal economy, and many times drugs are expired or 'fake'. These certainties pose very real problems; however, they are not beyond resolution. Legitimize the business, regulate, and provide a framework for operation to ensure the safety of both patrons and providers. By providing genuine drugs, bring the service out from the underground economy, and utilize and maximize the opportunities presenting themselves for a healthy, economically, and responsibly, improved community. The resources are present. Occultists and rural traditional healers cannot continue to be the primary caregivers. One must recognize that with the onset of degenerative diseases and 'diseases of affluence' such as diabetes and heart disease, that attributing gonorrhea and tuberculosis as 'diseases from your ancestors' will no longer be adequate. Movement toward bridging this disparity in real access to health care as well as the understanding of disease must happen.

6. Conclusion

The purpose of this study was to capture the current state of healthcare delivery in a rural area in Ghana in the face of failed structural reform and in the absence of equitable development. Moreover, a secondary objective of this study was to utilize critical theory and QD analysis to reframe the discussion around the achievement of health as determined by the political and economic determinants of health, rather than solely placing the burden of health on communities or individuals. The descriptions as a part of this study reflect the daily realities of living in rural communities. In addition, and as stated by van Dijk and Dekker (2010), macro-level data and national surveys that focus on representing modern healthcare facilities do not capture the wide spectrum of healthcare services that exist in the informal sectors such as those offering prayer or herbal remedies. The contextualizing that this study offers represents the realities and choices that communities must face regarding health and healthcare. While those in urban and wealthier communities overwhelmingly benefit from economic growth and development, rural communities disproportionately bear the burden of further marginalization. Solutions exist in the institutional and social structures of Ghana, but progress cannot occur without the recognition of how the disparities between the rural and urban populations were structured, and by then recognizing that it is the responsibility and obligation of the government to mobilize the resources that are present to solve the ills for everyone, equitably, and toward a more healthy and empowered society.

Given that an estimated 80% of the world's population obtain their primary health care from outside the biomedical model or from traditional healers (Amegbor, 2017; Airhihenbuwa & Harrison, 1993; Asefzadeh; Sameefar, 2001), it is valuable to examine the appropriateness and equity of integrated health care models to better serve everyone.

Ethics statement

This Qualitative Descriptive (QD) study was conducted honoring IRB stipulations. Furthermore, study participants remain de-identified throughout the secondary data analysis.

Author statement

The author, self, is responsible for both the parent study and the Qualitative Descriptive (QD) study including the data collection, data analysis, and preparation of this manuscript according to the Credit author guidelines. Courtney Queen: Conceptualization, Methodology, Validation, Formal Analysis, Investigation, Data Curation, Writing – Original Draft, Writing – Review and Editing. Derick Boakye: Data cleaning, Writing – Original Draft, Writing – Review and Editing.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2022.100079.

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