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Review Article

Issues, Constraints and Prospects of Establishing Hospitals and Other Health Facilities in Sub-Saharan Africa: Insights from Selected Nigerian Communities

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Abstract

The establishment of hospitals and other healthcare facilities is fundamental to improving healthcare accessibility, reducing preventable morbidity and mortality and achieving universal health coverage in Sub-Saharan Africa. However, the development of healthcare infrastructure in the region is constrained by several financial, geographical, infrastructural, human-resource, sociocultural and community-related factors. This study investigated the issues, constraints and prospects associated with establishing hospitals and other healthcare facilities in Sub-Saharan Africa, using selected communities in Nigeria as case studies. A community-based observational cross-sectional study design was employed. Data were collected from 300 households across ten randomly selected communities in Nigeria with 30 households sampled from each community using a combination of simple random and systematic sampling techniques. Information was obtained from adult participants through questionnaires following written informed consent. Data were analyzed using descriptive statistics including frequencies, percentages, arithmetic means and maximum values to determine the distribution and relative prominence of identified constraints across the communities. The findings revealed considerable variations in constraints reported across the study locations. Community support recorded the highest mean percentage (21.1%), followed by financial constraints (17.8%), distance (12.8%), people's priority (10.6%), accessibility (9.4%), inadequate water/ power supply (8.0%), beliefs (7.4%), manpower (7.3%), conflicts (3.3%) and community negligence (2.3%). Awareness recorded no reported responses (0.0%). At the community level, distance was most prominent in Biliri (63%), support in Akwanga (54%), inadequate water/ power supply in Bisewe Golote (53%), accessibility in Angiama (47%) and financial constraints in Amankwa Oghe (45%). These findings demonstrate that the challenges associated with healthcare facility establishment are heterogeneous and require context-specific interventions. The study concludes that sustainable healthcare infrastructure development in Sub-Saharan Africa requires adequate and consistent funding, effective government policies, equitable geographical distribution of facilities, reliable water and electricity, recruitment and retention of qualified healthcare professionals and meaningful community participation. Strengthening public-private partnerships and institutional collaboration may further improve the prospects of establishing functional and sustainable healthcare facilities across underserved communities.

Introduction

Sub-Sahara Africa is that part of Africa that lies and consists of all African countries that are located south of the Sahara desert. It is located in the eastern part of the Sahara desert. The demarcation is the southern edge of the Sahara desert [1]. Sub-Sahara Africa is being regarded as the birth place of human race (genus homo) especially the East Africa [2]. The early men of Africa lived by hunting for food and fishing but about twenty thousand years ago, some people began a more settled existence and a developed agriculture such as subsistence agriculture and the export of natural resources nowadays [3]. Inhabitants of Sub-Saharan Africa practice Christianity or Islam with a small percentage practicing traditional religion [2]. Majority of Sub-Saharan Africa is savannah with scattered trees. Climate is mostly influenced by distance from the equator; rainy and dry seasons alternate [4].

In most of the Sub-Saharan Africa nation, the need to feed growing population has resulted in unfairly use of natural resources such as overfishing and excessive use of water in the African Great lakes and these are having serious effects

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on the surrounding East African nations [3]. Expanding and developing opportunity for education in especially the rural areas is very important for the growth of the Sub-Saharan Africa in the nearest future [5]. The AIDS pandemic coupled with poor access to health care, low living standards, conflicts etc. has caused a great damage in most of the Sub-Saharan Africa's population such as leaving about 12 million AIDS orphans and death of about two million inhabitants of Sub-Saharan Africa and the number is still rising [1].

Here in Sub-Saharan Africa, healthcare systems have suffered lots of issues over the years which range from financial barriers to healthcare services with high rates of out-of-pocket expenditure, due to ineffective national health insurance systems. Most of the countries in this region are not able to meet the fundamental necessity for good healthcare systems [6]. Challenges facing healthcare systems in Sub-Saharan Africa demands in-depth probe to identify generate and implement provisional solutions that make significant population-level health gains with efficient use of resources [6]. The need to pay attention to the numerous challenges facing health care delivery in the context of Sub-Saharan Africa and to attain this, accomplishing individual health security at any country level is important [7].

The sub-saharan countries and the island nations

The Sub-Saharan Africa is made up of forty two (42) countries including six (6) island nations, namely:

West Africa

- Benin
- Burkina Faso
- Cameroun
- Chad
- Equatorial Guinea
- Gabon
- The Gambia
- Ghana
- Guinea
- Guinea – Bissau
- Liberia
- Mali
- Mauritania
- Niger
- Nigeria
- Senegal
- Sierra Leone
- Togo

Central Africa

- Burundi
- Central Africa Republic
- Democratic Republic of Congo
- Republic of Congo
- Rwanda

East Africa

- Djibouti
- Eritrea
- Ethiopia
- Kenya
- Somalia (including Somaliland)
- Sudan
- Tanzania
- Uganda

Southern Africa

- Angola
- Botswana
- Malawi
- Mozambique
- Namibia
- South Africa
- Swaziland
- Zambia
- Zimbabwe

African Island Nations

- Cape Verde (West Africa)
- Comoros (Southern Africa)
- Madagascar (Southern Africa)
- Mauritius (Southern Africa)
- Sao Tome and Principe (West Africa)
- Seychelles (East Africa)

Research methodology

Study Design

This was a community-based observational cross-

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Figure 1: A map of Africa highlighting the Sub-Saharan African nations, all shaded in green. Source: WorldAtlas.com

sectional study conducted to evaluate the issues, constraints and prospects associated with the establishment of hospitals and other health facilities in Sub-Saharan Africa using selected communities in Nigeria.

Research Locale

Research was performed by the researcher in the researcher's country of origin Nigeria, being one of the countries that make up the Sub-Saharan nations.

Population Size

The whole population size of Nigeria was not possible to study within the time frame of this research work. So the researcher exacted a target population to be studied. This consisted of 30 households in each community which makes it a total of 300 households.

Sampling Method

The sampling method that was used to select the 300 households during the course of this work is the simple random sampling, this was used to select the ten different communities that were involved in the research while the systematic sampling was used to select the household that were visited and who contributed to this research.

Stage 1: Selection of states using simple random sampling method.

i. The names of the thirty six (36) states in Nigeria were written out on pieces of paper.

ii. Ten (10) states where randomly picked from the list of states.

Stage 2: Selection of Local Government Areas using simple random sampling method.

i. The names of the total local government areas for each of these ten (10) states were written out on pieces of paper.

ii. One (1) local government area was randomly picked from each of these selected states which make it ten (10) local government areas.

Stage 3: Selection of communities using simple random sampling method.

i. The names of all the communities for each of these ten (10) local government areas were also written out on pieces of paper.

ii. One (1) community was randomly picked from each of these selected local government areas which make it ten (10) communities. These ten (10) communities constituted the sampling units.

Stage 4: Selection of houses using the systematic sampling method.

From each of these ten (10) communities, thirty (30) households were selected using systematic sampling method. In this stage, the first house was chosen using a random sampling then subsequently selected every 5th house. Where a household had more than one individual above the age of 18, those who were willing to participate underwent random selection to select just one of them. Where there was no individual up to the age of 18 in a household, the next household was chosen.

The Selected Communities

The communities that were randomly selected for this research work are as follows:

1. Ndioffia in Achara-Ezza district, Ezza North Local Government Area, Ebonyi State.
2. Amakwo Oghe in Ezeagu Local Government Area, Enugu State.
3. Angiama in Oporoma district, Southern Ijaw Local Government Area, Bayelsa State.
4. Upenekang in Ibeno Local Government Area, Akwa Ibom State.
5. Anantigha in Calabar South Local Government Area, Cross River State.
6. Bisewe Golote in Igbotu district, Llaje Local Government Area, Ondo State.
7. Ajebandele in Ijebu East Local Government Area, Ogun State.
8. Dutsin-Ma is the headquarters of Dutsin-Ma Local Government Area, Kastina State.
9. Akwanga is the headquarters of Akwanga Local Government Area, Nasarawa State.
10. Biliri is the headquarters of Biliri Local Government Area, Gombe State.

Method of Data Collection

The study population consisted of 300 households from

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10 randomly selected communities in Nigeria. An ethical clearance from the Ministry of health was obtained prior to the start of the research work. All the participated individuals were above the age of 18 and before the questionnaires were issued, the purpose of the research study was carefully and thoroughly explained to the participants and written informed consents were also obtained. Confidentiality and anonymity of participant information were maintained throughout the study.

Statistical Analysis

Data were analyzed using the descriptive statistics. Frequencies and percentages were used to summarize the reported constraints within each community. Arithmetic means were calculated to describe the average community-level percentage for each constraint while maximum values were used to identify the communities with the highest reported percentages. The constraints were ranked according to their mean percentages.

Research results

The following results are the responses and reasons the residents of the different randomly selected communities gave as issues and constraints of establishing health facilities in Sub-Saharan Africa.

Discussion

The following headings in table 1 and 2 can be explained as follows:

- **Finances:** if there are no financial funds/ support either from the government, private sectors, individuals, community contributions etc. it will be difficult and impossible to establish health facilities in any community since finance is the key factor to executing any project. Also establishing hospitals and other health facilities requires substantial investment in land, buildings, equipment, staffing, utilities and recurrent operational costs.
- **Peoples' priority:** in some cases the people of the community think that establishing health facilities in their community is not their core need as they rely on their traditional means of treating themselves. Hence, they may discourage this idea and rather prefer establishment of schools, markets etc.
- **Accessibility:** it is rather disappointing to know that some areas/ communities of Sub-Saharan Africa are still having the issues of bad/ inaccessible roads. This is a major problem for the people of the community to access/ utilize the facility after establishing.

Table 1: Shows percentage of residents reporting constraints to establishing health facilities by community.

Constraints	Ndioffia	Aman kwa Oghe	Angiama	Upene Kang	Anantigha	Bise we Golote	Ajebandele	Dustin-Ma	Akwanga	Biliri	Mean (%)	Maximum (%)	Community with maximum
Finances	30	45	12	3	18	10	17	43	-	-	17.8	45	Amankwa Oghe
People's Priority	7	-	41	17	9	-	13	-	2	17	10.6	41	Angiama
Accessibility	11	3	47	-	-	-	2	31	-	-	9.4	47	Angiama
Manpower	9	-	-	40	17	7	-	-	-	-	7.3	40	Upenekang
Community Negligence	4	13	-	-	-	3	3	-	-	-	2.3	13	Amankwa Oghe
Conflict	-	-	-	-	8	3	-	2	-	20	3.3	20	Biliri
Distance	16	9	-	-	-	19	1	20	-	63	12.8	63	Biliri
Awareness	-	-	-	-	-	-	-	-	-	-	0.0	0	None reported
Support	23	30	-	40	42	-	22	-	54	-	21.1	54	Akwanga
Beliefs	-	-	-	-	6	5	21	2	40	-	7.4	40	Akwanga
Inadequate Water/ Power supply	-	-	-	-	-	53	21	2	4	-	8.0	53	Bisewe Golote

'Nil' (-) was treated as 0% for the calculations. Means are arithmetic averages across all 10 communities including those reporting nil.

Table 2: Percentage of residents reporting constraints to establishing health facilities by community

Constraints	Mean (%)	Maximum (%)	Community with maximum
Support	21.1	54	Akwanga
Finances	17.8	45	Amankwa Oghe
Distance	12.8	63	Biliri
People's priority	10.6	41	Angiama
Accessibility	9.4	47	Angiama
Inadequate water/ Power supply	8.0	53	Bisewe Golote
Beliefs	7.4	40	Akwanga
Manpower	7.3	40	Ukpenekang
Conflict	3.3	20	Biliri
Community negligence	2.3	13	Amankwa Oghe
Awareness	0.0	0	None reported

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- **Manpower:** when there are inadequate/ unavailability of trained personnel that can work in a health sector/ facility that is to be established, that can cause a problem to establishing the health facility in that community.
- **Community negligence:** when the community members, starting from the leaders do not show concern or participate and get involved in the process of establishing health facilities in their community, this poses as a problem to this establishment.
- **Conflicts:** when the members/ residents of the community are living in disagreement, it will be a difficult task for any development to come into the community.
- **Distance:** some community areas where vast and adequate land can be obtained are not close to residential areas. In the case were health facilities are to be built and constructed in such areas, the people may feel discouraged taking such a long distance for their health services and at times lack of a means of transportation to the facility can be a barrier.
- **Awareness:** there is the need to educate the residents of the community on why they need proper medical treatment from trained personnel instead of relying on their usual traditional means of treatment that can be crude.
- **Support:** lots of support is required for a successful completion especially from the government e.g. since most lands are owned by the government and also assistance for power and water supply can be put in place by the government. Drug regulatory agencies which are also government owned could help with standard check of drugs and others. Where support is inadequate, effort to secure land, funding, infrastructure, equipment, personnel and long term operational resources may be affected.
- **Beliefs:** it is well known that African culture comes with lots of beliefs. Some of these beliefs prevent the people from proper medical care. These beliefs are regarded as customs and traditions. Such beliefs can affect healthcare-seeking behavior and community willingness to support or utilize newly established facilities.
- **Inadequate water/ power supply:** these are important things to consider and that are necessary in an established health facility since most of the equipment are operated with electricity and water is much needed to mention cleanliness and others. The Sub-Saharan African nations that are lacking these makes it more difficult for their community to get a health facility established.

Table 1, table 2 and figure 2 present the distribution of reported constraints affecting the establishment of hospitals and other health facilities across ten communities: Ndioffia, Amankwa Oghe, Angiama, Upenekang, Anantigha, Bisewe Golote, Ajebandele, Dustin-Ma, Akwanga and Biliri. The constraints assessed included: finances, people' priority, accessibility, manpower, community negligence, conflicts, distance, awareness, support, beliefs and inadequate water/ power supply. The findings reveal substantial variation in the pattern of reported constraints across the communities suggesting that the challenges associated with health facility development are heterogeneous and may require locally tailored planning strategies.

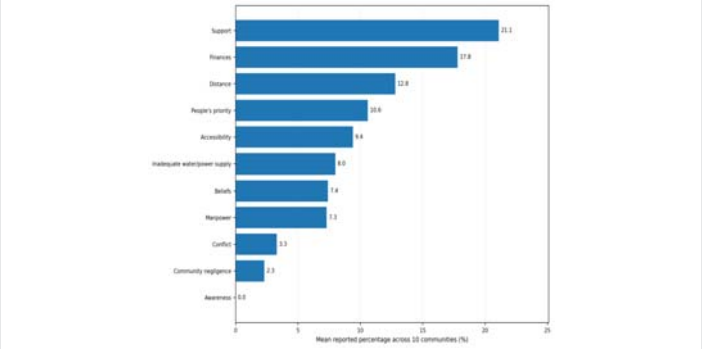


Figure 2: Horizontal bar chart showing the mean reported percentage for each constraint across the ten communities

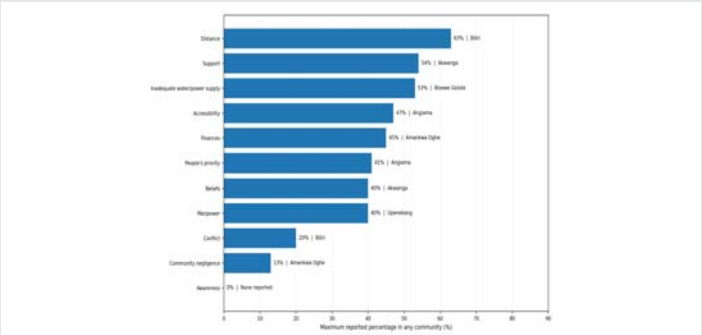


Figure 3: Horizontal bar chart showing the maximum reported percentage for each constraint and the community in which it was recorded.

Support: this recorded the highest mean percentage across the ten communities (21.1%), although the distribution varied considerably between locations. The highest value was observed in Akwanga (54%), followed by Anantigha (42%), Upenekang (40%), Amankwo Oghe (30%), Ndioffia (23%) and Ajebanele (22%). No responses were recorded for this category in Angiama, Bisewe Golote, Dustin-Ma or Biliri.

This identifies support as an important category in the data and highlights the need to examine the nature of support required for health facility development. Establishing a hospital or other health facility commonly involves coordination among government agencies, community leaders, residents, healthcare professionals and private investors. Support in the local context involves financial contributions, land allocation, community participation or assistance with infrastructure and service provision.

Finances: this recorded the second highest mean percentage (17.8%). The highest community values occurred in Amankwa Oghe (45%) and Dustin-Ma (43%), followed by Ndioffia (30%).

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Anantigha (18%), Ajebandele (17%), Angiama (12%), Bisewe Golote (10%), Upenekang (3%) while Akwanga and Biliri (0%).

The relatively high percentages in Amankwa Oghe and Dustin-Ma suggest that financing warrants particular attention in these locations. Health facility establishment requires both capital investment and the capacity to sustain operations. Capital costs may include land acquisition, construction, medical equipment, furniture and essential infrastructure. Recurrent costs may include staff salaries, medicines, consumables, utilities, equipment maintenance and other operational expenses. Consequently, planning that focuses exclusively on constructing buildings without accounting for recurrent expenditure may not ensure the delivery of sustainable healthcare services.

Distance: this recorded a mean percentage of 12.8% with considerable variation across the communities. Biliri had the highest value (63%), followed by Dustin-Ma (20%), Bisewe Golote (19%), Ndioffia (16%), Amankwa Oghe (9%) and Ajebandele (1%). No responses were recorded in Angiama, Upenekang, Anantigha or Akwanga.

The particularly high value in Biliri suggests that distance was a prominent concern in that community. Geographical proximity is an important consideration in health facility planning because the location of services can influence the practical effort required to obtain care. Where settlements are dispersed or transportation infrastructure is limited, residents may face substantial travel burdens when seeking healthcare. These considerations are especially relevant for services that require timely access, regular follow-up or repeated visits.

The findings support the need to consider settlement patterns, existing facilities, road networks, travel time and transportation availability when determining where new health facilities should be located. A geographical assessment could help identify underserved areas and determine whether a new facility, an upgraded existing facility or an improved referral and transport arrangement would be most appropriate.

People's priority: this recorded a mean percentage of 10.6%. Angiama had the highest value (41%), followed by Upenekang and Biliri (17%), Ajebandele (13%), Anantigha (9%), Ndioffia (7%) and Akwanga (2%). No responses were recorded in Amankwa Oghe, Bisewe Golote or Dusti-Ma.

The results suggest that health facility development must be considered alongside other demands. Participatory planning can help clarify community needs, communicate the anticipated benefits of healthcare infrastructure and identify feasible approaches to mobilizing resources.

Accessibility: this recorded a mean percentage of 9.4%. The highest values were observed in Angiama (47%) and Dustin-Ma (31%), followed by Ndioffia (11%), Amankwa Oghe (3%) and Ajebandele (2%). No responses were recorded in Upenekang, Anantigha, Bisewe Golote, Akwanga or Biliri.

The relatively high values in Angiama and Dustin-Ma suggest that accessibility deserves particular attention in these locations. Even where a facility is geographically nearby, residents may experience difficulties reaching it because of poor road conditions, transportation costs, seasonal barriers or limitations affecting people with disabilities. These factors may influence whether a proposed facility is suitably located and whether the population it is intended to serve can use it.

The contrast between the accessibility findings in Angiama and the distance findings in Biliri also illustrates why both categories should be examined separately. In Angiama, accessibility was reported by a relatively high percentage of respondents even though distance was recorded as zero.

Inadequate water/ power supply: this recorded a mean percentage of 8.0%. The highest value was observed in Bisewe Golote (53%), followed by Ajebandele (21%), Akwanga (4%) and Dustin-Ma (2%). No responses were recorded in Ndioffia, Amankwa Oghe, Angiama, Upenekang, Anantigha or Biliri.

The high percentage in Bisewe Golote makes utility provision a notable issue in the reported findings. Reliable water and electricity are fundamental components of health care infrastructure. Water is needed for sanitation, hygiene and infection prevention while electricity supports lighting, refrigeration, diagnostics equipment and essential operations. The adequacy and reliability of these utilities can therefore influence a facility's ability to function safely and consistently.

The result suggests that utility requirements should be incorporated into health facility planning from the outset. Depending on the local infrastructure, this may involve assessing the reliability of public electricity, the feasibility of alternative power systems, the availability of safe water sources and the cost of maintaining these services. Infrastructure planning should account not only for installation but also for long-term maintenance and operational costs.

Beliefs: this recorded a mean percentage of 7.4%. The highest value occurred in Akwanga (40%), followed by Ajebandele (21%), Anantigha (6%), Bisewe Golote (5%) and Dustin-Ma (2%). No responses were recorded in Ndioffia, Amankwa Oghe, Angiama, Upenekang or Biliri.

The findings indicate that beliefs were a notable response category in some communities, particularly Akwanga and Ajebandele. Community consultation may help identify local expectations and improve the acceptability of health facility development.

Manpower: this recorded a mean percentage of 7.3% with the highest value in Upenekang (40%). Other reported values were 17% in Anantigha, 9% in Ndioffia and 7% in Bisewe Golote. No responses were recorded in Amankwa Oghe, Angiama, Ajebandele, Dustin-Ma, Akwanga or Biliri.

The high percentage in Upenekang suggests that workforce considerations may be particularly relevant to health facility planning in that community. A facility requires an appropriate complement of qualified personnel with staffing levels and professional roles determined by the type and scale of services to be provided. Buildings and equipment alone cannot guarantee

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functional healthcare delivery if appropriately trained staff are unavailable.

Consequently, decisions about establishing new facilities should be accompanied by workforce planning. Relevant considerations include the availability of qualified personnel, recruitment and retention arrangements, staff remuneration, accommodation where appropriate professional development and capacity to sustain staffing over time. Coordination with relevant health authorities and training institutions may also be necessary.

Conflicts: this recorded a mean percentage of 3.3% with the highest value in Biliri (20%). Other values were 8% in Anantigha, 3% in Bisewe Golote and 2% in Dustin-Ma. No responses were recorded in the remaining six communities.

Although the overall mean was comparatively low, the concentration of responses in Biliri suggests that conflicts may warrant further investigation in that location because it may complicate site selection, resource mobilization, decision-making or collaboration among stakeholders. Where conflict is substantiated, transparent consultation and clear procedures for resolving disagreements may help facilitate planning.

Community negligence: this recorded the lowest non-zero mean percentage (2.3%). The highest value was observed in Amankwa Oghe (13%), followed by Ndioffia (4%) and Bisewe Golote and Ajebandele (3% each). No responses were recorded in Angiama, Upenekang, Anantigha, Dustin-Ma, Akwanga or Biliri.

The relatively low mean indicates that this category was reported less frequently thqn support, finances, distance or accessibility. Nevertheless, the higher value in Amankwa Oghe suggests that the issue may merit clarification in that community.

Awareness: this recorded 0.0% across all ten communities meaning that no non-zero values were reported for this category. This finding differs from the other categories which were reported in at least some locations.

However, the absence of recorded awareness-related responses should not automatically be interpreted as proof that residents were adequately informed about health facility development, available healthcare services, funding arrangements or government programmes.

Figure 3 presents the highest reported percentage for each constraint across the ten communities surveyed. Unlike the mean percentages (table 1, 2 and figure 2) which summarize the average distribution of reported constraints across communities, figure 3 highlights the communities in which individual constraints were most prominent. This distinction is important because an overall mean may conceal substantial local differences.

The highest reported values were observed for distance in Biliri (63%), support in Akwanga (54%), inadequate water/ power supply in Bisewe Golote (53%), accessibility in Angiama (47%), finances in Amankwa Oghe (45%), people's priority in Angiama (41%). Beliefs constraint was highest in Akwanga (40%) while manpower was most frequently reported in Upenekang (40%). Conflicts was highest in Biliri (20%) while community negligence reached its maximum in Amankwa Oghe (13%). No community recorded a non-zero value for awareness.

These results suggest that strategies for improving health facility establishment may need to be tailored to the most prominent constraints in each location.

Community-level interpretation of the major constraints

Distance: this was the most prominent single community-specific constraint, reaching 63% in Biliri. Other notable values were 20% in Dustin-Ma, 19% in Bisewe Golote and 16% in Ndioffia. This pattern suggests that geographical separation may be a particular important consideration in planning health facilities in Biliri.

Support: this recorded high percentages in Akwanga (54%), Anantigha (42%), Upenekang (40%), Amankwa Oghe (30%), Ndioffia (23%) and Ajebandele (22%).

Community participation can be relevant to health facility development through consultation, resource mobilization, local advocacy and collaboration with government. Where support is perceived to be inadequate, structured engagement with community leaders, residents, health authorities and development partners may help identify acceptable and sustainable approaches.

Inadequate water/ power supply: this was most prominent in Bisewe Golote (53%) followed by Ajebandele (21%), Akwanga (4%) and Dustin-Ma (2%).

Reliable water and electricity are essential for many healthcare activities including sanitation, sterilization, infection prevention, equipment operation, lighting and the appropriate storage of temperature-sensitive medicines and supplies. Inadequate utilities can increase operating costs and complicate the delivery of safe and reliable services.

Accessibility: this reached 47% in Angiama compared with 31% in Dustin-Ma, 11% in Ndioffia, 3% in Amankwa Oghe and 2% in Ajebandele.

The residents of the communities were rather concerned about obstacles to reaching the facility such as: inaccessible roads, transport availability and costs.

Finances: this was most frequently reported in Amankwa Oghe (45%) and Dustin-Ma (43%) followed by Ndioffia (30%). Establishing a facility generally requires resources for land acquisition, construction, equipment, staffing, utilities and the procurement of essential supplies. Sustaining services also requires recurrent expenditure.

People's priority: Angiama recorded the highest percentage here (41%) followed by Upenekang and Biliri (17% each). The result indicates a need for stronger consultation and health-planning advocacy.

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Beliefs: this was most prominent in Akwanga (40%) followed by Ajebandele (21%), Anantigha (6%), Bisewe Golote (5%) and Dustin-Ma (2%).

Engagement with community members and trusted local leaders may help ensure that facility planning is responsive to local expectations while maintaining appropriate healthcare standards.

Manpower: was highest in Upenekang (40%) followed by Anantigha (17%), Ndioffia (9%) and Bisewe Golote (7%).

Health facilities require an appropriate mix of qualified personal including clinicians, nurses, laboratory staff, pharmacists and support workers depending on the level of care intended. Infrastructure investment without a corresponding workforce plan may limit a facility's ability to provide sustained services. Planning should therefore consider recruitment, staff retention, accommodation where relevant, continuity professional development and the availability of referral networks.

Conflicts: was highest in Biliri (20%) with lower percentages in Anantigha (8%), Bisewe Golote (3%) and Dustin-Ma (2%).

Disputes within a community, disagreements over land or facility location or other forms of social tension measure up to conflict as a constraint.

Community negligence: this was highest in Amankwa Oghe (13%) followed by Ndioffia (4%) and Bisewe Golote and Ajebandele (3% each).

Awareness: this was not reported as a constraint in any of the ten communities. It does not necessarily establish that all communities had adequate awareness of health facility needs and healthcare services.

Prospects for Establishing Health Facilities in Sub-Saharan Africa

The findings from the ten communities provide an important basis for examining the prospects of establishing hospitals and other healthcare facilities in Sub-Saharan Africa. Although the study identifies several constraints, these do not necessarily imply that healthcare infrastructure development is unachievable. Rather, they highlight areas that require strategic planning, investment, institutional collaboration and community participation.

Therefore, a coordinated community-sensitive approach to health-facility development is required. Such an approach should consider the following priorities:

Effective government policies: clarify the roles of government agencies, community representatives, health authorities and development partners in planning, financing and supporting health facilities.

Adequate and consistent funding: despite limited public resources in many countries, there are opportunities to mobilize additional funding through government investment, private-sector participation, development partnerships, health insurance schemes and community-supported initiatives.

Equitable geographical distribution of facilities: consider settlement distribution, travel time, existing facilities, transport links and underserved populations when selecting locations for new facilities.

Reliable water/ power supply: assess water and electricity requirements before construction and ensure that plans include reliable supply and sustainable maintenance arrangements.

Recruitment and retention of qualified healthcare professionals: determine the staffing needs of each proposed facility and assess recruitment, retention and long-term operational capacity.

Meaningful community participation: consult residents and relevant local stakeholders to clarify priorities, understand concerns and establish transparent procedures for decision-making and resolving disagreements.

Conclusion

The establishment of hospitals and other healthcare facilities in sub-Saharan Africa is essential for improving access to quality healthcare, reducing preventable morbidity and mortality and promoting sustainable socioeconomic development. However, findings from the ten communities examined in this study demonstrate that healthcare infrastructure development is influenced by several interconnected financial, geographical, infrastructural, human-resource, social and community-related factors.

Among the identified constraints, community support and financial limitations emerged as prominent considerations while distance, people's prioritization of healthcare, accessibility, inadequate water/ power supply, beliefs and manpower shortages also presented important challenges. The differences observed across the communities suggest that these constraints are not uniformly distributed. Rather, each community experiences a combination of challenges shaped by its particular socioeconomic and infrastructural circumstances.

The findings further indicate that addressing these challenges requires more than the construction of additional healthcare facilities. Sustainable healthcare development depends on adequate and consistent funding, effective government policies, reliable water/ power supply, equitable geographical distribution of facilities, recruitment and retention of qualified healthcare professionals and meaningful community participation. Public-private partnerships, international development support, community engagement and the integration of appropriate digital health technologies may also contribute to improving healthcare infrastructure across underserved areas.

Importantly, interventions should be tailored to the specific needs of individual communities rather than adopting a uniform approach. Communities experiencing financial constraints may require innovative financing mechanisms while those affected

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by geographical isolation may benefit from strategically located primary healthcare centres. Similarly, communities facing inadequate water/ power supply require investment in essential infrastructure to ensure that healthcare facilities remain functional and sustainable.

In sum, although the establishment of hospitals and other healthcare facilities in sub-Saharan Africa faces considerable challenges, these constraints do not make healthcare infrastructure development unattainable. With appropriate planning, adequate resource mobilization, strong political commitment, effective institutional coordination and active community involvement, substantial progress can be achieved. Strengthening existing healthcare facilities alongside the establishment of new ones should remain a priority in efforts to achieve equitable healthcare access and universal health coverage across the region. The findings of this study provide useful community-level evidence to inform healthcare planning and policy interventions while further research involving a wider geographical coverage and more robust statistical analysis is recommended to establish the broader applicability of the findings.

Contribution to knowledge

Overall, this study contributes to knowledge by providing empirical, community-level insights into the multidimensional constraints affecting the establishment of hospital and other healthcare facilities. It highlights variations in the nature and distribution of these constraints across selected communities and underscores the importance of integrating financial, infrastructural, geographical, human-resource and sociocultural considerations into healthcare planning. The findings provide a basis for identifying community-specific priorities, developing targeted policy interventions and strengthening strategies for equitable healthcare infrastructure development in sub-Saharan Africa.

Furthermore, the study offers a foundation for future comparative research examining the relationship between community characteristics, healthcare infrastructure availability and the sustainability of healthcare facilities.

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