

If They Cannot Pay for Everything: Overcoming Barriers to Accessing and Utilising Formal Rehabilitation for People Who Use Drugs (PWUD) in Ga East Municipality, Ghana

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Abstract

This study assessed the views and experiences of service providers and individuals who have gone through rehabilitation for substance abuse in the Ga East Municipality of Ghana. Data was collected through in-depth interviews with rehabilitation healthcare providers and individuals who have received rehabilitation care. The study found that there is a significant gap in the provision of rehabilitation care for substance abuse in Ghana, with only a limited number of facilities available particularly outside of urban areas. The cost of treatment was identified as a significant barrier to accessing care, particularly for those from low-income backgrounds. The quality of care provided in rehabilitation facilities was also a concern for participants, with many noting shortfalls in standardisation across facilities. This study underscores the critical need for enhanced public education regarding substance abuse and its available treatment options. Additionally, it highlights the significant gaps in Ghana's rehabilitation care provision for substance abuse and emphasises the urgency of addressing these gaps. This includes initiatives aimed at improving access to care, enhancing the quality of care provided with a specific focus on implementing patient-centered approaches and reducing stigma. The study offers recommendations, including the enhancement of regulatory frameworks and low-cost rehabilitation facilities. Furthermore, the study advocates for subsidising treatment costs or incorporating them into health insurance plans, coupled with increased public education and support programs, thus providing valuable insights that can inform the development of evidence-based policies and interventions for rehabilitation care in Ghana. By addressing the identified gaps in access and utilisation of rehabilitation healthcare provision, such policies and interventions could contribute to achieving Sustainable Development Goal (SDG) 3, particularly Target 3.5 which focuses on strengthening the prevention of drug use and improving access to effective treatment services for individuals struggling with substance abuse.

Keywords: People Who Use Drugs, Rehabilitation, Substance Abuse, Access, Barriers, Utilisation

1. Introduction

Health care is recognised globally as a fundamental human right. However, access to rehabilitation health care presents a significant challenge and varies across different groups of care seekers. The topic of drug use and its effects on individuals stirs strong emotional reactions in many societies, as numerous

communities worldwide have suffered greatly due to drugs and substance use. The World Drug Report (WDR) estimated that nearly 36 million people globally suffer from drug use disorders (WDR, 2020). The Ghana Health Service (GHS) has implemented interventions to address drug abuse, mainly through primary healthcare services. Nevertheless, these efforts seem insufficient given the limited availability of rehabilitation facilities specifically dedicated to this purpose. Instead, hospitals and other allied health care facilities incorporate rehabilitation treatment within their general treatment services, which seem inadequate to cater for the medical needs of PWUD. Appiah et al. (2017), contend that various governments and health agencies have predominantly focused on medical treatment, with inadequate attention to the psychosocial needs of individuals with Substance Use Disorders (SUDs) or other drug-related conditions. PWUD face stigma and discrimination in various aspects of their lives. In many Ghanaian communities, PWUD are often treated with disdain and perceived as cursed or as societal misfits (Asante et al., 2021). This stigma has led to the proliferation of quasi treatments and treatment centres that view substance-abuse disorders as religious afflictions. As a result, some PWUD seek treatment at churches, prayer camps, or resort to other unconventional treatments. The influence of religion means that substance-use disorders are often poorly understood and are typically viewed as moral failings. This perspective fosters stigma and discrimination against PWUD (Bird, 2019). Similarly Paquette et al. (2018) found that many PWUD experience both structural and individual stigmatisation, which manifests as explicit discrimination when accessing healthcare services, thereby discouraging them from engaging in evidence-based treatments.

Statement of the Problem

Despite significant progress in healthcare, challenges remain in ensuring equitable access to rehabilitation services, particularly in developing countries. The World Drug Report (2014) estimated that nearly one in six drug users access treatment in hospitals annually worldwide due to significant shortfalls in service provision in many countries. In recent times, substance abuse has become a prominent issue, drawing attention from governments, healthcare institutions, local communities, and families due to its potentially harmful effects. PWUD pose potential risks to themselves, their families, the public, and the environment (Kellen et al., 2017). To overcome addiction and resume normal lives, PWUD need extensive rehabilitation services, encompassing comprehensive health care, social support, and substance use-related services. However, PWUD globally, and particularly in Africa, including Ghana, have persistent unmet treatment needs. PWUD face numerous obstacles in accessing treatment and support, reinforcing their reluctance to seek help (Jensen et al., 2004). Socioeconomic barriers, such as stigma, affordability, waiting times, inconvenient operating hours, and service availability, significantly impede treatment access for PWUD (Aldridge et al., 2018; Mincin, 2018). Although all teaching hospitals in Ghana have psychiatric units offering detoxification and psychosis treatment, specialised rehabilitation programs and sustained addiction support are lacking in many other health facilities. Ofori-Atta et al. (2014) note that, individuals seeking treatment for SUDs and other mental health conditions face challenges, including underfunded healthcare facilities and a shortage of mental health specialists. Prevalent stigma associated with drug use is also a major barrier to the well-being of PWUD. Bird (2019) underscored that stigmatisation deters many PWUD from seeking necessary treatment in Ghana.

Scheim (2018) highlighted that individuals who use drugs have complex and diverse needs requiring various types of care. Therefore, ensuring access to a wide range of affordable support is crucial. Treatment and rehabilitation should be tailored to the patients' needs, allowing them to set objectives and treatment plans with supportive care providers. Lin et al. (2019) found that low-barrier treatment options

can lead to high completion rates and client satisfaction, reducing risky substance use practices among PWUD. However, this ideal scenario does not seem to reflect the reality in Ghana. State-funded institutions offering specialized drug addiction support are resource-constrained and provide inadequate services (Bird, 2019). This has led to shortfalls in rehabilitation healthcare. Connery et al. (2020) highlighted that, the majority of those with SUDs do not receive treatment, resulting in one of the largest treatment gaps among all disorders. Overcoming barriers to accessing and utilising rehabilitation services for PWUD is crucial for effective harm reduction and public health promotion, however their health needs are often overlooked and inadequately prioritised in policy implementation, leading to treatment gaps and multiple challenges.

Research Objectives

This study investigates the accessibility and utilisation of rehabilitation health services among PWUD in the Ga East Municipality of Ghana. The study specifically aims to:

1. Explore the availability, accessibility, and utilisation of rehabilitation health services among People Who Use Drugs (PWUD) in the Ga East Municipality.
2. Identify the barriers and facilitators to accessing and utilising rehabilitation health services among PWUD in the Ga East Municipality.
3. Assess the effectiveness and responsiveness of existing rehabilitation health services in addressing the needs of PWUD in the Ga East Municipality.

Research Questions

This study seeks to answer the following research questions:

1. How do People Who Use Drugs (PWUD) in the Ga East Municipality experience the availability, accessibility, and utilisation of rehabilitation health services?
2. What are the barriers and facilitators to accessing and utilizing rehabilitation health services among PWUD in the Ga East Municipality, and how do socioeconomic factors influence access?
3. How effective and responsive are the existing rehabilitation health services in addressing the needs of People Who Use Drugs (PWUD) in the Ga East Municipality?

2. Literature Review

Background and Significance

Rehabilitation healthcare plays a vital role in recovery and improving the quality of life for individuals with various health conditions. Some studies have investigated rehabilitation health care in Ghana. Tinney et al. (2007) focused on medical rehabilitation for persons with disabilities in a developing country like Ghana and found a shortage of essential professionals such as therapists and physiatrists nationwide. Badu et al. (2016) also examined access barriers to healthcare among people with disabilities in the Kumasi Metropolis of Ghana, finding different access barriers for various disability types and socio-demographic groups. Furthermore, Adzrago et al. (2018) explored the experiences of rehabilitation service providers in Ghana's Central Region, determining that the availability of facilities, personnel, salaries, and the attitudes of patients, authorities, and staff members influenced the provision of rehabilitation services. Senayah et al. (2018) investigated the accessibility of health services for young deaf adolescents in Ghana, finding that while respondents did not face difficulties accessing health facilities, they encountered communication barriers. Furthermore, Cadri et al. (2021) researched the facilitators and barriers to health-seeking among people who use drugs in the Sunyani Municipality of Ghana, primarily addressing the health challenges faced by this group. These studies, however, did not focus on the experiences of patients

accessing rehabilitation health care and did not mainly explore factors such as facility and service availability, and how these factors influence service utilisation. However, the studies highlighted that different categories of healthcare seekers encounter different barriers to access and utilisation. Therefore, while studies have examined barriers to healthcare in general and rehabilitation healthcare specifically, the experiences of PWUD remain underexplored.

Overview of Drug/Substance Use

The World Health Organization (WHO) Drug Report of 2014 estimated that 162-324 million individuals aged 15-64 worldwide used illegal substances (WHO Drug Report, 2014). Furthermore, nearly 27 million individuals worldwide, struggle with substance use and dependence, according to the World Drug Report (World Drug Report, 2015). Ghana is having its share of the increasing effects of drugs. In addition to narcotics, the consumption of hard liquor is also increasing in Ghana. The Ghana Demographic Health Survey (DHS) found that per capita alcohol consumption is 30% for beer, 10% for wine, 3% for spirits, and 57% for locally brewed gin. While drug and substance use is distributed across the socio-demographic spectrum of Ghana, it is most prevalent among lower socio-economic groups. Similarly, data from health facilities across Ghana suggests a rising trend in substance misuse (Appiah et al., 2018). The observed trends of drug/substance abuse among PWUD in Ghana range from misuse of prescribed drugs to self-medication with substances like painkillers, aspirin, paracetamol, valium, kola, alcohol, tobacco, tea, coffee, marijuana, cocaine, and heroin, among others (UNODC, WDR, 2018).

Drug Policy and Legislative Framework

Drug policies and their legislative frameworks have a profound impact on individual lives, public health, and criminal justice systems. In Ghana, the Mental Health Act 2012 (Act 846) is the current law that governs the practice of mental health in Ghana and spells out policy guidelines for mental health. The law replaced the previous law, NRC Decree 30, of 1972 which hitherto focused largely on custodial care for mental health and allied treatments. The Ghanaian government enacted the Narcotics Drugs (Control, Enforcement, and Sanctions) Law (PNDCL 236) in 1990 to address the growing concerns surrounding drug abuse and illicit trafficking within the country. This legislation established the Narcotics Control Board (NACOB), subsequently renamed the Narcotics Control Commission (NACOC) under Act 1019 (1990). NACOC functions as the central coordinating body for drug control in Ghana, tackling both domestic drug abuse and the nation's involvement in the global illicit drug trade. One of NACOC's core objectives, as outlined in its founding legislation, is to promote treatment, rehabilitation, and social reintegration for individuals struggling with drug dependence. This focus on recovery encourages those who have become addicted to drugs to seek professional help at designated treatment centres. NACOC plays a crucial role in facilitating their rehabilitation journey and successful reintegration into society (NACOC, 2022).

Approaches to Healthcare in Ghana

The Ministry of Health (MoH) in Ghana provides policy guidance for all health-related matters in the country, while the Ghana Health Service (GHS) is responsible for delivering public health services. In their study, Eaton and Ohene (2016) reported that Ghana's health delivery system is administratively divided into 216 districts covering the country's 16 regions. Each district operates under decentralization and is overseen by a District Health Management Team (DHMT) led by a District Director, who reports to the Regional Director. Ideally, each district should have its own hospital, and every region in Ghana is expected to have a regional hospital. Health centres and CHPS Compounds serve sub-districts. Private hospitals and clinics in urban areas also, provide healthcare under the regulation of the GHS. The United

Nations Office on Drugs and Crime (UNODC) stresses that drug addiction is both preventable and treatable (UNODC, 2014). Experts advocate that for the rehabilitation of People Who Use Drugs (PWUD) to be effective, their active involvement in the rehabilitation process is crucial. According to the National Institute on Drug Abuse (NIDA), effective rehabilitation programs involve not only the patient but also their family and the community in the planning and implementation process (NIDA, 2018). The involvement of PWUD and communities has generally been shown to have positive effects on rehabilitation efforts.

Barriers to Accessing Rehabilitation Health Services

Achieving successful recovery from substance use disorders hinges on access to effective rehabilitation services. However, for PWUD, numerous barriers can impede their ability to receive this crucial support. Access to formal rehabilitation services remains a significant challenge for many individuals, hindering their ability to achieve optimal health and well-being. Han et al. (2017) observed that there is persistent unmet treatment needs among PWUD, with a significant number of those with co-occurring mental health and substance use disorders not receiving substance use treatment. Paquette et al., 2018 also found that stigmatisation and discrimination pose substantial barriers to accessing rehabilitation services, with many PWUD experiencing both organizational and individual stigmatisation, which deters them from seeking formal treatments. Like most other illnesses, family support is crucial for individuals recovering from substance use disorders (SUDs) and mental illness, yet some lack the needed family support due to cultural and social factors, including misinformation about mental health (Ofori-Atta et al., 2010; Thara et al., 2010; Purgato et al., 2020). Fischer and Neale, (2008), also contended that regulatory constraints, including criminalization of drug use, further impede access to rehabilitation services by instilling fear and reluctance to seek formal healthcare.

Equitable access to rehabilitation services is crucial for achieving successful recovery from substance use disorders among PWUD. Gyambrah et al. (2017) advocate for social support as a fundamental element of SUDs treatment and recovery, facilitating home and job reintegration processes. This involvement of the community in the process empowers patients and offers related benefits. Empowering PWUD is therefore deemed essential in the rehabilitation process. Burke et al. (2019) identify empowerment as pivotal in substance use recovery, enabling both health workers and clients to overcome self-shaming thoughts and attitudes, and enhancing self-efficacy. Scheim et al. (2018) argue that given the complex individual needs of PWUD, access to a variety of low-barrier support options is essential. They advocate for client-oriented treatment models that allow PWUD to have a say in their care, setting their own goals and treatment plans in collaboration with supportive care providers.

2.1 Theoretical Frameworks

This research applied a combination of the Social Determinants of Health (SDH) and the Access and Utilisation Framework (AUF) to explore how PWUD navigate rehabilitation healthcare. The underlying assumption is that the determinants of health-seeking behavior among PWUD are influenced by a variety of interconnected factors, including their socioeconomic, cultural, and physical environments.

Social Determinants of Health (SDH) Framework

The SDH framework highlights the importance of non-medical factors that influence health outcomes, such as access to healthcare, income, education, social support, and environmental conditions (Collins et al. 2018; WHO, 2015). This framework is especially relevant to PWUD, who often encounter multiple social disadvantages that hinder their ability to access and utilize rehabilitation services. The SDH

framework explains that health outcomes are shaped by a complex interplay of factors beyond medical care, including social, economic, and environmental conditions. It recognizes the impact of upstream determinants like income inequality and education levels, as well as downstream determinants such as housing and access to health facilities on individual health and well-being (Marandi, 2013; Collins et al. 2018). The SDH framework thus provides relevant variables, including various social, economic, and environmental factors that might hinder PWUD's access to rehabilitation services. Limited social support for instance can make it difficult for PWUD to maintain motivation and adhere to treatment plans. Societal factors such as unsafe neighbourhoods and lack of access to healthy food and exercise opportunities can also negatively affect health outcomes. The SDH framework therefore emphasises addressing the root causes of health inequities rather than merely treating individual symptoms, a systemic approach involving collaboration across various sectors, including healthcare, social services, housing, and education.

Access and Utilisation Framework (AUF)

The Access and Utilisation Framework (AUF) offers a comprehensive understanding of the complex factors that influence individuals' access to and use of healthcare services (Farideh et al. 2022; Choi et al. 2014). The AUF highlights the interplay between individual, service, and environmental factors, providing a valuable perspective for analysing barriers to rehabilitation access for PWUD. This framework also identifies individual factors such as age, gender, ethnicity, socioeconomic status, health literacy, knowledge of services, attitudes towards treatment, and stigma (Farideh et al. 2022). Environmental factors like social support, community norms, discrimination, and access to transportation and housing are also crucial within the AUF framework. Against this background, the SDH and AUF serve as a useful conceptual tool for researching barriers to accessing and utilising formal rehabilitation health services for PWUD in the Ga East Municipality of Ghana. The researchers used these frameworks, to gain a detailed understanding of the complex interplay of factors at the individual, service, and environmental levels that contribute to disparities in access and utilisation. This comprehensive approach informed the development of interview guides to collect data for assessing equitable access to rehabilitation services for PWUD.

3. Research Methodology

Research Design

Research design provides a structured framework for conducting research. This study adopted a descriptive research approach, which aims to observe, describe, and document phenomena as they occur naturally (Creswell, 2009). Specifically, a phenomenological methodology was employed to capture and understand the subjective experiences of individuals. Phenomenology focuses on identifying and detailing common characteristics of lived experiences. According to Wertz (2005), phenomenology is a reflective and meditative approach that prioritizes the concreteness of person-world relations, valuing lived experiences with all their indeterminacy and uncertainty. This approach enabled the researchers to document the personal experiences of PWUD and rehabilitation healthcare providers in the study area.

Study Setting

This study was conducted in the Ga East Municipality of Ghana, located in the Greater Accra Region, the nation's capital. Accra has notable drug use concerns, making the Ga East Municipality an ideal location for this study. The area also has the Pantang Psychiatric Hospital, a major facility providing rehabilitation healthcare services, including psychiatric care and substance abuse treatment. The municipality's diverse population, spanning urban and rural areas, allowed for an exploration of differences and similarities in access to and utilisation of rehabilitation health services among PWUD.

Sampling Procedure and Sample Size

The Ga East Municipality is divided into four Sub-Municipals (Abokobi, Dome, Taifa, and Haatso), each with one or two community clinics. This research employed non-probability sampling techniques, specifically purposive sampling, which is ideal in a phenomenological study. According to Opoku-Amankwa (2002), non-probability sampling involves selecting samples where each element has an unequal chance of being chosen. Purposive sampling was used to select PWUD and healthcare professionals providing rehabilitation healthcare in the study area. Kumekpor (2002) emphasizes that when certain individuals can provide more and better information on a subject, they should be purposely selected for the study. Guided by this, participants were selected from the four sub-municipal areas, forming the sampling frame for this study.

Hospital administrators and supervisors of health centres and clinics were contacted and informed about the research purpose. After agreeing to participate, they introduced the researchers to some of their patients who use drugs and are either receiving treatment or have been treated and discharged. Participants were also asked if they knew other PWUD who might be interested in participating. Only individuals aged 18 years or older were included in the study.

In this study, 20 interviews consisting of 6 key informant interviews with health professionals and 14 in-depth interviews with PWUD were conducted. This aligns with Guest et al. (2006), who advanced that in homogeneous studies using purposive sampling, 12 interviews are sufficient to achieve data saturation. The sample size was determined considering the research objectives, timeframe, data analysis method, and available resources. Patton (2015) acknowledges the role of resource limitations in determining sample size, and Merriam (2009) notes that it depends on the research questions, data to be collected, analysis methods, and resource availability.

Data Collection Methods

A qualitative approach was used for data gathering, enabling the researchers to understand and reconstruct the realities of PWUD and their experiences with rehabilitation healthcare. Given the complexities of assessing formal rehabilitation healthcare for PWUD, an explanatory methodological approach was necessary. Therefore, in-depth interviews with PWUD and key informant interviews with healthcare workers involved in patient rehabilitation were conducted to address the research objectives and assess PWUD's healthcare utilisation experiences. Key informants provided insights into the nature of rehabilitation healthcare, facilities, logistics, and human resource availability. In-depth interviews with PWUD aimed to uncover challenges in accessing healthcare services. These two data collection methods were used concurrently to ensure cohesive data collection. Interviews, as noted by Freebody (2003), are an effective way of collecting qualitative data, providing introspective insights into respondents' views, beliefs, practices, and concerns. The six key informant interviews were conducted with staff from Pantang Hospital and two private rehab facilities, including nurses and medical practitioners. These interviews provided background information on the operational functioning of rehabilitation health policy within the Ghana Health Service. Key informants also offered a top-down perspective on the challenges of operating formal rehabilitation healthcare programs in the study area. In-depth interviews on the other hand aimed to gather detailed information on experiences with drug/substance use and rehabilitation. These interviews occurred in familiar social settings to ensure participants' comfort and ease in discussing intimate topics. The researchers ensured that PWUD participants were informed that participation was voluntary and they could withdraw at any point. During the interviews, themes based on the research objectives guided the questions and ensured comprehensive data collection.

Data Analysis and Presentation

The data obtained from respondents was analyzed and presented using a thematic analysis approach, following several interconnected steps. Initially, the researchers transcribed audio files from all interviews and thoroughly read the transcripts to identify meanings and patterns. This process helped in drafting thoughts and ideas for potential codes. Subsequently, after familiarizing with the data, the researcher used initial thematic analysis coding to generate a set of initial codes representing the meanings and patterns in the data. The data was re-examined to identify significant excerpts, which were then coded using QDA Miner Lite software. Following this, excerpts associated with particular codes were grouped. This facilitated the automatic collation of codes and their corresponding data. Then, the initially collated codes were sorted into potential themes. Themes were identified to reveal trends and patterns in the data, with various codes matched to form major themes and sub-themes. The process continued with a review and revision of the initial set of themes to ensure each theme had sufficient supporting data from the literature and was distinct. Similar themes were merged, and themes lacking sufficient data were removed. Finally, a narrative was written to illustrate the data collected based on the revised themes. This narrative aims to validate the data analysis by telling a coherent story supported by vivid quotes. It included an interpretive analysis, offering insights into the respondents' views. The descriptive information generated was scrutinized to draw conclusions aligned with the research objectives.

Validity and Reliability

To ensure the trustworthiness of its findings, this study employed several strategies. Similar to Morse's (2015) call for rich descriptions, detailed contextual information was incorporated to enhance understanding and strengthen the credibility of the research. Member checking process was implemented to verify participant status as PWUD and confirm the research accurately reflected their experiences. Furthermore, clearly defined research focus and objectives ensured the study yielded results directly relevant to its intended outcomes. Finally, external validation was obtained through consultation with stakeholders such as health personnel and clinical psychologists, providing valuable feedback on the validity and credibility of the findings (Shenton, 2004). The relevant theoretical framework was also employed to provide necessary context and guide data collection, analysis, and interpretation. Reliability, emphasizing the consistency and replicability of the findings, was addressed through various approaches. Triangulation, as highlighted by Shenton (2004), was achieved by incorporating multiple data sources such as in-depth interviews, key informant interviews, and secondary data. This multifaceted approach provided a comprehensive understanding of the phenomenon under investigation. Furthermore, verbatim descriptions of participants' lived experiences were included, offering rich details about the research context, participants, and findings.

Ethical Considerations

Only adults over 18 were included. Participants were recruited from health facilities and provided informed consent before the interview. They could withdraw from the study at any time, however no participants withdrew during the study. The researchers ensured confidentiality throughout the study, to protect participant privacy, all identifying information was removed and participants were assigned pseudonyms. Data was anonymized for analysis and results reporting. All electronic files were stored securely on a password-protected computer. The study focused on self-reported information and perceptions, and both researchers and participants faced minimal risk.

4. Findings

Availability of Rehabilitation Services in Ghana

For the purposes of this study, formal rehabilitation healthcare encompasses professional medical and therapeutic interventions aimed at helping individuals recover from addiction and regain functionality. Licensed healthcare providers, such as physicians, nurses, counsellors, and psychologists, typically deliver this care in clinical or hospital settings. A decisive aspect of addiction treatment is the availability and accessibility of rehabilitation services. This study specifically explored the availability of such services in Ghana, with a focus on the Ga East Municipality. For this study, availability refers to the existence and accessibility of formal programs and facilities offering treatment, support, and care for People Who Use Drugs (PWUD) within this region. Availability encompasses not only the physical presence of these services but also their capacity to meet the needs of individuals struggling with substance abuse. In Ghana, the Mental Health Services policy governs the provision of rehabilitation healthcare. A participant explained that:

“The rehabilitation services offered by Ghana Health Service are inclusive of the medical and psychiatric care so people with substance use disorders would come to us based on the fact that they need some form of psychiatric care and medication.” (Edem, Mental Health Nurse)

Mental health services in Ghana are organized into two levels, institutional care, and community mental health, which is commonly referred to as community psychiatry. Institutional care is delivered within public psychiatric hospitals and some private psychiatric facilities, while the community component is primarily administered at the primary care level, led by Community Psychiatric Nurses (CPNs). Ghana currently has three psychiatric hospitals, namely, the Accra Psychiatric Hospital, the Ankaful Psychiatric Hospital in the Central Region, and the Pantang Psychiatric Hospital, which was established to supplement the Accra Psychiatric Hospital. Notably, both the Ankaful and Pantang hospitals are associated with nursing training schools, where registered mental nurses are trained. Furthermore, there is an ongoing initiative to create psychiatric and rehabilitation healthcare beds in hospitals located in the regional capitals of Ghana. Thus, rehabilitation healthcare is typically rendered by psychiatric hospitals, and in cases where general hospitals provide these services, psychiatric units within those hospitals are responsible for their delivery. Furthermore, as indicated in Table 1, private healthcare facilities also offer rehabilitation services, particularly in the Greater Accra, Central, and Ashanti Regions of Ghana, contributing significantly in filling the shortfalls in public health service delivery. Psychiatric hospitals play a central role in diagnosing and treating patients, they have dedicated rehabilitation facilities catering for long-stay patients.

Treatment Facilities and Options for PWUD

A notable finding from this study indicates that in Ghana, mental hospitals and psychiatric wards within general hospitals primarily cater to patients in the acute phases of their illnesses or those requiring continuous supervision due to the severity of their symptoms. Rehabilitation centres offer various treatment procedures, ranging from the traditional 12-step approaches to holistic and therapeutic methods aimed at addressing the underlying traumas associated with addiction and co-occurring mental health issues.

Table 1: Rehabilitation Centres in Ghana

Rehabilitation Centre	Status	Location
Accra Psychiatric Hospital	Public	Accra
Ankaful Psychiatric Hospital	Public	Central region

Pantang Psychiatric Hospital	Public	Ga East Municipality
House of St. Francis Clinic	Private	Tema
Hope Sobriety Home	Private	Ga Central, Gbawe
WellCare Ghana Wellness Centre	Private	Adenta, Greater Accra Region
Physio Solutions and Rehabilitation Centre	Private	21 Lagos Ave, Accra
Chosen Rehab Centre	Private	Tetteh Okuley Ave, Rd
Greenhills Stroke Rehabilitation Centre	Private	Hyde St, Accra
Redemption Place Rehabilitation	Private	Greater Accra region
REMAR Christian Rehabilitation Centre	Private	Accra, Kumasi
Serenity Place Psychiatric Hospital	Private	Greater Accra region
Addictive Diseases Unit Korlebu	Private	Greater Accra region
Pankrono Neuro-Psychiatric Hospital	Private	Ashanti Region
West African Behavioural Health Addictions & Recovery Management	Private	Greater Accra Region
Padre Pio Rehabilitation Centre	Private	Elmina, Central Region

The study further explored the different kinds of rehabilitation facilities and services available. Participants mentioned accessing formal rehabilitation services primarily through the Ghana Health Service (GHS), with Pantang Hospital being a prominent service provider. Some NGOs, such as REMAR, a Christian faith-based organization, also offered formal rehabilitation services. Other facilities, like the House of St. Francis (HSF), a Christian-based residential treatment center located in Tema, were identified as alternative options for rehabilitation.

“I have been to Pantang rehabilitation and then House of Saint Francis at Ashaiman, it is a private institution and you pay cash for the detox and rehabilitation.” (Kofi, PWUD).

“The first rehabilitation I had was virtually free, from an NGO called REMAR” (Kwasi, PWUD).

The study found that some churches and faith-based organisations in the municipality offered faith-based rehabilitation services. Participants explained:

“we have rudimentary forms of treatment for drug users where drug users are taken to maybe some form of correctional institutions or maybe religious places to try to help them” (Abena, Clinical Psychologist)

“Some of the clients themselves have been to various places of religious orientation and have seen that these places don't work, it usually gets worse before they come in here.” (Kwame, General Nurse)

Faith-based rehabilitation focuses on spiritual foundations, viewing addiction as an attempt to compensate for internal voids and aiming to guide individuals towards sobriety and recovery through inner strength. While the study did not extensively explore faith-based rehabilitation, participants acknowledged it and recognised its potential importance in the treatment value chain. Participants mentioned that faith-based centres sometimes served as referral points, directing individuals to seek formal treatment after realising that addiction was not solely a spiritual issue.

“... Some of the faith-based centres when patients go there those who know about rehabilitation tell them that this is not a spiritual problem and refer them here.” (Nana, Mental Health Nurse)

Some participants shared experiences of attempting faith-based rehabilitation before seeking formal treatment. They revealed that while some clients found success with faith-based approaches, others reported that their conditions worsened before eventually seeking formal rehabilitation services. Key informants acknowledged that patients who had been to faith-based centres were sometimes referred to formal treatment facilities after realizing that their struggles were not solely spiritual.

Accessibility and Utilisation of Rehabilitation Services

In the context of the study, accessibility refers to the ease with which PWUD can obtain and utilise formal rehabilitation health services. Accessibility goes beyond the mere physical presence of rehabilitation facilities, taking into account the various services offered and other factors that may facilitate or hinder an individual's ability to engage with and benefit from the available treatment options. With this theme, the study identified several rehabilitation services accessible to PWUD as indicated in Figure 1. Inpatient rehabilitation services were reported as fundamental. This provides PWUD with comprehensive medical and psychological care in a facility setting. The data pointed out that, detoxification is typically the initial phase of inpatient treatment in Ghana, highlighting the most severe physical symptoms of addiction.

Figure 1: Services Offered at Rehabilitation Facilities



Medication-Assisted Treatment (MAT) was found to be an essential component of rehabilitation healthcare, involving providing counseling and medication to aid individuals in their recovery process. Aside medical practitioners, counsellors impart personal hygiene skills, home maintenance, and social interaction skills to PWUD as reported by respondents.

“We provide counselling, medication or both of them. For those who need medication to recover we give them medication in addition to the counselling.” (Abena, Clinical Psychologist)

“We have counsellors and you can actually request for your personal counsellor. The counsellors educate us on various issues about our lives and society.” (Yaw, PWUD)

This indicates that counselling services are regarded as valuable resources, offering a supportive environment for PWUD to address their addiction and work towards recovery. Furthermore, behavioural therapy emerged as an evidence-based approach, focusing on behaviour modification through various techniques, including engaging patients in physical and social activities. These findings shed light on the diverse range of formal rehabilitation services available in the district and their significance in supporting PWUD in their journey towards recovery.

Barriers and Facilitators to Accessing and Utilising Rehabilitation Health Services

The second objective of this study sought to explore the factors that influence PWUD utilisation of rehabilitation services and further explore the determinants of services received by PWUD in formal rehabilitation healthcare centres. Sub-themes that emerged from the data analysed under this major theme include the cost of rehabilitation, health insurance coverage of rehabilitation healthcare, stigma and discrimination, and social support systems as shown in Figure 2.

Cost of Rehabilitation

Service providers explained that the availability of inpatient or outpatient rehabilitation services depends on the specific needs of patients and their financial capabilities. The data analysed highlighted the significant impact of cost and financing on the accessibility of rehabilitation healthcare for PWUD. The cost of rehabilitation emerged as a dominant obstacle for PWUD seeking formal rehabilitation care, particularly for those from low-income backgrounds. The financial burden associated with treatment was a major hindrance to accessing rehabilitation services, preventing individuals from seeking help for their drug addiction problems. Participants in the key informant interviews and in-depth interviews (PWUD) expressed concerns about the high cost of rehabilitation. It was reported that the average Ghanaian cannot afford the expenses involved in rehabilitation services, with monthly charges reaching as high as 6,000 Ghana cedis per person for a minimum treatment duration of six months.

“Rehabilitation of course is very costly, the amount we charge is about 6,000 Ghana cedis a month per person and the minimum is 6 months so that amounts to 36,000 Ghana cedis, so how many people can afford it?” (Adom, Private Rehab Facility Administrator)

“It is really very expensive, it is expensive to get rehabilitation in Ghana. If you should tell somebody that you are paying about 3000 to 5000 cedis a month for treatment, many of them will be afraid to come for treatment, because the salary of most people is not even up to this.” (Paa, PWUD)

As a result, many individuals, especially those with limited financial resources, found it challenging to cover the costs of rehabilitation, even when they acknowledged the need for treatment.

Figure 2: Factors that Influence PWUD Utilisation of Rehabilitation Services



Lack of financial resources was similarly identified as a significant barrier to seeking rehabilitation healthcare. Participants reported that individuals and families experiencing financial stress often could not afford the cost of care, leading them to forgo seeking rehabilitation, or opting for other non-medical options such as prayer camps, despite their willingness to get formal rehabilitation.

“Money is important because honestly without the money if I were asked to come to this rehabilitation centre with my own money I would have looked for a cheaper alternative because it will be a lot on my budget.” (Kojo, PWUD)

“the treatment cost is high so a lot of people are not able to come for healthcare, some people just come here to enquire and once they hear of the amount they go and then they don't come back because of the amount involved.” (Esi, General Nurse)

The high cost of rehabilitation care not only discouraged individuals from seeking medical attention but also limited the type of services they could receive at the facilities. Due to financial constraints, some patients received only partial treatments, such as detox and counseling, instead of the full course of treatment. This compromised the quality of care and hindered the possibility of achieving full recovery for those individuals as reported by a participant.

“... If they cannot pay for everything they are given some medication instead of the whole treatment and with the rest you think that the client should be able to survive.” (Edem, Mental Health Nurse)

Furthermore, the research revealed that the high cost of rehabilitation led to low numbers of people seeking treatment, affecting the sustainability of private rehabilitation service providers. Some care providers mentioned that the facility's revenue was dependent on the number of patients they could treat, and the financial strain posed challenges in covering expenses and paying workers.

“The cost puts a lot of pressure on us in the facility here, for those who come in and they cannot afford, instead of let's say staying for 6 months because they don't have money they want to go at the end of 4 or 3 months. So what you want to achieve with them you can't achieve it with them since they have not fully recovered.” (Adom, Private Rehab Centre Administrator)

The financial burden of rehabilitation healthcare also pushed some PWUD to seek loans and credit facilities to finance their treatment costs. This economic vulnerability increased the risk of relapse in the event of payment difficulties, and anxiety further reinforced the reluctance to seek rehabilitation care. Consequently, the high costs of treatment contributed to maintaining addiction among PWUD, leading to severe consequences.

Health Insurance Coverage of Rehabilitation Healthcare

Health insurance for rehabilitation emerged as a significant factor in healthcare as indicated by participants. In the context of Ghana, the absence of health insurance coverage for rehabilitation healthcare emerged as a significant barrier to accessing treatment. The Ghana National Health Insurance Scheme (NHIS) does not extend its coverage to rehabilitation services, both in the study area and nationwide. This lack of insurance coverage for rehabilitation results in higher treatment costs for PWUD and their families, making it financially challenging for them to seek treatment.

“As it stands now in Ghana here there is no insurance covering rehabilitation health or treating issues related to rehabilitation so there are no insurance policies covering rehabilitation and this makes it very expensive. There is no insurance and most of the clients are coming from low-income backgrounds” (Esi, General Nurse).

“My rehabilitation treatment was mainly cash because health insurance does not cover rehabilitation treatments for anything related to it.” (Amoako, PWUD)

Participants highlighted that the absence of insurance coverage specifically for rehabilitation services contributes to the high cost of treatment. Despite the limitations concerning rehabilitation services, health insurance plays a pivotal role in covering the treatment costs for other ailments that PWUD may experience during their rehabilitation journey.

“The last time I was at Pantang I had to go to the eye clinic to go see the eye doctor so there I used the health insurance. So with other treatments that are not related to the rehabilitation that is where you are able to use the health insurance” (Ato, PWUD).

Thus, conditions unrelated to rehabilitation, such as headaches, malaria, and fever, are eligible for insurance coverage, easing the financial burden on patients for these specific medical needs.

“They do take health insurance in Pantang. I know they use insurance because when people got sick they asked their caretakers to bring their health insurance to undergo medical treatment” (Akwasi, PWUD).

Stigma and Discrimination

Stigma, characterized by negative attitudes and beliefs surrounding drug addiction and PWUD, and discrimination, involving harmful actions or mistreatment towards this population, were identified as significant deterrents to seeking care. The theme of stigma emerged prominently during the interviews, shedding light on the pervasive nature of stigma associated with drug use and its influence on PWUD's decisions to seek formal health services. Participants emphasized that stigma plays a pivotal role in discouraging PWUD from pursuing rehabilitation healthcare, regardless of their social status or background.

“Stigma is one of the reasons why people may not want to come out formally to seek formal healthcare for their ailments...currently the issue of drug use is still a great stigma for people who use drugs so most people usually want to stay anonymous when they come for treatment so that their backgrounds will not be known”. (Esi, General Nurse)

“Because of the stigma he did not tell them that he's bringing me for rehabilitation, he told them that he has a doctor that he's very free with and he wants the doctor to examine me.” (Baffour, PWUD)

“Yes because where I am working like this I have just told you that I work at the University so if this information should break out that I am here it is going to affect me at my workplace and it will be like a source of embarrassment to me.” (Nii, PWUD)

PWUD's fear of being stigmatized and judged by society often leads them to remain anonymous when seeking treatment. Participants reported that individuals with drug addiction issues, including professionals and respected members of the community, prefer to conceal their identities while undergoing rehabilitation due to the prevailing negative perceptions surrounding drug use.

Furthermore, the blending of mental healthcare with rehabilitation services at health facilities contributes to the stigmatization of those seeking rehabilitation. PWUD expressed concerns that being associated with rehabilitation care might lead others to assume they have mental health problems or be considered "mad." It is important to emphasize that the use of such terms as 'mad', and 'crazy' to describe PWUD is common, in Ghana despite efforts by health authorities to educate people about its contribution to the stigmatization of PWUD. A participant narrated their experience:

“... always if I am here and somebody knows me comes around here I don't want them to see me because they may think that I am crazy because this hospital is for people with mental problems” (Osei, PWUD)

This stereotype further discourages individuals from seeking rehabilitation treatment at psychiatric hospitals due to the fear of being labelled and ostracized. The impact of stigma also extends to the family level, as some participants mentioned that families hesitate to disclose their loved ones' rehabilitation status to avoid societal judgment and embarrassment.

“I think this is because they don't want to be stigmatized, when some families bring their people around they don't want the larger family to know that someone is undergoing treatment or rehabilitation.” (Esi, General Nurse)

This fear of stigma poses a significant barrier to accessing appropriate healthcare and support for PWUD

Social Support Systems

Social support, derived from family members, friends, and other community individuals or groups, plays a crucial role in providing emotional and financial assistance to those seeking rehabilitation. Participants highlighted the significance of social support in facilitating PWUD's access to rehabilitation care. A strong social support system was found to enhance the likelihood of individuals seeking and successfully undergoing rehabilitation. Family support emerged as a critical factor in PWUD's decision to pursue formal healthcare and their overall success in achieving long-term recovery.

“...we are paying about 5,000 Ghana cedis and so if you are going to stay here for about 6 months that's about 30,000 Ghana cedis excluding other expenses, so if you do not have a good support system you will not be able to undergo rehabilitation care.” (Yaw, PWUD)

“I am lucky because I have parents who don't want to give up on me and so they keep trying their best for me, they don't blame me for it.” (Kwabena, PWUD)

“If my son was not able to pay, Oh by this time I don't think I would have been alive” (Kwadwo, PWUD)

Family support provides individuals with a sense of safety and security, which helps to alleviate fears and anxieties related to seeking rehabilitation care. Moreover, families often extend financial support to their loved ones during the rehabilitation process, thereby reducing the overall cost burden for PWUD undergoing treatment. Conversely, inadequate or lacking family support can become a barrier to seeking care. In cases where family members do not understand or stigmatize drug addiction, individuals may face discouragement from seeking rehabilitation.

“I have a whole lot of friends who are using drugs and they wish to stop but the family is not supportive and so they can't” (Kwasi, PWUD).

“...rehabilitation is really very expensive and so if someone cannot get the family support to actually pay the amount involved the person cannot come for treatment” (Edem, Mental Health Nurse).

“Most of the resources used in a rehabilitation health care is usually provided by the family of those going through treatment so in case the family doesn't have any resources it is going to be difficult for the person to get treatment.” (Abena, Clinical Psychologist)

These findings suggest the cost of rehabilitation care can also be excessive without sufficient family resources, limiting access to treatment for those in need.

Structural and Systemic Factors

Structural and systemic factors also emerged as a dominant theme in limiting access to rehabilitation healthcare. The data shed light on the structural and systemic factors that hinder individuals from accessing rehabilitation healthcare for Substance Use Disorders (SUDs). Limited access to healthcare facilities, a shortage of trained healthcare providers, and inadequate healthcare financing systems were identified as major challenges. The lack of rehabilitation facilities emerged as a significant barrier, leading to delays in seeking treatment and an increased risk of relapse. Participants highlighted the shortage of suitable facilities and the inadequate availability of logistics, equipment, and personnel, affecting the quality of care provided.

“The facilities are not enough at all so assuming everyone who is a substance abuse person wants to access rehabilitation will there be space for them? No there will not be space for them at all because there are so many users.” (Kofi, PWUD)

“There is the problem of lack of facilities, with the facilities they are not enough, and some facilities can only take as many as 20 people. Compare this to the whole Ghana. The facilities too are mostly based in the south of Ghana” (Nana, Mental Health Nurse).

“I will say that among all the facilities in Ghana our facility (Pantang) is one of the one of the best but I will not say it is up to the international standards that we would have wanted it to be. We have the personnel to work with and we also have a little space that we have been using for a number of years now so there's more to do for more facilities” (Kwame, General Nurse)

Distance to facilities was also identified by participants as another significant barrier, particularly for individuals residing far from the rehabilitation centres. The associated costs and time required for travel created additional hurdles, particularly for those with limited financial means or other responsibilities.

“That is a big challenge, sometimes people want to access our services but the distance is the problem. People come all the way from Kumasi and other places to come and seek healthcare” (Abena, Clinical Psychologist).

“...We can also talk of distance to the facility or to or access a rehabilitation facility. It is a problem because I will say that the whole rehabilitation thing is centralised and you can find most of them only here in Accra.” (Kwame, General Nurse)

Thus, the concentration of rehabilitation facilities in urban areas within the Greater Accra, Ashanti and Central regions, compared to the other regions in Ghana poses difficulties for individuals in rural or remote regions to access treatment, particularly for those with limited financial resources.

Lack of knowledge about available rehabilitation facilities contributes to a perception that viable treatment options were scarce. Individuals often mistake them for psychiatric hospitals and this lack of information led some to delay seeking treatment or opt for inadequate alternatives.

“I think a lot of people don't know about it, especially given the fact that this is a psychiatric hospital, so the mentality is that it is people who have mental issues that do come to the psychiatric hospital.” (Nana, Mental Health Nurse)

“I think publicity is becoming a problem so a lot of people are not aware, despite our facility being online. A lot of people especially illiterate people do not know exactly what we do here so I will say people are not aware.” (Abena, Clinical Psychologist)

“Pantang rehabilitation you know is a psychiatric place, so people think you when you are here you are coming for psychiatric treatment. People don't have that knowledge that rehabilitations don't even give medications that are used for treating mental patients” (Akwas, PWUD).

The conditions of healthcare facilities and the quality of care provided significantly influence the success of rehabilitation and may serve as good or bad references based on the experiences of PWUD. Understaffed and under-resourced facilities may be unable to provide adequate support, leading to lower treatment adherence and increased risk of relapse. The quality of care also influenced patients' motivation and engagement in the recovery process. Participants raised some concerns:

“With a proper rehabilitation facility, ideally we should have the psychologists, the drug counsellors and nurses where everybody is to be assigned to a duty but when you come to Ghana here, what we have a jack of all trade in the work. One person is a drug addiction counsellor, a

psychologist, nurse and doing so many things at the same time which is not making the process effective.” (Kwame, General Nurse)

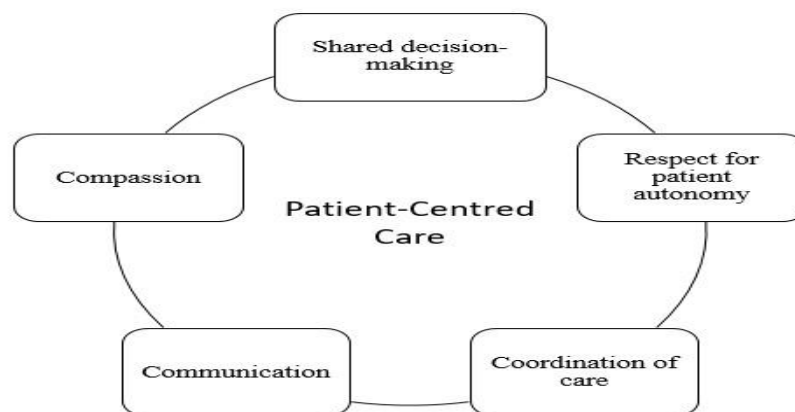
“With the private sector their structures are not up to standard because I have been to other rehabilitations and if I should assess I think the government ones are more structured or well-structured than the private ones.” (Yaw, PWUD)

These concerns raised by some respondents provide significant insights into the state of drug rehabilitation in Ghana. The findings suggest that rehabilitation facilities may be understaffed or lack qualified personnel. This may create a situation where rehabilitation facilities often have personnel who are responsible for multiple roles.

Effectiveness and Responsiveness of Rehabilitation Health Services in Addressing the Needs of PWUD

In responsiveness, Patient-Centred Care (PCC) is an important component of the rehabilitation process. PCC is an approach that puts the patient's needs and preferences first. It is a shift from a paternalistic approach, where the doctor makes all the decisions, to a collaborative approach, where the doctor and patient work together to develop a care plan. PCC is important because it can lead to better health outcomes for patients. The situation of policies and procedures for patient-centred rehabilitation in Ghana is still developing. However, there are some initiatives underway to promote patient-centred care. The Ghana Physiotherapy Association (GPA) launched its Patient-Centred Care Guidelines in 2019. These guidelines provide a framework for physiotherapists to deliver patient-centred care and emphasised the importance of patient autonomy, shared decision-making, and collaboration. In addition, the Ghana Health Service (GHS) is also developing patient-centred care guidelines for other rehabilitation professions, such as occupational therapy and speech therapy while also working to implement patient-centred care standards in all rehabilitation facilities in Ghana.

Figure 3: Ghana Physiotherapy Association’s Patient-Centred Care Guidelines



As shown in Figure 3, the key elements of Patient-Centred care (PCC) are shared decision-making, respect for patient autonomy, coordination of care, communication, and compassion. These elements are interconnected and essential for providing high quality PCC. The study explored this theme to find out if these are part of the rehabilitation process. Participants' views varied concerning their awareness of specific policy guidelines for PCC, with some mentioning a lack of clarity on the existence of a policy

specifically tailored to PCC. However, the need for interventions tailored to different needs of PWUD was emphasized.

“About the policy in rehabilitation health care in the Ghana Health Service, yes the health sector has a policy on rehabilitation but I am not sure if it is specific with drug abuse or drug addiction so for that I can't talk much about it.” (Abena, Clinical Psychologist)

“When you say rehabilitation policy, for policy that is sanctioned by the Ghana Health Service I do not know any of that sort.” (Nana, Mental Health Nurse)

“I have not sighted any policy from Ghana Health Service for rehabilitation care. But we are guided by what NACOB tells us to do, we are also guided by HeFRA (Health Facilities Regulatory Agency)” (Adom, Private Rehab Center Administrator).

These responses suggest some rehabilitation healthcare providers may not be abreast with the Patient-Centred Care Guidelines proposed by the Ghana Physiotherapy Association (GPA) in 2019. With regard to supervision and regulation, participants emphasized the need for a supervisory body to ensure adherence to evidence-based treatment practices and minimum standards in rehabilitation facilities. Standardisation across facilities was considered essential to reduce disparities in service quality and fees. Proper supervision and regulations were deemed vital to ensure safe and effective treatment delivery.

“...if there was a supervisory body that can take care of some of these things and make sure that we all fall in line, and then ensuring that we all use evidence-based treatment and which is monitored over period of time of time I think this will go well for both the service providers and clients.” (Adom, Private Rehab Center Administrator)

“There should be a general standard, NACOB or the Ghana Health Service should ensure that if you are running a rehabilitation centre it should be one format. There should also be a unified fee charging system as well as some minimum standards required in rehabilitation.” (Abena, Clinical Psychologist)

Overall, the situation of rehab policies and procedures for patient-centred rehab in Ghana is improving. However, there is still more work to be done to ensure that all patients have access to patient-centred care.

5. Discussion

The findings from this study highlight the availability and accessibility of rehabilitation services for People Who Use Drugs (PWUD) in the Ga East Municipality of Ghana. Formal rehabilitation healthcare provided by trained professionals in clinical or hospital settings is the primary form of rehabilitation service available. The Pantang Psychiatric Hospital was identified as a significant provider of formal rehabilitation services, along with some non-governmental organisations and faith-based centres. Furthermore, the presence of faith-based rehabilitation services in the study area indicates the integration of spiritual foundations in the treatment approach. This finding is in line with a comprehensive analysis of three key studies conducted by Lyons et al. (2017), Miller and Thoresen (2018), and Salyers et al. (2021) which highlights the effectiveness of faith-based treatment programs in addressing substance abuse. These studies underscore the positive impact of faith and spirituality on substance abuse treatment and recovery. In exploring accessibility and utilisation of rehabilitation services, it emerged that accessibility of rehabilitation services goes beyond the physical presence of facilities, as various factors influence their utilisation by PWUD in the Ga East Municipality. Factors influencing utilisation were identified as cost and financing, stigma and discrimination, and the role of social support systems. The high cost of formal rehabilitation services emerged as a significant barrier, especially for individuals from low-income

backgrounds. This finding is consistent with Bryant et al. (2008) and Fischer et al. (2008) who underscored that the cost of rehabilitation is a major barrier to PWUD's access to comprehensive healthcare. The financial burden associated with treatment is therefore a major hindrance to accessing rehabilitation services, preventing individuals from seeking help for their drug addiction problems.

As a result, many individuals, especially those with limited financial resources, found it challenging to cover the costs of rehabilitation, even when they acknowledged the need for treatment. Participants emphasized that individuals and families experiencing financial stress often could not afford the cost of care, leading them to forgo seeking rehabilitation services, despite their willingness to get help. The findings further established that financial constraints might lead to compromises in the quality and effectiveness of rehabilitation, with some individuals receiving only partial treatments. The lack of health insurance coverage for rehabilitation services adds to the financial burden for PWUD seeking treatment, further hindering accessibility. These significant findings from the study align with insights from Im et al. (2020), Lammertse et al. (2019) who found that the cost of formal rehabilitation services poses a significant impediment for patients, particularly those hailing from low-income backgrounds. These studies further explain that the lack of insurance coverage exacerbates financial barriers, amplifying the challenges faced by individuals accessing requisite rehabilitation services.

Stigma and discrimination also significantly affect the willingness of PWUD to seek formal rehabilitation healthcare. This notable finding agrees with a study by Paquette et al. (2018) who found that many PWUD experience both organizational and individual stigma, which can lead to overt discrimination when accessing healthcare services and deter them from participating in evidence-based treatments. Accordingly, fear of judgment and ostracising from society discourages individuals from seeking care, perpetuating the cycle of addiction. The blending of mental healthcare with rehabilitation services also contributes to stigmatization, leading to reluctance in seeking treatment. Stigmatization not only affects PWUD, but also affects their families, as some hesitate to disclose their loved ones' rehabilitation status to avoid embarrassment. Respondents emphasised that stigma is a major barrier to PWUD seeking rehabilitation care, regardless of their social status or background.

The study also established that the role of social support systems, especially from family members, is crucial in facilitating PWUD access to rehabilitation care. Strong social support enhances the likelihood of individuals seeking and completing rehabilitation. On the other hand, lacking family support serves as a barrier to seeking care, with unsupportive relationships discouraging PWUD from accessing treatment. This is in line with studies by Kumar and Preetha, (2012) which highlighted that health and social well-being are influenced by a variety of factors, including sociodemographic characteristics, family structures, and community social and cultural norms. It is also consistent with Gyambrah et al. (2017) who argued that social support is essential for substance use disorder treatment and recovery, as it can help people reintegrate into their homes and jobs.

With the determinants of services received by PWUD in formal rehabilitation healthcare centres, the findings from this study shed light on the structural and systemic barriers that hinder individuals from accessing rehabilitation healthcare for substance use disorders (SUDs) in the study area. These barriers encompass both supply-side challenges, such as limited healthcare facilities and trained health service providers, as well as demand-side obstacles, including stigma, lack of awareness, and religious beliefs. Therefore, findings from this study agree with Im et al. (2020), Lammertse et al. (2019) who found that common barriers include limited access to services, transportation difficulties, and financial obstacles, collectively underscoring the multifaceted nature of impediments to rehabilitation for individuals. One of

the significant supply-side barriers identified in this study is the limited access to healthcare facilities and rehabilitation centres. The concentration of these facilities in urban areas creates geographical disparities, making it challenging for individuals from rural or remote regions to access treatment. This results in increased financial burden and time constraints due to long-distance travel. Moreover, the shortage of trained healthcare providers, including psychologists, drug counsellors, and nurses, hampers the quality of care provided.

Furthermore, inadequate healthcare financing system in Ghana poses a substantial financial barrier to accessing rehabilitation healthcare for SUDs. Since PWUD are often marginalised and economically disadvantaged, the cost of treatment becomes a major deterrent. Lack of knowledge about available rehabilitation services contributes to delays in seeking treatment and reliance on inadequate alternatives. Participants in the study often mistook rehabilitation centres for psychiatric hospitals, highlighting the need for targeted community outreach programs and early education.

In the context of the effectiveness and responsiveness of rehabilitation health services in addressing the needs of PWUD, the findings established that Patient Centered-Care (PCC), is still at an early stage and thus facilities may not be prioritizing PCC due to structural and systemic challenges. The data shows that the situation with patient-centred rehabilitation in the Ga East Municipality of Ghana leaves much to be desired. This finding agrees with studies by Ampiah (2015) and Josephine et al. (2015) which highlighted that although Ghanaian physiotherapists perceive patient-centred rehabilitation to be an important approach, aspects regarding consideration of patient preferences are not practised. It is also in line with Appiah et al. (2017), who highlighted that despite recent efforts by the Ghanaian government and health agencies to expand services in major psychiatric hospitals, a persistent challenge lies in ensuring these services adequately address the psychosocial needs of individuals with SUDs or other drug-related issues. Thus, patient-centered approaches were advocated by participants, emphasizing the importance of involving the individual in their treatment journey. Participants in this study called for the need for healthcare providers to foster a collaborative and supportive environment, empowering patients to actively participate in their recovery process. This call is consistent with notable studies, which posit that rehabilitation programs should involve the patient, their family, and the community in planning and implementation in order to achieve optimum results (NTA, 2006; Hubbard et al., 2007; NIDA 2018).

Limitations of the Study

This study was conducted in the Ga East Municipality of the Greater Accra Region, which represents a specific context within Ghana, hence the findings may not be universally applicable to all settings in Ghana. However, the study provides valuable insights into the experiences and perspectives of PWUD in this particular region, contributing to a deeper understanding of the complex issues surrounding drug use and addiction in Ghana. Future research can build upon these findings to explore broader generalizability and contextual variations.

Summary of Key Findings

The study found that various rehabilitation services were accessible to PWUD in the area, including counselling, detoxification, group therapy, and medication-assisted treatment. Counselling was considered essential in helping individuals understand and cope with their addiction. Detoxification was seen as an important first step in managing withdrawal symptoms. However, accessibility of these services was viewed as a significant issue, with financial constraints, inadequate facilities, and stigma being the primary barriers. The cost of rehabilitation healthcare was found to be beyond the reach of the average income, making it unaffordable for those from low-income backgrounds. The lack of financing options

like insurance coverage or sliding scale fees further exacerbated the cost issue. This led some to resort to alternative, less effective forms of treatment, such as local medicine or herbs.

The stigma associated with drug use is also a pervasive barrier, as it discourages PWUDs from seeking formal healthcare services. Health personnel acknowledged that stigma remained a significant reason for people not seeking care and highlighted that drug use was stigmatized. Furthermore, the study revealed that stigma was exacerbated by the perception that rehabilitation care often involved mental health treatment, leading to a false belief that individuals undergoing rehabilitation may also be suffering from mental health conditions. This misconception deterred people from seeking help.

The role of social support systems was also discussed. Family support was identified as a crucial factor enabling individuals to access and sustain rehabilitation care, providing emotional and practical assistance. However, social support could also serve as a barrier if individuals lack supportive relationships or face negative attitudes and beliefs within their social networks.

The study also identifies several structural and systemic barriers hindering PWUDs from accessing rehabilitation healthcare in Ghana, including limited healthcare facility access, a shortage of trained rehabilitation healthcare providers, and inadequate financing systems. These barriers can pose significant challenges, as many rehabilitation facilities are concentrated in the central business district, making healthcare financing difficult for some.

Thus, the presence of these barriers can impede PWUDs from accessing the care they require, potentially resulting in delays in seeking treatment, exacerbation of addiction, and a higher risk of relapse. The findings of the study suggest that there is a lack of clarity regarding the existence and nature of Ghana Health Service policy on rehabilitation care services for PWUDs especially on patient-centred care, with participants emphasizing the need for clear policies to guide and standardise these services. Largely, the study finds that high treatment costs are a major concern, with calls for government intervention to make treatment more affordable and accessible. Participants also advocate for the inclusion of rehabilitation healthcare in health insurance to reduce financial barriers.

Conclusion

The study concludes that substance abuse and addiction have become a significant public health concern in Ghana, and the provision of rehabilitation services is essential to address this problem. From the study, it is evident that there is a need for the integration of rehabilitation services into Ghana's primary healthcare system, and the establishment of more centres in areas where they are currently non-existent or inadequate. Additionally, providing low-cost rehabilitation facilities, government support for private individuals and organizations who want to establish rehabilitation centres, and educational programs aimed at creating awareness about substance abuse and addiction are essential steps towards addressing this issue. It is also imperative to strengthen standardisation and regulation of rehabilitation centres to enhance uniformity and efficiency.

Recommendations

1. This study emphasizes the importance of ensuring that all rehabilitation services, whether public or private, adhere to the necessary standards to optimize the outcomes for those seeking assistance. Therefore, the Ghana Health Service (GHS) and related authorities should establish a dedicated policy for treating individuals with substance use disorders with an emphasis on patient-centred care and incorporate it into Ghana's healthcare system to enhance standardisation and prevent variations in cost

and quality of services provided. This can be done by retooling and strengthening the capacity of the Health Facilities Regulatory Agency (HeFRA).

2. The pervasive stigma associated with drug use is a major hurdle for both rehabilitation healthcare providers and PWUD. Educational programs aimed at creating awareness about substance abuse and addiction should be strengthened, particularly at the community level. Furthermore, health workers should ensure that rehabilitation care is seen as a distinct service from mental healthcare to reduce the stigma associated with it.
3. The government should consider subsidizing or including rehabilitation healthcare in the National Health Insurance Scheme (NHIS) to make it more accessible and affordable for individuals seeking treatment. Additionally, the government of Ghana should establish rehabilitation centres in every district, especially in regions where they are currently lacking. In the meantime, efforts should be made to strengthen community-based hospitals with rehabilitation health units attached to enable them to do more outreach work. Moreover, rehabilitation centres need to be adequately equipped with resources, including medication, logistics, and infrastructure, to ensure the delivery of high-quality services.

These recommendations offer a foundation for future research and policy interventions aimed at dismantling barriers to rehabilitation care and ultimately reducing the burden of substance use disorders.

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