A STUDY TO DETERMINE THE COMMUNITY PERCEPTION OF THE NEIGHBOURHOOD HEALTH COMMITTEE FUNCTIONS IN KASAMA URBAN DISTRICT

BY

KAPULU KADIMBA

UNZA

OCTOBER, 2002

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

A STUDY TO DETERMINE THE COMMUNITY PERCEPTION OF THE NEIGHBOURHOOD HEALTH COMMITTEE FUNCTIONS IN KASAMA URBAN DISTRICT

By

KAPULU KADIMBA

RM 1990, NDOLA
RN 1985, LUSAKA

A RESEARCH DISSERTATION
SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF BACHELOR OF SCIENCE DEGREE IN NURSING OF THE UNIVERSITY OF ZAMBIA.

OCTOBER, 2002

ACKNOWLEDGEMENTS

I am thankful to the Lord God Almighty for making it possible for me to go through this course. I am also grateful to the Ministry of Health and Central Board of Health for the scholarship, which permitted me to pursue the Bachelor of Science in Nursing Degree.

I greatly appreciate the guidance, advice and patience of my research supervisor Mrs C. Ngoma without whom this research would not have been a success.

I would like to acknowledge the following:

1. The management and staff of the Kasama District Health Management for their support.
2. The Clinic in-charges of the Kasama Urban Clinic and TAZARA Clinic in Kasama Urban District for their guidance and support.
3. The Headmen of the Musenga, Kapoka, Chishipula and Nakapampa Chale Villages in Kasama Urban District for making it possible for me to carry out the study.
4. To all the respondents for their participation, without whom the study would not have been a success.
5. Mr Chiwele my workmate and a brother in the Lord for assisting me to get relevant information from Kasama when I needed it.
6. My classmates for their encouragement and support.
7. I also thank my family for their support, especially my parents.
8. My sister Cathryn and my niece Chali who have been so supportive.
9. My husband Fred and my two children Makasa and Wana for their patience.
10. Lastly to all who advised me in one-way or another to make this research a success.

TABLE OF CONTENTS

TITLE	PAGE
Acknowledgements	i
Table of Contents	ii
List of Tables	v
List of Figures	vii
List of Abbreviations	viii
Declaration	ix
Statement	x
Dedication	xi
Abstract	xii

CHAPTER 1

1.0	Background Information	1
1.1	Country Profile	1
1.2	Decentralization under Health Reforms	2
1.3	Primary Health Care	4
1.4	Partnership with the community	6
1.5	The Neighbourhood Health Committees (NHCs)	7
1.6	MoH Guidelines, Roles and Functions for NHCs, 1995	8
1.7	Statement of the Problem	9
1.8	Diagram of Problem Analysis	16
1.9	Justification of the Study	17
1.10	Research Objectives	17
1.10.1	General Objectives	17
1.10.2	Specific Objectives	17
1.11	Hypothesis	18
1.12	Operational Definition of Terms	18
1.13	Variables	18
1.14	Variables and cut-off points	19

CHAPTER 2

2.0 Literature Review.. 20

2.1 Introduction.. 20

2.2 Global literature on perception of NHCs..................... 21

2.3 Regional literature on perception of NHCs.................. 23

2.4 Zambia' literature on perception of NHCs................... 25

2.5 Conclusion.. 27

CHAPTER 3

3.0 Research Methodology.. 28

3.1 Introduction.. 28

3.2 Research Design... 28

3.3 Research Setting... 29

3.4 Study Population... 32

3.5 Sample Selection... 32

3.6 Sample Size.. 34

3.7 Data Collection Tool... 35

3.8 Data Collection Technique...................................... 36

3.9 Pilot Study.. 36

3.10 Validity.. 37

3.11 Reliability.. 37

3.12 Ethical and Cultural Consideration............................ 37

3.13 Dissemination of Findings...................................... 38

CHAPTER 4

4.0 Data Analysis and Presentation of Findings........................... 39

4.1 Introduction.. 39

4.2 Data Analysis.. 39

4.3 Presentation of Findings.. 40

CHAPTER 5

5.0 Discussion of findings and Implications for the Health Care system.. 65

5.1 Introduction.. 65
5.2 Characteristics of the sample.................................... 65
5.3 Discussion of each variable...................................... 66
5.4 Implications of the findings to the health care system...... 76

CHAPTER 6

6.0 Conclusion and Recommendations.................................... 79
6.1 Conclusion.. 79
6.2 Recommendations... 80
6.3 Limitations of the study.. 81

References.. 82

APPENDICES

Appendix 1: Research work schedule.. 85
Appendix 2: Gantt Chart for Research Study................................ 86
Appendix 3: Budget for Research study...................................... 87
Budget Justification.. 88
Appendix 4: Permission to collect Research Data........................... 89
Appendix 5: Permission for pilot study in Kalingalinga compound..........90
Appendix 6: Permission for pilot study from L.U.D.M.B......................91
Appendix 7: Permission to collect data from K.D.H.M.B......................92
Appendix 8: Permission to collect data in Musenga village...................93
Appendix 9: Permission to collect data in Kapoka village.....................94
Appendix 10: Permission to collect data from Chishipula village.......... 95
Appendix 11: Permission to collect data from Nakapampa Chale
Village.. 96
Appendix 12: Questionnaire... 97

LIST OF TABLES

TABLE PAGE

1.1 Health care Activities promoted by the NHCs.................................... 10

1:2 Kasama Disease Summary all Quarters.. 13

1:3 Variables and Cut-Off Points.. 19

3:1 Kasama District Health Vital Statistics 2002....................................... 30

3:2 Study population, Study units, Sampling method and Sample size............. 34

4:1 Respondents' Age Distribution.. 40

4:2 Respondent's Sex Distribution... 40

4:3 Respondents' Residential Distribution.. 41

4:4 Respondents' Marital Distribution... 41

4:5 Respondents' Community Role.. 41

4:6 Respondents' Occupation Distribution.. 42

4:7 Respondents' Monthly Income... 43

4:8 Respondents' Number of household Members...................................43

4:9 Respondents' responses on why NHCs were important..........................48

4:10 Respondents' responses on support for NHCs.................................. 49

4:11 Respondents' reason for support for NHCs....................................... 49

4:12 Respondents' responses on whether NHCs held meetings.......................53

4:13 Respondents' responses on information NHCs gave during meetings...........53

4:14 Respondents' responses on whether NHCs got feedback........................ 54

4:15 Respondents' responses on outcome of feedback 54

4:16 Respondents' responses on influence of feedback on services offered..........55

4:17 Respondents' responses on whether NHCs were effective...................... 55

4:18 Respondents' responses on whether NHCs worked with other CBOs......... 57

4:19 Respondents' responses on why NHCs did not work with other CBOs....... 58

4:20 Respondents' responses on CBOs that worked with NHCs.................... 58

4:21 Respondents' responses on whether NHCs had conflicts....................... 59

4:22 Respondents' responses on reasons why conflicts existed among NHCs...... 59

4:23 Respondents' Knowledge towards NHCs in relation to Age distribution...... 60

4:24 Respondents' Knowledge towards NHCs in relation to Sex distribution...... 60

4:25 Respondents' Knowledge towards NHCs in relation to Residential Area..... 61
4:26 Respondents' Knowledge towards NHCs in relation to Marital Status........ 61
4:27 Respondents' Knowledge towards NHCs in relation to Educational Level.... 61
4:28 Respondents' Knowledge towards NHCs in relation to Monthly Income...... 62
4:29 Respondents' Attitude towards NHCs in relation to Age......................... 62
4:30 Respondents' Attitude towards NHCs in relation to Sex Distribution...........63
4:31 Respondents' Attitude towards NHCs in relation to Residential Area...........63
4:32 Respondents' Attitude towards NHCs in relation to Educational Level........ 63
4:33 Respondents' Attitude towards NHCs in relation to Monthly Income.......... 64
4:34 Respondents' Attitude towards NHCs in relation to Knowledge................ 64

LIST OF FIGURES

1:1 Diagram of Problem Analysis.. 16
4:1 Respondents' Educational Distribution Level.................................... 42
4:2 Respondents' Knowledge on whether they had heard about NHCs............ 44
4:3 Respondents' Knowledge on Existence of NHCs................................ 44
4:4 Respondents' Source of Information on NHCs.................................. 45
4:5 Respondents' response on Definition of NHCs.................................. 45
4:6 Respondents' responses on who forms NHCs.................................... 46
4:7 Respondents' responses on the Role of NHCs................................... 46
4:8 Respondents' responses on whether NHC activities were beneficial............47
4:9 Respondents' responses on why NHC activities were beneficial.................47
4:10 Respondents' responses on whether NHCs were importance.................... 48
4:11 Respondents' responses on whether the NHCs asked for support.............. 50
4:12 Respondents' responses on who supported the NHCs........................... 50
4:13 Respondents' responses on NHC presentation of information.................. 51
4:14 Respondents' responses on how NHCs presented information.................. 51
4:15 Respondents' responses on whether they were satisfied with NHC Role.... 52
4:16 Respondents' responses on active CBOs.. 52
4:17 Respondents' responses on contributing factors to NHCs ineffectiveness......56
4:18 Respondents' responses on solutions to make NHCs effective...................57
4:19 Respondents' responses on whether NHCs worked with Health Centre.........59

LIST OF ABREVIATIONS

1. **AIDS** : Acquired Immunodeficiency Syndrome
2. **CBDs** : Community based Distributors
3. **CBOs** : Community Based Organisations
4. **CBoH** : Central Board of Health
5. **CDR** : Committee for the Defence of the Revolution
6. **CHCs** : Community Health Committees
7. **CHWs** : Community Health Workers
8. **CMAZ** : Churches Medical Association of Zambia
9. **CSO** : Central Statistics Office
10. **DHMT** : District Health Management Team
11. **HIV** : Human Immunodeficiency Virus
12. **IEC** : Information Education Communication
13. **KDHMB** : Kasama District Health Management Board
14. **LUDHMB** : Lusaka District Health Management Board
15. **MoH** : Ministry of Health
16. **NGO** : Non-Governmental Organisations
17. **NHS** : British National Health System
18. **NHCs** : Neighbourhood Health Committees
19. **PLA** : Participatory Learning in Action
20. **RHS** : Regional Health Authority
21. **TAZARA** : Tanzania Zambia Railways
22. **TBAs** : Traditional Birth Attendants
23. **TB** : Tuberculosis
24. **UNICEF** : United Children's Fund
25. **VCW** : Village Community Workers
26. **WHO** : World Health Organisation
27. **ZDHS** : Zambia Demographic Health Survey
28. **ZIHP** : Zambia Integrated Health Program

DECLARATION

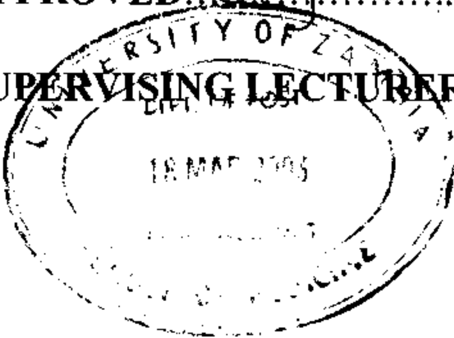
I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either wholly or in part for any other degree and is not being submitted for any other degree course.

SIGNED:.................... **DATE:** 18/03/05

STUDENT

APPROVED:.................... **DATE:** 18/03/05

SUPERVISING LECTURER



STATEMENT

I hereby certify that this is entirely the result of my own independent investigation and labour. The various sources to which I am indeed indebted are clearly indicated in this paper and in the references.

SIGNED:...K. Kus Se........ **DATE:**...18/03/05...........................

DEDICATION

This work is dedicated to my husband, Fredrick Chishimba for his unfailing support and love, which inspired me to continue on even when it was such a difficult task.

It is also dedicated to my parents Mr and Mrs W.K. Kadimba who always encouraged me to pursue a degree programme one day. To my family as a whole for their encouragement and especially my sister Cathyrn who came to Lusaka at the right time to make it possible for me to complete this research. Lastly my niece Chali for sharing light moments with me during my dull moments.

ABSTRACT

The study aimed to determine the community perception towards the Neighbourhood Health Committee (NHC) functions in Kasama Urban District. The study was prompted by a rise in disease burden in the case of Kasama district between 1999 and 2001. The NHCs are indirectly responsible for the rise in disease burden as they are expected to teach on disease prevention to the community. Therefore the researcher sought to determine the contributing factors to the problem by investigating the community perceptions on the functions of the NHCs. The researcher sought to find out how the community readily adhered to the NHC functions in order to reduce the disease burden in the community.

Information from the Global, Regional and Zambia's literature was reviewed. It was established that the concept of the Neighbourhood Health Committees was not only being practiced in Zambia, but widely in many countries to bring the health care as close to the family as possible. This concept is found to be effective as it involves community participation through the NHCs. However, there have been certain limitations to its effectiveness, though in some areas it has been found to be effective.

A non-interventional descriptive design was used to obtain an accurate account of the phenomenon under study. Simple random sampling method was used to pick two health centres from the four health centres found in Kasama Urban District namely Kasama Urban Clinic and TAZARA Health Centre. Multistage cluster sampling technique was used to select four different communities namely Musenga, Kapoka, Chishipula and Nakapampa Chale falling under the Kasama Urban clinic and the

Tanzania Zambia Railways clinic respectively. Each of the communities was divided into sections and three (3) sections were selected from each of the communities using the rotary method. Respondents were selected from sixty (60) households using systematic random sampling technique from the selected sections. The respondents comprised of heads of households found in the respective communities. A structured interview questionnaire was used to collect data from the respondents.

A pilot study was conducted in the month of August 2002 in Kalingalinga compound to test the tool for validity and some adjustments were made to the instrument. The data for the study was collected from 9th to 22nd September 2002. Raw data collected from the respondents was analysed, organised and summarized to describe the phenomenon under study for possible inferences to the target population. The study findings revealed that the knowledge levels of the community had increased in comparison to the previous studies done on NHCs. The study results also showed that (62%) of the respondents exhibited adequate knowledge on the NHC functions.

On the contrary it was also revealed that more than half (53%) of the respondents had a negative attitude towards the NHCs. It was further found out that among those that had a negative attitude, most of them attained lower primary education and had no source of income. The findings also revealed a number of factors that could have attributed to the NHC ineffectiveness that could have lead to the community's negative attitude towards the NHCs.

It was therefore recommended that the government should strengthen the role of the NHCs by conducting workshops/seminars and establishing an efficient financial

support system in order to make NHCs more effective. This would help improve the Neighbourhood Health Committee role and eventually improve the community's perception. Ultimately the NHCs would be motivated to function effectively and efficiently to reduce the disease burden in the community.

CHAPTER 1

1.0 BACK GROUND INFORMATION

1.1 COUNTRY PROFILE

Zambia is a landlocked country covering a surface area of 752 614 square kilometres. It is situated within the sub-Saharan African region. It shares boarders with Zaire and Tanzania in the North, Malawi and Mozambique in the East, Zimbabwe and Botswana in the South, Namibia in the Southwest, and Angola in the West *(Zambia Demographic Health Survey (Z.D.H.S), 1996).*

According to the Central Statistics Office (C.S.O) preliminary results of the 2000 census, the population of Zambia is estimated at 10 285 631 with a growth rate of 3.6% per annum. Zambia is divided into nine (9) provinces and seventy-two (72) districts. This study was carried out in Kasama the provincial Headquarters' of the Northern province. The total population for Northern province is 1 407 088 and for Kasama it is 179 936 *(Central Statistics Office Preliminary report, 2000).*

The country's Gross National Production stands at 430 United States Dollar, which does not match with the growth production, causing an economic decline and eventually having a negative effect on the health care system in Zambia. The main health care provider in Zambia is the Government through the Ministry of health, which is inadequate to meet the health needs of the nation. Other health care providers include the mine hospitals, private hospitals and traditional healers.

Traditionally the health care system in Zambia was excessively centralized and heavily dependent on hospital care until 1989. Districts carried out activities under detailed instructions from the Ministry of health and provincial level guidelines. The capacity at the district level for planning and managing was not

encouraged under this system. All authority for resource management was also centralized. Districts were allocated equipment and supplies as the province deemed appropriate. This prevented service providers to respond to the needs of the communities they served according to their priority problems *(National Strategic Health Plan, 1995-1999).*

The financing policy encouraged inefficient health care system, giving a greater proportion of the budget to the referral hospitals where less cost-effective and essential services would be provided. This created a disparity in the standards of care in various health centres. Health care services were also provided free of charge which allowed individuals seeking health care to easily by-pass the health centres which had inadequate staff and only provided basic services. This situation created congestion for the bigger hospitals, as more people preferred these hospitals to the health centres.

Since independence Zambia had gone a long way in improving its health facility. Between 1964 to 1981 the number of hospitals and health centre beds doubled and between 1964 and 1989 there was a remarkable reduction in infant mortality, which dropped from 147 per 1000 live births in 1969 to 79 per 1000 in 1990, but afterwards it rose from 108 per 1000 in 1993 due to many factors *(National Health Policies and Strategies MoH, 1992).*

The implementation of the structural adjustment plans by the government in 1991 also contributed to the lower social economic status of the Zambians. The health services and health status have suffered from a declining economy to a level where the capital of the system to deliver health services had been seriously undermined. The health infrastructure and medical equipment in the hospital deteriorated *(National Health Policies and Strategies, 1991).*

1.2 DECENTRALIZATION UNDER THE HEALTH REFORMS

In 1991 the movement for Multiparty Democracy came into power and adopted the National Health reform process which are Strategic plans for designing, constructing an affordable, effective health care system and defining the strategy

for transforming the existing health care system into a more cost effective one. The reform process involved a redefining of the Ministry of Health as the health policy-making body of Zambia and creation of the Central Board of Health as a technical unit responsible for health services and implementation of the health reforms. The health reform policy was characterized by a move from an excessively centralized system to a more effective decentralized system in which the centres provide support and national guidance. Underlying these reforms was effective building of Leadership, Accountability and Partnership at all levels in order to provide equity of access to a cost-effective quality health care as close to the family as possible. The process of decentralization was initiated in order to better provide for the health needs of the Zambian citizens.

The Ministry of Health is the executive body for the council and its role is to give advice and support to all levels. The Central Government's role includes ensuring that limited national resources are used in a way, which will produce the best outcome for the nation as a whole. The Regional Health Advisors at the Provincial level are the local representative of the Ministry and have delegated authority to District Health Boards to ensure that they are tackling key issues. All referral hospitals run as autonomous boards of management and are accountable to the Ministry of health for their overall performance. The District is the key intermediate level of health care delivery because of its closeness to the local community. The district operates within national policies and requires support from the health centre in their decision making process.

The central ministry recognizes that each district will have unique health needs and local constraints which will affect how inputs must be used to meet the real health needs of the community they serve. The districts have to adapt to the national standards based upon the nationally established packages of care, to their own situations. The Ministry of Health can more accurately define national needs for personnel, procurement, management and support, human resource development and financing. The districts therefore, are accountable for ensuring that all Zambians have access to an essential package of care *(National Strategic Health Plan, 1995-1999)*.

The National Health reform was embarked on because of the following reasons

1. Lack of equity access to quality health services to most of the Zambian people.
2. The increase of case of malnutrition, HIV/AIDS, T.B. Malaria, Sexually Transmitted Diseases and epidemics like cholera and dysentery.
3. High maternal and infant mortality rate, Demography Health Survey 1996 showed maternal deaths being 649/1000 live births.
4. Congestion in the hospitals, which necessitated for referral system in order to decongest the hospitals.
5. Lack of community participation thus introduction of the Neighbourhood Health Committees.
6. To intensify the Outreach programmes, which are integrated services. *(National Health Policies and Strategies, 1992)*

1.3 PRIMARY HEALTH CARE

The government adopted the primary health care strategy as the most appropriate vehicle for meeting the health needs of the Zambian people.
Primary Health Care was launched at a time of major economic change in the world at the International Conference on Primary Health Care held in September 1978 in Alma-Ata the capital of the Soviet Republic of Kazhakh. There was an expressed need for urgent action by all governments to protect and promote health for all the people in the world. The 134 countries that were in attendance, accepted unanimously the declaration including Zambia in particular *(Alma-Ata, 1978 WHO/UNICEF JOINT REPORT).*

Primary health care is defined as the essential health care based on practical, scientifically sound and socially accepted methods and technology made

universally accepted to individuals through their full participation and at a cost that the community and country can afford. Primary health care forms an integral part of the health system of which it is the nucleus of the social and economic development of the country *(WHO/UNICEF JOINT REPORT, 1978).* Primary health care in Zambia is action-oriented focused on promotive, preventive and rehabilitative efforts within and outside the health sector. Primary health care does not merely mean accessibility to health services but people participation in their quality of life and gaining power to master their affairs for health improvements *(National Health Policies and Strategies, 1991).*

The operational principles underpinning the concept of primary health care strategy are:

1. Individual, family and community self-reliance and participation.
2. Equity of distribution of health care services which should be affordable, acceptable and available to the people throughout the country.
3. Preventive focus with emphasis on promotive and preventive health services because it is cheaper to prevent than to cure.
4. Appropriate Technology referring to the development and use of low cost health services acceptable by the community.
5. Inter-sectoral Collaboration which refers to health ministry working together with other sectors such as Ministry of Agriculture, Education, International Non Governmental Organisational and others in the health promotion activities. *(National Health Policies and Strategies, 1991)*

1.3.1 COMPONENTS OF PRIMARY HEALTH CARE

1. Provision of safe water supply and basic sanitation.
2. Health education concerning prevailing health problems, methods of prevention and controlling them.
3. Maternal and child health services.
4. Family planning.

5. Immunisation against major infectious diseases.
6. Prevention and control of locally endemic diseases.
7. Promotion of mental health.
8. Appropriate treatment of common diseases and injuries.
9. Provision of essential drug.

1.3.2 HEALTH VISION

The government of Zambia is committed to the fundamental and humane principle in the development of the health care system to provide Zambians with equity of access to cost effective quality health care as close to the family as possible. This means provision of better management for quality health care for individuals, the family and the community.

1.3.3 HEALTH GOALS

1. To achieve equity in health opportunities.
2. To increase life expectancy of Zambians.
3. To create environments which support health.
4. To encourage life styles which support health.
5. To provide quality assured health services.
6. To promote public policies that support health.
7. To improve individuals and family health through efficiently administered population control activities.

1.4 PARTNERSHIP WITH THE COMMUNITY

Partnership in health refers to a positive relationship between all stakeholders who come in contact with health service delivery to achieve set objectives and to make improvements in the provision and sustainability of health services *(Integrated Technical Guidelines for Frontline Health Workers, CboH., 2002).*

Community outreach activities and most public health services were not part of the government-financing package of care as they were only funded through special funding projects. In the past and to a large extent even now community

level work supported by health workers was characterized by outreach program. Professionally trained health workers would go into the communities to provide specific services such as immunisations, education and home-based care. The outreach paradigm sees the community as a recipient of the services provided, then wait for the next outreach activity *(National Strategic Plans, 1995-1999).*

Community based health care represents a major component of the Central Board of Health Vision for improvement of health in Zambia. Under the Health Reforms a new approach for the community level work is being implemented called ***'Community Empowerment'*** rather than out-reach. Under the new title the community is viewed as being capable of being an active participant in analysing problems, identifying and prioritising solutions, implementing health interventions and evaluation progress. Under ***'Community Empowerment'*** the health centre staff work hand-in-hand with communities in the catchment area to organise, establish, train Neighbourhood Health Committees, develop and implement joint health centre-community work plans. These work plans provide information to the health centre for the annual health centre-district planning and budgeting cycle by identifying specific community determined priority needs *(Integrated guidelines for frontline health workers, CboH., 1997).*

1.5 THE NEIGHBOURHOOD HEALTH COMMITTEES (NHCs)

The concept of Neighbourhood Health Committee is not a new one, having existed earlier in various forms and called either Village Health Committee or Neighbourhood Health Committee. Partly because of the history, it is the one committee that is wide spread and it operates at the grassroots level therefore impinges directly on the health status of the individual member of the community. Its mission statement is "***to promote and contribute an increased sense of ownership and responsibility by the community for the health services and care in the neighbourhood to improve their own health status.***"*(Sumaili, F. and Milimo, T., 1996)*

The government of the republic of Zambia realised the great need for communities to be involved in the prevention of illness and delivery of health care. Therefore they established the Neighbourhood Health Committees through an Act of Parliament.

1.6 M.O.H. GUIDELINES, ROLES AND FUNCTIONS FOR NHCs, 1995.

MISSION STATEMENT

"To provide and contribute an increased sense of ownership and responsibility by the community for the health services and care in the neighbourhood to improve their own health status."

ESTABLISHMENT: The District Health Board is to facilitate the process of establishing the Neighbourhood Health Committee.

COMPOSITION: The Neighbourhood Health Committee will consist of not less than five members and not more than fifteen members. Among whom should be headmen, religious leaders, traditional healers, schoolteachers, extension workers, women leaders and any other member from the community.

RESPONSIBILITY: Community and Health Centre

PROCEEDINGS: Meetings on monthly basis, minutes to be taken and forwarded to Health Centre Committee.

Chairman, secretary and treasurer have to be identified by the members of the committee.

FUNCTIONS

1. Identify community needs and integrate these into health centre action plan.
2. To be the linkage between community and health centre staff.
3. To initiate and participate actively in health related activities at household and community level.
4. Develop mechanism for sustainability for community based health care workers.

5. Initiate and strengthen all local development initiative with other sectors such as Education, Agriculture, housing, social welfare etc.
6. Identify training needs for and support community based health care volunteers (CBDs and TBAs).
7. Collect relevant community based data.
8. Implement community based diseases control programmes like malaria.
9. Mobilize and accountability of local resources.

An essential channel of the delivery of the health care is the Neighbourhood Health Committee who assist the community to identify health problems. The Neighbourhood Health Committees (NHCs) are Community-Based support groups that are formed by the community with the help of the health workers to identify leaders in the communities who are concerned about their community *(A booklet for neighbourhood health committees, CBoH undated).* The basic objective of the NHCs is to play an advocacy role in disease prevention and control through increased community participation in health care management and delivery system *(NKC Ltd and GLM Inc., 2001).*

The NHCs are involved in a variety of activities in environmental health promotion. These activities include reporting to health centres concerning outbreaks of diseases, undertaking sensitisation campaigns on good hygiene practices, and sanitation in the community. (Table 1.1, page 10) The same information is also reported to the DHMTs on the status of the community by the health centre staff so as to find solutions concerning any problems that the community may face. The NHCs undertake their functions through specialized sub-committees formed to deal with specific challenges.

TABLE 1:1 HEALTH CARE ACTIVITIES PROMOTED BY THE NEIGHBOURHOOD HEALTH COMMITTEES

SAFE MOTHERHOOD AND FAMILY PLANNING	Promote health education on care during pregnancy and childbirth. Encourage women in danger during pregnancy to go to the clinic. Form mother support groups for promotion of health. Promote family planning services. Encourage use of traditional birth attendance.
CHILD HEALTH AND NUTRITION	Promote health education on nutrition, immunisation and growth monitoring. Promote child-to-child programmes for health promotion. Organise community-based growth monitoring promotion. Encourage early treatment of illness. Support community-based immunisations/vaccination programmes.
MALARIA	Promote health education on prevention of malaria. Kill mosquitoes. Destroy places where mosquitoes lay eggs. Promote use of insecticide-treated mosquito nets. Encourage early treatment for fevers.
WATER AND SANITATION	Promote health and education on safe water and clean surroundings. Promote water treatment. Dig, build and use protected wells pit latrines and rubbish pits.
TUBERCULOSIS (TB)	Promote health education on tuberculosis. Find TB patients who stopped taking treatment and their families. Support home-based care. Encourage family of TB patients to help and observe patient taking medicines.
HIV/AIDS AND STDs	Promote health education on HIV and AIDS. Encourage counselling for people living with AIDS. Promote condom use in the community. Support home-based care.

Source: Health care within the community: A booklet for neighbourhood health committees CBoH (Undated).

1.7 STATEMENT OF THE PROBLEM

As part of the health reform program Zambia began to promote community involvement to bring essential health care as close to the family as possible. It is states that 50% of the Zambians are not within normal walking distance of a clinic. Therefore, the Neighbourhood Health Committees were created to be a link between the clinic and the communities. Approximately 300,000 NHCs, countrywide need to be strengthened to be health promoters and community mobilisers *(Radio show concept paper, (ZIHP)., 2002).*

The Government of Zambia through the Ministry of health, the Central Board of Health (CBoH), Provincial Health Office, District Health Management Office (DHMT) and the Health centres set up the structure of the Neighbourhood Health Committees within the health system. This was made possible through the partnership with the Non Governmental Organisation, Churches and the Community. The Non Governmental Organisations play a pivotal role in supplementing the Government efforts to realise the health vision. For example the Zambia Integrated Health Program (ZIHP) strengthens the effectiveness of the NHCs through strengthening the health care system at various levels.

ZIHP collaborates with the CBoH by controlling the financing scheme meant for the community health projects by ensuring that such funds are directed for the intended purpose of strengthening the work of the NHCs. At the Provincial Health Office, sensitisation workshops are held with the staff to familiarize them with the objectives of the CBoH in terms of the NHC functions. The Provincial Health Office therefore, as an important conduit can source for financial assistance to support the work of the NHCs in various DHMTs.

The Government has shown its commitment to the work of the NHCs by providing 10% of the total grant received by the DHMTs for community projects. ZIHP also ensures that the DHMTs utilize the percentage for

community-based projects in twelve (12) districts, while other NGOs like Care International and Africare concentrate in other districts in the country. The capabilities of the DHMTs are increased to serve and respond to the needs of the hard to reach areas by ZIHP. In addition ZIHP also collaborates with CBoH to produce a model of NHC training manual to strengthen their knowledge of the 'Essential Health Care Package' and in planning community mobilisation tools with a focus on the Participatory Learning in Action (PLA) methodology.

ZIHP has also engaged a distance radio programme meant to provide emotional support to the NHCs dealing with health promotion and community mobilisation techniques in various NHCs within the country. DHMTs are encouraged to identify and support effective NHCs and encourage peer education with ineffective NHCs.

The world Health Organisation (WHO) and United Nation Children's Funds (UNICEF) compliments the efforts of the NHCs by facilitating procurement of resources and provision of expertise to support agreed upon programs. Churches Medical Association of Zambia (CMAZ) compliments the efforts of the Ministry of Health in providing health services. CMAZ offers technical and supervisory advise to individual Organisations to strengthen the NHCs in Zambia such as World Vision International. Many mission hospitals are sub-contracted at district level to strengthen the work of the NHCs. The community also supplements the efforts of the government by offering support to the NHCs by complying with health promotive projects within the community by providing or mobilizing resources.

Despite the Government putting up measures to ensure that the NHCs are formed and collaborating with the NGOs to train and strengthen the NHC function. The disease burden in the communities has not been reduced for example in Kasama district, which this study focuses on.
Table 2: 1 on page 13 shows a steady rise in the disease burden up to the year 2001.

TABLE 1:2 KASAMA DISEASE SUMMARY ALL QUARTERS

DISEASE	1999	2000	2001
Malaria	36 552	46 418	60 990
Diarrhoea non-blood	4 696	6 986	9 049
Pneumonia	2 898	5 594	9 924
Non Pneumonia Respiratory infection	13 647	13 413	16 293
Eye Infection	3 834	5 917	6 587
Skin Infection	2 365	2 506	2 902
AIDs	146	267	317
Malnutrition	742	1 158	1 457
Anaemia	1 567	2 508	3 764
TB suspected & confirmed	262	256	465
Sexually Transmitted Diseases	912	1 147	1 362

Source: Kasama provincial health office.

This information implies that there is a discrepancy between the ideal and the reality in terms of achieving the health vision of bringing health care as close to the family as possible. This increase in the incidence rate implies that the community is not complying to the promotive and preventive health care in order to reduce the incidence. This scenario indirectly impinges on the functions and roles of the Neighbourhood Health Committees as they are expected to give promotive and preventive health education so as to reduce the above mentioned diseases. This also could otherwise mean that the functions of the NHCs are not adequately being implemented to bring a positive change in terms of the number of cases. There are several factors that are likely to influence the community's perception of NHC role. Some of the examples of such factors could be: -

Social Cultural Factors: This factor may affect the community's perception in several ways. If the community has confidence in the treatment offered to them by the traditional healers, they might hold the traditional healers in high esteem than the NHCs. This may negatively impact the perception of the community towards the NHCs in that they may readily accept information or assistance given to them by the traditional healer than NHCs. As a result the community may not easily accept health information offered to them by the NHCs.

Inadequate Knowledge: The community may not have adequate knowledge on the existence and activities of the NHCs. This may affect their attitude towards the NHCs, as the community may not readily accept them. This may result in the community not recognising the NHCs as a result fail to support the NHCs.

Lack of clear policies on economic support for the NHCs: The NHCs may constantly demand for support from the community for the service they offer. However, the community may be unable to meet their demands due to economic constraints. As a result the community may have negative attitudes towards them, which may also impinge on the functions of the NHCs. Therefore there is need for the government to formulate clear policies on economic support for the NHCs considering the poor social economic status of the community.

Political Interference: Due to the multiparty politics the country adopted, in some communities the ruling party may be stronger than the other parties. This may result in a situation where the ruling party may support health programs in the areas of their strongholds than the other parties. As a result this may have an adverse effect on the functions of the NHCs as they may fail to carry out their work especially in areas where they are dormant. The community therefore may view the NHCs as being ineffective there by losing confidence in them.

Health related factors: The health workers may not inform the community concerning the functions and significance of the NHCs. This may lead the community to lack confidence and have misconceptions about the NHCs due to lack of knowledge.

Attitude of the NHCs towards the community: The NHCs may forcefully compel the community to comply with their functions, which may cause misunderstanding and negativism of the community. Eventually this may have an adverse effect on the work of the NHCs due to lack of compromise with the community.

Social Economic factors: Most of the people in the community are poor and cannot afford to pay for the services offered by the NHCs. Hence they may not utilise the services and develop a negative attitude towards the NHCs. As a result there may be friction between the NHCs and the community.

Lack of well-defined roles between the Community Based Organisations and NHCs: There may be conflicts between the CBOs and NHCs which may negatively affect the work of the NHCs due to lack of well defined roles by the relevant authorities. Therefore the community may view the NHCs as a non-working committee and then lose confidence in them.

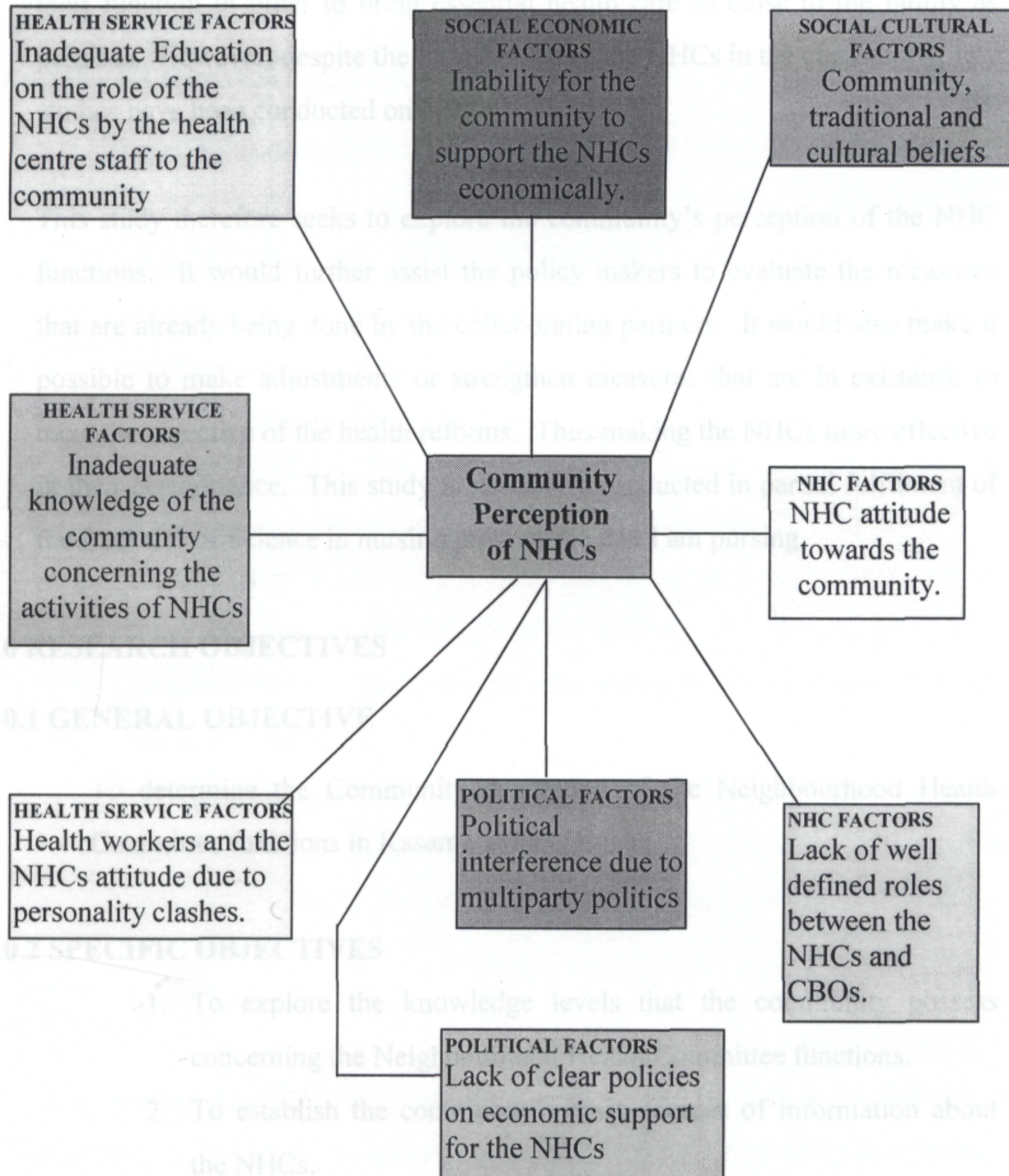
Attitude of the health workers towards the NHCs: The NHCs may have personality clashes towards the health workers as a result this may lead to lack of cooperation to achieve the goals. This can lead to negative effects towards the functions of the NHCs, which also leads to negative perception of the community towards them.

This study therefore seeks to find out through the perception of the community towards the NHCs the factors that would be indirectly related to the functions of the NHCs, which ultimately lead to the rise in the disease burden as in the Kasama case. This study also seeks to explore the reasons why this gap in the disease pattern seems to be widening inspite of having NHCs in place. The study further seeks to assist in making recommendations to policy makers, who will focus on further development of effective and feasible promotive interventions. To increase and facilitate the functions of the NHCs in the

communities in order for the health vision to be a reality as expected by the health reforms.

1.8 DIAGRAM OF PROBLEM ANALYSIS

FIGURE 1.1 DIAGRAM OF PROBLEM ANALYSIS



1.9 JUSTIFICATION

This study would be relevant to policy makers, health care providers and the community at large because they would acquire information concerning the obstacles that the NHCs face in the delivery of the healthcare activities in order to have a health community. As mentioned earlier in the background information the reason why the government introduced the NHCs was to reduce the burden of diseases through teaching the community on disease prevention as their function in order to bring essential health care as close to the family as possible. However, despite the introduction of the NHCs in the community, few studies have been conducted on NHCs.

This study therefore seeks to explore the community's perception of the NHC functions. It would further assist the policy makers to evaluate the measures that are already being done by the collaborating partners. It would also make it possible to make adjustments or strengthen measures that are in existence to meet the objective of the health reforms. Thus making the NHCs more effective in their performance. This study is also being conducted in partial fulfilment of the Bachelor of Science in nursing programme that I am pursing.

1.10 RESEARCH OBJECTIVES

1.10.1 GENERAL OBJECTIVE

To determine the Community perception of the Neighbourhood Health Committee functions in Kasama Urban District.

1.10.2 SPECIFIC OBJECTIVES

1. To explore the knowledge levels that the community possess concerning the Neighbourhood Health Committee functions.
2. To establish the community's main sources of information about the NHCs.
3. To identify activities of the NHCs in the community.
4. To identify the support rendered by the community to the NHCs.
5. To determine the community's attitudes towards the NHCs.

6. To identify factors influencing the community's attitudes towards the NHCs.
7. To make recommendations to relevant authorities.

1.11 HYPOTHESIS

The higher the knowledge the community has on the NHC functions, the more positive their perception would be towards the NHCs.

1.12 OPERATIONAL DEFINITION OF TERMS

The definitions below are solely used in this research study and not for any other purpose-:

1. **PERCEPTION OF THE COMMUNITY:** This refers to how the community/respondents understand functions of the NHCs. That being explicit and convincing (positive) or not helpful (negative) in terms of how they relate to the community.
2. **KNOWLEDGE:** This refers to the information acquired by the community to understand who the NHCs are and their functions.
3. **ATTITUDE:** This refers to the opinion or way of thinking that the community has towards the role of the NHCs.
4. **COMMUNITY:** These are the respondents in the community who are heads of households.
5. **NEIGHBOURHOOD HEALTH COMMITTEES:** These are the community based support groups formed by the community with the help of health workers to over see the health related issues in the community.

1.13 VARIABLES

The **independent** variable is the variable that causes changes in the **dependent** variable. In this study the **independent** variable is the **community perception.** The **dependent** variable is that variable which is influenced by the **independent** variable. In this study the **dependent** variable is **knowledge** and **attitude.**

INDEPENDENT VARIABLE

Perception

DEPENDENT VARIABLE

Knowledge

Attitude

The variables and cut-off points for this study are indicated in Table 1.3 below.

1.14 VARIABLES AND CUT-OFF POINTS

TABLE 1:3 VARIABLES AND CUT-OFF POINTS

VARIABLE	CUT OFF POINT	INDICATOR	QUESTION No
KNOWLEDGE	Inadequate knowledge	Responses with scores between 0-5	13 14 16 17 18
	Adequate knowledge	Responses to questions with scores between 6-10	13 14 16 17 18
ATTITUDE	Negative	Responses with scores between 0-5	21 23 28 30 37
	Positive	Responses with scores between 6-10	21 23 28 30 37

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review is a critical summary of research on a topic of interest, often prepared to put a problem in context or as the basis for an implementation project *(Polit, F.D. and Hungler, P.B., 1997).* Literature review provides the reader with background knowledge of similarities and differences between the present study and the prior research. It also helps the researcher to identify gaps in knowledge as well as weaknesses in previous studies including discovering connections and relations between different research results *(Bless, C. and Achola, P., 1988).*

The literature review discussed in this chapter is in relation to the research problem identified in the study namely ***'The community perception towards the Neighbourhood Health Committee functions in Kasama Urban District'.*** Perception is about the relationship between knowledge and people's attitudes. It is important to consider people's perceptions because they strongly influence their actions whether they are right or wrong *(World Health Organisation, Geneva, 1999).* Many countries in the world following the Alma-Ata declaration of 1978 are practicing the concept of Neighbourhood Health Committees (NHCs) in their health services.

The NHCs were created to be a link between the clinics and the communities *(ZIHP, NHC Radio Show Concept Paper, 2002).*
There are no studies done on **community perception** towards the Neighbourhood Health Committee functions.

The literature review in this study has been arranged according to three major headings namely **Global, Regional** and the **Local situation**.

2.2 GLOBAL LITERATURE ON PERCEPTION OF NHCs

The health system of developed countries like the United States, Great Britain and Canada have reformed their health system and tried to involve communities in various governance structures. However, there have been few published articles documenting their experiences.

A case study carried out on **Community Involvement in Hospital Boards,** revealed that in Great Britain the Community Health Councils were introduced in 1974. These bodies are composed of people nominated from local authorities, voluntary organisations, and the regional health authority (RHA). An additional mechanism for community involvement, the British National Health System (NHS) that allows individuals to participate in the governance of health services through several structures was also introduced. The NHS Boards are comprised of an executive and part-time non-executive board members from the community. They have several responsibilities including presenting annual reports to the Ministry of Health, prepare long term strategic plans, overseeing the delivery of health services, monitoring performance against objectives, providing financial stewardship and ensuring high standards of behaviour, appointing appraising and remunerating senior executives, ensuring dialogue between the organisations and community. Great Britain has developed a series of sophisticated orientation manuals and guidebooks to educate the public about their role in the health system in general and on NHS Boards specifically. Despite government's clearly stated aims, structures and guidelines. Some researchers believe that community participation is insufficient within the NHS and subject to party political manipulation because of the lack of local accountability. Another study found that NHS Boards have few blacks or ethnic minority non-executive members making it very difficult for Board members to address the needs of the communities because they do not understand. Further criticism suggests that Boards are dominated by professionals and are not clear about their roles. As a result, NHS Boards manage hospitals effectively, but are not accountable to local needs. Britain may have achieved management efficiency through their NHS Boards. However, it is clear that they have not

effectively engaged communities and particularly disadvantaged communities in this process *(Boomberg, J., 1996).*

This study shows that Britain also involves the concept of the Neighbourhood Health Committees who are the same as the Community Health Councils. According to this study, though there is community participation it has not been effective because of denying the participation of the disadvantaged communities.

According to the Citizen's handbook, **A Guide to building Community in Vancouver,** Vancouver has created Neighbourhood Integrated Service Teams in response to the call for more efficient and effective services. Their goal is to bring City services closer to the community level so that City workers from many departments can deal with local issues in collaboration with local residents. A multi-departmental service teams were created for each of the 15 different areas of the City. Each team is responsible for working with the community to identify and resolve local issues. The Vancouver/Richmond Health Board is made up of volunteer community members, government appointees, elected representatives from groups such as school boards, city council, and Community Health Committees (CHCs). The CHCs identify community health needs and priories. Vancouver Community Health Planning Groups have been meetings across Vancouver since 1993. Their task has been to inform their community about health care reform and to involve as many people as possible in discussions around health planning at the local level *(Vancouver Programs, March 2002).*

A case study from Bangladesh on ingestion of water pollution carried out in Orissa, India on **performance of Village Health Committees** revealed several findings in the different villages. In Buxibari village, regular meetings were held with the committee around health issues and collection of instalment payments for bed nets. Community appreciated the committee's work in mobilising families for bed nets.

In Tentlaposi village, the committee held few meetings as a result there was no significant activity and the community was indifferent to the committee.

In Kalathigaon village the committee held monthly meetings to discuss preventive health issues. Each member visited twenty (20) households to disseminate information on environmental sanitation and no diarrhoea was reported for three years. They also put pressure on Government for provision of safe drinking water.
In Bhalukuma village, a women's Village Development Committee organised women and held monthly meeting to discuss health promotion issues including economic empowerment through income generation. Village youth clubs also supported the committee. The work was appreciated by the village men *(Peppin, in Ahmed, S.A. et al., 1998).*

A study done on the **Community Development process in Langs farm village in Cambridge City** began in 1978 revealed that involvement of the Neighbourhood helped to resolve and restore a sense of belonging. The ability to work in partnership and creation of two Neighbourhoods resulted in the social net works. This also helped to reduce the negative stigma associated with the target areas and eliminate the perception of services for the rich and the poor. Another benefit is the ability to work in partnership with other systems. The Neighbourhood has a strong collaborative planning and programme with other service providers such as the City of Cambridge, the Community Health Department and Community Development Association. For example the teens in the Neighbourhood developed a different perception of the Waterlool Regional police through their involvement in joint sport activity, the police recognised the work was effective to meet the objective of the community based police *(Cambridge Neighbourhood Organisation, 1996).*

2.3 REGIONAL LITERATURE ON PERCEPTION OF NHCs

A study done to evaluate the client's view point on the **impact of a 6-year programme on community based rehabilitation in Mashonaland, Zimbabwe** revealed that 61% of community members rated the rehabilitation process as very good, 10% rated it as fair and 20% rated it as poor. Suggestions

from the community for improvement of the service aimed at more information, training for family members, Village Community Workers (VCW) and support for income generating projects to make clients economically independent *(Health Systems Research for Development HRS, Newsletter/Journal., 1998).*
The Village Community Workers (VCW) in this research could have similar functions to that of the Neighbourhood Health Committees in the Zambian situation.

A case study was conducted a new district hospital built in Khayelitsha (south Africa). The aim of the study was to assess community involvement in the hospital activities. The case study revealed that there was a power struggle-taking place within communities, especially in an area where employment give a tremendous influence and had greater than 50% control over job selection. The Hospital Boards were viewed as powerful institutions where inevitable battles could occur as the community sought to be represented *(Boomberg, J., 1996).*

In Dolisie, a city in southern part of Congo Brazzavile, which suffered greatly recent conflicts, eighty-four (84) Community Volunteers were involved in Information Education Communication (IEC) on disease prevention, sanitation and hygiene throughout the city. The Red Cross Movement's achievements include repair to the water supply system and the reopening of several health facilities. In June 2001, nine teams of volunteers worked in nine areas to improve water supplies including many hours dedicated to cleaning and improving wells and instructing populations on the dangers of contaminated water. The water resource office and the Mayor was pleased with this action and they pledged their support by providing supplies and water chemicals for the improved 257 wells *(Reported by Makaya-Jean. Sec. Gen. Dolisie Branch. Congo., July 2001).*

In Burundi, Red Cross recruited a team of 279 volunteers and trained them to give people basic health information on immunisation, sexually transmitted diseases, HIV, nutrition and diarrhoea diseases. The volunteers also gathered information about the general state of health and hygiene, referring the needy

cases to the nearest medical facilities, assisting with spraying insecticides and distribution of impregnated mosquito nets to combat malaria. This programme was done by the Red Cross throughout Africa *(Reported by Landiech, F. French Red Cross., January 2001).* The two reports illustrate responsibilities that the volunteers do which are similar to the functions of the Neighbourhood Health Committees.

2.4 ZAMBIA'S LITERATURE ON PERCEPTION OF THE NHCs

According to the study carried out on the **community involvement in hospitals,** states that in the 1990's the Zambian government put forward a wide range of proposals to reform the health care services and decentralise the health administration. It was believed that these governance changes would increase the influence of communities and individuals. Unfortunately because these reforms were recently implemented, it was difficult to evaluate their effectiveness and to measure their impact on community involvement in the health care system *(Boomberg, J., 1996).*

In a study done in the Eastern, Copperbelt, Northern and Western provinces to assess the **Impact of the Community participation in the Zambian Health Reforms**. It was found that communities did not understand the health reforms and they perceived the reforms as the government's way of asking the communities to run the services because it had no money to run the services. Concerning the NHCs the study revealed that the community supported NHCs whom they had democratically selected and this was applicable to Western province and Northern provinces. On the contrary on the Copperbelt province the NHCs were closer to the health centre Staff than to the people they represented *(Ngulube, T.G., 1998).*

In another study on **Analysis of community based structure and community involvement in health care planning and delivery in Zambia,** Implications for Accessing Health Care. The findings were that NHCs were widely known in the study communities but were perceived to have been initiated by health

institutions and not the community *(CBoH, 2001)*. The two studies support the fact that NHCs are known and supported by communities.

In a study done in Lundazi to determine **factors contributing to low participation of NHCs in solving health problems.** It revealed that 85% of respondents did not know the existence of the NHCs and that NHCs were not holding meetings with the community. Apart from that Health Centre Staff were not visiting the NHCs *(Mkandawire, H., 2000).*

A study conducted by Rosemary Likwa, in selected Districts to **Assess the Performance of the NHCs** revealed some of the contributing factors to ineffective performance of the NHCs included the following:

1. Inadequate utilisation of NHC members by the community because of community's negative perception of NHCs.
2. Poor selection criteria of NHC members.
3. Inadequate knowledge on the roles and functions of NHCs by NHC members, the community and the health workers.
4. Lack of appropriate communication channels for dissemination of health information to the community and vice versa to the district health office. Some respondents stated that by the time information reached the community, it would have already been diluted, if not stale.
5. Lack of moral and technical support by the health workers to the NHCs and the communities. Some community members mentioned that health workers only visited the community to immunise children.
6. Lack of adequate resources to manage NHCs and related community initiatives.

According to the researcher, health workers at both health centre level and district health office were not rendering comprehensive community health service support. This consequently led to poor community participation. According to data, it showed that community participation in Zambia was low. It was between 6% and 10% in comparison to countries like Kenya, Tanzania, Zimbabwe and Nepal *(Health Reform News., October 1998).*

2.5 CONCLUSION

The literature review shows that many countries are practicing the concept of the neighbourhood widely. However, it seems to show that the functions of the NHCs still need to be strengthened in order for the communities to benefit from their services. It also indicates that the functions hinge on the fact that there is need for community involvement in order for the NHCs to be successful.

CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

A research methodology is the study of collecting research data *(Treece, E.W. and Treece, J.W., 1986)*. It provides the researcher the mode or method of carrying out the study. The purpose of the study was to ***determine the community perception of the Neighbourhood Health Committee functions in Kasama Urban District.***

3.2 RESEARCH DESIGN

A research design is the researcher's overall plan for answering questions being studied and how to handle some of the difficulties encountered during the research process *(Polit, D.F. and Hungler, B.P., 1995)*. The design keeps the researcher headed in the right direction as it provides guideposts as well as assisting the researcher answer rightly to the research questions or solutions to the research problems encountered. For the purpose of this study a non-Interventional descriptive study was used to obtain information from the community as the most appropriate method.

A descriptive survey is a method of collecting data from subjects in order to obtain new information *(Sweeney, L. et al., 1981)*. Surveys are useful to obtain demographic data, information about people's behaviour, their intentions, future behaviour, beliefs, attitudes, opinions and interests. It also enables the respondents to provide information from the self-report in their natural setting relationships *(Treece, E.W. and Treece, J.W., 1986)*. A descriptive cross-sectional survey enabled the researcher to obtain a descriptive account of the situation at one point in time and to provide baseline data for further research.

However, there are some limitations in that a descriptive survey is not aimed at discovering the cause of the phenomenon. The survey approach offers little

control over extraneous variables since the researcher is not necessarily working with a single independent variable. Another limitation is that the researcher may find that verbal responses are unreliable because people often do not express their true reactions to the questions *(Treece, E.W. and Treece, J.W., 1986).*

3.3 RESEARCH SETTING

A setting is a physical location and conditions in which data collection takes place in a study *(Polit, D.F. and Hungler, B.P., 1997).* This study was conducted in Kasama, the provincial headquarters for the Northern province. It is 850km to the north of Lusaka the Capital City of Zambia and is located between 8^0 and 12^0 south of the equator. Kasama is estimated to have a geographical area of 10 550 square kilometres and the whole district is a medium land which is 1 384 metres above sea level *(Kasama District Health Board Action Plan, 1999).* The total population is 179 436 *(Central Statistics Office Preliminary report., 2000).*

The majority of the population (75%) live in the rural areas while a small proportion (25%) live in the township and its surrounding peri-urban areas. The social economic status of the population is low as few people practice commercial farming, while the rest of the farmers are involved in subsistence farming. Many people living in the urban and peri-urban are in formal employment and private business. The district has five (5) high schools, twenty-three (23) upper basic, thirty-four (34) middle basic, six (6) lower basic, four (4) private schools, six (6) community schools and the total being seventy-eight (78). Kasama District has a total of twenty-one (21) health facilities, which provides preventive, curative and promotive health services with the help of the Neighbourhood health Committees (See Table 3.1 page 30). Among these four (4) health centres are in Kasama Urban District namely Kasama Urban Clinic, Lukashya health Centre, Location Urban Clinic and Tanzania Zambia Railway Clinic (TAZARA) *(Kasama District Health Board Action Plan, 1999).*

TABLE 3:1 KASAMA DISTRICT HEALTH VITAL STATISTICS 2002

No	Name of Health facility	Distance from district	Location	Population	No of NHCs	Social activity
1	Chiombo	65km	West	5 142	8	Agriculture
2	Chilongoshi	50km	West	3 443	4	Agriculture
3	Chilubula	35km	West	16 834	7	Agriculture
4	Kateshi	34km	North	5 198	9	Coffee Growing
5	Kasakula	30km	West	4 017	9	Agriculture
6	Kasama Urban	00km	Central	34 741	9	Urban Activity
7	Location	02km	Township	28 629	13	Urban Activity
8	Lubushi	91km	West	4 764	8	Agriculture
9	Lukashya	05km	Township	8 117	5	Urban Activity
10	Lukupa	10km	North	15 321	13	Agriculture
11	Milima	08km	North	8 714	8	Agriculture
12	Misamfu	06km	North	5 199	7	Agriculture
13	Misengo	94km	North	4 385	5	Agriculture
14	Mulanshi	30km	East	4 372	9	Agriculture
15	Mulobola	40km	East	4 122	8	Agriculture
16	Munkonge	75km	East	4 765	8	Agriculture
17	Musa	18km	South	5 575	5	Agriculture
18	Mwamba	25km	North	5 352	7	Agriculture
19	Nkolemfumu	41km	South	11 822	8	Agriculture
20	TAZARA	08km	Township	9 260	10	Agriculture
21	Z.N.S.	45km	West	3 625	9	Agriculture
	Total			**193 497**	**169**	

Source: Kasama District Health Office

This study concentrated on the four health centres, which are, located in the Kasama Urban. It was conveniently chosen to make it possible for the researcher to collect data with minimum difficulties due to the limited time and resources. A simple random sampling technique using the rotary method was used to pick the Kasama Urban clinic and Tanzania Zambia Railways clinic (TAZARA).

Kasama Urban Clinic is currently being conducted in the Kasama General Hospital Out-Patient Department, which is located within the Kasama Township along Chawama Road. The total population under the Kasama Urban Clinic is 34 741 *(Kasama District Health Office., 2002)*. The health centre provides both curative, promotive and preventive health services. Kasama Urban clinic has a total of nine (9) Neighbourhood Health Committees in their respective areas. The NHCs act as a link between their communities and the Kasama Urban clinic by providing data concerning the health problems in the communities. The communities are divided into nine (9) Zones according to the NHCs. The communities under the Kasama Urban clinic are Kapoka, Mutale, Mambila, Nyola, Lwimbo, Central Town, Musenga, New Town and Chikumanino.

The Tanzania Zambia Railway (TAZARA) health centre is 08km from the town centre with a population of 9 260 *(Kasama District Health Office, 2000)*. It is situated along the Kasama-Mpika Road. The health centre has a total of ten (10) Neighbourhood Health Committees who also work in conjunction with the health centres to bring health care as close to the family as possible. The communities that fall under this centre include: - Chumangulu, James Shimulamba Chombela, Tibi, Kapampa, Nakapampa Chale, Tazara, Amini, Songolo, Chisanga and Chishipula. They are also divided into ten (10) Zones according to the Neighbourhood Health Committees.

3.4 STUDY POPULATION

The target population refers to the set of elements that the researcher focuses upon and to which the results obtained by testing the sample should be generalised *(Bless, C. and Achola, P., 1988).* The targeted population in this study consisted of heads of households either male or female found in the different communities falling under the four health centres in Kasama Urban *District.*

Accessible population refers to those cases that conform to the eligibility criteria and that are accessible to the researcher as a pool of subjects for the study *(Polit, D.F. and Hungler, B.P., 1997).* For this study the accessible population were the heads of the households found in the four communities falling under the Kasama Urban health Centre and TAZARA Clinic respectively. These communities were targeted because they were within the Kasama Urban District and had Neighbourhood Health Committees. It was hoped that the information that would be obtained would be representative of the Kasama Urban District in terms of the research topic of this study.

3.5 SAMPLE SELECTION

Sample selection is a process of selecting number of individuals from the delineated target population in such a way that the individuals in the sample, represents as nearly as possible, the characteristics of the entire target population *(Dempsey, P.A. and Dempsey, A.D., 2002).* The respondents included in the study were those found in the communities falling under Kasama Urban District. This was aimed to facilitate for the researcher to collect data within the minimum allocated time and resources to complete and compile the report. Thus respondents found in Kasama Rural were excluded from the study because the researcher concentrated on the sample found in the Kasama Urban District.

For the purpose of this study a multistage cluster sampling technique was chosen as the most appropriate method for data collection due to lack of