

**FACTORS HINDERING PRIMARY HEALTH CARE
DELIVERY IN CHIBOMBO DISTRICT**

BY

PENZI SHIKABI

**A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN
PARTIAL FULFILMENT OF THE REQUIREMENT OF THE DEGREE
OF MASTER OF PUBLIC ADMINISTRATION**

THE UNIVERSITY OF ZAMBIA

LUSAKA

2013

DECLARATION

I, PENZI SHIKABI, declare that this dissertation represents my own work and that it has not been previously submitted for a degree, diploma or other qualifications at this or another university.

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CERTIFICATION OF APPROVAL

This dissertation of PENZI SHIKABI has been approved as partial fulfilment of the requirement for the award of the Degree of Master of Public Administration by the University of Zambia.

NameSignature Date

Prof. J.C. Moomba ----- -----

Dr. A. M. Ng'oma ----- -----

Dr. L. W. Kaela ----- -----

ABSTARCT

The study investigated factors hindering primary health care delivery in Chibombo District.

The Zambia government adopted the primary health care model as a strategy for improving the health of its population. The aim of primary health care is to provide efficient, cost effective and quality health services as close to the community as possible. However, despite the adoption of this model, primary health care delivery in rural areas of Zambia has continued to be a challenge. According to the Zambia Demographic and Health Survey (2007), rural areas in Zambia experience high level of mortality and morbidity due to preventable and treatable diseases.

The overall objective of this of this study was to investigate the factors which impede primary health care delivery in Chibombo District. The specific objectives of the study were; to identify primary health care facilities and services provided in Chibombo District; to identify the constraints faced by primary health care facilities in Chibombo District; to investigate the barriers which people face in accessing primary health care facilities in Chibombo District and; to examine the level of community participation in primary health care in Chibombo District.

The sample size of this study was 130 respondents. These consisted of 100 households, 20 staff in charge of health facilities, 4 chairpersons of Neighbourhood Health Committees (NHCs), 3 Community Health Workers (CHWs), 2 councillors and the District Medical Officer. Both primary and secondary data were used for this research. Qualitative and quantitative data was used for the study. Qualitative data was analysed by transcribing it into the major themes which emerged. Quantitative data was analysed using Statistical Packages for Social Sciences (SPSS).

The study found out that health facilities in Chibombo District were inadequate and existing one experienced shortages of personnel, lack of equipment, stock outs of drugs and low budgetary allocation which hampered delivery of primary health care. The study found out that physical and economic barriers were major obstacles which people faced in accessing primary health care facilities and services.

The study recommends that the number of primary health care facilities in Chibombo District be increased and human resources management and administration should be strengthened to avert staff shortages in health facilities. A contingency plan for the supply of drugs and equipment to health facilities should be developed. Budgetary allocation to health facilities should be increased as well as scaling up on community health system strengthening.

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To ChimukaBeenzuShikabi

ACKNOWLEDGEMENTS

I would like to thank all the people and organisations who rendered their support to me during the preparation of this dissertation. I am indebted to my supervisor Dr.Mulenga C. Bwalya for his inspiration and guidance. My gratitude also goes to all members of the Department of Political and Administrative Studies at the University of Zambia for their intellectual guidance. I am also grateful to Chibombo District Health Management Team, Neighbourhood Health Committees, key informants and all households which participated in this study. Finally, I acknowledge the University of Zambia for awarding me a Staff Development Fellowship and for funding this research.

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LIST OF ABBREVIATIONS AND ACRONYMS

ADCs	Area Development Committees
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AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
BHCP	Basic Health Care Package
BP	Blood Pressure
CDCC	Constituency Development Coordinating Committee
CDE	Classified Daily Employees
CDF	Constituency Development Fund
CDHMT	Chibombo District Health Management Team
CDMO	Chibombo District Medical Office
CHAZ	Churches Health Association of Zambia
CHWs	Community Health Workers
CMR	Child Mortality Rate
CP	Cooperating Partners
CSO	Central Statistical Office
DAPP	Danish Aid from People to People
DHMT	District Health Management Team
DMO	District Medical Office
DOTs	Direct Observation Treatment
DSA	District Situational Analysis

EHT Environmental Health Technician

FDGs Focus Group Discussions

GRZ Government of the Republic of Zambia

HCCs Health Centre Committees

HIMS Health Information Management System

HIV Human Immunodeficiency Virus

IEC Information Education and Communication

ITMN Insecticide Treated Mosquito Nets

MMR Maternal Mortality Rate

MoH Ministry of Health

NGOs Non-Governmental Organisations

NHC Neighbourhood Health Committee

ORT Oral Rehydration Treatment

PMTCT Prevention of Mother to Child Transmission

RDT Rapid Diagnostic Test

SFH Society for Family Health

STIs Sexually Transmitted Infections

VCT Voluntary Counselling and Testing

WDC Ward Development Committee

WHO World Health Organisation

ZEM Zambia Enrolled Midwife

CHAPTER ONE

INTRODUCTION

Background

The Zambian government adopted the primary health care model as a strategy for improving the health of its population. Primary health care is a term used to refer to activities of health care providers who act as the first point of consultation for all patients. These include health care clinicians who may be physicians, nurses or various other workers trained for purposes of providing health care and are based in communities as opposed to hospitals. The World Health Organization (2008) estimates that 75% to 85% of the world population seeks care at primary health care level yearly. Primary health care provides both initial and majority health care services of a person or population, this is in contrast with tertiary health care which is consultative, short term and disease oriented for the purposes of assisting the primary health care providers in developing countries. Conversely, tertiary care is reserved for patients with unusual illnesses requiring specialised care.

The objective of primary health care is to provide efficient, cost effective and quality health care services as close to the community as possible. Primary health care tracks the most common diseases of a country, provides a system of referral for serious cases, promotes health and prevents patients' diseases where possible. While there are many definitions of primary health care, the principles of accessible, affordable, quality, continuous and coordinated care in the context of family and community are consistent. Effective primary health care encompasses preventive programs, curative services and health education.

According to the Government of the Republic of Zambia (2010), there are disparities which exist in primary health care delivery in Zambia between rural and urban areas. It is estimated that 90% of households in urban areas live within 5 kilometers to the nearest health facility compared to 50% in rural areas. The

shortage of health personnel in rural areas is more critical than in urban areas with most rural health facilities operating with 45% of the required staff establishment as compared to urban health facilities which operate with about 55% of the required staff establishment. Furthermore, most private health care providers in Zambia are mainly concentrated in urban areas and along the line of rail.

To enhance the delivery of primary health care, the Zambian government has over the years instituted various health reforms and has been periodically revising the National Health Policy. Primary health care in Zambia currently focuses on child health, maternal health, control and management of communicable diseases, malaria, tuberculosis, Sexually Transmitted Infections (STIs), Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDs), mental health, control and management of non communicable diseases, epidemic and disaster prevention, preparedness and response, school health and oral health (Ibid). To foster primary health care delivery in Zambia, especially in rural areas, various interventions have been put in place such as setting up health posts, rural health centers, training of traditional birth attendants, training of community health workers, establishment of safe motherhood groups and neighborhood health committees.

However, there has not been a significant improvement in the health of the Zambian population. Overall mortality rates are high and life expectancy has dropped. There has been an increasing toll from the spread of the HIV/AIDS epidemic in Zambia which accounts for more than 40% of deaths. The major health problems facing Zambia include diarrheal diseases, malaria, acute respiratory infections, HIV/AIDS, tuberculosis and malnutrition. According to the Zambia Demographic and Health Survey (2007), Neo-natal Mortality is currently 34 per 1000 live births, Child Mortality is 70 per 1000 live births and HIV/AIDS prevalence is 14.3%. Malaria accounts for 50,000 deaths and there are 4,000,000 clinical cases every year. There are 545 cases of tuberculosis per 100,000 population. Malnutrition is estimated at 48% among children below 5 years and

Maternal Mortality Rate (MMR) is 591 per 100,000 live births. In rural areas, health statistics show a grimmer picture of the health situation than in urban areas.

The United Nations Development Programme (2011), states that many deaths in Zambia could be prevented if there was an effective primary health care system. It estimates that 99% coverage of interventions currently available and for which there is sufficient evidence can prevent a large proportion of death. More than 65% of deaths due to pneumonia can be prevented, moreover 38% of deaths due to neo – natal complications, 89% of deaths due to malaria and 88% of deaths from diarrhea can all be prevented. It is further estimated that a total of about 51,286 deaths of children below 5 years can be prevented each year in Zambia, 20,363 due to malaria, 13,939 due to diarrhea, 10,296 due to pneumonia and 6, 688 due to neo-natal complications. For Zambia, 51, 286 preventable deaths per year would translate into 58% of the total number of deaths among children below 5 years being averted. This indicates the majority of child deaths in Zambia are preventable.

Rural areas in Zambia are the worst affected by the high prevalence of preventable and treatable diseases which blight the lives of children and adults. According to the Government of the Republic of Zambia (2010), the fertility rate in rural areas is 7.5%, only 31.6% of births in rural areas are delivered by a trained birth attendant and the prevalence of malnutrition in children is 24.7%. In urban areas, access to malaria treatment is 92% compared to 81.1% in rural areas. Malaria prevalence during pregnancy is 91.3% in rural areas compared to 84.1% in urban areas. The number of children who do not receive vaccination in rural areas is 6.3% compared to 2.1% in urban areas.

Statement of the Problem

According to the Zambia Demographic and Health Survey (2007), there is a high prevalence of preventable and curable diseases in rural Zambia despite the Zambian government having adopted the primary health care model as a strategy

for providing efficient, cost effective and quality health care services as close to the community as possible. The delivery of primary health care in rural areas has continued to be a major problem as evidenced by high levels of morbidity and mortality. Statistics show that in rural areas, Under five Mortality Rate (UMR) is 139 per 1,000 live births, malnutrition prevalence in children is estimated at 28.5%, malaria treatment is estimated at 81%, Child Mortality Rate (CMR) is 62 per 1,000 live births and only 24% of births are done with the help of a nurse or midwife. While in urban areas, Under five Mortality Rate (UMR) is 129 per 1,000 live births, malnutrition prevalence in children is estimated at 16%, malaria treatment is estimated at 94%, Child Mortality Rate (CMR) is 56 per 1,000 live births and 80% of births are done with the help of a nurse or midwife, (Ibid).What are the factors which have hindered the attainment of effective primary health care delivery in rural Zambia?

Research Questions

1. Are primary health care facilities available in Chibombo District?
2. What challenges do primary health care facilities face in Chibombo District?
3. What barriers do people in Chibombo District face in accessing primary health care services?
4. Does the community in Chibombo District participate in primary health care?
5. How can the delivery of primary health care in Chibombo District be improved?

Objectives of the Study

Overall Objective

To examine factors which impede primary health care delivery in Chibombo District.

Specific Objectives

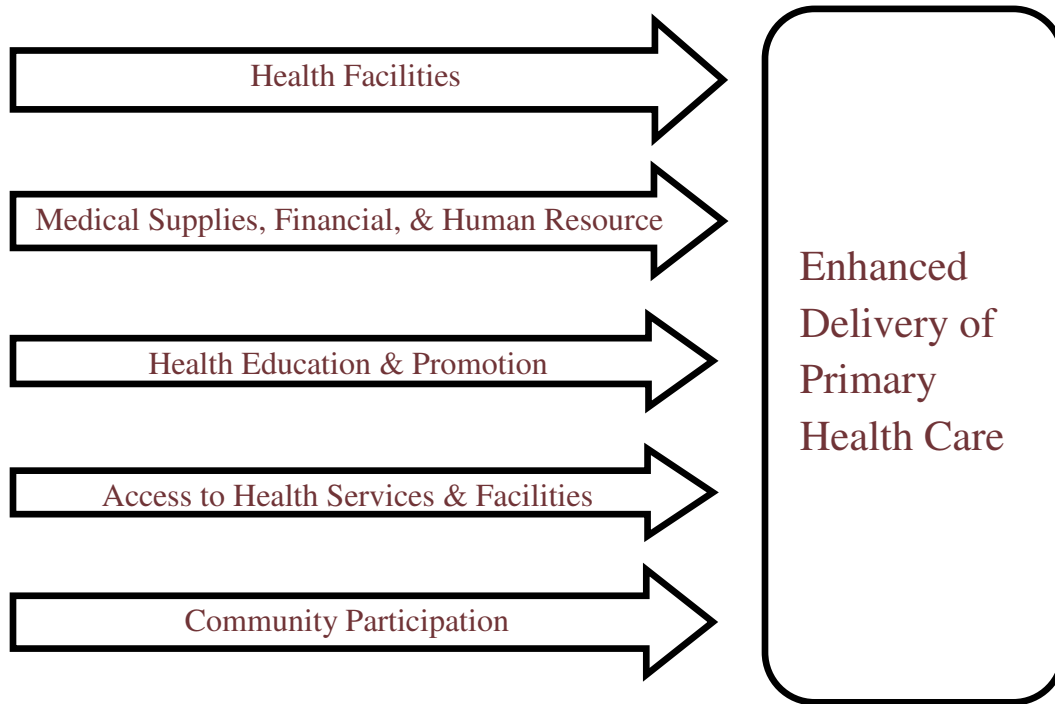
- 1 To identify primary health care facilities and services provided in Chibombo District.
- 2 To identify constraints faced by primary health care facilities in Chibombo District.
- 3 To investigate barriers which people face in accessing health services in Chibombo District.
- 4 To examine community participation in primary health care in Chibombo District.
- 5 To propose the way forward for improving primary health care delivery in Chibombo District.

Significance of the Study

The researcher decided to undertake this study due to the following reasons: The first being to provide sufficient explanation of the factors which have hindered effective delivery of primary health care in rural Zambia. The second being to provide policy makers and health care administrators with evidence based information on constraints faced by primary health care facilities in rural areas, this will enable them to design viable interventions which would improve primary health care delivery in rural Zambia. The third being to identify gaps in primary health care delivery such as availability of health facilities, supply chain of drugs, vaccines, equipment, personnel, budgetary allocation, access to health services by people in rural areas and community participation in primary health care. Lastly, the information which has been generated by this study is useful to researchers and scholars in the areas of primary health care in Zambia and elsewhere as it builds on existing knowledge of primary health care delivery in rural areas.

Conceptual Framework

Figure 1.1 Conceptual Framework for Primary Health Care Delivery



The study used a conceptual framework on primary health care delivery which focused on five (5) drivers of primary health care as shown in figure 1.1 above. The framework explains primary health care delivery by looking at the concepts of; (i) health facilities; (ii) medical supplies, financial and human resources; (iii) health education and promotion; (iv) access to health services and; (v) community participation. The study used these concepts to understand the factors which impede primary health care delivery in Chibombo district.

Health Facilities

For purposes of this research, health facilities refer to community health centers, clinics, rural health centers or any structure where people can access conventional health services. Furthermore, health facilities should have the necessary amenities such as water, electricity or solar, adequate infrastructure, communication facilities, transport and refrigerators for storage of drugs. Availability of amenities such as electricity or solar is important because it enables health facilities to

provide services on 24 hours basis. Health facilities also need transport and communication facilities for them to be able to refer patients they cannot treat to the next level of care. Therefore, availability of health facilities in Chibombo district is important for primary health care delivery as this increases health service delivery points hence making health care more accessible to people in the community.

Medical Supplies, Financial and Human Resource

Medical supplies refer to drugs, vaccines and equipment used by personnel in health facilities. Human resource refers to people trained to provide health care services such as doctors, clinical officers, nurses, midwives, pharmacists and other staff trained to provide health services. To have effective delivery of primary health care, health facilities should be adequately staffed with trained health personnel who are motivated to provide health services to people in the community. Having adequate health personnel should be accompanied by availability of medical supplies because without these, health personnel cannot effectively provide health services. Health facilities also need financial resources for them to manage their day to day activities

According to the World Health Organisation (2008), Health personnel and medical supplies are important for the purposes of carrying out medical diagnosis, which is the process of identifying diseases in patients. When made at an early stage, diagnosis can prove to be a life changing event as it helps in having an insight into the disease. Disease diagnosis is essential irrespective of the system of treatment offered to the patient as this is useful in treating patients, educating the patient regarding the cause of illness and in providing advice in maintaining health. The World Health Organisation (2009) notes that diagnosis helps in advising patients, understanding the depth of the disease, treating the medical condition and preventing the spread of the disease when done early. Therefore, availability of health personnel, financial resources and medical supplies in primary health care facilities are critical factors in the delivery of primary health care in Chibombo

District as contemporary health systems rely on the contribution of health personnel and medical supplies.

Health Promotion and Education

Health promotion and education include all actions which are implemented in order to avoid or reduce the prevalence of diseases. These include activities such as advocacy, information dissemination, immunisation and other related activities. People in the communities must be empowered with information in order to know how to prevent ill health. Preventive measures are often more successful and less expensive and are appropriate means to tackle certain health problems. However, this is not to condemn curative care as unnecessary but rather to uncover the potential of health promotion and prevention. Although knowledge about health is no guarantee for healthy behavior, it clearly influences individual choices.

Health care education is also important because it is a prerequisite for successful community participation and prevention measures especially in the areas of hygiene, sanitation, nutrition for children and babies and family planning. Mosley (2001) notes that health education improves the health status of individuals, families, communities, states, and the nation by reducing premature deaths and improving the quality of life. This study examined health promotion and education services provided by health facilities in Chibombo district with a view of identifying challenges which exist.

Accessibility of Primary Health Care Services

Primary health care services should be accessible to all individuals and communities. People should be able to afford the care which is provided at community level. Whether individuals are seeking diagnosis, treatment, palliative care or advice on how to prevent disease, the right services should be provided to all individuals at the right time. Rifkin (1988), states that access is the product of the availability of services, the possession of the means of access and the non-discriminatory attitudes of health care providers. Access and utilisation also

depend on spatial factors such as distance. Studies have shown that physical access has an impact on service utilization. Non-spatial factors include social barriers, economic constraints and cultural barriers (Ibid).

Non-cost barriers can be further sub-divided into quality, information and cultural barriers. Quality barriers such as insufficient trained health workers result in health services offered by health facilities being of poor clinical quality. Furthermore, in situations where there are shortages of drugs, equipment and other input, patients are not able to receive adequate and quality treatment. Information barriers may result from individuals not being well informed on the benefits of formal health care (both preventive and curative) thus resulting in underutilisation of health services. This is typically more marked amongst those with little or no formal education. Individuals may also not be well informed about free or subsidised treatment for all or certain health services. Therefore, this study investigated the barriers which people face in accessing health services in Chibombo district.

Community Participation

In order for primary health care to be effective in rural areas, people must be able to participate at both individual and community level in the provision of health care. Individuals should be involved in making decisions with regards to areas of intervention, utilization of resources by primary health care facilities and in deciding on what programs are to be implemented by the health facilities. The expected outcomes of community participation in the health sector include more health consciousness which pushes up the demand, more access to health care through community health workers and improvements of community level health infrastructure. The availability of community health workers in different areas of primary health care is essential for improving the health of people in the community as this brings health care closer to the people. Community health workers should be trained, motivated and provided with necessary logistics for them to do their work. Community members should also be able to exercise healthy practices in their everyday lives. The ability of individuals to take care of their own health is essential for effective delivery of primary health care.

Therefore, this study examined community participation in primary health care in Chibombo district.

Summary of the Conceptual Framework

The conceptual framework has shown that factors which would impede primary health care in Chibombo district include shortages of health facilities, shortages of health personnel, shortages of equipment, shortages of drugs and inadequate funding. Other factors may also include barriers to accessing health services due to distance, cultural beliefs, dissatisfaction with service provided and economic reasons. Furthermore, inadequate health education and promotion as well as lack of community participation in primary health care are among the factors which would impede primary health care delivery in Chibombo district.

Literature Review

The World Bank (2009) conducted a survey entitled *Primary Health Care Delivery in Nigeria*. The study found out that (i) services provided by primary health care facilities varied significantly depending on the size of the facility and (ii) most health facilities had decaying infrastructure, did not offer basic services, lacked equipment, personnel, pharmaceutical and medical supplies. The study concluded that these factors made it difficult for the health facilities to offer a range of services which they were supposed to provide at primary health care level. The study also found that factors such as low personnel qualifications, low job satisfaction and poor remuneration undermined the efficiency of primary health care services in Nigeria.

The study by the World Bank (2009) was important to this research because it identified problems faced by primary health care facilities such as lack of drugs, equipment, pharmaceuticals and staff. The literature by the World Bank was beneficial to this research because the research sought to find out how the identified problems impact on service delivery by primary health care facilities in Chibombo district. However, this literature did not provide information on the

supply chain of the identified medical supplies to health facilities and how often stock outs of essential supplies occur. For example, there was need to know how long it took health facilities to get replacement whenever essential supplies run out. This research also found out what category of health personnel which is in short supply going by the required staff establishment for primary health care facilities and how frequently stock outs of essential supplies occur. This research therefore sought to fill the identified gaps.

Das Gupta and Rani (2003) in *Strengthening Primary Health Care in India*, found out that strengthening primary health care was an effective means of reducing communicable and non communicable diseases like HIV/AIDS, tuberculosis and malaria. In combating HIV/AIDS, the strategies used were prevention, care and surveillance. For sexually transmitted diseases, awareness raising and condom provision were part of the prevention programme which was used. Knowledge of HIV/AIDS grew and the programme managed to reduce HIV/AIDS infections by 10% within a year although in rural areas, the prevalence rate remained high due to low level of knowledge about the diseases. Similarly, a malaria prevention and control programme managed to reduce malaria cases from 1,650, 000 in 2003 to 945,000 in 2005. Strategies which were used are early diagnosis, prompt treatment, promotion of mosquito nets, in - door residual spraying, Information, Education and Communication (IEC) materials and community conversations. Furthermore, the study found out that by training community members in Direct Observation Treatment (DOTS) 85% of tuberculosis patients were being cared for by community members. The programme had promoted early detection and effective treatment of the diseases.

Although the survey observed that the majority of public health clinics were found to be clean and functioning, there were some suggestions of poor quality services, as some of the conditions that were reported to be the main causes of morbidity and mortality in children namely diarrhea, lack of vaccines and preventable

diseases could not be handled by the clinic. Simple treatments for conditions such as childhood diarrhea were not available in 70% of the health facilities surveyed.

The study by Das Gupta and Rani (2003) was important to this research because it highlighted the interventions which are necessary for strengthening primary health care such as undertaking awareness raising activities to prevent ill health and involvement of communities, individuals and households in primary health care. This research benefitted from the literature because it sought to find out what outreach activities were carried out by primary health care facilities in Chibombo district. However, this literature did not tell us about the level of community participation in primary health care. It was important to find out if community members are able to prevent ill health at household level. There was also need to find out if the community was involved in planning, budgeting and implementation of primary health care activities. Furthermore, this research found out the knowledge, attitudes and perceptions of the community members towards participation in primary health care as well as the obstacles to community participation in primary health care. Therefore, this research sought to fill the identified gaps.

A study conducted by Help Age International (2008), entitled *Primary Health Care for Older People* found out that the majority of old people had low expectation of access to primary health care services. Older people experienced their condition with a sense of fate and were not aware of interventions which would improve their health condition. There were also physical barriers to accessing primary health care services by older people. In the countries surveyed, the study found out that staff in rural health facilities lacked training and did not provide age friendly services.

This study by Help Age International (2008) was important to this research because it explained how lack of access to information and age friendly services in primary health care facilities acted as barriers to accessing health services.

However, this literature did not tell us about the physical, economic and cultural barriers which affect access to health services. There was hence need to find out about other factors which are a barrier to accessing health services by people in rural areas. Furthermore, the literature by help age international only focused on access to primary health care services by old people. This research investigated the barriers to primary health care services by all age groups. Therefore, the research sought to address the gaps identified in this literature.

McCoy (2005) conducted a study at the community health centre in Khayelitsha, South Africa on *Pediatric Utilisation of a Teaching Hospital over the Community Health Centre*. The study found out that the median waiting time at the clinic in both the curative and preventive services was long (4.1 hours and 2.6 hours respectively). The major problem encountered was the separation of preventive and curative services. Improvements made were staggering of staff tea and lunch breaks so as to maintain patient flow and designated child health sessions which were extended from 2.5 to 4 days per week. Thirteen months later, patient flows and work processes were analysed and the changes proved to decrease waiting time for the preventative services only. The separation of curative and preventive paediatric care resulted in many missed opportunities for immunisation in the curative service (92% versus 16%). The suggestion for improvement was that provision of immunisation services had to be provided on a daily basis. The utilisation of a teaching hospital was preferred because mothers perceived the quality of care at the clinic to be poor and were being turned away because of overcrowding. Accessibility and quality of care at the clinic needed to be improved.

McCoy's (2005) publication was important to this study because it highlighted problems faced by primary health care facilities in providing health services to pediatrics. This research benefited from the literature because it used these findings in examining the challenges faced by primary health care facilities in Chibombo district. However, this literature did not tell us about the challenges

faced in accessing services such as antenatal, reproductive health, HIV/AIDS and other related services which are supposed to be provided by primary health care facilities. The literature only focused on the challenges with services offered to children but there was need to look at challenges in providing services to both children and adults.

Masiye et al (2008) did a study entitled *Removal of User Fees at Primary Health Care Facilities in Zambia. A Case Study of the effects on utilisation and Quality*. The study found out that there was 55% increase in the utilisation of primary health care facilities 12 months after the removal of user fees in 2006. Rural health facilities recorded a higher utilisation of health services by children than urban areas. On patients perceptions of the quality of health care, the study showed that the quality had remained the same since the removal of user fees. Most patients who were surveyed said drug availability had worsened after the removal of user fees. Patients were simply being given prescriptions because not all types of medications were available at the health facility. The staff workloads were also significantly higher in rural areas than in urban areas after the removal of user fees.

The study by Masiye et al (2008) managed to examine the effects of the removal of user fees at primary health care facilities on service utilisation and patients' perceptions of the quality of services provided. This research benefited from the literature as it guided the research in investigating the quality of services provided by primary health care facilities in Chibombo district. However, there was need to find out if primary health care facilities were able to provide the basic health care package which is supposed to be provided at primary health care level. According to the Government of the Republic of Zambia (2006), there are eleven priority areas of health services which are supposed to be provided by primary health care facilities, these are: child health, nutrition, environmental health, control and management of communicable diseases, including malaria, tuberculosis, STIs, and HIV/AIDS, mental health; control and management of non-communicable diseases, epidemic and disaster prevention, preparedness and response, school

health and Oral health. This research found out the services provided by primary health care facilities, as a way of assessing if the major health problem facing communities were being addressed. This research sought to fill the gaps in the literature.

According to the study done by Rango (2003) entitled *Decentralised Delivery of Primary Health Care Services in India*, many health facilities reported shortages of basic equipment. For instance 95% did not have microscopes, 59% did not have sterile gloves, 98% did not have malaria smear and 95% did not have urine test trips. The absence of laboratory equipment meant that health personnel had to rely on syndromic treatment which was ineffective in the treatment of diseases like malaria. More than 69% of health facilities experienced stock out of drugs for three months or longer and lack of cold storage equipment meant that vaccines were not available in a number of health facilities.

The study by Rango (2003) highlighted the challenges faced by health facilities in providing curative services. The main challenges identified in this research were shortage of drugs and equipment. This literature was beneficial to this research as it provided a guide in identifying constraints faced by health personnel in providing curative services in Chibombo district such as shortages of drugs and equipment. However, the study did not investigate other challenges faced by primary health care facilities such as budgetary allocation to health facilities as well as challenges faced in undertaking health promotion activities for people in the community. The study did not also investigate the challenges faced by primary health care facilities in making referrals and dealing with clinical emergencies. This research sought to address the gaps identified in this literature.

Meyer et al (2006) did a survey entitled *Quality of Pediatric Health Care in Primary Health Care Facilities in Johannesburg*. The study found out that the quality of child health services for sick children offered at the clinics in Johannesburg was disproportionately poor. The main areas of concern were long waiting hours, poorly skilled staff, poor history taking and examination skills,

limited identification of children with HIV, over prescription of antibiotics, absence of emergency services and limited practice of child health promotion services. There was also inadequate attention to routine health promotion and prevention activities such as growth monitoring and development assessment. The study also found out that the determinants of the quality of services provided by primary health care facilities included qualifications of health workers, quality of scheduled supervision of health workers, availability of health facilities and regulations of services offered.

The findings by Meyer et al (2006) were important to this study because they showed shortcomings on the part of primary health care personnel in providing services to pediatrics. This literature was beneficial to this research as it provided a guide in examining the quality of service provided by health facilities in Chibombo district. However, the literature by Meyer only observed gaps in the way primary health care personnel were performing their duties without examining the challenges which health personnel in primary health care facilities faced as these are an obstacle for them to effectively perform their duties. There was hence need to investigate the constraints which health personnel faced as these have an impact on how they performed their duties. This research endeavored to fill the gaps identified in the literature.

The World Health Organization (2009) *World Health Report* projects access to primary health care as a basic social right. Dissatisfaction with primary health care services offered by health facilities leads people to jump to higher level hospitals for primary health care, leading to considerable inefficiency and loss of control over efficacy and quality of services. The World Health Organisation (WHO) further contends that poverty does not only exclude people from the benefits of the health care system but also restricts them from participating in decisions that affect their health. Not only do the fees and expenditures incurred on medication count but also the fare spent to reach the facility and hence the total amount spent on treatment becomes big. The article further states that effective primary health care is supposed to be accessible and equitable to all individuals in communities.

Primary health care ensures that the right provider is offering the right care at the right time and at the right place. Effective primary health care means individuals, communities and families actually participate actively in issues affecting their health. The goal of health promotion is to enable individuals and communities live healthier lives.

The literature by the World Health Organization (2009) was important to this study because it explained the importance of access to primary health care in order to improve the health of individuals. This research sought to find out if health facilities were available at the community level to facilitate the provision of health service to people in Chibombo district. There was also need to find out if the available health facilities had the necessary infrastructure and amenities to ensure effective provision of services. This research also investigated whether primary health facilities in Chibombo District provided services to address major health problems affecting people as stipulated under the Basic Health Care Package and whether these services were readily available or could easily be accessed by people in the communities.

Haines (2007) in *Primary health care comes of age* shows that despite the movement towards the selective package of care and health reforms, the idea of primary health care is attracting new interests. There are several reasons for this. Shortages of health workers, especially in Africa have renewed interest in the role of community health workers. Also many programs that address specific diseases have been shown to interact adversely with each other and lead to inefficient use of limited resources. The article highlighted the growing research evidence of cost effectiveness of some components of primary health care such as the role of community participation in improving maternal health in developing countries. The article also notes that primary health care is better placed to address health inequalities such as poor coverage of basic health care and lack of community participation. Finally the article lists areas which need to be addressed if primary

health care is to become effective such as the utilisation of primary health care services and the quality of service offered by health care providers.

The article by Haines (2007) noted that the performance of primary health care has been assessed in terms of coverage of services with little attention to quality of services provided. The ability to assess quality of care provided is an essential component of quality assurance and improving quality. It argues that inadequacy in the quality of service delivery at primary health care level is a product of failure in a range of measures. It will be difficult to separate Medicare from primary health care except for health promotion and education. Medicine plays a crucial role among the other components of primary health care. The important role occupied by medicines in the implementation of health care requires minimum competence of health professionals to ensure rational use of medicines.

In view of the observation made above, this research was also interested in the performance of primary health care not only in terms of access and utilisation levels but examining clients' or households' satisfaction with the services provided by primary health care facilities.

Goldstein and Price (2001) did a survey entitled *Quality of Clinical Care Delivered to Children by Primary Health Care Workers; Including an Assessment of the Treatment of common Childhood Illnesses, Counseling and Health Promotion*. The study found out that the quality of child health services for sick children offered at clinics in Johannesburg was disappointingly poor. The main areas of concern were: poorly skilled staff (e.g. unfocussed consultations; poor history taking and examination skills, limited identification of children with HIV and over-prescription of antibiotics); absence emergency management facilities and; limited practice of child health promotion activities. There was inadequate attention to routine health promotion and prevention activities such as growth monitoring and promotion, immunisation, vitamin A supplementation and development assessment. Food supplementation was mostly unavailable for

children who were failing to thrive. In this study basic amenities were available but emergency equipment such as dextrostix, nebulisations, laerdal bags and resuscitation masks were not available at all clinics. Essential drug lists and growth monitoring protocols were not available in all clinics.

The literature by Goldstein and Price (2001) was important to this research because it provided information on the constraints faced by primary health care facilities in providing quality health services. However, the research by Goldstein and Price was carried out in Johannesburg which is a cosmopolitan city with different social and economic characteristics from those of Zambia. Although the researcher used the same indicators to measure quality of service provided by health facilities, the results obtained were different because this research investigated the quality of services provided by health facilities in a rural area as opposed to an urban area.

Adeniyi et al (2003) did a Survey on *Primary Health Care in Kogi*. The study found out that lack of health personnel and equipment had effects on health care delivery in the study area. One such effect was the resort to the use of local or spiritual treatment for ailments or the use of roadside chemist for the treatment of sicknesses by patients. The survey revealed that in the prevailing circumstance, most patients used other means for their primary health care. Out of the 400 people interviewed, 44% used the hospital and the primary health care centers more often, 30.7% used the health centers more often while 15.3% relied on local chemist for treating their ailments 10 percent patronized roadside chemist. About 64.2% of patients who relied on traditional means and 57% of those that used the chemist more often did so because of lack of personnel and equipment in primary health care facilities.

The survey by Adeniyi et al (2003) was important to this research because it managed to bring out challenges of shortages of personnel and medical equipment in primary health care facilities. However, the literature did not find out the causes of the observed shortages in health facilities. This research investigated the causes

of shortages in personnel and essential supplies as a way of filling the gaps identified in this literature.

Birch (1994) in *Oxfam 's Experience of Working in Primary Health Care in Zambia* observed that community health workers faced many challenges which impacted on their ability to deliver primary health care to people in their communities. The study found out that lack of supervision from district staff, lack of support from the communities they served and lack of material resources weakened the link between the community health workers and the health facility.

The study further revealed that lack of support for community health workers arose from several factors. Firstly, community health workers were seen by many villagers as government employees. Understandably, since the government trained them and supplied them with bicycles and drugs, they were supposed to be remunerated by the government. Community health workers were seen as being accountable to the government or donors and not to their communities. Secondly, the areas which community health workers had to service were too large, many of them worked long hours each week with inadequate financial and logistical support. Thirdly, the status of community health workers was eroded when their supply of drugs ran out, although the supply of drugs to the nearest health center was good, there was no extra stock with which to equip community health workers.

The research by Birch (1994) was important to this study because it identified some of the major challenges faced by community health workers in providing services to people in their communities. However, the survey did not investigate the training needs of community based volunteers and the kind of service they provided. This research sought to fill these gaps. Furthermore, Birch conducted his study more than 15 years ago and with the passage of time the situation may have changed. This research therefore, also investigated whether community health workers still faced the same challenges as was observed by Birch. This research also probed the knowledge, attitude and perception of people in Chibombo district towards participation in primary health care.

Summary of the Literature Review

The findings of these studies showed that there were variations in the quality of primary health care services provided by health facilities depending on the size of the health facility. The literature further revealed, shortages of personnel, equipment, drugs, poor quality of service provision in many primary health care facilities, poor diagnosis of diseases, limitations in the numbers of services provided, community dissatisfaction with services provided, overcrowding, inadequate community access to primary health care services, decaying infrastructure, lack of effective community participation, inadequate health promotion activities and limited access to primary health care services by people in rural areas.

Methodology

Research Design

The study was both descriptive and explanatory in terms of its design. It was descriptive in that it provided an account of factors which impede primary health care delivery in Chibombo district. The study was also explanatory as it showed the cause and effect relationship between variables which impede primary health care delivery in Chibombo district. Quantitative methods were used in order for the researcher to collect statistical information about primary health care delivery in Chibombo district. The use of quantitative and qualitative methods was necessitated by the fact that the study required several methods to be used to collect data in order to achieve desired results.

Study Site

The study was conducted in Chibombo, a rural district in Central Province. The district population in the 2010 census was 224,215. The choice of this area for this research was based on the existing health care indicators such as the high prevalence of mortality and mortality. According to the Zambia Demographic and Health Survey (2007), Chibombo district has an HIV/AIDS prevalence of 17.6% compared to the national prevalence rate of 14.3%, only 33.5% of births in the

district are delivered by a skilled provider compared to the national average of 46.5%. It is also estimated that 58% of women in the district do not get post natal check up compared to the national average of 50.5% and the prevalence of diarrhea in children is 18.9% compared to the national average of 15.5%. Central Province is among the districts with the highest number of child and maternal mortality rate in the country.

Sampling

Simple random sampling was used to select the ten (10) wards in Chibombo district where the research was conducted namely; Muchenje, Chilochabalenge, Chitanda, Kabile, Mashikili, Keembe, Mungule, Kalola, Chunga and Katuba. A total of 130 respondents were interviewed comprising; (20) health personnel in-charge of health facilities, (2) councilors, (3) community health workers, (5) Chairpersons of Neighborhood Health Committees and (100) ordinary local people. Ten (10) local people were selected from each of the ten (10) wards which were selected for this study.

Data Collection

Data for this study was collected from 25th September 2011 to 28th October 2011. Data was collected using both primary and secondary sources. In-depth Interviews were conducted by the researcher, the format of these interviews was semi-structured, this enabled the researcher to ask questions in the same manner. The use of semi – structured interview also enabled the researcher to explore areas of interest from the responses which were given by key informants. Focus Group Discussions (FDGs) were used in this research to collect data which revealed the experiences, feeling, knowledge, perceptions and beliefs of local people on various aspects of primary health care under consideration in this study. A voice recorder was used to record information during interviews and Focus Group Discussions (FDGs). Questionnaires containing both close ended and open ended questions were used to collect qualitative and quantitative data. The inclusion of open ended questions was meant to elicit detailed responses. All the questionnaires were

administered by the researcher. This is because rural areas are mostly characterized by low levels of literacy and most people in the communities are not able to read and write. The above data collection methods were used to collect primary data. Secondary data was collected through desk research from various sources such as the Health Information Management System Records (HIMS), health facility reports, health bulletins, internet and other relevant publications.

Data Analysis

The data from questionnaires was analysed using Statistical Package for Social Sciences (SPSS) while data from focus group discussions and key informants interviews was transcribed into major themes which emerged. The themes which emerged formed the basis of data categorization. Written notes were verified by using voice recordings which were taken during key informants interviews and Focus Group Discussions (FDGs).

Organisation of the Dissertation

This dissertation is divided into seven chapters. Chapter One gives an introduction to the study, statement of the problem, objectives of the study, significance of the study, conceptual framework, literature review and methodology of the study. Chapter Two presents the socio-economic profile of Chibombo district and the organization of health care delivery in Chibombo district. Chapter Three presents information on availability of primary health care facilities in Chibombo district and services provided. Chapter Four discusses the constraints faced by primary health care facilities in Chibombo district. Chapter Five discusses the barriers faced by people in accessing primary health care services in Chibombo district. Chapter Six discusses community participation in primary health care. Chapter Seven presents the conclusions and gives recommendations.

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CHAPTER TWO

SOCIO – ECONOMIC PROFILE OF CHIBOMBO DISTRICT AND ORGANISATION OF HEALTH CARE DELIVERY IN THE DISTRICT

Social and Economic Profile of Chibombo District

Introduction

Chibombo District is located in Central Province of Zambia between 27° 15 south of Equator and 29° 10 east of Greenwich. It is bordered by Lusaka on the South, Kabwe on the North, Chongwe on the East and Mumbwa on the West. It also shares small borders with Kapiri -Mposhi and Mkushi Districts. Its civic center is approximately 90km from Lusaka, which the capital city of Zambia and 50km from Kabwe, the provincial headquarters of Central Province. Chibombo covers a total surface area of 13,670, square kilometers, Chibombo District Situational Analysis (2010).

The district's proximity to Kabwe and Lusaka offers great potential for socio-economic development. However, it also renders the district vulnerable to major health problems such as high prevalence of HIV/AIDS/STIs and cholera. The central position of the district offer great potential to development as it is relatively near two major towns of Kabwe and Lusaka which can be outlets as well as sources of goods and services needed to enhance development.

Demography

The national census was conducted in 2010 and the final results are yet to be officially announced. However, the extrapolation in the table shown below is based on the 2000 census. An estimated population for the year 2012 stands at 358,456 people imposing a population density of 26 people/km² and 3.3% population growth rate. The population analysis revealed that there are more females than males in the district.

Table 2.1: Population of Chibombo District

Category	2012	
	Number	%
Children 0 – 11 Months	14,729	4.1
<5 Years	67,748	18.9
5 – 14 Years	99,291	27.7
Women 15 – 49 Years	79,936	22.3
All Adults 15 Years+	191,416	53.4
Total Male (All ages)	178,153	49.7
Total Female (All ages)	180,303	50.3
Total Population	358,456	100
Population Growth Rate		3.3
Expected Pregnancies	16,632	4.64
Expected Delivers	16,381	4.57
Expected Live Births	15,593	4.35

(Source: CSO 2000 Census extrapolated by CDMO)

Central Statistical Office (2000) reveals that Chibombo district has the largest share of the population in Central Province. The district has 21.4% of the total population of the province. The district has a high rate of population growth due to immigrations from other provinces and high birth rates. The high rate of population growth has implications such as development of squatter settlements which create environmental problems and exert pressure of existing infrastructure and other social amenities.

Population distribution, Sub-district divisions and Tribal Groupings

The average population density for Chibombo district is 17.7 persons per square kilometer. Most of the population is scattered in villages with some concentrated along major roads such as Great North Road, Landless Corner to Mumbwa (Old Mumbwa Road), Chitanda - Muchenje Road in Chief Mungule's area, Lusaka – Mumbwa Road and townships of Chisamba and Chibombo (Old and new district administrative centres respectively). The district has three constituencies namely; Keembe, Chisamba, and Katuba. Kembe Constituency has a population of 116, 840 with 21, 129 households, Katuba has a population of 76, 675 with 14, 935

households and Chisamba has a population of 100, 250 with 18, 534 households, Central Statistical Office (2010). The district has a total of twenty two (22) wards. Six (6) wards are in Chisamba Constituency namely; Muswishi, Mulungushi, Chikonkomene, Chamuka, Chisamba and Liteta. Katuba Constituency also has six (6) wards namely Katuba, Chunga, Mungule, Muchenje, Chilochabalenje and Kabile while Keembe Constituency has ten (10) wards namely; Chaloshi, Kalola, Kakoma, Ipongo, Chikobo, Chibombo, Chitanda, Mashikili, Keembe and Lunjofwa. The Lenje are the predominant ethnic group in the district. There are other ethnic groups who have migrated to the district such as the Tonga and others but are in the minority. The language widely spoken in the district is Lenje although Tonga is used in a few areas.

Education

Chibombo district has one hundred and seventeen (117) registered primary and basic schools, four (4) high schools namely, Chibombo High School, Moomba High School, Kafushi High School and Mulungushi High School and one (1) Secondary School that is Chipembi Girls Secondary School. The district has also one (1) private secondary school that is Banani International School. In addition the district has one hundred and two (102) registered community schools although it does not have a college or any tertiary institution. At community level the Parents Teachers Associations (PTAs) work hand in hand with respective school administrators. Despite having such a number of schools the pupil teacher ratio is still high for primary schools and the majority of community schools lack trained teachers. This situation has given extra burden to available teachers in the district. Many schools in the district lack basic infrastructure such as water supply and sanitation facilities, classroom space and power. The illiteracy levels in the district are very high. According to Central Statistical Office (2000) only 48% of the people in the district are literate. There are also more girls who are illiterate than boys. This is because the district mostly experiences low enrolment and progression rate for girls at various levels of education. This is because Chibombo being a predominantly rural area is still characterized by high levels of early

marriages and other cultural beliefs and values which favor boys over girls in terms of access to education.

Economy

The economic base of the district is mainly the agricultural sector. About 90% of the inhabitants depend on agriculture for their livelihood and most of them are peasant farmers. The commercial farmers are concentrated along the Great North Road. The main cash crops grown are maize, tobacco, vegetables and fruits. The minor crops include cowpeas, paprika, cassava, sweet potatoes, beans and groundnuts. More than 45,000 families in the district are small scale farmers who cultivate an average of 2.5 hectares of various crops mainly maize. Agriculture wise, the district is divided into six blocks namely Chibombo at the Centre, Chisamba on the Eastern side, Katuba on the Southern end, Kalola on the South-Western part, Keembe on the Western part and Muswishi on the Northern part. These Blocks are further divided into 30 Agricultural Camps. The district has about 256 commercial farms mainly concentrated in Chisamba area with an average area size of 450 hectares each, where they mainly grow maize, tobacco, vegetables and fruits. The commercial farmers also do game ranching and livestock rearing. The mean area cultivated for major crops is about 200, 000 hectares for the smallholder farmers. The district has about 41, 000 small scale farmers and about 5, 100 medium scale farmers, Chibombo District Situational Analysis (2011).

Other existing employment opportunities include small-scale fishing on the Lukanga swamp, transport, retail trading and self-help projects. However, a small population is in formal employment. The major industries are meat and dairy processing plants at Fringilla and Zambeef. Hotel services are offered at Fringilla, Protea, Bed & Breakfast and Ibis Gardens. Additionally there are two crocodile farms, Kalimba and Shiwangando as well as quarries and brick making plants at Patel and Katuba farms respectively.

There is very little trade which takes place in Chibombo. Most of the trading is in agriculture products. There are a few agri - businesses which buy produce from farmers such as Primark. The district only has one bank, the Zambia National Commercial Bank (ZANACO) which is located at Chisamba where the majority of commercial farms are found. There are five (5) gazetted markets in the district which are John Chinena, Chibombo, Liteta, Mwayasunka and Chisamba which are regulated by the council. These consist of small retail shops and make - shift stands. However, a number of points exist where informal vendors regularly sell their merchandise.

Health

The district has one (1) first level hospital, twenty five (25) health centers and six (6) health posts. In 2010, five (5) newly constructed health facilities were commissioned namely; (Chamakubi, Namayani, Mwanjuni, Mwapula and Muntemba). According to the District Medical Office (2011) Chibombo District experiences a number of preventable and treatable diseases. There were a total of 353 deaths in 2010 and the ten major causes of death were pneumonia 16.7%, severe malnutrition 12.2%, diarrhea 10.2%, anaemia 9.9%, cryptococcal meningitis 9.1%, cardiovascular disease 6.2%, TB 4.8, digestive system 4.0%, severe diarrhea 2.8%, pneumocystis carini pneumonia 2.5% and other diseases accounted for 21.6%, Chibombo District Health Strategic Plan (2011).

Chibombo District has an HIV/AIDS prevalence of 17.6% compared to the national prevalence rate of 14.3%, only 33.5% of births in the district are delivered by a skilled provider compared to the national average of 46.5%. It is also estimated that 58% of women in the district do not get post natal checkup compared to the national average of 50.5% and the prevalence of diarrhea in children is 18.9% compared to the national average of 15.5%. Central Province is among the districts with the highest number of child and maternal mortality rate in the country.

Table 2.2: Major causes of mortality in Chibombo district

No	2010			2009			2008		
	Disease	No Dead	%	Disease	No Dead	%	Disease	No Dead	%
1	Pneumonia	59	16.7	Pneumonia	40	12.2	AIDS	64	20.8
2	Severe Malnutrition	43	12.2	Anaemia	38	11.6	Diarrhoea non Bloody	48	15.6
3	Diarrhoea non Bloody	36	10.2	Diarrhoea non Bloody	34	10.4	Cardio-Vascular diseases	28	9.1
4	Anaemia	35	9.9	Pneumocystis Carinii Pneumonia	28	8.5	Pneumonia	25	8.1
5	Cryptococcal meningitis	32	9.1	Severe Malnutrition	27	8.2	Anaemia	20	6.5
6	Cardio-Vascular diseases	22	6.2	TB	20	6.1	PEM	19	6.2
7	TB	17	4.8	Trauma burns	7	2.1	Malaria	19	6.2
8	Digestive system (not infectious)	14	4.0	Digestive system (not infectious)	6	1.8	RI Non Pneumonia	17	5.5
9	Severe Diarrhoea with dehydration	10	2.8	RI Non Pneumonia	5	1.5	Meningitis	10	3.2
10	Pneumocystis Carinii Pneumonia	9	2.5	Severe Diarrhoea	5	1.5	Poisoning	8	2.6
	Total others	76	21.6	Total others	116	36.1	Total others	49	16.2
Total		353	100	Total		100	Total	307	100

(Source: Chibombo CDMO)

Table 2.2 above shows the most prevalent diseases in Chibombo district. In 2010, the most prevalent diseases in Chibombo district were pneumonia 270.7 cases per 1000 population, diarrhea 76.2 cases per 1000 population, muscular skeletal 50.8 cases per 1000 population, digestive system 40.2 cases per 1000 population, trauma 39.8 cases per 1000 population, eye infections 32.6 cases per 1000

population, skin infections 32.6 cases per 1000 population, throat infections 23.4 cases per 1000 population and dental carries 22.8 cases per 1000 population.

Environmental health indicators show that 61% of the people in Chibombo district have access to safe water supply while 29% of the population uses shallow wells and streams as their source of water. Furthermore, 8% of the people in Chibombo district use flush toilets, 48% use pit latrines and the others use bushes. The low coverage of water and sanitary services contribute highly to high morbidity and mortality due to diarrhea, Chibombo District Situation Analysis (2011).

Water and Sanitation

Water supply systems in Chibombo district can be divided into two (2) types, the reticulated systems that supply water to townships. These systems are at Chisamba and Chibombo townships. The Chisamba system was handed over to the Council by the Department of Water Affairs in December 1997. The condition of water network is generally poor. However, the demand for water in the townships is high and the council is overwhelmed such that it is even unable to meet the demand. The non – reticulated water supply in the district is the other category of water supply used for rural areas. According to Community Management and Monitoring Unit (CMMU), the district had a total of 668 water points of which 476 were in use by October 2009. The Central Province Rural Water Supply and Sanitation Project has drilled 358 boreholes in the district and PLAN international has also drilled about 55 boreholes since they came to the district.

The district has three types of sanitary facilities in use. These include flush toilets, pit latrines and bushes. According to Chibombo District Health Management board Action Plan (2010) only 8% of the population is using Flush toilets. Most of these live in urban areas of the district i.e. those living in Chibombo, Chisamba, Mwachisompola, and Mwayansunka. Forty eight (48%) of the population use pit latrines and most of these live in rural areas, schools and those other areas that

have no access to piped water and 44% of the population uses bushes and other means.

However, the Central Province Rural Water Supply and Sanitation project, through the D-WASHE is facilitating the construction of Ventilated Improved Pit Latrines and drilling boreholes. Also under the same programme the D-WASHE is educating the communities on hygiene and other good health practices. They are also facilitating the formation and training of Village WASHE committees. In addition Plan International is also involved in the same activities in the district. From the statistics available, it shows that accessibility to conventional sanitation facilities is still very low in the district. However, there is need for more public health education to encourage people about the importance of using sanitary facilities.

Waste Disposal

The common form of waste disposal in the district is the conventional one i.e. use of rubbish pits and incinerators (in health posts/ health centers). Both households and business outlets rely on the same mode of disposal. For business outlets most of the wastes is collected in card boxes and dumped into rubbish pits. For solid waste disposal the district has no designated dumping site. Most of the people do rely on the use of rubbish pits. Furthermore the district has no liquefied waste disposal site. Most of the institutions rely on the use of aqua privies (septic tanks and soak ways). However, there is need for the district to have waste stabilisation ponds, as the mode of disposal is not safe because it pollutes ground water.

Public Transport and Communication Services

The provision of public transportation in the district is supported by some public facilities. These include a railway station and a number of bus stops. The passenger train is available in the district with a railway station in Chisamba. The district is also a transit point for minibuses and buses that connect Lusaka and Kabwe and as far as Livingstone, Copperbelt and Northern provinces. There is no local minibus transportation established in the district and people travel locally primarily on foot,

bicycles and using ox-carts and private vans for those who can afford transport fares. The remote rural areas are mostly disadvantaged because of the poor state of roads and this poses challenges for the local people when selling their farm produce and in reaching social amenities. Therefore, the district needs alternative modes and means of transport so as to assist such communities' access services within the shortest possible time.

Management of Primary Health Care in Chibombo District

Management of primary health care in Chibombo district is the responsibility of the Chibombo District Health Management Team (CDHMT). The establishment of the District Health Management Team (DHMT) was done under the health sector reform program which was aimed at decentralizing health service delivery through devolution of key management responsibilities and resources to the district level.

The major roles of CDHMT include: (i) Ensuring that health centers or health posts work in close collaboration with their communities and with community representatives to facilitate and support community health initiatives; (ii) Mobilizing and distributing resources (finance, supplies, equipment and human) to health centers, health post and first referral services; (iii) Monitoring and evaluating health care performance in the district in terms of quality and to take corrective action where necessary; (iv) Providing or facilitating training for health centers or health posts and first level referral hospital staff; (v) In health related matters, leading and coordinating the work of all NGOs and other stakeholders in the district, such as agriculture, local government and education whose activities influence outcomes through the District Development Coordinating Committee (DDCC); (v) Analyzing and consolidating district information and providing feedback to health centers or health posts; (vi) Providing effective management of health staff and promoting retention and effective performance and; (vii) Fostering research in health and related fields and ensuring that research results are disseminated and utilised.

In relation to planning, CDHMT has the following roles; (i) Agreeing with health posts, health centers and first level referral services on priority health problems in the district and setting general district objectives for the next three (3) years and ensuring that each year's targets are reflected; (ii) Providing each health center, post and hospital offering first level referral services with details of the projected funding and budgetary ceiling for the next three years; (iii) Offering guidance and support to health centers, health posts and hospitals providing first level referral services in selecting appropriate interventions to achieve district objectives; (iv) Assisting health centers, health posts and hospitals offering first level referral services to develop their plans and budgets; (vi) Consolidating the health centers, health posts and first level referral hospital plans into an overall district medium term plan and budget; (vii) Facilitating dialogue with popular structures within the district premises on identifying key problems to include in the action plans and; (viii) Advocating for better prioritisation and planning for interventions that influence health outcomes by collaborating with other line ministries or departments through the District Development Coordinating Committees (DDCCs), such as roads, water and sanitation, transport and others.

In relation to monitoring and evaluation, the CDHMT performs the following roles: (i) Setting up performance targets for health facilities; (ii) Monitoring performance against set targets within and across health facilities; (iv) Enhancing community participation in monitoring and evaluation; (vi) Conducting operational research, (vii) Adjusting plans based on the performance assessment results and; (viii) Undertaking technical support visits to address weaknesses identified within the system.

Organization Structure of the Chibombo District Health Management Team (CDHMT)

Chibombo District Health Management Team (CDHMT) is headed by the District Medical Officer as shown in figure 2.1 on page 37b.

The main duties of the District Medical Officer include; developing and managing effectively the implementation of policies in the district in order to provide guidelines, overseeing the implementations of programmes in the district in order to ensure effective delivery of the district health services, supervising the provision of health care to patients in order to improve quality of life and reduce mortality, overseeing timely preparation and implementation of action plans and budgets in order to facilitate the attainment of set objectives and resource mobilisation, managing and coordinating operational research in order to generate information, monitoring the delivery of services in the district in order to generate information, providing capacity building and conducting performance management, managing the effective utilisation of human, financial and material resources. CDHMT has four (4) units namely, Public Health Unit, Clinical Care Unit, Planning and Health System Unit and Human Resource Unit.

Public Health Unit

The Public Health Unit is responsible for handling all components of public health. These include, monitoring health status to identify community health problems, conducting research to investigate health problems and health hazards in the community, enforcing laws and regulations that protect health and ensure safety, carrying out health education and promotion activities, provide environmental health services and conducting research on new insights and innovative solutions to health problems.

Clinical Care Unit

The clinical care unit is responsible for handling components of clinical care. These include, monitoring the quality of service provided by health facilities to ensure that they meet the required standards set by the Ministry of Health and the World Health Organisation. Providing capacity building to health personnel in health facilities in order to improve the quality of services provided. Undertaking operational research, management of pharmaceuticals in order to ensure their

availability and monitoring the utilisation of essential drugs and pharmaceuticals in order to ensure availability of essential drugs.

Planning and Health Systems Unit

The Planning and Health Systems Units is responsible for coordinating the development of Action Plans and budgets in order to facilitate acquisition and utilisation of resources. The unit undertakes timely updating of the database in order to facilitate access and flow of information, monitors the timely submission of health information in order to implement appropriate interventions. The unit also undertakes and implements regular updates in health information and management in order to impart appropriate skills and knowledge.

Human Resource Unit

The Human Resource Unit is responsible for conducting regular and accurate interpretation and implementation of Terms and Conditions of Service and the Code of Conduct in order to enhance adherence to Public Service regulations. The unit undertakes timely identification of vacancies in order to facilitate filling of vacant positions, preparation of payroll in order to facilitate recoveries as well as payment of salaries and allowances. The Human Resource Unit also undertakes human resource forecasting in order to determine appropriate interventions such as timely processing of documents for separations, resignations and retirement in order to facilitate decision making.

Purchasing and Supplies Unit

The purchasing and Supplies Unit is responsible for undertaking all procurement for the District Medical Office. The unit ensures that there is timely procurement and distribution of items such as drugs, vaccines, pharmaceuticals, equipment and other items to all health centers, health posts, and the referral hospital in the district. The unit also maintains an up to date stock record in order to facilitate decision making.

Accounts Unit

The Accounts Unit is responsible for managing all financial transactions for the District Medical Office. The unit carries out all the accounting operations so as to facilitate accountability of public funds, the unit prepares financial reports for the District Medical Office in order to facilitate decision making and it also maintains all the financial records such as banking records in order to facilitate efficient storage and retrieval of information.

Administration and Logistics Unit

The Administration and Logistics Unit is responsible for providing support services to the District Medical Office. The unit is in charge of managing transport services and providing logistical support to the district medical office.

Primary Health Care providers in Chibombo District

Health posts

Health posts are the smallest type of government clinics which provide health services to communities in Chibombo district. One health post is meant to provide health services to a population of 500 households (3,500 people) in rural areas or to be established within 5Km radius for sparsely populated areas. There are six (6) health posts in Chibombo District namely, Chikonkomene, Lunjofwa, Mwachisompola, Momboshi, Mwanjuni, Mwapula and Namayani.

Health Centers

Health centres are the other type of government clinics found in Chibombo district. These are bigger than health posts and are meant to service a catchment area of 29 Km radius or population of 10,000. Chibombo district has twenty six (26) Rural Health Centres namely Chibombo, Chikobo, Chipembi, Chipeso, Chisamba, Chitanda, Golden Valley, Ipongo, Kabangala, Kaparu, Kayosha, Keembe, Malambanyama, Malombe, Mboshya, Mulungushi Agro, Muswishi, Mwachisompola Demonstartion Zone, Mwachisompola, Naluyanda, Shimukuni, Twalumba, Chisamba ZNS and Muntemba.

First Level Referral Hospital

Chibombo district has one (1) first level referral hospital, Liteta Mission hospital. The hospital is intended to serve a population of between 80,000 and 200,000. The hospital provides all clinical services to support health center referrals.

Community Health Workers

Chibombo district also has a number of community health workers who provide services to people in their communities. Community Health Workers (CHWs) are just one of many terms used to describe an indigenous outreach health worker. They are also known as community health aides or advisors, lay health advisors, community health motivators, community health advocates and community health volunteers. In general, CHWs are local lay community members who interface directly with residents in the community to convey a variety of health messages that promote health and to improve access to and utilisation of health services. As frontline health care professional, CHWs have essentially three primary functions; (i) to serve as mediators between community members and health agencies (ii) to establish a social network, and (iii) to offer a range of services from emergency care to health protection and social support.

Non-Governmental Organisations (NGOs)

Non – Governmental Organisations (NGOs) are also involved in the provision of primary health care services in Chibombo district. NGOs which are operating in various catchment areas in the district include; Plan International, World Vision, Zambia Prevention Care and Treatment (ZPCT), Society for Family Health (SFH), John Snow Incorporation, Association of Medical Doctors in Asia, Danish Aid from People to People (DAPP), Flying Specialists, Chibombo Child Development Agency, Chipulumutso Community Health Trust, Bwafwano, Moomba Home Based Care and Churches Health Association of Zambia (CHAZ). Services which are provided by these NGOS include community mobilisation on HIV/AIDS, referral network on AIDS clients, management of opportunistic infections,

voluntary counselling and testing, male circumcision, Antiretroviral Therapy (ART), safe motherhood and child health services.

Conclusion

It has been revealed that Chibombo is a rural district with an estimated population of 358,454. The majority of its people live in villages and are mainly peasant farmers. The district has poor social indicators which are determinants of health such as high poverty levels due to little economic activities. Illiteracy is estimated at 58% of the total population in the district. Access to clean water and sanitation in the district is low, many people use shallow wells and streams as a source of water. The number of people without sanitary facilities is also high. Chibombo district experiences a high prevalence of preventable and treatable diseases which lead to high mortality rates. The transport system in the district is bad mainly due to poor road infrastructure. The government is the main provider of health services in the district and almost all the health facilities are government owned. The Chibombo District Health Management Team (CDHMT) which is a decentralised agency of the central government is responsible for managing health care delivery in the district.

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CHAPTER THREE

IDENTIFICATION OF PRIMARY HEALTH CARE FACILITIES AND SERVICES PROVIDED

Introduction

In order to provide health services to people, there is need to have health facilities which are fully functional. Availability of health facilities enhances easy access to health services. Furthermore, health facilities should have all the necessary amenities such as water, electricity or solar, radio system for communication, refrigerator for storage of drugs and vaccines, counseling room, examination room, separate delivery room, dispensary and an ambulance or vehicle for patient referral. Shortages of health facilities deprive people in communities of access to health services. When health facilities lack amenities and equipment, service delivery is compromised because health facilities fail to function effectively. Health facilities should also be able to provide the Basic Health Care Package to address the major health problems facing people in their communities. These services should be provided on a continuous basis in order to make health care easily accessible. Therefore, availability of health facilities is essential for enhanced delivery of primary health care in Chibombo district.

Availability of Health Facilities in Chibombo District

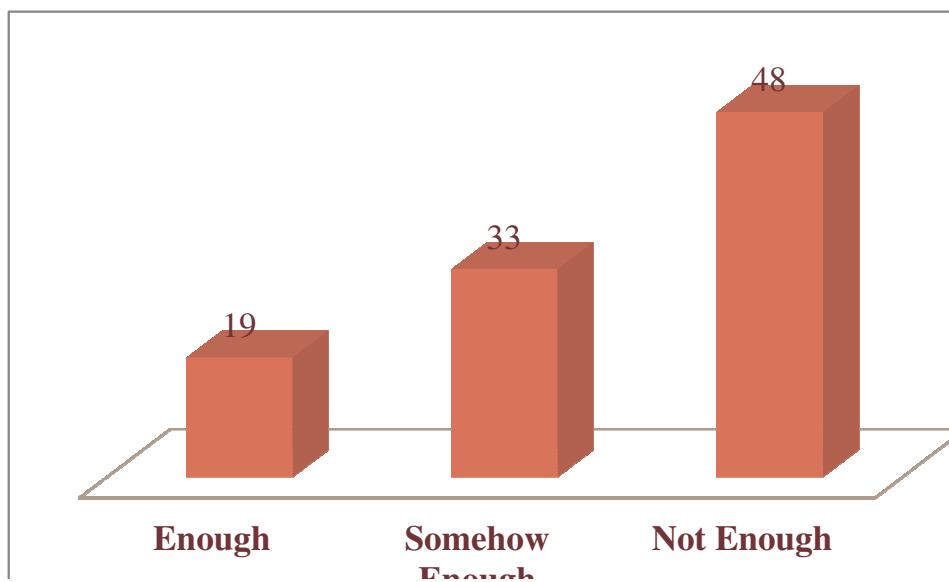
The study found out that health facilities exist in Chibombo District, these were mainly rural health centres which represented 16 out of 20 identified health facilities and health posts which represented 4 out of 20 identified health facilities. However, there was unequal distribution in the number of these health facilities. The number of health facilities available in each ward ranged between 1 and 3. Two (2) out of 10 wards surveyed had 3 health facilities each, 5 out of 10 wards surveyed had 2 health facilities each and 3 out of 10 wards surveyed had 1 health facility each.

The majority of health facilities in Chibombo District were government owned. Of the 20 health facilities identified, 19 out of 20 were government owned while 1 out of 20 was privately owned. The private health facility was located near the line of rail and along the main tarred road linking Chibombo district to Lusaka and Kabwe. The area where this facility is located is also surrounded by commercial farms.

Fourteen (14) out of 20 identified health facilities were built by the government, 4 out of 20 of the identified health facilities were built by Non-Governmental Organisations in partnership with the community while 1 out of 20 identified health facilities was built by the Church and 1 out of 20 was privately owned. All the four (4) health facilities which were built by Non-Governmental Organisations in partnership with the communities and one (1) which was built by the church have been handed over to government and were being managed by Chibombo District Health Management Team (CDHMT).

The majority of households in Chibombo District said the available health facilities were not enough. Figure 3.1 on page 46 illustrates this point, 48 out of 100 respondents said the available health facilities were not enough, 33 out of 100 said the available health facilities were somehow enough and 19 out of 100 said the available health facilities were enough. Those who said the number of health facilities in their area was not enough complained of the long distance they travelled to get to the nearest health facility while other complained of overcrowding at health facilities. The respondents said although there was a big increase in the catchment population covered by health facilities, there were no additional health facilities built or expansion of existing ones in order to cater for increased demand for health services. During Focus Group Discussions, it was revealed by the participants that they spent a lot of time standing in queues before they could be attended to. In most health facilities people had to sit outside the health facility while other stood in corridors as they waited to be attended to because the waiting rooms were always congested.

Figure 3.1 Views of local people on the available health facilities.



(Source: Primary Data)

Although health facilities exist in Chibombo District, they are inadequate hence making it difficult for people in areas with few health facilities to access health services. According to the Government of the Republic of Zambia (2006), a population of 3,500 people is supposed to be serviced by one (1) health post while a population of 10,000 people is supposed to be serviced by one (1) rural health center in order to ensure effective delivery of health services. However, this study found out that the majority of the wards surveyed did not have the required number of health facilities to match the size of their population. For example Mashikili ward which had a population of 22,675 people only had one (1) rural health center which is ideally supposed to service 10,000 people. Similarly, Muswishwi ward which had a population of 16,046 people only had one rural health center which was supposed to provide health services to a population of 10,000 people. Therefore, lack of expansion at existing health facilities and construction of additional ones in light of increase in population had exerted pressure on existing health facilities in Chibombo district. The findings in this study are similar to those of a study done by Onokerhoraye (2003). His study found out that there was a disproportionate distribution of health centers among settlements in Bayelsa State,

Nigeria. The location, number and size of health facilities were not matched with the increase in population. This precipitated the problem of poor health care delivery.

State of Primary Health Care Facilities

The study found out that the majority, 17 out of 20 identified health facilities did not have water in the facility. However, 14 out of 20 identified health facilities had a borehole within their premises, 3 out of 20 identified health facilities had no borehole or any source of water within their premises and had to fetch water outside the health facility premises. Only 3 out of 20 identified health facilities had running tap water inside the health facility. All the facilities without tap water inside the clinic had buckets for water storage kept in the health facility.

At the time of the study only 3 out of 20 identified health facilities had electricity connection while 13 out of 20 had solar panels although they were all not functioning due to lack of maintenance and battery problems, 2 out of 20 had solar power and 2 out of 20 did not have any source of power. All the health facilities without any source of power and those whose solar system were not functioning relied on candles to operate at night when attending to emergencies.

Three (3) out of 20 identified health facilities had functioning radio system for communication, 17 out of 20 identified health facilities had radio system for communication but the radios were not functioning due to various problems such as lack of maintenance and batteries. All the health facilities identified did not have telephones or cell phone for communication even in areas where there was network for mobile phones.

The majority, 15 out of 20 identified health facilities had working refrigerators for storage of vaccines and other medicines while 5 out of 20 had no refrigerator for storage of drugs and vaccines. The refrigerators in health facilities which did not have electricity or solar were using gas. All the (4) health posts and one (1) rural

health centre had no refrigerators, drugs and vaccines requiring refrigeration were stored on shelves. In some instance, the health facilities without refrigerators kept their drugs and vaccines at the nearest health facility which had a refrigerator.

Seventeen (17) out of 20 identified health facilities had a separate dispensary room or pharmacy while 3 out of 20 had partitioned a section of their consulting rooms which were being used as pharmacies. All the identified health facilities 20 out of 20 had toilets for patients and staff. Thirteen (13) out of 20 identified health facilities had a separate delivery or maternity rooms while 7 out of 20 had no separate delivery or maternity rooms. In the health centers with no separate delivery rooms, female patients admitted at the facility were mixed with expecting mothers.

All the identified health facilities in this study had consulting rooms for patients. Sixteen (16) out of 20 identified health facilities had examination beds in their consulting rooms while 4 out 20 had no examination beds. Maternity beds were only available in 7 out of 20 health facilities while 13 out of 20 health facilities were using ordinary beds.

Eighteen (18) out of 20 identified health facilities had no separate counselling or Voluntary Counselling and Testing (VCT) room. Fourteen (14) out of 20 health facilities did not have any form of transport while 6 out of 20 had motorbikes. All the health facilities identified had no vehicle or ambulance for patient referral.

The general impression from the findings of this study was that primary health care facilities in Chibombo district were poorly maintained based on the high number of health facilities with non-functioning equipment due to lack of maintenance. With the exception of newly built health facilities most of the identified facilities were reported having leaking roof, falling ceilings, broken benches, chairs and tables. Lack of amenities and adequate space in health facilities affected effective delivery of health care. Key informants reported that lack of refrigerators in some

health facilities made it difficult for them to provide immunisation service on a regular basis because they could not keep vaccines unrefrigerated for a long time. It was further mentioned that lack of solar or electricity also made it difficult for health providers to attend to emergencies at night. The findings of this study are similar to those of a study done by Newman et al (2003), the study found that 40% of primary health care centres in Manicaland had decaying infrastructure such as cracked floors, and broken window panes due to inadequate budgetary allocation to support regular maintenance. The study also found that only two-thirds of primary health care centres had functioning fridges or freezers and all the primary health care centres lacked transport.

Services Provided by Primary Health Care Facilities

Child Health

The study found out that most of the identified health facilities, 19 out of 20 provided child health services. The services were growth monitoring and immunisation. Growth monitoring services included weighing of children below the age of 5 years on a monthly basis, provision of vitamin A supplements once, to all infants aged at least 6 months, provision of vitamin A supplement to each child every 6 months from 12 to 60 months and provision of nutrition education. The immunisations provided at the health facilities were BCG (Tuberculosis) vaccine, OPV (Poliomyelitis) vaccine O dose to newly born children, OPV (Poliomyelitis) vaccine 1st dose to children 6 week after birth, OPV (Poliomyelitis) vaccines 2nd dose to children 10 weeks after birth, OPV (Poliomyelitis) vaccine 3rd dose to children 14 weeks after birth, OPV (Poliomyelitis) vaccine 4th dose to children 18 months after birth. DPT – Hib+ HepB (Diphtheria/Tetanus/Pertussis- Haemoglobin influenza B) vaccine 1st dose to babies 6 weeks after birth, DPT- Hib+HepB (Diphtheria/Tetanus/Pertussis- Haemoglobin influenza B) 2nd dose to babies 10 weeks after birth, Hib+HepB (Diphtheria/Tetanus/Pertussis- Haemoglobin influenza B) 3rd dose to babies 14 weeks after birth and Measles vaccination which is given to children below 1 year.

HIV/AIDS

Most of the identified health facilities, 19 out of 20, provided HIV/AIDS services. The services included preventive services such education on HIV/AIDS prevention, male and female condom distribution, HIV/AIDS counseling and testing, HIV/AIDS awareness raising and Prevention of Mother to Child Transmission (PMTCT). There were variations in the provision of HIV/AIDS care and support services offered by health facilities, only 12 out of 20 provided Home Based Care, 2 out of 20 provided nutritional support to HIV/AIDS positive patient. Disease monitoring was only provided in 2 out 20 of the identified health facilities. All the identified health facilities provided nutritional sensitization as well as psychosocial counseling to HIV/AIDS positive patients. The provision of HIV/AIDS treatment varied across all the facilities surveyed. Antiretroviral Therapy (ART) for adults and children was only provided in 2 out of 20 health facilities. Prevention of Mother to Child Transmission (PMTCT) prophylaxis was provided in all the health facilities. Prophylaxis was provided to pregnant mothers at antenatal as well as to newly born babies to prevent transmission of the virus from the mother to the child.

Family Planning and Reproductive Health

Nineteen (19) out of 20 identified health facilities provided family planning services. The family planning methods provided included condom, oral pill, injectable and implant. Two (2) out of 20 of the identified health facilities provided abortion services and abortion care. Only 3 out of 20 health facilities provided youth friendly services as a way of enabling more youth to access reproductive health services. Screening and treatment of STIs was provided by all the health facilities.

Safe Motherhood

The study found out that 19 out of 20 identified health facilities provided reproductive health services. The services included antenatal care to expecting mother. Antenatal care services covered screening for anemia, testing for syphilis,

cervical cancer and breast cancer. Pregnant women were also given a number of prophylaxes to prevent illness which include Intermittent Presumptive Treatment (IPT) 1st, 2nd and 3rd dose for malaria. Folic acid, Ferrous sulphate dose, Mebendazole and Tetanus toxoid dose or booster dose. Post - natal services were also provided to women after giving birth which included vitamin A dose given to women six weeks after delivery.

Environmental Health

Nine (9) out of 20 health facilities provided environmental health services. The services included inspection of premises to check compliance with health standards, food inspection, water source inspection, sanitary facility inspection, food testing, water testing, rodent and vector control management, mosquito spraying and refuse collection.

Management of other Diseases

Most of the identified health facilities, 19 out of 20 provided Rapid Test and Diagnosis (RDT) of malaria as well as malaria treatment. Nine (9) out of 20 health facilities provided diabetes drugs to patients while hypertension, asthma, cardiovascular diseases, nervous system disorder, sickle cell anemia management was provided in all the facilities. Only 2 out of 20 health facilities managed HIV/AIDS associated diseases such as cryptococcal meningitis, herpes zoster, pneumocystis carini pneumonia and kaposi sarcoma. All the health facilities provided ear, eye, nose, and mouth and throat diseases. Oral health hygiene was also provided in all the health facilities. Nineteen (19) out of 20 health facilities provided TB diagnosis and treatment.

The findings of this study showed that health facilities in Chibombo District provided most of the basic health care components. All the health facilities provided, child health, family planning, safe motherhood, voluntary counseling and testing, Prevention of Mother to Child Transmission of HIV/AIDS and management of chronic illnesses. However, oral health and mental health were not

being provided in all the identified health facilities. Only 2 out of 20 health facilities provided Antiretroviral Therapy (ART) and 3 out of 20 provided youth friendly services. This hinders access to HIV/AIDS treatment because very few health facilities are providing the service. The findings of the study agree with the National AIDS Council (2010) where only 17% of health facilities in rural Zambia were reported to be offering antiretroviral treatment.

Although all the identified health facilities provided reproductive health services, youth friendly services were only provided in 3 out of 20 of the identified health facilities. The scarcity of youth friendly services made it difficult for young people to access reproductive health services in Chibombo district. Post abortion care is only provided in 1 out of 20 of the health facilities this is because other health facilities lack trained personnel to provide this service. The majority 11 out of 20 of the health facilities identified did not provide environmental health service. These health facilities were not able to prevent the causes of diseases in communities thus making communities vulnerable to contracting preventable illnesses.

Availability of Service in Health Facilities

Table 3.1 Number of days allocated for the provision of services

Services Provided	Number of Days								
	0	1	2	3	4	5	6	7	Monthly
Immunisation	-	-	-	-	-	5	-	15	
ART	17	-	-	-	-	-	-	-	3
Antenatal bookings		12	8						
Family Planning		7	9	4					
Counselling & Testing		2	3	7		8			
Antenatal Re-attendance		14	6						
Environmental Health	12	2							6
Under 5		14	6						
Chronic care						5	14		
PMTCT Prophylaxis									20
Curative						5	15		
Institutional deliveries								20	

(Source: Primary Data)

The study found out that availability of basic health care services provided by health facilities in Chibombo district varied between different health facilities. Table 3.1 above illustrates this point. Fifteen (15) out of 20 health facilities provided immunization services 7 days in a week, 5 out of 20 provided immunization services 5 days in a week. Antiretroviral Therapy (ART) was provided monthly by 3 out of 20 health facilities while 17 out of 20 did not provide this service. Booking for antenatal services was only done 1 day in a week by 12 out of 20 of health facilities and 2 days in a week by 8 out of 20 health facilities. Seven (7) out of 20 health facilities provided family planning 1 day in a week, 9 out of 20 health facilities provided family planning 2 days in a week while 4 out of 20 health facilities provided family planning 3 days in a week. Two (2) out of 20 health facilities provided testing and counseling 1 day in a week, 3 out of 20 provided counseling and testing 2 day in a week, 7 out of 20 provided counseling

and testing 3 days in a week and 8 out of 20 provided counseling and testing 5 days a week.

Fourteen (14) out of 20 identified health facilities provided antenatal re-attendance 1 day in a week while 6 out of 20 provided antenatal re-attendance 2 days in a week. Twelve (12) out of 20 health facilities did not provide environmental health services, 2 out of 20 provided environmental services 1 day in a week while 6 out of 20 provided environmental health services 1 day in a month. Fourteen (14) out of 20 health facilities provided under 5 services 1 day in a week while 6 out of 20 health facilities provided under 5 services 2 days in a week. Twenty (20) out of 20 health facilities provided Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) once every month. Five (5) out of 20 health facilities provided chronic care management 5 days a week while 15 out of 20 health facilities provided chronic care management 6 days a week. Five (5) out of 20 health facilities provided curative services 5 days in a week while 14 out of 20 provided curative services 6 days in a week. Twenty (20) out of 20 health facilities provided institutional deliveries 7 days in a week.

The majority, 19 out of 20 health facilities were open from 08:00 to 16:00 hours from Monday to Friday. On Saturday, 8 out of 20 health facilities operated from 08:00 to 10:00, 3 out of 20 operated from 08:00 to 12:00 while 9 out of 20 of the health facilities were often closed on Saturdays. Four (4) out of 20 health facilities operated from 08:00 to 10:00 on Sunday while 16 out of 20 of the health facilities were closed on Sundays. Thirteen (13) out of 20 of the identified health facilities did not operate on public holidays while 7 out of 20 operated during public holidays from 08:00 to 10:00 but only attended to emergencies. The majority of the health facilities 19 out of 20 attend to deliveries, accident and serious medical emergencies after working hours, at night and on public holidays.

The availability of basic health care services in primary health care facilities in Chibombo District varied between health facilities. This implied that people had

limited access to these services as they were not readily available every day throughout the week. Having different days allocated for different services meant that people were not provided with all the services they wanted when they went to the health facilities because every service provided was allocated a specific day. This forced people to make repeated visits to health facilities. Furthermore, most health facilities did not operate on public holidays and those which operated only attended to deliveries and other emergency cases. All the identified health facilities did not operate for 24 hours in a day hence depriving people of access to health care during certain hours of the day. The findings of this study are similar to those by Anja (2009) the study found that there was lack of integration in primary health care facilities in rural India. People could not get all the services they needed when they went to the clinic instead they were given an appointment to come on an appropriate day when the service was being provided. Lack of integration was seen as a missed opportunity for people to access desired services because due to challenges of distance in rural areas, people found it difficult to make repeated visits to a health facility.

Outreach Activities and Services Provided

The study found out that 19 out of 20 identified health facilities had outreach posts or centers in the communities where they went to provide their services. The number of outreach posts or centers for these health facilities ranged between five (5) and twelve (12). During the outreach programmes, the major services provided were HIV/AIDS education, condom distribution, testing and counseling, distribution of Information, Education and Communication (IEC) materials. Growth monitoring and promotion activities were provided to children below 5 years. Immunisation services, antenatal care, family planning and safe motherhood services were also offered at outreach post or centers.

Two (2) out of 20 identified health facilities were collaborating with schools by providing health services to children in schools. The services provided were physical inspection or screening of children for diseases, deworming, tetanus

injections to Grade1 pupils, provision of vitamin A and inspection of school premises to ensure a healthy learning environment.

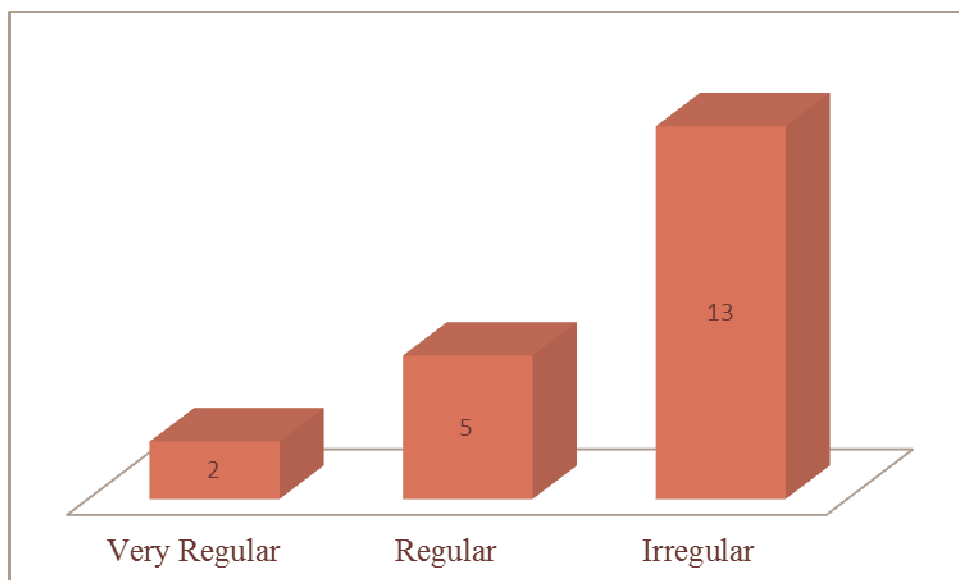
Most of the identified health facilities, 19 out of 20 organised meeting in the villages to educate community members on health issues such as environmental health, sensitisation on HIV/AIDS prevention, treatment, care and support, malaria prevention, safe motherhood, family planning and PMTCT (Prevention of Mother to Child Transmission of HIV/AIDS).

Five (5) out of 20 identified health facilities organised events in the communities such as soccer tournaments, drama, traditional dances and popular theater. These events were aimed at mobilizing people who came to attend such activities to access health services. On the sides of these events, VCT and family planning services were provided. These health facilities also made use of local and national events being commemorated in their communities such as the Independence Day, World AIDS Day, local sports tournaments and traditional ceremonies to provide health services and health education at such gatherings.

Three (3) out of 20 identified health facilities conducted household visits to inspect sanitary facilities. Four (4) out of 20 health facilities had trained malaria agents who were providing indoor residual spraying to households in their community. Sensitisation on hygiene and malaria were also done during household visits.

The study found out that 9 out of 20 identified health facilities carried out inspections in the communities to ensure compliance with environmental health practices. Food and water samples from these trading places were also taken for testing. Samples of water from wells and boreholes were also taken in order to assess the quality of the water which people were using in the communities.

Figure 3.2 Frequency of community outreach activities conducted by primary health care facilities.



Source: (Primary Data)

Figure 3.2 above shows that most of the identified health facilities, 13 out of 20 conducted outreach activities on a very irregular basis, the health providers interviewed in these health facilities said they conducted outreach services once in six (6) or twelve (12) months period. They cited logistical challenges such as lack of transport, money for fuel and allowances to undertake these activities. Most health facilities were only able to undertake outreach activities during the child health week. Child health week activities were sometimes funded by the CDHMT. Five (5) out of 20 health facilities conducted outreach services on a regular basis, these health facilities were able to visit their outreach posts at least once in a month as well as conducting school visits, visiting households and market places to test water and food samples. Two (2) out of 20 health facilities conducted outreach services on a very regular basis. These health facilities were able to conduct outreach services on a weekly basis. They were able to visit one or two of their outreach posts or centers every weeks to provide child health services, immunisation, growth monitoring and promotion as well as other services.

Regular outreach activities by health facilities are important in promoting the health of the people in the communities. Through outreach services, health facilities are able to promote their services and educate people on health issues. This enables people to prevent and control diseases at an individual level. However, very few of the identified health facilities conducted outreach activities. Furthermore, even the few health facilities which conducted outreach activities were not able to do them on a regular basis. These health facilities were therefore not able to effectively prevent diseases at community level. The findings of this study are similar to those by the World Bank (2009) in which it was found out that there were weaknesses in health education and promotion activities by primary health care facilities in the two northern states of Nigeria. Only 33% of people reported having received health education and outreach services in Nigeria. In the state Kaduna and Buchi the study found out that less than 25% of health facilities were able to conduct regular outreach and health education activities. This significantly contributed to the rise in preventable diseases in the two states.

Household Satisfaction with Services Provided by Health Facilities

The study found out that satisfaction levels among households with the services provided by health facilities in Chibombo District were low. Figure 3.3 on page 59 shows that only 7 out of 100 respondents said they were very happy with the services provided by health facilities, 34 out of 100 respondents said they were happy with the services provided by health facilities, 31 out of 100 respondents said they were neither happy nor unhappy with the services provided by health facilities, 23 out of 100 respondents said they were unhappy with the services provided by health facilities and 5 out of 100 respondents said they were very unhappy.

Figure 3.3 Households satisfaction with the nearest health facility



(Source: Primary Data)

The study found out that the major source of dissatisfaction with health facilities by households in Chibombo was long period of waiting time at health facilities. Seventy six (76) out of 100 respondents said they always experienced long period of waiting time at health facilities. It took too long before one could be attended to by health personnel at health facilities, 21 out of 100 respondents said they were sometimes subject to long waiting time while 3 out of 100 respondents said they were rarely subjected to long waiting time.

Forty three (43) out of 100 respondents said there was lack of personnel at health facilities, 31 out of 100 respondents said they rarely experienced this problem while 26 out of 100 respondents never experienced lack of personnel at health facilities.

Forty six (46) out of 100 respondents said they sometimes experienced shortages of drugs and medical supplies at health facilities, 17 out of 100 respondents said they rarely experienced shortages of drugs and medical supplies while 33 out of

100 respondents said they never experienced shortages of drugs and medical supplies.

Seventeen (17) out of 100 respondents said they always experienced lack of respect or attention by health personnel at health facilities, 30 out of 100 respondents mentioned that they sometimes experienced this problem, 12 out of 100 respondents rarely experienced this problem although 41 out of 100 of respondents said they had never experienced this problem.

Fifteen (15) out of 100 respondents said they were sometimes dissatisfied with the quality of services provided by health facilities, 31 out of 100 of respondents said they experienced this problem on rare occasions while 54 out of 100 of respondents said they had never experienced dissatisfaction with the quality of service provided by health facilities.

The major causes of dissatisfaction with service provided by health facilities in Chibombo District were long period of waiting time, lack of personnel and shortages of drugs and supplies. Although other reasons like lack of respect or attention, quality of service provided and cleanliness of the surrounding were mentioned, they were not a big factor. Patient satisfaction with services provided at health facilities is very important as this can encourage or discourage them from using the health facilities. When households are dissatisfied with services provided, they tend to underutilise health facilities. The findings of this study are similar to those by Afrobarometer (2011). The survey on Trends and Opinions in Public Health Care in Zimbabwe found that the most commonly cited problem of health care delivery in Zimbabwe, mentioned by 47% of respondents was lack of medicines and supplies while 44% complained that they had to wait for a long time before being attended to. One in three (33%) of respondents were often treated poorly by staff and 39% regularly found health personnel to be absent.

Conclusion

Although primary health care facilities existed in Chibombo District, they were inadequate as population growth had outstripped the capacity of available facilities to satisfy the demand for health service. The available health facilities were also poorly maintained and lacked basic amenities. The majority of health facilities provided most of the health services which are supposed to be provided at primary health care level although oral health and mental health services were not provided in all the health facilities. Very few health facilities provided youth friendly services as well as Antiretroviral Therapy (ART). There was also lack of integration in the provision of primary health services. Access to particular services was limited to specific days which were allocated by the health facilities. Most health facilities did not operate on public holidays and their operations were limited to day time. Household satisfaction with services provided by health facilities was low due to various problems such as long period of waiting time at the health facility, staff absenteeism and shortages of drugs. Having identified primary health care facilities, services provided, availability of services and household satisfaction with services, the next chapter looks at the constraints faced by primary health care facilities in Chibombo district.

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CHAPTER FOUR

CONSTRAINTS FACED BY PRIMARY HEALTH CARE FACILITIES

Introduction

This chapter discusses the constraints faced by primary health care facilities in Chibombo District. In order to effectively provide health care to people in the communities, health facilities should be adequately staffed with trained personnel who are able to effectively discharge their duties. There is also need for health facilities to be adequately stocked with essential drugs and equipment at all times, this enables health personnel to provide health services without interruptions. Health facilities should have transport to be able to take patients who need specialist care to referral centers or hospitals. Funding to health facilities should also be sufficient to enable them meet their operational costs. Therefore, this chapter examines the availability of health personnel, drugs, equipment and sufficiency of budgetary allocation to health facilities in Chibombo district. The chapter also examines the availability of transport for patient referral in primary health care facilities.

Human Resources Constraints

The study found out that most of the identified health facilities in Chibombo District were understaffed. The number of health care personnel also varied significantly between health facilities. Of the sixteen (16) health centers identified, one (1) health center only had one (1) health personnel. Eleven (11) health centers had two (2) health personnel each, three (3) health centers had three (3) health personnel each and one (1) health center had five (5) health personnel. Of the four (4) health posts identified, three (3) health posts had one (1) health personnel each while one (1) health post did not have trained health personnel. There was a Classified Daily Employee (CDE) who was attending to patients at this health facility.

Half, 20 out of 40 personnel providing health services in the identified health facilities were Zambia Enrolled Midwives (ZEM), 10 out of 40 were Environmental Health Technicians (EHTs), 8 out of 40 were registered nurses and 1 out of 20 was a Classified Daily Employee (CDE). Of the four (4) health posts, three (3) had one (1) Zambia Enrolled Midwife each and one (1) health post only had a Classified Daily Employee. The composition of the staff in health centers was also different. Among the eleven (11) health facilities which had two (2) trained health personnel each, six (6) had one (1) registered nurse and one (1) Zambia Enrolled Nurse (ZEM) each while five (5) health centers had one (1) registered nurse and one (1) Environmental Health Technician (EHT) each. The three (3) health centers which had three (3) health personnel each had the following staff composition, two (2) had two Zambia Enrolled Midwives and one Environmental Health Technician each while one (1) health centers had one (1) registered nurse, one (1) Zambia Enrolled Midwife and one (1) Environmental Health Technician. The health center with one staff only had an Environmental Health Technician (EHT). The health center which had five (5) health personnel had one (1) clinical Officer, two (2) registered nurses, one (1) Zambia Enrolled Midwife and one (1) environmental health technician.

The observed staffing levels in most of the health centers were below the required staff establishment for health centers and health posts. The required staff establishment for a health centers is three (3) trained health personnel while for a health post is one (1) trained health personnel. Thirteen (13) out of 20 identified health facilities had shortages of personnel, this made it difficult for them to operate effectively due to unmanageable workloads. For example, Mboshya Health Center had one (1) trained personnel who had to attend to over forty (40) patients who came to seek health care. However, the World Health Organization (WHO) recommends fifteen (15) as the highest number of patients to be attended to in a day by one health personnel. Health personnel also complained that they sometimes worked at night when there was an emergency such as helping an expecting mother to give birth. The same health personnel who was working at

night had to continue working during the day. This was worse in health facilities which had one health personnel. In order to get some rest, the health workers reported for work very late the following day and in some instances they ended up closing the health facilities early. This situation led to disruptions in the normal operations of health facilities. Health personnel also complained of negative incentives which they faced such as low remuneration, late payment of allowances, poor accommodation, lack of transport and poor state of feeder roads.

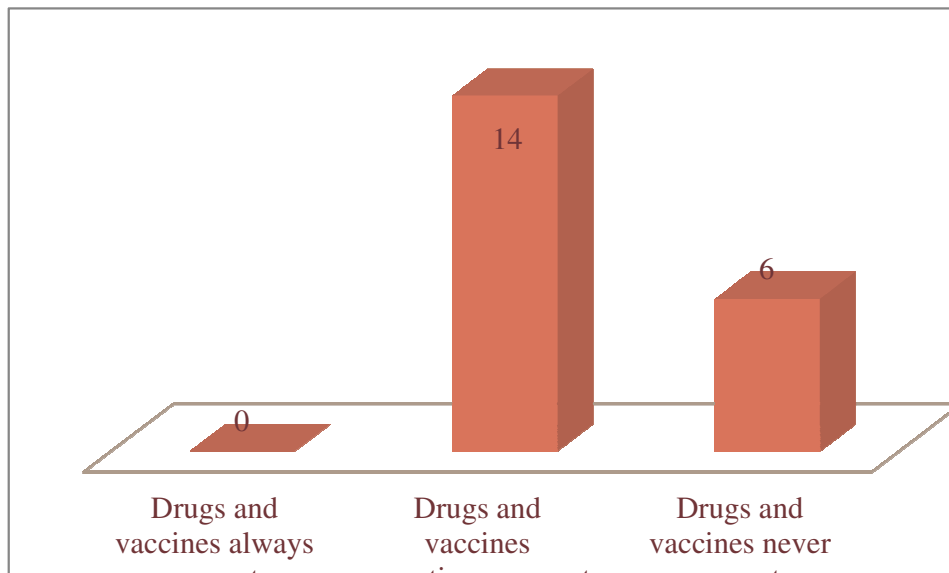
Furthermore, due to shortages of personnel, Environmental Health Technicians (EHTs) who are trained to provide environmental health services were the ones attending to patients and issuing drugs in most health centers. This is a job supposed to be done by nurses and clinical officers. The high workload at health centers made it difficult for EHTs to provide environmental health services to people in their communities but instead concentrated on clinical care, a job which they were not trained to do.

Supply of Drugs and Vaccines to Health Facilities

The study found out that supply of drugs and vaccines to health facilities in Chibombo district was done on a quarterly basis. Every three month, personnel from health facilities went to Chibombo District Health Office (CDHO) to collect drug kits. The drug kits which health facilities received consisted of all essential drugs which health facilities were supposed to administer in line with the Basic Health Care Package which was provided at primary health care level. The distribution of drugs to health facilities was done following certain indices which included the population covered by the health facility as well as the epidemiological (disease outbreak) situation in the area. All the drugs which Chibombo District Health Office (CDHO) distributed were provided by the government. Chibombo District Medical Office received drugs and vaccines from the government on a quarterly basis, these were later distributed to health facilities in the district. However, the majority of health facilities in Chibombo district

reported that they sometimes ran out of drug and vaccine supplies. Figure 4.1 below illustrates this point further.

Figure 4.1: Availability of drugs in health facilities in Chibombo district



(Source: Primary Data)

The majority, 14 out of 20 health facilities said they sometimes run out of drugs and vaccines, 6 out of 20 health facilities said drugs and vaccines never run out while no health facility indicated that they always run out of drugs and vaccines. When drugs and vaccines ran out, health facilities said they were able to request for supplementary drugs from the District Health Management Team (DHMT) and others got some from the nearest health facility which still had stocks of the drugs they needed. However there were differences in the amount of time it took to get emergency drugs. Of the fourteen (14) health facilities who reported that they sometimes ran out of drugs, ten (10) health facilities reported that it took between one (1) week and two (2) weeks for them to get supplementary drugs while four (4) health facilities said it took them between two (2) and three (3) weeks to get supplementary drugs.

Some health facilities reported that it took them long to get replenishment of drugs when they ran out of stock due lack of transport to go to Chibombo District Medical Office (CDMO) office. In instances where the health facility had no transport, health personnel had to use their own money to travel to the district and it took them long to find money for transport. Other health facilities also reported that sometimes CDMO had no supplementary drugs hence health facilities had to wait until CDMO received quarterly stocks from the government. It was mentioned that some health facilities became inaccessible during the rainy season and it took longer for these health facilities to get new stocks in case of stock outs during this period.

A key informant at CDMO acknowledged that drug shortages occurred in health facilities as a result of increased demand for health care and logistical problems in getting new supplies. Sometimes, the drug kits which health facilities got on a quarterly basis from CDMO ran out before the end of the quarter when new stocks were provided. Although health facilities were able to request for supplementary drugs from CDMO, they faced logistical challenges such as lack of money for transport or fuel to go and get supplementary drugs. Sometimes the District Medical Office (DMO) was found to have exhausted its budgetary allocation for emergency drugs hence health facilities experiencing stock out had to wait until the end of the quarter. Drug shortages affected the availability of services in health facilities in Chibombo district because during stock out of drugs health personnel could not provide services to people. Therefore, drugs shortages in health facilities led to frequent disruptions in the provisions of health services in Chibombo district.

Referral System

All the 20 identified health facilities had no transport for patient referrals. These health facilities had to call for an ambulance from Liteta hospital, which is the referral hospital for the district. Most of the health facilities were very far from the district center and the period of waiting time for the ambulance after being called

ranged between 1 hour and 3 hours. In some instances it took much longer for the ambulance to come and get a patient as there is only one ambulance which carters for all the thirty two (32) health facilities in Chibombo District.

All the identified health facilities did not provide transport for non-maternal cases. This was because the provision of transport for patient referral in the district was restricted to maternity cases, complications with pregnancies or when giving birth. All other patients regardless of the emergency had to organise their own transport. The reasons for this were lack of transport and fuel costs which Chibombo District Medical Office (CDMO) could not meet hence priority was given to maternity cases. Patients who were not eligible to be provided with transport in case of an emergency had to organize their own transport, either by hiring a van, using an ox-cart or getting on public transport.

Although most of the health facilities reported that they had a radio for communication, the majority of these facilities were not functioning. Some areas had completely no cell phone network while in other places the cell phone network was poor. This posed a challenge when it came to communicating with the referral centers. The health providers had to go to where there was cell phone network for them to get in touch with the referral center. For patients who were not eligible to being provided with transport, the health personnel only provided the patient with a referral note which they presented at the referral hospital.

During a Focus Group Discussion at Kanyanja on 6th October, 2011, participants complained that Muntemba rural health center did not provide transport for referral of other medical emergencies apart from maternity cases. It was mentioned that even after being given a referral note and told to go and organize their own transport to go to the referral hospital, it took time for a patient to go to the referral center because most families could not raise K550, 000.00, the amount required to hire a van from Muntemba rural health center to Liteta hospital. One female participant had this to say: “Money is difficult to find here in the villages, when a

patient is referred to Liteta hospital we struggle to find money to hire transport.”(A female participant at a Focus Group Discussion at Kanyanja held on 6th October, 2011). Other discussants said lack of transport was a major problem for them and they could only afford to find money for a passenger fare to use commuter vans.

Lack of transport by health facilities in Chibombo District affected their ability to send patients who need referral to the next level of care. Relying on one ambulance from the district hospital led to delays in patients getting to the referral center. This was because the distance between primary health care facilities and the referral center was very far. The issue of the time taken for patient to get to the referral center was also worsened by the fact that the ambulance was stationed very far away from the health facilities, it took time for it to reach the health facilities to pick patients. The restriction of ambulance service to maternity cases denied patients with other medical emergencies.

Budgetary Allocation

The study found out that the main sources of funding to primary health facilities in Chibombo District were government grants through the Ministry of Health (MoH), Constituency Development Fund (CDF), community contributions and donors.

Government Grants

Government grants were the major source of funding to health facilities in Chibombo District. To provide adequate and sustainable financing to the health sector, the health financing policy seeks to ensure that revenue collected through general taxes constitutes the dominant source of funding and that the government allocates a minimum of 15% of the national budget to the health sector in line with the Abuja and Maputo Declarations. In the total annual budgetary allocation to the health sector by the government, Cooperating Partners (CPs) also make a contribution directly to certain activities under the health sector which are included in the estimates of revenue when formulating the national health budget.

Constituency Development Fund (CDF)

The money which government gives to constituencies to undertake various developmental activities is sometimes used to support health projects. Although this money is not specifically meant for the health sector, Members of Parliament, councilors, Areas Development Committees (ADC), Ward Development Committees (WDC) and the Constituency Development Coordinating Committees (CDCC) do sometimes fund health centers and health posts in their constituency. However due to the huge demands for this fund in the constituencies, health facilities are seldom supported. Most of the projects supported by CDF were to do with drilling boreholes, construction of staff houses, construction of maternity wards and waiting rooms among others. However, health facilities declined to disclose to the researcher the actual amounts of money they have been receiving from CDF.

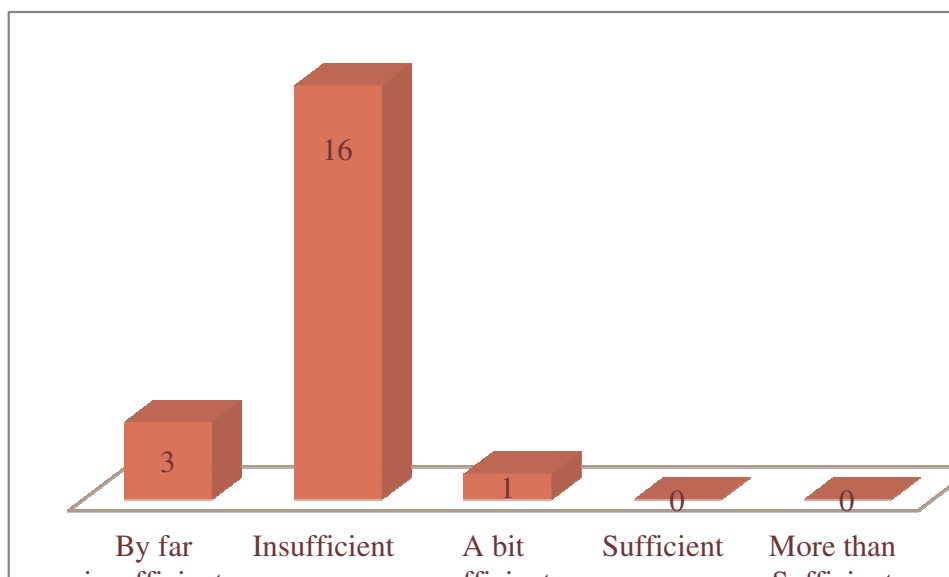
Community Contribution

Communities also made monetary contributions to health facilities. The amounts contributed varied depending on the purpose of the contribution. For example, mothers were sometimes requested to pay a fee of K1, 000.00 through their Neighborhood Health Committees (NHC) towards allowances for medical staff to conduct community outreach on child and maternal health. This was because health facilities had no money to undertake outreach services.

Donor Funding

Donors also provided direct support to health facilities to undertake projects or to fund service delivery in certain area. This support was different from what donors contributed as Cooperating Partners (CPs) towards the national budget to support the health sector. However, donor support was not provided to all the identified health facilities.

Figure 4.2: View of health personnel on budgetary allocation to health facilities.



(Source: Primary Data)

The study found out that most of the identified health facilities in Chibombo District received insufficient funding. Figure 4.2 above shows that 16 out of 20 staff in charge of health facilities said the budgetary allocation to their health facilities was insufficient, 3 out of 20 said the budgetary allocation was by far sufficient and 1 out of 20 said the budgetary allocation was a bit sufficient. Most of the staff in charge of health facilities complained of low and unrealistic indicative planning figures handed down to health facilities when making their annual budgets. The low budgetary allocation is restrictive to them when it comes to planning and implementing various programs. Even after making their budget based on low indicative figure which are handed to health facilities by Chibombo District Medical Office (CDMO), the monthly grants health facilities got were sometimes lower than what was approved in their annual budgets.

The Sister in - Charge at Mwachisompola rural health center complained that the population figures used to allocate funds to the health facility contributed to the poor performance of primary health care programmes. It was observed that census

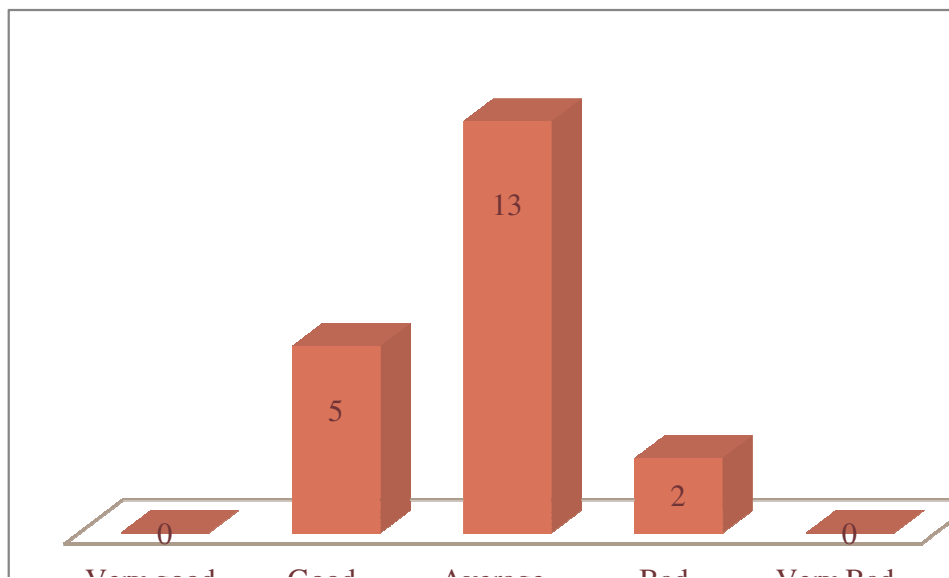
population figures used when allocating resources to health facilities were lower than the actual number of people being serviced by health facilities. This meant that health care delivery was under-budgeted and resources were inadequate to make any significant impact.

Low budgetary allocation to health facilities in Chibombo District undermined their ability to effectively provide services to people in the communities. Budgetary constraints prevented many health facilities from performing their core functions such as environmental services and community outreach programmes because funds allocated to them could not meet the cost of conducting these activities on a regular basis. The infrastructure in most health facilities was also reported to decaying, due to low budgetary allocation, Chibombo District Health Management Team (CDHMT) could not carryout renovations of health infrastructure in the district. Key informants and health personnel mentioned that health facilities sometimes requested patients to buy their own medical supplies. This was due to the fact that many health facilities lacked funds to buy medical supplies when they ran out.

Availability of Equipment

The study found out that 13 out of 20 staff in - charge of health facilities said the availability of essential equipment in their health facility was average, 5 out of 20 said the availability of essential equipment in their health facilities was good while 2 out 20 staff in charge of health facilities described the availability of equipment at their health facility as bad. Figure 4.3 on page 73 illustrates this point. Those who described the availability of essential equipment in their health facilities as bad or average cited lack of equipment like BP machines, pressure sterilisers, shortages of suction tubes, examination couch, adult weighing scale, refrigerator, pregnancy test kits, shortage of beds for patient admission, microscopes, shortage of tables and chairs, cord clamps, gloves, cotton wool, and drug kits for community health workers.

Figure 4.3: Views of health personnel on the availability of equipment in health facilities.



(Source: Primary Data)

All the health facilities surveyed reported that they had no budget line for maintenance or replacement of equipment. When equipment needed to be repaired or replaced, health facilities merely report to the Chibombo District Health Management Team (CDHMT). This was because all the equipment in health facilities had to be bought by CDHMT. It sometimes took a year or more to have equipment replaced because there was no money kept for repair or maintenance of equipment by CDHMT. All expenses for replacement or maintenance had to be put in the annual budget for the following year by the district.

Fifteen (15) out of 20 staff in - charge of health facilities described the availability of equipment in their health facilities as average or bad. Shortages of equipment affected service delivery in Chibombo District because health personnel could not effectively provide health services in the absence of required tools. Shortages of equipment did not only compromise the quality of services provided, it was reported that health facilities sometimes suspended the provisions of certain services as they could not be provided without the required equipment. For

example, shortages of pregnancy test kits and Rapid Diagnostic Treatment (RDT) for malaria made it difficult for health personnel to conduct standard diagnosis but were instead made to rely on symptomatic treatment which is at times faulty or inappropriate. Furthermore, lack of refrigerators in health facilities affected the supply of medications because health facilities were not able to stock sufficient quantities of drugs due to lack of storage facilities.

Conclusion

It has been shown that service delivery by health facilities in Chibombo District is hampered by shortage of personnel, insufficient budgetary allocation, shortages of drugs, poor referral system and lack of equipment. Staffing levels in most health facilities were below the required staff establishments. The available health personnel also faced constraints such as high workload, low remuneration, late payment of allowances, poor accommodation and limited training opportunities. Drug stock outs experienced by health facilities caused disruptions in health care delivery. The referral system was also ineffective mainly due to lack of transport by health facilities and the poor road network which made it difficult for patients to get to the referral center. Shortages of equipment affected the quality of service provided as some service provided did not meet required standards. Furthermore, health facilities budgetary allocation was mainly from government grants was insufficient to sustain operations. This negatively affected the ability of health personnel to effectively perform their duties. Having discussed the constraints faced by health facilities, the next chapter discusses the barriers to accessing health services by communities in Chibombo District.

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CHAPTER FIVE

BARRIERS TO ACCESSING HEALTH SERVICES IN CHIBOMBO DISTRICT

Introduction

This chapter discusses the barriers which people face in accessing primary health care services in Chibombo District. The barriers have been looked at in various contexts such as, physical, socio-economic, cultural and quality of service provided by health facilities. According to Babar and Hatcher (2004), utilisation of a health care system, whether public or private, depends on socio-economic factors, social structures, levels of education, cultural beliefs and practices, environmental conditions and the health care system itself. For people living in rural areas poverty coupled with illiteracy, inadequate water and sanitation facilities have a deep impact on health indicators. It is therefore important to understand the barriers to accessing health services as these explain the impediments to health care delivery in Chibombo district.

Physical Barriers

The study found out that physical accessibility was one of the barriers to accessing health services in Chibombo district. Sixty three (63) out of 100 respondents said they often experience distance as a problem in accessing health services at health facilities. Twenty (20) out of 100 respondents said they have experienced distance as a challenge in accessing health services at the facility a few times, 11 out of 100 said they have experienced distance as problem once or twice while 6 out of 100 said they had never experienced distance as problem in accessing health services at the health facility.

During Focus Group Discussions (FDGs), most participants said health facilities were very far and it took them a lot of time to get there. They further complained that during the hot season, they had to walk in the scorching sun and even got

soaked during the rainy season. Some discussants further explained that it was not possible for a person to set on a journey to the clinic on a rainy day, one had to make sure that it was not going to rain so that they would go to the health facility. Most of the discussants said they had to borrow a bicycle from someone for them to get to the clinic as the distance they covered was too long. With regards to the distance covered to get to health facilities, a female participant at a Focus Group Discussion in Chitanda ward held on 10th October, 2011 repeated the views of the majority when she said, “As it is far I would have to go in an ox-cart or on a bicycle, which I don’t have. I have high blood pressure and cannot walk for a long distance. Because I can’t get there I sometimes treat myself, which is dangerous but I am only risking myself.”

In the same vein, a male participant at a Focus Group Discussion in Chitanda ward held on 10th October, 2011 put it as follows: “While you are healthy it is okay, but if you get a snakebite that is not simple, you have to hope to God it’s not a stormy day with much rain. How would you get a sick person out of here? Walking is impossible, a vehicle would not get there, a patient would die!”

Yet a female participant at a Focus Group Discussion in Keembe ward held on 15th October, 2011 had this to say, “Transport is a problem if you don’t have money. Sometimes I use a bicycle or sometimes a good Samaritan will take you by coach cart. It is 12km, it would take 2 hours to walk.”

Key informants mentioned that there were few health facilities in Chibombo District. This forced people to travel long distances to seek care. The road network was also bad, most of the roads were in a bad state and even by bicycle or ox-cart it was an ordeal to get to the health facilities during the rainy season. For example, Mboshya rural health center was reported to be poorly located. The health center is far from the main communities and is surrounded by streams and there are no bridges, during the rainy season even a vehicle cannot reach this health facility.

Key informants noted that poor the state of roads made it difficult for people to reach facilities when they had an emergency. A member of Namayani Neighbourhood Health Committee made this complaint during an interview held on 20th October, 2011: “Because of long distance to health facilities and the poor roads, some expecting mothers give birth on their way to the clinic and this has happened several times. With such incidences a very sick person can even die on the way.” As a result of the difficulties in getting to health facilities most expecting mother would rather give birth at home with the help of a traditional birth attendant instead of risking giving birth on their way to the health facility.

In rural areas like Chibombo, the effect of distance on access to health facilities becomes stronger when combined with the absence of transportation and poor roads, which increase challenges faced to access health services. Physical distance to health facilities and time taken to reach the facility are a huge barrier to accessing health services. Similar findings by Duong et al (2004) show that distance separating patients from the nearest primary health care facility was an important barrier to service use, particularly in rural areas where distance was found to be a disincentive to seeking health care. The study also revealed that the factor of distance was more pronounced than other factors such as lack of transport.

Economic Barriers

The study found out that costs which people incurred at health facilities in Chibombo District hindered access to health services. During focus group discussions, it was revealed that women who went to give birth at health facilities were required to buy items like buckets, surgical gloves, a baby blanket, towel, shawl, nappies and other baby clothes in order to have a complete baby suit. In the absence of these items, some clinics did not discharge the women after giving birth until these items were bought. However, a lot of women complained about this arrangement because most of them had to sell their property to buy these items. A female participant at a Focus Group Discussion in Kalola ward held on 3rd October, 2011 represented the views of the majority when she said: “Most women

would rather give birth from home because it is embarrassing when you go to deliver at the clinic and you do not have the required items.”

This view was also expressed by another female participant at a Focus Group Discussion in Keembe ward held on 15th October, 2011 who said: “Finding the baby items which are required at the clinic is a nightmare for most families here. Money is very difficult to come by here in the village.”

Other women said they would rather call for a traditional birth attendant to help them give birth because they did not demand for items which were demanded at the clinic. It was mentioned that traditional births attendants did not charge anything but were given a token of appreciation by the women they helped to deliver. This token of appreciation could be in “kind”, that is in form of a gift like a chicken, goat, a bucket of maize, groundnuts, a chitenge material or any material item which a woman could afford to give. The token of appreciation could also be given as “cash”. When it is cash the person who has been assisted to deliver gave the traditional birth attendants any amount of money they could afford. Furthermore, the appreciation given to traditional birth attendants could be paid anytime whenever one was ready.

Participants at Chitanda ward complained that they were charged K70, 000.00 at the clinic to get an under 5 card for a baby born at home. This penalty fee was introduced to discourage women from giving birth at home but this had become a barrier to accessing health services by children. This was because most women continued to give birth at home due to distance and other challenges they faced to get to health facilities. Therefore, women who gave birth at home could not take their children to the clinic until they raised the penalty fee.

Participants at a Focus Group Discussion in Malambanyama held on 12th October, 2011 said most people could not raise transport money to go and receive treatment when they were referred to Liteta hospital. A male participant put it as follows: “It

is easy for people who have transport to take their patients to the referral center. For us who do not have transport we have to move from house to house before you find someone who could lend you money for transport.”

Another male participant at the same Focus Group Discussion in Malambanyama held on 12th October, 2011 had this to say: “It is difficult for people on Antiretroviral Therapy (ART) to find money for transport to go and get free drugs at Chiyuni Rural Health Centre. It costs K15, 000.00 to go, plus coming back its K30, 000.00. You do not only need to budget for transport but food as well. When you go in the morning, expect to come back late in the afternoon. The distance is long (25KM) and you have to be prepared to stand in a long queue.”

Most of the participants in the Focus Group Discussions mentioned that they found it difficult to raise money for transport when they had an emergency or were referred to the next level of care. They noted that patients delayed in going for treatment because most of them had to sell property to raise money. The longer it took to find money for transport, the more the patient was delayed to go to the referral center.

Key informants also mentioned that there were instances when patients with chronic illnesses such as HIV/AIDS failed to go and collect drugs due to lack of money for transport to go to health facilities. Furthermore, some health facilities requested patients to buy their own medical supplies whenever they ran out at the clinic. This proved to be a challenge to those who could not buy their own medical supplies as they could not receive the services they needed at the clinic.

Although the Zambian government adopted the Free Health Policy, there are still some direct and indirect costs which people incur when accessing health services at health facilities in Chibombo District. These hinder a lot of people from accessing health services as they cannot meet the costs. This problem is compounded by high poverty levels in rural areas. Some of these costs have arisen

due to inadequate funding to health facilities by the government where people are sometimes requested to buy their own medical supplies.

Quality of Service Provided by Health Facilities

The study found out that dissatisfaction with services provided by health facilities impeded access to health services in Chibombo District. Focus Group Discussions revealed that some people in the community failed to go to the clinic due to dissatisfaction with the services provided. Drug shortages which health facilities experienced had created negative perceptions among people as they tended to think they would not be given drugs at the clinic. Some participants said, when they went to the clinic they were sometimes told to come later when the drugs were in stock. So instead of going to the clinic and be told there were no drugs after walking a long distance, some people opted to look for money to buy their own medicine. Others said it was common practice at the clinic to sometimes give patients a pain killer like panadol regardless of what a person was complaining about. With regards to the quality of service provided by health facilities, a female participant at a Focus Group Discussion in Mashikili ward held on 9th October, 2011 said the following:

“What makes people not to go to the clinic is because they know that even if I go there after walking long distance I will just be given panadol, for the rest of the medicine I will be told to come later. You are not even properly diagnosed because the nurse has a lot of patients to attend to. When you consider the distance and the time I have wasted, it was better to buy panadol from the shops.”

Another male participant at a Focus Group Discussion in Chitanda ward held on 10th October, 2011 put it this way: “Often, clinics just give prescriptions because they have no drugs. It’s not like in the past when we could go to hospital and get drugs. The only drugs we can get are Panadol (a painkiller) and Flagyl (for diarrhoeal diseases).”

During Focus Group Discussions, participants also said health personnel were sometimes not found at the health facilities. They complained that during the rainy season the health providers first went to their fields and came for work later. “If you went to the clinic very early in the morning you will be kept waiting until the health provider finishes what he is doing at his fields.” (Views of a female participant at a Focus Group Discussion in Kanyanja ward on 6th October, 2011). Negative attitudes by health personnel were also reported by youths in their Focus Group Discussion. The majority said they were reprimanded by the nurses when they went to ask for contraceptives like condoms. The youths said it was even worse when one was found with an STD (Sexually Transmitted Disease) because the health providers were very harsh. This forced most youths to seek help from traditional healers in order to avoid getting embarrassed by the health providers at the clinic.

It was also mentioned that there was no privacy at some health facilities as expecting mothers were mixed with other patients due to lack of separate delivery rooms. However, the standard medical requirement is that expecting mothers should not be mixed with other patients. Therefore, instead of delivering in such an environment, some expecting mothers would rather deliver from home with the help of a traditional birth attendant where their privacy would be guaranteed. Some women mentioned that a lot of expecting mothers also opted to give birth at home as they felt insecure to go to health facilities due to staff shortages. It was reported that health personnel in most facilities were never there to monitor expecting mothers during labour instead they were left to be monitored by cleaners.

Overcrowding and understaffing in health facilities were also mentioned as reasons why some people avoided going to health facilities. The discussants in Focus Group Discussions said people in the community sometimes felt lazy to go and stand for a long time in a queue at the clinic. Shortages of staff in most health facilities coupled with overcrowding worsened the amount of waiting time. As one participant observed: “Sometimes when you look at the number of people waiting

to see the nurse, you would think twice, whether to join the queue or come another day. If you are not feeling very bad, it is better you just go back home and come some other day.” (Views of a female participant at a Focus Group Discussion in Mashikili ward held on 9th October, 2011). Some health facilities did not even have enough benches where patients could sit while waiting to be attended to. This made the process of waiting very difficult as people were made to wait while sitting on the floor or standing.

In health facilities which had one health personnel, there were times when a health provider was too tired to attend to patients because he or she was attending to an emergency at night. A member of Namayani Neighbourhood Health Committee had this to say during an interview held on 20th October, 2011: “Sometimes a nurse can work the whole day alone and when she knocks off, an expecting mother is brought and she will spend the whole night waiting for the woman to give birth. The following day the nurse is too tired to attend to patients.” Other key informants said disruptions with service provision also occurred at health facilities when the nurse went to town or was out for a funeral or family problem. This is because there was usually no one to sit in for her in such situations except for the cleaner and when people went to the clinic, they were told to go to other health facilities or come when the nurse was around.

Satisfaction with the quality services provided at health facilities affect access to health services in Chibombo district. The findings of this research are similar to those by Newman et al (2003) the study found that low use of public health centers in Manica Province was attributed to issues of accessibility, long waiting time, short or inflexible opening hours, shortages of staff and drugs, poor staff attitude and lack of confidentiality in socially stigmatized diseases. Client-perceived quality of services and confidence in the health provider also affected the health service utilisation.

Cultural Barriers and Lack of Information

Cultural Barriers

Cultural norms, values and beliefs were mentioned as obstacles to accessing health services in Chibombo District. Most participants in Focus Group Discussions said it was very common in their communities for people to try consulting family members or elderly people before going to the clinic. The reason for this was that elderly people were perceived to be more knowledgeable and their advice on health issues could not be ignored. It was also mentioned that it was still common among people in their communities to relate certain health problems to traditional beliefs. As one participant said, “If a child cries too much, some parents do not think of taking the child to the clinic because it is assumed that it could be ancestral spirits who may have rejected the name which had been given to the child.” (Views of a member of Kalola Neighbourhood Health Committee during an interview held on 3rd October, 2011). Even in instances where an adult falls ill from an illness which is not common, the first thing which is suspected is witchcraft and people try to seek treatment from traditional healers. When things fail, that is when they think of going to the clinic. Key informants said some people in communities still held beliefs that a baby should not be taken in public even going to the clinic because it is culturally believed that a baby may contract diseases once taken to such places. Therefore, due to such beliefs some mother could not take their babies for child health services such as growth monitoring and immunisation unless the child fell sick then the mother would take the child to the clinic.

Most key informants revealed that traditional beliefs were a major obstacle to accessing family planning services in Chibombo District. Due to cultural values, children are seen as a source of wealth among certain families as having a lot of children would enable one to have a big workforce to support farming activities. There was also a notion that having a lot of female children would translate into wealth when they got married. Although most people in Focus Group Discussions said they had heard of family planning, some still believed that there was nothing

wrong with having a lot of children. They felt that it was important for a person to have a lot of children because in old age people had to be taken care of by their children.

A key informant at Chibombo District Health Management Team reported of religious beliefs which affected access to health services during an interview on 22nd October, 2011. It was mentioned that among Christians in Chibombo District, there was an Apostolic religious sect whose faith forbade its followers from seeking conventional (modern) medicine and immunisation services. It was also mentioned that there was a preference for traditional medicines among some people hence even in instance where conventional medicine was available at health facilities, some people preferred using traditional medicines as they believed it was more effective than the conventional medicine provided at the clinic. The sister in-charge at Chiyuni Rural Health Centre had this to say during an interview held on 16th October, 2011: “We have cases whereby a people give up taking Antiretroviral Drugs (ARVs) and starts using traditional medicines thinking that these would be better than the treatment they are getting at the clinic. This has unfortunately resulted in several deaths.”

Gender based violence also affected access to health services by women in Chibombo District. During Focus Group Discussions, it was mentioned that some women had to seek permission or consent of their spouses even on matters of personal health such as using contraceptives or going for VCT. When it came to going for VCT some women complained that their husbands did not allow them, if they decide to go then it had to be done without their husbands’ knowledge. If they succeeded in going for VCT then their results were kept secret. Once the spouse discovered, a woman would be harassed and even chased from the matrimonial home.

Participants in Focus Group Discussions also noted that that the culture of early marriages among communities affected access to health services by teenage

mothers. This was because most of the young girls who were married off were too young to take care of their babies. They were also too young to take good care of themselves during pregnancy and after they delivered because they were unable to notice danger signs hence making it difficult for them to seek care at health facilities.

Lack of Information

Lack of information about health issues perpetuated stigma, discrimination as well as myths and misconceptions about certain illnesses and health services. Participants in Focus Group Discussions noted that the level of stigma and discrimination among people living with HIV/AIDS were still high among people in Chibombo district due to lack of adequate information on HIV/AIDS. This lack of information resulted in stigma against those infected and consequently those already infected were not able to disclose their HIV status for fear of isolation and discrimination. HIV was reported to be a reason for divorce, as some key informants mentioned cases of marital separation where a spouse was found to be HIV/AIDS positive. Fear of stigma and discrimination also prevented people from seeking health services such as counseling and testing due to fear of being isolated following disclosure of their status.

It was suggested by key informants that there was also need for more education and awareness raising in communities in order to increase access to health services such as family planning and Antiretroviral Therapy (ART) as some women in the communities avoid taking family planning pills because of the belief that anyone who took such drugs would never be able to have children as the medicines led to infertility in women. There were also misconceptions about the side effects of family planning drugs and ARV in communities which made people uncomfortable to utilise these services.

Lack of information on health issues among members of the community led to delays in seeking care at health facilities. It was observed that some patients only went to the clinic when their illness was well advanced and other patients did not

go for post disease checkup. This was largely due to people not having much education about health issues; this made it difficult for them to identify signs of illness which require them to seek medical attention at the clinic. Furthermore, lack of information on health issues perpetuated myths, misconceptions, norms, values and beliefs which are impediments to accessing health care at health facilities.

Conclusion

It has been established that physical, social, economic, cultural, quality of services provided and information barriers hamper access to health services by people in Chibombo District. Distance to the health facilities coupled with poor state of roads act as a disincentive in accessing health services. Although the government adopted a policy of free health care, there were still indirect costs to accessing health services which people incurred hence lack of income was still an obstacle to accessing health services. This chapter has also revealed that lack of satisfaction with the quality of services provided by health facilities, lack of adequate information on the services provided, cultural norms and values as well as social factors hinder people from accessing health services. In view of the challenges which communities face in accessing health services, the next chapter discusses community participation in primary health care delivery in Chibombo District.

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CHAPTER SIX

COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE

Introduction

This chapter discusses community participation in primary health care. In order for primary health care delivery to be effective in Chibombo District, people must be able to participate at both individual and community level in the provision of health care. Community participation in health care enables members of the community either individually or collectively to assume greater responsibility for their health needs and problems. According to Rifkin (1996), the expected outcomes of community participation in the health sector include more health consciousness which pushes up the demand, more access to health care through community-level workers and improvement of community level health infrastructure. Therefore, this chapter examines community participation in health care delivery in Chibombo district by discussing the scope of community participation, people's knowledge of community participation, attitude towards participation and obstacles to community participation in primary health care in Chibombo district.

Scope of Community Participation in Primary Health Care

Planning and Management

The study found out that there are decentralised structures of health care management in Chibombo District known as Neighborhood Health Committees (NHCs). All the identified health facilities serviced specific catchment areas and within a catchment area there were several Neighborhood Health Committees (NHCs) which worked hand in hand with health facilities. At the health facility level, each health center or health post has a Health Center Committee (HCC) which is made up of all the Chairpersons of NHCs in the catchment area serviced by the health facility. During the annual planning process for the district, NHCs, who are representatives of the community, meet with members of the community

to review experiences, determine priorities and to agree on community actions. Community representatives thereafter meet with staff at the health facility to draft community action plans. The community action plans are then submitted to DHMT for inclusion into the district action plan which is later submitted to the Ministry of Health through the Provincial Health Office, Government of the Republic of Zambia (2010). Communities in Chibombo District participated in the day to day management of health facilities through their elected representatives who are Chairpersons of the Neighborhood Health Committees (NHCs). Chairpersons of NHCs are members of the Health Center Committees (HCCs). The HCCs were responsible for managing the operations of health facilities.

Budgeting

Community members in Chibombo District participate in budgeting for health care activities in the district. Every year Neighborhood Health Committees (NHCs) identify activities which they want to undertake and these are submitted to Chibombo District Health Management Team (CDHMT). After the community action plans have been submitted to CDHMT, NHCs are then given budget ceiling for their action plans which they use as a guide in budgeting for community health activities. At the health facility level, community representatives (Chairpersons of NHCs) also take part in formulating the budget for the health center or health post as members of the Health Center Committees, (Ibid).

Service Delivery

The finding of the study revealed that members of the community participated in the provision of health services as community health workers. The following are the categories of community health workers who were identified in Chibombo District and the service they provide:

Twelve (12) out of 20 identified health facilities had trained some community members as malaria agents. The malaria agents were providing Rapid Diagnosis Testing (RDT) to people in their communities, administer malaria drugs, distribute

Insecticide Treated Mosquito Nets (ITMNs) and conducting sensitisations on malaria prevention.

Sixteen (16) out of 20 identified health facilities had trained some community members as HIV/AIDS counselors. The counselors were providing HIV/AIDS counseling in their community and at the health facility on days when the health facilities were providing HIV/AIDS counseling.

Five (5) out of 20 identified health facilities had trained some community members as nutrition advisors. The nutrition advisors were involved in teaching mothers in their communities about nutrition. They were also providing their service to mothers at the health facilities who went for under 5.

Twelve (12) out of 20 identified health facilities had trained community members to provide Direct Observation Treatment (DOT) to tuberculosis (TB) patients in their communities. TB treatment supporters were working as adherence counselors to patients on TB treatment. They were also conducting sensitisation on TB to people in their community.

Six (6) out of 20 identified health facilities had trained some community members as growth promoters. Growth promoters were conducting sensitisations on how to monitor the growth of children, advising mothers on how to prevent illnesses in children and how to notice signs of ill health.

Three (3) out of 20 identified health facilities had trained community members in Integrated Management of Child Illnesses (IMCI). Those trained were providing diagnosis and treating all the major illnesses in children. They were also attending to children at clinics during Under 5 besides providing services to children in the community.

Fourteen (14) out of 20 identified health facilities had trained some community members in Home Based Care. Those trained were working as caregivers who looked after HIV/AIDS patients and other patients who were not able to take care of themselves. They were also sensitising people in the community on HIV/AIDS prevention, treatment and support. Eleven (11) out of 20 identified health facilities had trained some community members as traditional birth attendants (TBAs). Those trained were helping expecting mother to deliver.

Six (6) out of 20 identified health facilities had trained some community members in safe motherhood. Those trained were mobilising pregnant women in their communities to access antenatal services at health facilities. They were also sensitising pregnant women on danger signs during pregnancy.

The study also found out that the community in Chibombo District participates in construction of health facilities by providing labour, building materials and transport. Four (4) out of 20 (20%) of health facilities identified in this study were built by Non-Governmental Organisations (NGOs) in partnership with the community. The communities provided 25% of the total project cost while the donor, Christian Children Fund (CCF) contributed 75 %.

The community in Chibombo District participates in primary health care delivery through planning of community health activities, management of health facilities, construction of health facilities and provision of health services as community health workers. However, there were very few communities which had community health workers in Chibombo as most of the identified health facilities said they did not have money to train more community health workers. Furthermore, the available community health workers worked as volunteers and were not paid anything for their work; this discouraged a lot of people from continuing with their voluntary work. There were other negative incentives which community health workers faced such as shortages of drug kits and lack of transport.

Knowledge of Community Participation in Primary Health Care

The study found out that 64 out of 100 respondents in this study did not know members of their Neighbourhood Health Committees (NHCs), however, when asked if they had heard of NHCs, 82 out of 100 said they had heard of NHCs. With regards to the roles of the neighborhood health committee, the majority of respondents only knew about the service delivery roles performed by the NHCs.

Thirty two (32) out of 100 respondents said the role of the Neighborhood Health Committee (NHC) was to distribute drugs to sick people, 16 out of 100 respondents said the role of the NHC was to distribute mosquito net, 25 out of 100 respondents said the role of the NHC was to educate the community on health issues such as HIV/AIDS, family planning, hygiene, safe motherhood, TB and other illnesses. Seventeen (17) out 100 respondents said the role of the NHCs was to inform people of what was happening at the clinic while 10 out of 100 respondents said the role of the NHC was to inspect sanitary facilities in the community.

Seventy (70) out of 100 respondents did not know how members of the Neighbourhood Health Committee (NHC) came to occupy their positions. They thought NHC members were appointed by the sister in - charge at the health facility while 30 out of 100 said NHC members were elected by community members. Furthermore, among people who did not know how members of the NHCs occupied their positions, some thought NHC members were employees of the local clinic and were therefore not accountable to the community. Participants during focus group discussions said they were only called for meetings by the NHCs if there was work at the clinic or monetary contributions which the NHCs wanted community members to make. Even when community members were requested to make monetary contributions by NHCs, they were not told how much money the NHC wanted to raise. One male participant at a Focus Group Discussion in Mashikili ward held on 9th October, 2011 had this to say, “These

people (NHC members) are not known by the majority of community members because they rarely call for meetings.”

When community members were asked if they were told about the money allocated to community activities by Chibombo District Health Management Team (CDHMT) in the annual budget, most participants in Focus Group Discussions said they did not know anything about budgetary allocations as none of them could ever remember being called to a meeting to talk about the budget for community health activities. Most participants thought it was not for the community to decide on what they wanted to do and how much money they needed, they thought the community was there to follow what was said at the clinic.

Other participants said although community members were not called for regular meetings by NHCs or involved in issues to do the planning for health services and budgeting, they said NHCs had done a good job in teaching them about how to prevent diseases. “We have been taught how to keep our surroundings clean by slashing long grass and covering stagnant water with soil so that we can protect ourselves and children from malaria.” (Views of a male participant at a Focus Group Discussion in Mashikili ward held on 9th October, 2011). Other participants also said everyone in their village now knew about malaria and the importance of using insecticide treated mosquito nets. Another participant represented the views of the majority when she said: “We now know about putting chlorine to drinking water in order to prevent diarrhea and cholera. If you do not have chlorine you can even boil your drinking water to kill germs.”(Views of a female participant at a Focus Group Discussion in Mashikili ward held on 9th October, 2011).

Key informants further explained that in most villages there were Non-Governmental Organisations which were sensitising the communities on various health issues such as personal hygiene, child health, nutrition, HIV/AIDS, malaria, TB, cholera, diarrhea and other health issues. A lot of people were being reached with information on health through community outreach programs.

While most people were aware of the decentralized structures of community participation in health care delivery in Chibombo district, 64 out of 100 respondents said they did not know member of their Neighbourhood Health Committee (NHC) and how they came to occupy their positions. The people at the grass roots were also not informed of issues of budgetary allocation to community activities as NHCs rarely held meetings. However, communities are supposed to hold elections every year to elect members of their NHCs. It was revealed that most NHCs had never held elections from the time they were formed. Furthermore, most people did not know much about the roles and responsibilities of NHCs. The identified weaknesses with NHCs in Chibombo district excluded the majority of people from taking part in decision making concerning the delivery of health care. Most people in the communities were knowledgeable about how to prevent illnesses at household and community levels in view of the sensitisation they were receiving although most of the awareness raising which was done in the communities was in the area of HIV/AIDS, hygiene, malaria and diarrhea.

Attitudes of Community Members towards Participation in Primary Health Care

The study found out that the attitude of community members towards participation in health care varied depending on the level of participation being sought. It was found that community members were more willing to contribute their labor to health projects as well as to be trained as community health workers. During Focus Group Discussions a lot of community members expressed willing to be trained as community based volunteers.

Key informants mentioned that it was prestigious to be a community health worker and to be approached by people in the community for help. The chairperson on the Namayani Neighbourhood Health Committee had this to say during an interview held on 20th October, 2011: “When the Neighbourhood Health Committees are requested by the health facility to select people to be trained as community health workers, there are always complaints from community members as to why they

have not been considered. However when it comes to performing menial work like fetching water, mounding building blocks or cleaning the surroundings, very few people are willing to volunteer.” It was also revealed that community members were not good at attending meetings to discuss health issues, when meetings were called very few people went, this had forced NHCs to abandon the idea of calling for regular meetings. When NHCs had urgent information they just informed a few people who were in turn requested to inform their neighbours.

It was also explained by some key informants that sometimes community members were not willing to participate in health projects because they thought donors or government had already provided the money. There were times when the Health Centre Committees (HCCs) identified problems at the health facility and requested the community to make contributions, community members were usually skeptical as they tended to think someone wanted to steal their money even when they were able to see the need for such a project.

In the same vein, a female participant at a Focus Group Discussion in Kalola ward held on 3rd October, 2011 put it this way: “The community does not see any sense in participating in projects because they tend to feel that they were not involved right from the beginning. They are also not sure of the benefits of participating in such activities, especially if they had a bad experience from their previous contributions. Sometimes they believe that donors or government have given money for everything.”

At household level, it was found that individuals were still not able to participate in health care by safeguarding their own health. A female member of Kalola Neighbourhood Health Committee had this to say during an interview held on 3rd October, 2011: “Even after distributing mosquito nets to pregnant women, some of the recipients do not use them because they say they feel uncomfortable to sleep under an Insecticide Treated Mosquito Net (ITMN).” Some members of the Neighbourhood Health Committees (NHCs) who were interviewed complained

that some people did not use the chlorine which they distributed for free to households because they did not like the test of chlorine.

With regards to participation by individuals in improving their health at household level, a male member of Namayani Neighbourhood Health Committee represented the views of the majority during an interview held on 20th October, 2011 when he said: “Even when we tell households to come and get bottles of chlorine every month, most of them do not come. They just like rushing to us when they are sick to ask for help.”

The chairperson of Kalola Neighbourhood Health Committee put it this way during an interview held on 3rd October, 2011: “When we go round the villages, we still find a lot of households with dirty surroundings. Some households do not have toilets despite the NHC having taught them about hygiene and sanitation. When asked why they do not have toilets, they give unnecessary excuses like, we were busy at the fields or we were thinking about doing that tomorrow. Even when we go back for inspections after three months, we still find the same situation and we are given the same excuses.”

Although most community members were knowledgeable about how to prevent diseases at individual or household level, there were negative attitudes among community members towards adhering to measures aimed at preserving their health. Most members of NHCs explained that even after introducing penalty fees for not complying with agreed action points, community members were not adhering to these action points. This signifies that although knowledge about health issues is important for mobilising communities to take care of their own health, such knowledge does not guarantee adherence to good health practices. It is therefore important that that behaviour change be promoted at individual and community level in order to enhance community participation in primary health care.

Perception of Community Members towards Participation in Primary Health Care

The study found out that people in Chibombo District did not see themselves as having much to do in primary health care delivery as they did not consider themselves as initiators or decision makers when it came to health matters in their communities. Participants in Focus Group Discussions were of the view that because the ordinary community members did not know how to read and write, all decision making and issues of planning should be done by the health facility. They said the community could not change or influence decisions which were made by the health facility.

However, when it came to the participation of community members in providing health services to people in the communities, the majority of discussants in the Focus Group Discussions said they were of the view that more community health workers needed to be trained because they were easily accessible than health facilities which were in most cases located very far away from the communities. One of the discussants mentioned that when she went to see a community health worker, she was given more attention than at the health facility. She said the community health worker was fast to attend to patients unlike at the health facility where patients waited for a very long time before being attended to. It was further mentioned by other participants that at the clinic, the nurse spent very little time with patients and did not ask or explain much to them. Some community members disclosed that they were more comfortable going to a community health worker than visiting a health facility. However, they complained that community health workers were rarely given drug kits hence could not do much to help patients in their communities.

A female participant at a Focus Group Discussion in Chitanda ward held on 10th October, 2011 had this to say: “In the past when Kaparu mission was being run by the Catholic Church, community health workers never ran short of drugs, we never used to go to the health facility frequently because community health workers were

able to attend to us. They could even visit sick people in their homes. Nowadays things have changed, even for headache you have to go to the clinic because the community health workers rarely have drugs, they do not even have transport to visit very sick people.”

Some Neighbourhood Health Committee (NHC) members also complained that although they were the representatives of their communities, they were less frequently invited for meetings and tend to know very little with regards to what is happening at the district level. They lamented that even though they were requested to make budgets for their communities, they were given figures or budgetary ceilings for all activities to be implement at community level. These sometimes left out the most important things which the community wanted.

In the same vein, the chairperson of Namayani Neighbourhood Health Committee put it as follows during an interview held on 20th October, 2011: “The issue is the amount allocated to us is very little, our plans are shattered upon hearing the figure (on which) to plan from. For the 2010 activities we were told to budget on about K300, 000.00. Now what can you budget on this amount? We were all frustrated but we had to do the planning anyway so as not to sour the existing relationships which are there. We ended up planning for less important things.”

Focus Group Discussion revealed that community members were more willing to go to a community health worker than going to the health facility. This was due to the fact that community health workers were more accessible and there were interpersonal relations which existed between community health workers and members of the community. Because they live together in the community, community health workers tend to know their clients very well. However, despite being regarded as important in the provisions of health services by community members, there were very few community health workers and they were constrained by limited training and shortages of drug kits. Furthermore,

community health workers did not receive any support for their work, this acted as a disincentive to them.

Obstacles to effective community participation in primary health care

The study found out that there were various issues which communities raised as obstacles to community participation in primary health care. At community level, members of the Neighbourhood Health Committees (NHCs) complained that they were no longer called very often for meetings at the District Health Management as they used to. The excuse which had been given for this by the Chibombo District Health Management Team (CDHMT) was that they lacked resources to support such meetings. There were even complaints that community representatives were kept hungry at one of the meetings they went to attend. NHCs also mentioned of being frustrated in their effort to participate in the budgeting process for community health activities because the indicative planning figures which they were given were too low. Besides the annual budgets allocated to community health activities being very low, NHCs complained of erratic funding to community health activities by Chibombo District Health Management Team (CDHMT), this frustrated community effort in primary health care.

Most people in Chibombo district were ignorant of the structures put in place to foster community participation. They did not know how these structure operated as well as what the roles and responsibilities of community members where. Some households did not know that as community members, they had a role to play in health care delivery in their communities.

It was also learnt that some people lacked interest to participate at the community level in primary health care. Even when meetings were called, others did not see the need of participating because they did not see any immediate benefits in doing such. This was precipitated by the high level of ignorance which made it difficult for some community members to understand how certain issues were of direct benefit to them.

Members of the community could also not participate in primary health care programmes like attending community meetings due to personal commitments. Others were not available when meetings were called because they were too busy with personal things.

High poverty levels also affected people's participation in primary health care activities. At a household level, it was reported that some households could not afford the cost for labour and materials to build sanitary facilities. Individuals also found it difficult to raise money in order to make monetary contributions to health care projects in their areas.

Community members also complained of lack of adequate support to community health workers. It was learnt that community health workers were demotivated to participate in health care programs because they were rarely provided with kit to enable them provide services to people in their communities. The majority of community health workers had to cover big catchments and were not provided with any form of transport, this hampered their efforts in terms of reaching out to people in their communities. Community health workers did not also receive any form of motivation for their work. This made it difficult for them to sustain their efforts of providing services to the communities. Furthermore, community health workers were not given extra training to enhance their skills.

Some community members also complained of the distance they had to travel to attend meetings. They said even when meetings were called at the health center or health post, it was difficult for them to attend because the distance they had to cover to get to the meeting was too long. This was worsened by the fact that some people did not have transport.

Lack of accountability and transparency also made it difficult for the community to participate in primary health care. Some community members could not make

financial or material contribution towards health projects because they did not trust their leaders. Lack of transparency and accountability had also created mistrust between the community and their leaders. When NHCs asked for contributions from the community some people refused to contribute as they thought everything was funded by government or donors.

The obstacles which community members face towards participating in primary health care delivery do not only frustrate community involvement but also excludes community members either individually or collectively from assuming greater responsibility for their health needs and problems. Community participation is cardinal for effective delivery of primary health care because the outcomes of community participation in the health sector include more health consciousness which pushes up the demand, more access to health care through community health workers and improvements of community level health infrastructure.

Conclusion

The chapter has shown that community participation in primary health care in Chibombo District is mainly restricted to service delivery. There were variations in the types of community health workers and services provided. Most people did not understand how structures put in place to foster community participation in health care functioned. At the individual level, people were still not able to take care of their own health as there were negative attitudes towards community participation in primary health care. The study has also identified lack of motivation, distance, ignorance, poverty, lack of transparency and personnel commitments as obstacles to community participation in primary health care in Chibombo District.

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CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The study has concluded that although health facilities exist in Chibombo district, they are inadequate to meet the needs of people in the communities. As discussed on page 46, lack of expansion in existing health facilities and construction of new ones in light of population increase has rendered the available health facilities to be inadequate. This had led to overcrowding in most health facilities.

The study has concluded that the infrastructure and equipment in most primary health care facilities in Chibombo district is poorly maintained based on the number of health facilities with non – functioning equipment and those in need of repair, maintenance or renovations. As discussed on page 48, some health facilities could not provide immunisation services on daily basis because refrigerators were not functioning and hence failed to sustain vaccine stocks. Breakdowns in the radio communication system and solar power affected effective delivery of primary health care in most health facilities.

The study has concluded that most health facilities in Chibombo district provide the Basic Health Care Package which is supposed to be provided at primary health care level. However, there was no integration in the provision of health services. As discussed on page 54, all services provided by health facilities have been allocated specific days on which they can be accessed and all the identified health facilities did not operate for 24 hours a day.

The study concluded that the number of households dissatisfied with service provided by health facilities in Chibombo district is high. As discussed on page 61, the major causes for these were long period of waiting time, lack of personnel and lack of respect or attention.

The study has concluded that shortages of personnel in primary health care facilities impede delivery of health services. As discussed on page 64, 13 out of 20 identified health facilities had shortages of personnel, this made it difficult for the available staff to operate effectively due to high workloads and some health facilities were also using cleaners to attend to patients.

The study has concluded that shortages of equipment in health facilities compromise the delivery of health services in Chibombo district. As discussed on page 73, shortages of equipment made it difficult for health facilities to provide health services on a continuous basis because certain services could not be performed in the absence of required equipment.

The study has concluded that stock out of drugs in health facilities hinders effective delivery primary health care in Chibombo district. As discussed on page 67, it took about 3 weeks for some health facilities to get supplementary drugs when they ran out of stock, this led to disruption in provision of health services.

The study has concluded that inadequate funding prevents many health facilities from effectively sustaining their operations. As discussed on page 72, many health facilities could not perform their core functions such as providing environmental services as well as community outreach programmes because their budgetary allocation could not meet the costs of conducting these activities on a regular basis.

The study has concluded that access to health services by people in Chibombo district is hindered by physical, social, economic, cultural, quality of services provided and information barriers. As discussed on page 76, 78 and 81, distance to the health facilities coupled with poor state of roads acts as a disincentive in accessing health services. Although the government adopted a policy of free health care, there are still indirect costs to accessing health services which people incur hence lack of income is still an obstacle to accessing health care.

The study has concluded that there is poor community participation in primary health care delivery in Chibombo district. As discussed on page 93 and 98, community participation in primary health care in Chibombo district is hindered by limited training of community health workers, lack of motivation, lack of interest, personal commitments, ignorance and inadequate support to community health workers.

Recommendations

The study recommends that the number of health facilities should be increased in order to increase health service delivery capacity in Chibombo district. Expansion of existing health facilities should also be done to enable them cope with the increase in demand for health services due to population growth.

The study further recommends that a programme should be put in place to focus on regular maintenance of health facilities in order to enable them function effectively. Regular assessments of health facilities should also be conducted in order to appraise the infrastructure in health facilities.

The study recommends that there should be integration in the provision of health services in health facilities so that people should be able to access all the services they need whenever they visit a health facility. Furthermore, all health facilities should operate for 24 hours in a day and should be open on public holidays in order to enhance access to health care.

The study recommends that more health personnel be recruited and should be equitably distributed in all health facilities based on the existing staff establishments. There is also need to strengthen managerial and administrative procedures to ensure that staff shortages which occur as a result of health

personnel going on leave, transfer and retirement are expeditiously taken care of to avoid disruptions in the delivery of health services.

The study recommends that availability of equipment in health facilities should be improved by: (i) establishing and maintaining an equipment database system which will provide information on the status and adequacy of equipment in primary health care facilities; (ii) developing and implementing appropriate equipment development plans so as to ensure a planned and coordinated approach to equipment management, (iii) ensuring compliance with the established maintenance policy and guidelines at all levels and (iv) improving capacities for management and maintenance of equipment at all levels.

The study recommends that the distribution of drugs to health facilities should be strengthened to make it more effective by; (i) ensuring adequate supply of drugs to health facilities by giving them more than the average quarterly allocation they get and; (ii) developing and implementing a contingency or emergency plan to sustain the supply of drugs in an event of stock outs.

The study recommends an increase in the amount of funding to health facilities in Chibombo district to enable them meet the costs of their operations and funding to health facilities should also be consistent with their monthly action plans.

The study recommends that the following should be done to increase access to health services including ART by people in Chibombo district: (i) constructing of more health facilities to cope with increased demand for health services due to population growth. (ii) sufficiently stocking health facilities with needed supplies to avoid passing the costs of these supplies to patients; (iii) health facilities should also stop charging all forms of penalty fees; (iv) improving the quality of services provided by health facilities through increasing availability of trained personnel to reduce waiting time by patients.

The study recommends that the following be done to improve community participation in primary health care in Chibombo district: (i) train more community health workers; (ii) Scale up of behaviour change communication to enable people assume responsibilities for their health at individual, household and community level; (iii) provide adequate support to community health workers through regular provision of drug kits and empowering them with income generating activities.

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[http:// www.eldis.org/go/topic/health](http://www.eldis.org/go/topic/health)

APPENDICES

APPENDIX A

Questionnaire for Health Personnel in Primary Health Care Facilities

Dear Respondent,

My name is Penzi Shikabi, I am a postgraduate student at the University of Zambia in the school of Humanities and Social Sciences. I am carrying out a study to enable me partially fulfill the requirements of the Degree of Master of Public Administration (MPA).

You have been selected as a respondent and I would be most grateful if you spared a few minutes, to answer the questions in this questionnaire. This is a study on *Primary Health Care Delivery in Chibombo District*. All the information you will offer will be handled with utmost confidentiality and will only be used for the MPA Dissertation. I would be very grateful if you can give me sincere answers to the questions.

Instructions: Tick in the circle against the appropriate response or fill in the blank space.

Part 1: Personal Data

1. Gender

1. Male 2. Female

2. Age_____

3. Position? _____

4. Highest level of qualification attained_____

5. How long have you been working in this facility_____

Part2: Identification of Primary Health Care Facilities and Services Provided

5. What Kind of health facility are you working in?

1. Health Post () 2. Small Rural Health Centre ()

3. Medium Rural Health Center () 4. Zonal Rural Health Centre ()

5. Others_____ (Specify)

6. Who owns the health facility?

1. Government () 2. Church () 3. NGO () 4. Community
()

6. Others_____ (Specify)

7. What is the name of the ward where your health facility is located?

8a. Are there other health facilities in this ward?

1. Yes () 2. No ()

8b. If your answer to question 8a is yes, how many are there?

9. In your opinion, do you think about the number of health facilities in this ward?

1. Every few () 2. Few () 3. Somehow Enough () 4. Enough
()

5. Very Enough ()

10. How would you describe the state of the infrastructure at your health facility?

1. Very good () 2. Good () 3. Average () 4. Bad () 5.
Very Bad ()

11. Indicate the available of amenities and facilities at your the health facility

a. Water in the facility ()

b .Electricity/Solar ()

c. Radio /telephone for communication ()

d. Fridge for drugs and vaccines ()

e. Dispensary (Pharmacy) ()

f. Separate delivery/maternity room ()

g. Toilet for patients and staff ()

- h. Maternity bed ()
- i. Counseling room ()
- j. Examination room ()
- k. Ambulance/Vehicle ()

12. Does your health facility provide the following health programs?

- a. HIV/AIDS ()
- b. TB ()
- c. Child Health ()
- e. Environmental Health ()
- f. Sexually Transmitted Diseases ()
- g. Maternal Health ()
- h. Reproductive Health ()
- i. Malaria ()
- j. Management of chronic illnesses ()

(Asthma, diabetes etc)

13. What specific services are provided in your health facility under the health programs you have indicated?

13a HIV/AIDS

13b.TB

13c. Child Health

13d. Environmental Health

13e. Sexual Reproductive Health

13f. Maternal Health

13g. Malaria

14a. Does your health facility conduct community outreach programs?

1. Yes () 2. No ()

If your answer to question 14a is No, skip question 15b and 15c.

14b. If yes, what outreach activities do you conduct?

14c. If yes how regular are they?

1. Very Regular () 2. Regular () 3. Irregular ()

15a. Are there specific days which are allocated for the provision of certain services at your health facility?

1. Yes () 2. No ()

15b. If your answer to question 15a is yes, what services do you provide and on which days._____

16. What are the opening times of your facility for consultation?

17. Does is your facility open during public holidays?

1. Yes () 2. No ()

18a. Does your health facility collaborate with other government ministries in the provision of health care?

1. Yes () 2. No ()

18b. If your answer to question 18a is yes, which sectors are these and how do you collaborate with them?_____

Part 3. (Constraints faced by Primary Health Care Facilities)

19. How many staff do you have at your health facility?_____

20. How is your workload? 1.Very High () 2. High () 3. Moderate () 4. Low () 5. Very Low ()

21. How would you describe your level of motivation?

1. Very Low () 2. Low () 3. Average () 4. High () 5. Very High ()

22. What are some of the negative incentive which you face?

a. Low salaries ()

b. Late payment of allowances and salaries ()

c. Limited opportunities for training ()

d. Poor/ lack of accommodation ()

e. Lack of equipment ()

f. Others _____(Specify)

23. How would you describe the availability of drugs and vaccines in your health facility?

1. Drugs and Vaccines always run out. ()
2. Drugs and Vaccines Sometimes run out. ()
3. Drugs and Vaccines never run out. ()

24. When Drugs and Vaccines run out at your facility, do you request for some more?

1. Yes ()
2. No ()

25. If yes, it takes..... to get new stock.

26. How do you rate the availability of equipment in your health facility?

1. Very good ()
2. Good ()
3. Average ()
4. Bad ()
5. Very Bad ()

27. How available are essential supplies at your health facility?

1. Never available ()
2. Rarely Available ()
3. Sometimes Available ()
4. Always Available ()

28. What happens when you run out of essential supplies? Tick what applies to your facility

	Yes	No
1. We ask patients to come with their own supplies	()	()
2. We request for more supplies	()	()
3. The health facility buys new ones	()	()

29. Does your health facility have transport to take patient who are very sick

1. Yes () 2. No ()

30. What happens when you have an emergency?

Yes No

1. We call for an ambulance () ()
 2. We ask the family to organize their own transport () ()

31. If you call for an ambulance, it takes _____ for it to come.

32. How do you perceive the budget allocation to your facility?

1. By far insufficient () 2. Insufficient () 3. A bit sufficient ()
 4. Sufficient () 5. More than sufficient ()

33. Does your health facility encounter the following problems in budget execution? Tick what applies to your facility

Yes No

1. Late transfer of funds from the government () ()
 2. Delays in the possessing of funds by the district office () ()
 3. Weaknesses in administrative capacity at the district () ()

Part 4 (Quality of Services Provided)

34. Does your health facility have clinical guidelines for all the services which you provide?

1. Yes () No. ()

35. Who monitors the quality of services you provide?

36. How is the quality of service you provide monitored?

37. How often do you get feedback from your supervisor on the services you provide?

38a. Do you get feedback from your patients on the quality of services you provide?

1. Yes () 2. No ()

38b. If yes how and if no why _____

39a. Are supervisory visits made to your health facility?

1. Yes () 2. No ()

39b. If yes, how often? _____

40. What is the purpose of the supervisor visits?

- a) Provide support to problem solving ()
- b) Training to improve performance ()
- c) Reviewing individual performance ()
- d) Inspecting mandatory or statutory functions ()
- e) Others specify _____

41a. Do you sometimes receive complaints from patients?

1. Yes () 2. No ()

41b. If your answer to question 41a is yes, what do they complain about? _____

42. How are you kept updated with new developments in the provision of health care?

43. What would you recommend should be done to improve the quality of service you provide?_____

Chapter 6 (Barriers to accessing primary health care services)

44. What is true about the health seeking behavior of your patients?

- a) They come to the facility when their disease is well advance ()
- b) Patients come for post disease checkup when their medication is finish ()
- c) Patients come to the facility when symptoms first appear ()
- d) Patient try family advise first before coming to the facility ()

45. Is your health facility open to public holidays?

1. Yes () 2.No. ()

46a. Are there any cultural values and traditions of people in this community affect their utilization of certain services such as family planning, child health services and others?

1. Yes () 2. No. ()

46b. If your answer to question 46a is yes, please give examples

47. How informed are people in your community about the services provided by your health facility?

48a. Are there any charges which people pay to access certain charges at your health facility?

1. Yes () 2. No. ()

48b. If your answer to question 48a is yes, what are some of the fees you charge?

49. What other factors affect people's access to services provided by your health facility?

Chapter 7 (Community Participation)

50. How do you work with the community?

- a. We organize meetings with the communities to discuss health issues ()
- b. We give general information about health behavior to the public in village ()
- c. Visit families in the villages to give information about healthy lifestyles ()
- d. We give health information for children at school ()
- e. We ask the community to give feedback on our services. ()
- f. We promote our services to the communities in our service area. ()
- g. We assess the health needs of our communities. ()

51a. Does the community participate in health care delivery?

1. Yes () 2. No ()

51b. If your answer to question 51a is yes, explain how have they been participating?

52. According to your opinion, how would you describe the commitment by community members in promoting good health at the individual or family level?

53. What do you think are the factors which affect community participation in primary health care?

APPENDIX B

Questionnaire for Households

Dear Respondent,

My name is Penzi Shikabi, I am a postgraduate student at the University of Zambia in the school of Humanities and Social Sciences. I am carrying out a study to enable me partially fulfill the requirements of the Degree of Master of Public Administration (MPA).

You have been selected as a respondent and I would be most grateful if you spared a few minutes, to answer the questions in this questionnaire. This is a study on *Primary Health Care Delivery in Chibombo District*. All the information you will offer will be handled with utmost confidentiality and will only be used for the MPA Dissertation. I would be very grateful if you can give me sincere answers to the questions.

Instructions: Tick in the circle against the appropriate response or fill in the blank space.

Personal Information

1. Gender

1. Male () 2. Female ()

2 Age_____ years

3. What is your highest level of education?

1. Never been to school () 2. Primary () 3. Secondary () 4. College ()
5. University ()

4. How often do you go without income?

1. Always () 2. Sometimes () 3. Never ()

Part 1(To Identify primary health care facilities and services provided)

5. Which of the following health provider are there in your community?

- a) Traditional Birth Attendants ()
- b) Government clinics ()
- c) Drug shops ()
- d) Private Clinics ()
- e) Community Health Workers ()
- f) Herbalists ()
- g) Traditional Healers ()
- h) Others_____ (Specify) ()

6. How many health facilities do you have in your ward? _____

7. Do you think the available health facilities are enough?

1. Yes () 2. No ()

8. How would you describe the buildings at these facilities?

1. Unsatisfactory () 2. Satisfactory () 3. Good () 4. Very Good ()
5. Excellent ()

9. Does the health facility nearest to your community operate on public holiday?

1. Yes () 2. No ()

9a. Does the health facility carryout health promotion and education activities in the community?

1. Yes () 2. No ()

If your answer to question 9a is No, skip question 9b and 9c.

9b. If yes, how many times ?

1. Very regular () 2. Regular () 3. Irregular ()

9c. What are the main issues on which these health education and promotion activities are conducted?

Part 2 (Constraints faced by health care facilities)

10. How would you describe the number of staff at your nearest health facility?

11. Does your nearest health facility have sufficient equipment?

1. Yes () 2. No ()

12. How would you describe the availability of drugs and vaccines at your nearest health facility?

1. Never available () 2. Rarely Available () 3. Sometimes Available ()
4. Always Available ()

13a. Does your nearest health facility have transport for patient referrals?

1. Yes () 2. No ()

13b. In case of an emergency, does your nearest health facility organize transport for the patient?

1. Yes () 2. No ()

14. Do you think the infrastructure at your health facility is adequate?

1. Yes () 2. No ()

Part 3 (Quality of services Provided by Health Facilities)

15. How would you described the staff attitude at the nearest health facility

1. Excellent () 2. Very Good () 3. Good () 4. Satisfactory () 5. Unsatisfactory ()

16. How is the availability of drugs at your nearest health facility?

1. Excellent () 2. Very good () 3. Good () 4. Satisfactory 5. Unsatisfactory

17. How would you describe the level of cleanliness at the nearest health facility?

1. Excellent () 2. Very good () 3. Good () 4. Satisfactory () 5. Unsatisfactory ()

18. How would you describe the availability of staff your nearest health facility?

1. Unsatisfactory () 2. Satisfactory () 3. Good () 4. Very Good () 5. Excellent ()

19. How would you describe the amount of waiting time at the facility before seeing a health practitioner? _____

20. Are all the health personnel offering services at your nearest health facility trained?

21. How satisfied are you with the services nearest health facility?

1. Very happy () 2. Happy () 3. Neither happy nor unhappy () 4. Unhappy () 5. Very unhappy ()

Part 4 (Barriers to Accessing health services)

22. Do people in your community always go to the clinic for treatment?

23. Have you ever experienced distance as a challenge to seeking medicare at a health facility?

1. Yes () 2. No ()

24a. Does lack of money affect access to health services by people in your community?

1. Yes () 2. No ()

24b. If your answer to question 24a is yes, explain how?

25a. Do your traditions or beliefs affect people's access to health services such as family planning, Child health and other related services?

1. Yes () 2. No ()

25. If your answer to question 25a is yes, explain how?

26. How informed are you about health services provided at your nearest health facility?

27a. Are there other factors you know of which affect which affect people's access to health services in your community?

1. Yes () 2. No. ()

27b. If your answer to question 27a is yes, explain

28. Have you ever faced any of the following problems with the nearest health facility?

Never Once/twice a few times Often No Experience

- a) Lack of money to pay () () () () ()
- b) Lack of medicines and supplies () () () () ()
- c) Lack of attention/respect () () () () ()
- d) Lack of health personnel () () () () ()
- e) Long waiting time () () () () ()
- f) Dissatisfaction with quality of service () () () () ()

Provided

Part 5 (Community Participation)

29. Do you know the members of the neighborhood health committee in your area?

- 1. Yes () 2. No ()

30. In your opinion, what is the role of the neighborhood health committee?

31. How often does the neighborhood health committee hold meetings with the community?

32. Are aware of the expenses of your neighborhood health committee?

- 1. Yes () 2. No ()

33a. Do you have community health workers in your community?

- 1. Yes () 2. No ()

If your answer to question 33a is yes, skip question 33b and 33c.

33 b. If your answer to question 35a is Yes, Do you think the number of community workers is sufficient?

- 1. Yes () 2. No. ()

33c. Do you think community health workers are well trained?

1. Yes () 2. No ()

34. What services do community health workers provide to people in your community?

35. Do you think community health workers do their work very well?

36. What problems do community health workers face in your community?

37. Do you think the needs of the community are taken care of by the neighborhood committee?

1. Yes () 2. No ()

38. Does your community organize transport for patients and expecting mothers?

1. Yes () 2. No ()

39. How supportive are people in your community in providing financial, material and logistical support to health care projects?

40. Why do some people in your community fail to attend community health meetings, contribute money to health projects or volunteer to offer health services?

43a. Are you undertaking any measure as a household to prevent preventable diseases like malaria and diarrhea?

1. Yes () 2. No ()

43b. If your answer to question 43a is Yes, What preventive measures are you taking?

APPENDIX C

Interview Guide for Focus Group Discussions: Neighborhood Health Committees (NHCs)

1. When was your neighborhood health committee created?
2. Have there been any changes to date?
3. How available are the services at your nearest health facility?
4. What challenges do health facilities in your communities face?
5. What barriers do people in your community face in accessing services?
6. Are you involved in budgeting for health services by your health facility?
7. Does your committee have influence on decision made by the health facility?
8. What is the level of community support and participation in activities in your area?
9. What are the factors which affect the participation of member of your community in health care in primary health care?
10. What challenges do community health workers face in your community?

APPENDIX D

Interview Guide for Focus Group Discussions: Members of the Community

1. How would you describe the availability of health facilities in your areas?
2. What challenges does the health facility nearest to your community face?
3. What challenges do people in your area face in accessing health services?
4. Do you the members of your Neighborhood Health Committee (NHC), their role and how the assume their position?
5. Do you think your community has influence on decisions made by your health facility?
6. How do you perceive the role of Community Health Workers (CHW) in your community?
7. How active are members of your community in in undertaking measures aimed at improving their health?
8. What challenges do people in your community face in participating in health care activities?
9. How can community participation in primary health care in your community be improved?