Geographic access is defined as the absence of barriers including distance, transportation, and other physical challenges in accessing care when needed. This is influenced in part by decisions made in allocation of resources, equity, and investments into infrastructure.

**Visual Aid - Geographic Access**

**BARRIERS TO GEOGRAPHIC ACCESS**

**Human Resources**

Is there a provider present in my facility or community?
Geographic Access is a component of Access

System
- Governance & Leadership
  - Primary Health Care Policies
  - Quality Management Infrastructure
  - Social Accountability

- Health Financing
  - Payment Systems
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  - Empowerment
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  - Team-based Care Organization
  - Facility Management Capability & Leadership
  - Information Systems Use
  - Performance Measurement & Management Outreach

- Access
  - Financial
  - Geographic
  - Timeliness

Outputs
- High Quality Primary Health Care
  - First Contact Accessibility
  - Continuity
  - Comprehensiveness
  - Coordination
  - Person-centered

- Effective Service Coverage
  - Health Promotion
  - Disease Prevention
  - RMNCH
  - Childhood Illness
  - Infectious Disease
  - NCDs & Mental Health
  - Palliative Care

Outcomes
- Health Status
- Responsiveness to People
- Equity
- Efficiency
- Resilience of Health Systems

Social Determinants & Context (Political, Social, Demographic & Socioeconomic)
Geographic Access is a component of Access
What can you learn about Geographic Access from the Improvement Strategies?

**SECTION 1**

What is Geographic Access?

What it is: Learn more about the core principles and goals of Geographic Access and its role in PHC improvement.

**SECTION 2**

How do I assess my performance?

What it is: Learn more about some indications that improvements might be relevant in your context and what you can achieve by focusing improvements on Geographic Access.

**Vital Signs Profile:** Use the information in your Vital Signs Profile to help determine relevant areas for improvement.

**SECTION 3**

How do I get started?

**What others have done:** Learn from implementation approaches and challenges in other country contexts.

**How to succeed:** Consider your country context, what elements are not functioning properly, and what needs to be in place to support effective improvements.

**What to ask:** Use guiding questions to help determine how you might begin to plan and enact reforms in your country context.

Guided by the above considerations and relevant resources, start to build out an improvement plan with your CE lead and/or focal point.
What can my country achieve by focusing on Geographic Access?

Goals & Outcomes

- **Equity and improved health outcomes**: Reducing or removing geographic barriers to care helps to ensure that patients can access needed services where and when they need it, important for improving health outcomes and achieving Universal Health Coverage.

- **First contact access and continuity**: Geographic access ensures that the PHC system can serve as the first point of contact for a patient’s needs throughout their life course, in turn allowing patients to develop an ongoing relationship with a provider or with a care team.
Geographic Access – How do I assess my performance?

Learn more about whether you should focus on Geographic Access in the Vital Signs Profile.
How do I assess my performance?

Use the information in the Vital Signs Profile to help determine relevant areas of improvement.

Completion of a Vital Signs Profile gives countries a holistic understanding of PHC strengths and weaknesses, a critical first step in the measurement for improvement pathway.
What are other indications that Geographic Access might be an appropriate area of focus?

Other Indications

- **There is a shortage of providers**, either due to an overall low provider to population ratio, a shortage in certain geographic areas, or a shortage or misdistribution of a particular type of provider (e.g. doctor, nurse, technician).

- **Facilities are physically unavailable or are unevenly distributed** across a geographic area. In addition, community-based health providers are unable to access facilities to restock supplies or to refer patients to higher levels of care.

- **Patients and/or providers face transportation barriers to accessing services**, such as those due to checkpoints and curfews. Transportation barriers may also contribute to provider absenteeism, making it difficult for patients to access needed services, even when they can physically seek care.
Geographic Access - What is it?

Learn more about the core principles of [Module] and what you can achieve by focusing improvements in the What it is section.
What is Geographic Access?

**Geographic access** or physical accessibility “is understood as the availability of good health services within reasonable reach of those who need them.”¹

Geographic access is also defined as **the absence of barriers including distance, transportation, and other physical challenges in accessing care when needed**. This is influenced in part by decisions made in allocation of resources, equity, and investments into infrastructure.

Geographic access is a **key component of access to primary care health care**.

**What is Geographic Access?**

Geographic access is the geographic or physical accessibility “is understood as the availability of good health services within reasonable reach of those who need them.”


**What should I know before beginning improvements?**

**Who is not accessing care due to geographic barriers?**

Geographic barriers are best measured by the amount of time to travel to services rather than physical distance. Individuals who live in rural areas or conflict zones face the greatest barriers in geographic access to care. Access barriers may also align with social characteristics. If there are restrictions on the movement of groups of people, geography may disproportionately disfavor these groups.

**Why are individuals not covered under existing systems?**

An adequately sized and competent health workforce is a precondition for ensuring geographic access to health services. Geographic access is also characterized by the physical availability and distribution of clinics. Geographic accessibility may also be constrained by inadequate transportation. Even in areas where clinics are close to communities, if there is not adequate transportation to reach them, accessibility is compromised.
What is Geographic Access?

Geographic access is the geographic or physical accessibility “is understood as the availability of good health services within reasonable reach of those who need them.”

What are some key steps to improving Geographical Access?

1. Effectively and equitably retain, recruit, and station providers. Strategies for “Posting and Transfer” may improve geographic access to needed services from the patient perspective and encourage providers to stay in geographically disadvantaged areas. Strategies may include strengthening existing primary and rural care programs and providing incentives and support for providers to work in rural areas, among others.

2. Engage in partnerships to provide greater access to PHC. In certain areas, public/private partnerships (PPPs) may increase geographic accessibility. PPPs may be pursued to build infrastructure. Another type of PPP is an integrated partnership in which governments contract private organizations to use existing infrastructure and service delivery in places that lack access to public facilities.

3. Implement electronic health (E-Health) in areas where clinics are inaccessible but sufficient technological infrastructure is in place. Using computers and phones, patients and providers may access telemedicine videoconferencing or receive consultations via helplines or text messaging. These services are not exclusive to PHC and can also be used to strengthen access to specialty care.

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Visual aid: Geographic Access

Geographic Access
The absence of barriers to accessing care when needed, including excessive distance, inadequate transportation, and other physical challenges.

BARRIERS TO GEOGRAPHIC ACCESS

**Human Resources**
Is there a provider present in my facility or community?

**Facility Distribution**
Is there a physical facility nearby?

**Inadequate Transportation or Difficult Terrain**
Am I able to get to the facility?
Deeper dive: Barriers to Transportation

Transportation can pose a barrier to first contact access if patients do not have access to vehicles or if available vehicles are too costly or not appropriate for the terrain. Additionally, transportation barriers may occur when primary care facilities refer patients to higher level facilities.

Solutions to reduce transportation barriers include:

**Transportation vouchers**
Transportation vouchers may reduce geographic barriers to care when cost is the primary barrier to accessing care.

**Community-based transportation systems**
Facilities and community members may come together to maintain vehicles individuals may use to access care. The vehicles may range from ambulances to motorcycles or carts. These community-based transportation systems should be coupled with means of communication so patients can access vehicles and drivers when needed.
Geographic Access – How do I get started?

Derive information from **What others have done**, **What to ask** and **How to succeed** to help determine where and how you might begin to plan and enact forms in your country context.
Planning for improvement in your context

The guidance and recommendations described within the Geographic Access module are not intended to provide a one-size-fits all solution.

The considerations involved in planning and implementing strategies will depend on your local context.

Sample activities

- **Consider** implementation challenges and approaches in other country contexts

- **Understand how the features of your health system**, such as how decisions get made and the role of the private sector, will impact your improvement plans

- **Identify** key elements that need to be in place to support improvements

- **Use the guiding questions in the Improvement Strategies** to spur thinking about Geographic Access in your country context and stimulate ideas for improvement

- **Start to develop** an improvement plan
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ How does geographic access to care differ across the country and does access align with population characteristics?
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ How does geographic access to care differ across the country and does access align with population characteristics?

☐ How is the health workforce distributed by specialty, geography, and cadre?
Questions to ask to help you get started

The **specific considerations** involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful **starting place to determine how you might begin to plan and enact reforms** in your context.

**Sample questions**

- How does geographic access to care differ across the country and does access align with population characteristics?

- How is the health workforce distributed by specialty, geography, and cadre?

- In areas where the population does not live within an appropriate distance to the facility, would it be efficient to build a facility? Is there an adequate workforce to staff the facility? Are there enough individuals in the area to access the facility?
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ How does geographic access to care differ across the country and does access align with population characteristics?

☐ How is the health workforce distributed by specialty, geography, and cadre?

☐ In areas where the population does not live within an appropriate distance to the facility, would it be efficient to build a facility? Is there an adequate workforce to staff the facility? Are there enough individuals in the area to access the facility?

☐ What structures are available to support activities to improve geographic access to PHC? For instance, are there any existing systems of empanelment, and are there opportunities to provide community-based services to those not accessing care?
Learn from what others have done

Train-Based Mobile Clinics | Kazakhstan
Three train-based mobile clinics offered PHC services, reaching nearly 40,000 patients from 2012 to 2014.

Sustainable Emergency Referral Care (SERC) | Ghana
SERC is a community-based emergency transportation system that has successfully directed patients needing emergency care to appropriate facilities.
In Kazakhstan, the Ministry of Health partnered with the Committee of Emergency Situations within the Ministry of Internal Affairs to develop three train-based PHC clinics.
### Kazakhstan: At-a-glance context

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<th>GDP per capita ($PPP)</th>
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<th>Percentage of population living under $1.90 per day</th>
<th>Population</th>
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</table>
Learn from what others have done: Kazakhstan

Background & rationale

Mobile clinics are used to provide PHC in crises where access to services has been severed due to:
- Widespread infrastructural damage
- Safety concerns
- Inadequate capacity to address specific care services

The WHO has implemented clinics in Iraq, Jordan, Syria, Ukraine, and Yemen. The supply of vans and equipment, and partnerships with local providers, differs according to existing infrastructure at each site.
Learn from what others have done: Kazakhstan

Approach

Mobile clinics have been implemented in non-acute settings in places where geographic access poses a barrier to PHC.

In Kazakhstan, the Ministry of Health partnered with the Committee of Emergency Situations within the Ministry of Internal Affairs to develop three train-based clinics.

Each train comprises eight wagons with clinical, diagnostic, and radiology equipment. Thirty-six medical staff including 18 specialists work in conjunction with 44 operations personnel to provide care in 832 stations on a rotation of approximately 20 days.
Learn from what others have done: Kazakhstan

- This train-based clinic intervention demonstrates **creative use of existing infrastructure to deliver care to remote populations**.

- Between 2010 and 2014, **the trains provided care to nearly 37,000 individuals** who would otherwise have limited access to PHC.

Kulkayeva G. Using medical trains to improve access to health services across Kazakhstan. WHO collaborating centre for Integrated Health Services based on Primary Care. 2016.
Learn from what others have done: Kazakhstan

- While mobile clinics are commonly implemented in crises, a mobile system is unable to provide first-contact, continuous, and comprehensive care and may not be a reasonable option for sustainable PHC system strengthening.
In the early 2000s, the Ghana Essential Health Intervention was implemented to expand coverage within Ghana’s national primary health care system.
## Ghana: At-a-glance context

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<td>Life expectancy at birth</td>
<td>63</td>
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<td>Percentage of population living in rural areas</td>
<td>45%</td>
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<td>Percentage of population living under $1.90 per day</td>
<td>12%</td>
</tr>
<tr>
<td>Population</td>
<td>30.4M</td>
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</table>
Learn from what others have done: Ghana

Approach

The Ghana Health Service launched the Sustainable Emergency Referral Care (SERC) program in the Bongo District in 2012, and it was then extended to a 12 district pilot in 2013.¹ The primary purpose of SERC was to enable a community and sub-district level emergency transport system supported by communication technology and community education.

Learn from what others have done: Ghana

Approach

The expanded SERC pilot was supported by a fleet of 24 three-wheel motorcycles. These motorcycles – called Motorkings – were distributed among the 12 districts using geographic information systems (GIS) data, and each was supported by two volunteer drivers. Health facilities, volunteer drivers, and community health officers were given mobile phones to ensure that all communities had communication capabilities.

While payments were not required for pregnant women and children under five, other patients were charged a small fee determined by the District Health Management Team. Finally, awareness activities were planned during pre-existing community meetings called durbars.
Learn from what others have done: Ghana

- SERC was able to direct emergency care patients to facilities that had the capabilities to manage their acute needs, reducing facility-based mortality and accident-related mortality.

Outcomes & Impact

References:
Learn from what others have done: Ghana

- **Continuous facility improvement:** In places where competent facilities were far from communities, patients often neglected to use SERC.\(^1\) Thus, *emergency transport systems should be coupled with efforts to improve capacity in first contact facilities*, and this challenge may be more acute in countries where the quality of care is weaker than Ghana.

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Recap: Geographic Access

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