THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
POST BASIC NURSING DEPARTMENT

A STUDY TO DETERMINE FACTORS AFFECTING OUTREACH ACTIVITIES IN LUSAKA URBAN DISTRICT - ZAMBIA

BY

NALISHEBO MULONDA KWALEYELA

ZRN (LUSAKA) 1984

ZRM (LUSAKA) 1990

RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF POST BASIC NURSING, SCHOOL OF MEDICINE, UNIVERSITY OF ZAMBIA, IN PARTIAL FULFILLMENT FOR THE AWARD OF BACHELOR OF SCIENCE IN NURSING

OCTOBER, 1997

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

MOH	MINISTRY OF HEALTH
MCH	MATERNAL CHILD HEALTH
OPD	OUT PATIENT DEPARTMENT
LW	LABOUR WARD
CHN	COMMUNITY HEALTH NURSE
RM	REGISTERED MIDWIFE
RN	REGISTERED NURSE
FHN	FAMILY HEALTH NURSE
EM	ENROLLED MIDWIFE
EN	ENROLLED NURSE
CO	CLINICAL OFFICER
EHO	ENVIRONMENTAL HEALTH OFFICER
EHT	ENVIRONMENTAL HEALTH TECHNICIAN
MO	MEDICAL OFFICER
EPI	EXPANDED PROGRAMME ON IMMUNIZATION
BCG	BACILLUS CALMELTE GUERIN VACCINE
DPT	DIPTHERIA TETANUS PERTUSIS VACCINE
OPV	ORAL POLIO VACCINE
BD	BOOSTER DOSE
FV	FULLY VACCINATED
TT	TETANUS TOXOID
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
PHC	PRIMARY HEALTH CARE
IMR	INFANT MORTALITY RATE

DEDICATION

This research work is passionately dedicated to my husband Lubinda Kwaleyela without whose patience, spiritual, financial and moral support and encouragement my study and this work would not have been possible.

To our beloved children Liseli and Nobu Ngula who were denied motherly love at the time when they needed it most.

To my mother Miss Mary Mabebo who is the source of my inspiration.

Lastly to my grandmother Miss Mwangala Kalaluka, who has been denied love and care in her old age at the time that she needed it most.

STATEMENT

I, Nalishebo Mulonda Kwaleyela, hereby certify that this study is entirely the result of my own independent investigation. The people and sources to which I am indebted are clearly indicated in the paper and in the references.

Signed: Kwaleyela

Candidate

Date: 13th February 1998

DECLARATION

I declare that with the exception of the assistance acknowledged, this dissertation is the result of my own studies. This work has not already been accepted in substance for any degree and is not being currently submitted by candidature for any degree.

Signed: _____ Date: 13th February 1998

Signed: _____ Date: Dec 8th 1997
Supervising Lecturer

ACKNOWLEDGMENT

Many people and institutions have contributed tremendously towards the completion of my course and this project study. I wish to acknowledge my gratitude to them.

My sincere gratitude goes to Mrs. Ndele, My supervising lecturer for her support.

I wish to thank my sponsors, Director of Human Resources for this sponsorship in my 2nd, 3rd, and 4th years in order for me to complete the Bachelor of Science degree in nursing programme.

I thank most sincerely the love and support of my husband and children, my friends Mrs. L. Hampande, Mrs. Ireen Simbuwa, Mrs. E. Maliwa, Ms B. Mwape, Mrs. P. K. Lubemba, for their knowledge and support shared throughout the course.

I am greatly indebted to the 50 health workers who participated in my sample questionnaire.

I am hopeful that their expectations from the study will not be too disappointing to reflect.

ABSTRACT

The aim of the study was to identify factors that lead to low implementation of outreach activities in Lusaka urban district. It was hoped that the study could be used to identify areas in the existing service that may be contributing to the Lusaka urban district health centers not carrying out outreach activities as they ought to, so that policies, and programmes could be revisited to ensure maximum utilization of the service.

The specific objectives of the study were:

1. To determine the knowledge of members of staff about outreach activities.
2. To determine the level at which health centers are carrying out outreach activities.
3. To establish the socio economic factors that may contribute to the health of workers not carrying out outreach activities effectively.
4. To make recommendations to all parties concerned on what changes should be made to improve outreach activities in Lusaka urban.

Literature review was from studies done in Africa and other parts of the world. I did not come across studies done in Zambia.

The study was conducted in Lusaka from March to October 1997. The sample size was 50 health workers 20 to 50 years old who were practicing in Lusaka urban district. A self administered questionnaire was used to collect data from the health workers. A stratified random sampling was used to ensure representations of different groups within the study population.

The research finding revealed that under implementation of outreach clinics could be due to inadequate knowledge about outreach activities by some health workers who did not train adequately in outreach activities at school and, have had no inservice training in outreach activities after they qualified. The study also revealed that the district is under staffed especially in the area of community health nurses who should supervise these activities to ensure that the standards of performance is high and up to date. The district also lacks the services of environmental health technicians and officers who should look into the areas of sanitation, water, and environmental hygiene of the shanty compounds. This explains why outreach activities have concentrated in the areas of children's clinic, antenatal and family planning as the outreach teams comprise mainly of nurses only.

Socio economic factors like inadequate guidelines on outreach activities, inadequate planning, inadequate resources like human, money and drugs, insufficient supervision by zonal community health nurses, lack of transport to far way places, inadequate co-ordination with neighborhood committees may also be a contributing factor to low implementation of outreach activities.

The study also revealed that lack of incentives such as lunch allowance and under staffing may be another contributing factor to low implementation of outreach activities.

The information obtained is relevant to Lusaka urban District Health Management Team and Lusaka urban health centers to enable them revisit the current practice of outreach activities and plan for how they can plan and offer outreach activities to the communities adequately.

Families need improved health life styles for them to be productive and useful to themselves and the nation.

CHAPTER 1
1.0 INTRODUCTION
1.1 Background Information

Zambia is developing country of sub-Saharan Africa. it covers an area of 752,614 square kilometers which is 2.5% of the total area of Africa. It is a land locked country sharing boundaries with Zimbabwe, Mozambique, Malawi, Tanzania, Democratic republic of Congo (Zaire), Angola, Botswana and Namibia.
There are Nine (9) provinces in Zambia namely Western, Southern, Eastern, Northern Copperbelt, Lusaka, Central, Luapula and North western.

The country experiences a tropical climate with temperatures ranging from 8 degrees centigrade in the cool-dry season which begins in May, to 32 degrees centigrade in the hot-dry and hot-wet seasons which begins around September and ends around April.

Zambia attained independence from Britain in 1964. At that time the populations was about 4 million. At the last Census in 1990 the Zambia population was 7.8 million people. The projected population 1996-2015 is about "9.453 894, with an annual growth rate of 3.2%". 1

During the pre-independence era, Health care services were provided by mission and mining hospitals. Health Care Services were limited to families living within the vicinity of the few missions and mining hospitals. As a result, the majority of the population had no access to health care.

Outreach activities were not carried out, people had to walk long distances in order to get to the nearest mission hospitals for health care. Health services are now available at provincial and district levels. Each district has a district hospital, and each provincial headquarters has a General hospital where cases that cannot be treated at district level can be referred to. There are several health centers in each district, but some areas still have no health institutions especially in rural areas. The need to provide health care to the families that have no access to health care facilities, has necessitated carrying out outreach activities in order to reduce maternal and child morbidity and mortality rates. The other reason that has led to the need for carrying out outreach activities is that, most of the hospitals were built before Zambia attained independence, when the population was still small; These hospitals can no longer meet the demands of the growing population.

In Zambia outreach activities began with immunization programmes. In the early 1980s, Expanded Programme on immunization's (EPI) activities were initiated with the formulation of the programme policy, the training, and the appointment of expanded programme on immunization coordinators at national, provincial, and district levels. Outreach posts were then established. Lusaka urban established a mobile immunization team, immunizing children in areas which are distant from the health centers, schools, and in peri-urban areas where communities are under-served, at risk and vulnerable to diseases.

In 1992, The government of Zambia through it's national health policy introduced the reformed health care system to decentralize health services. The implication of the reform process means allocating resources to District Health Management Teams (DHMT). Each DHMT manages all health activities in it's service areas. DHMTs use resources to plan and carry out health interventions addressing priority health needs.

The decentralization of health services led to the dissolving of the mobile outreach team in Lusaka urban. Outreach activities are now planned and carried out by the staff of each health center in their catchment area. "Outreach clinics are those which take place out beyond the normal area covered by a health center". 2

In peri-urban areas, outreach clinics are carried out for the purpose of providing health care to the people who live in these areas, as some of them do not make use of the available health care facilities.

Information about the nature of health care services provided to families need to be part of every health education programme in hospitals, health centers, schools, colleges and clubs.

Outreach activities that are carried out are:-

- School health services (done separately)
- Registration of attendants in order to have records.
- Weighing of children for growth monitoring.

- Immunization of children and women of child bearing age.
- Health education about prevailing health problems and methods of preventing and controlling them.
- Antenatal and postnatal examination, and family planning.
- Nutrition demonstration.
- Identification of any other problems that might affect the health of the community.
- Adequate supply of safe water and basic sanitation
- Prevention and control of endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

These activities of primary health care are endorsed as the way to health for all by the year 2000.

Primary health care is defined as "essential health care made universally accessible to individuals and families by means acceptable to them, through their full participation land at a cost that the community and country can afford".[3]

Team work is encouraged during outreach activities. Team work implies working with people of different professions with a team spirit so that all their individual skills are used to the best advantage of the community.

1.2 STATEMENT OF THE PROBLEM

Lusaka urban district is the capital of Zambia. It is densely populated, with a population of "1,326,446" [4] as projected by the bulletin of health statistics of 1989 -1992, out of a population of 1.6 million for Lusaka province.

The district shares boundaries with Kafue in the south, Chongwe and Luangwa in the east, Kabwe in the north and Mumbwa in the west. The district falls under the south-east region, a combination of Eastern and Lusaka provinces. The Lusaka urban district health centers are under the supervision of the District Health Management Team based in Makishi road.

There are six hospitals in the district, namely University Teaching Hospital Board and Chainama College of Health Sciences Board. These two are government hospitals, while the Zambia Consolidated Copper Mines hospital, Monica Chiumya, Maina Soko military hospital and Hill Top are private.

There are twenty-three (23) health centers in the district which provide both out patients and maternal and child health services. Eight (8) of these are being upgraded in order to enable them admit thirty patients each. Nine (9) of these centers offer delivery services as well. George, Chelstone, Matero main, Chawama and Chainama offer dental services. The district has four first aid clinics at Munali, International airport, Evelyn Hone and Prison. there are several private surgeries scattered all over the city.

A walk in the city communities or slums and city streets brings to the attention of the observer the poor sanitation of some parts of the city, especially the shanty compounds. The closeness of heaps of garbage near homesteads sometimes goes hand in hand with the presence of faeces as most homes still do not have pit latrines which are the most common sanitary faecal disposal method in the compounds. Broken pieces of metal, empty tins and plastics lie around many homesteads increasing the risk of cuts and infections.

The discarded containers and ditches fill with stagnant water in the rain season, and become breeding sites for mosquitoes, flies can also be seen hovering over dirty utensils or uncovered food in many homes. Worm infestation is common among children. Malnutrition is also common, it is shown by the mental apathy and hair changes associated with the condition.

Outbreaks of measles are also common in the months of August to September every year. This is as a result of the district having a problem of urbanization as well as people drifting from rural areas to the city in search of employment. The rural urban drift has led to a number of shanty compounds to increase, as the available planned accommodation cannot accommodate everybody. Most people fail to find employment and end up building themselves shelters using any material they come across.

The increase of these overcrowded shanty compounds with unplanned housing, roads water and sanitation has led to outbreaks of disease like cholera, dysentery, upper respiratory diseases especially tuberculosis and diarrhoeal diseases. Most houses are over crowded as many people live with the members of the extended families, or rent out some rooms for income generation. The city attracts traders from other provinces and neighboring countries, street vending is common in the city. 70% of the population is considered poor and sell different kinds of foodstuff in unhygienic places along the street to generate income to feed their families.

Only a few health centers carry outreach activities in Lusaka urban. Statistics from the district health nurse show that only six (6) health centers out of twenty-three (23) carried out outreach activities in 1996. School health services were not carried out.

Outreach activities should be carried out by all health centers in their catchment areas. Outreach posts should be visited at least once a month.

This is a big problem because Lusaka urban is only offering more curative care services than preventive care. Outreach activities are aimed at health maintenance, primary prevention, and expansion of health education in order to promote healthy living styles among the targeted population. There is not much being done in this area which has a population of 1,326,446 people. Children of up to eleven (11) months old are estimated to number about 47, 343. Those between one and five years are around 213,050 while women of child bearing age number about 260,395 and school going children about 177,542. The District growth rate is estimated to be 6.5%.

DIAGRAM SHOWING OUTREACH STATISTICS FROM THE LUSAKA DISTRICT PUBLIC HEALTH NURSE (1996)

HEALTH CENTER	MONTH	BCG	DPT	DPT	DPT	BD	OPV	OPV	OPV	BD	MEASLES	FV	TT1	TT2	TT3	TT4	TT5
CHELSTONE	JAN.	7	7	8	9		7	8	9		2	2	1				
		1				2				2							
KAUNDA SQUARE	JAN.	11	22	27	18		21	25	19		44	27					
KAUNDA SQUARE	JAN.					29				18							
KAUNDA SQUARE	FEB.	9	8	21	15		8	21	15								
		1				12				10							
CHELSTONE	MARCH	8	10	9	10		10	9	10		19	19	11	20	2	14	3
CHELSTONE	APRIL		14	29	18		14	29	18		9	9					
						21				21							
CHELSTONE	MAY		4	15	10		4	15	10		11	11					
						10				10							
KAUNDA SQUARE	MAY	5	23	15	17		13	17	14		22	22					
			56	60	55		56	60	55		40	28	6	4	10	8	6
CHELSTONE	JUNE	2	5	5	8		5	5	8		8	8					
MATERO REF.	AUGUST		48	186	63		48	186	63		38	28					
KAUNDA SQUARE	AUGUST	3	11	12	12		12	12	8								
						27				21							
MUTENDERE			61	54	62		63	54	52		107	58					
MUTENDERE	SEPT.		21	19	23	52	21	19	23	52	72						
CHIPATA	OCT.		88	131	131	257	144	133	102	257	2148						
KAUNDA SQUARE	OCT.	3	14	17	21	24	12	16	24	22	31	21					
KABWATA	OCT.		2	1	3	10	2	1	3	10	636						
MUTENDERE	OCT.		18	13	33	136	18	13	33	136	7275	955	34	53	14	14	6
KABWATA	NOV.		2	2		3	2				317						
KAUNDA SQUARE	NOV.	33	18	19	20	19	13	20	19	18	49						
CHIPATA	NOV.		76	100	89	32	28	34	56		79						
		7	1	1	2		20	22	35		983						
KABWATA		7	36	43	40	102	43	51	40	110	1524		56	22	21	46	10
TOTALS		97	545	787	659	736	564	750	616	687	13414	1188	108	99	47	82	25

Robert Kohn in his book "The Health Center Concept in Primary health Care", (1983 ed.) says "Outreach means a change ;in the basic stance of ;medical services. No longer are health workers merely waiting for people to come to them but take the initiative in taking the knowledge and skill to the population they serve".[5]

The most affected people are children and women of child-bearing age in shanty compounds, as well as villages served by these health centers. Mostly women in these places are illiterate and economically poor. Many of them do not turn up for the health care services offered to them by the health care centers. Therefore, there is need to carry out outreach activities in order to provide health care to these families.

Dr. Khonda Tony in his book "Primary Health Care" (1986 ed.) says "We have to deal with two different types of families. There are those who have the ability to attend and benefit from the ;health care structures provided. These have the resources to follow up ;the treatment and advice provided by the centers. The poor face a different problem. Many of them do not turn up to the services offered". [6]

These women do not turn up for health care offered at health centers because they feel ashamed that they and their children do not have good clothing. Even when they turn up, they are often blamed for the condition they find themselves in. The advice they receive is totally irrelevant to their needs. The service personnel rarely approach the poor in an accommodating, humble manner. They are often rude and assume their advice is not followed because the recipients are ignorant, lazy or even stupid. There

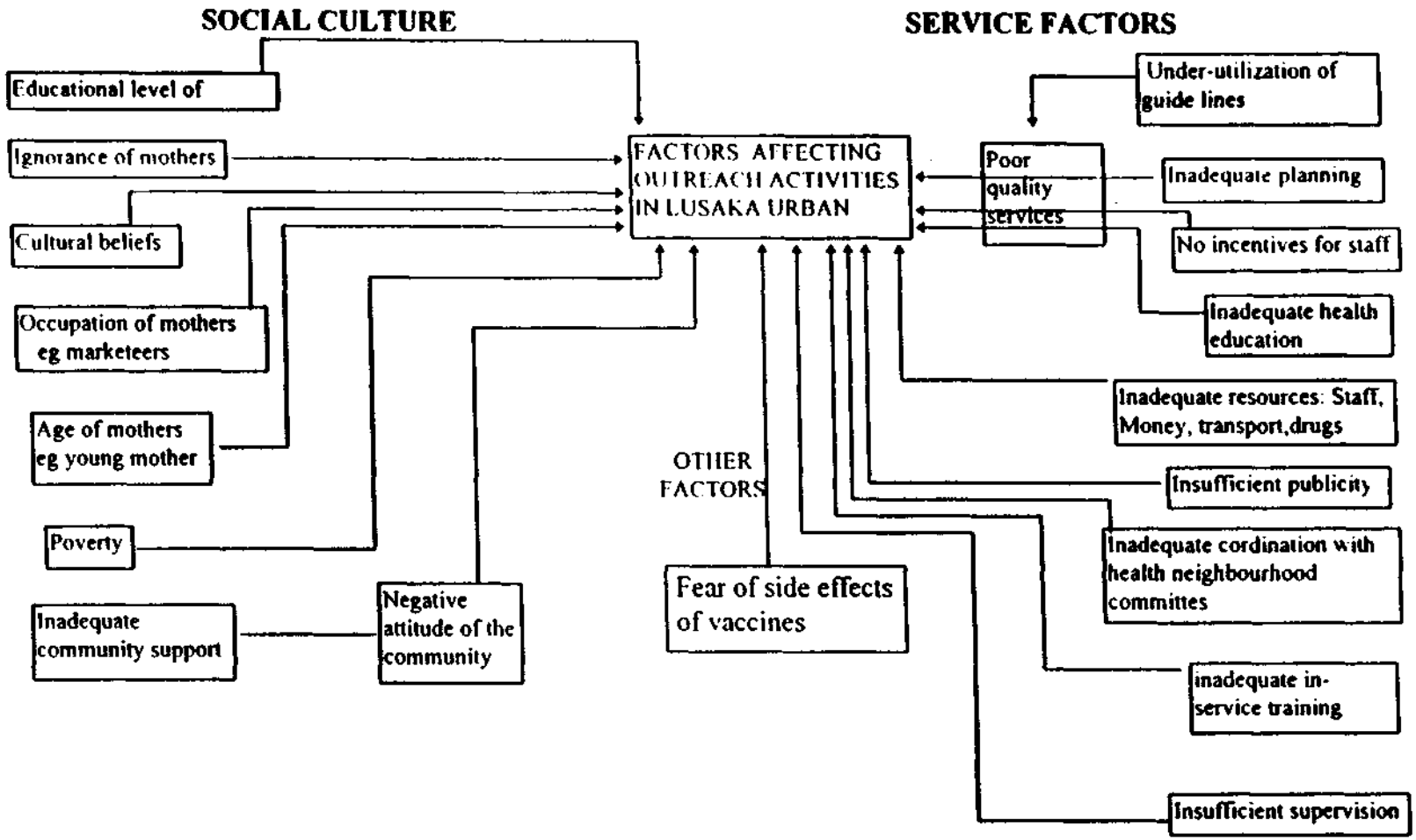
is never a question of trying to learn the prevailing situation of such people or adjusting the advice so that it becomes more relevant to the families for which it is intended.

Outreach activities should be carried out in order for health care providers to identify the poor people's health needs and provide them with appropriate advice according their situational needs. The aim being the following

- to achieve equity in health opportunities
- to reduce mobidity and mortality from common illnesses and communicable diseases
- to improve productivity and survival
- to provide accessible, cost-effective and quality assured services which support health for all.

The consequences of not carrying out outreach activities are that material and child mobidity and mortality rates will continue to rise and communicable diseases such as cholera will continue to prevail in the city. "There is increasing evidence that in developing countries, material and child mobidity and mortality are among the leading causes of deaths in children under five years and women of reproductive age". [7]

"In Zambia, the ;material mortality rate is estimated at 202 in every 100,000. The infant mortality rate is estimated at 107 in every 100,000." [8]



FACTOR ANALYSIS DIAGRAM

Some of the contributing factors for not carrying outreach activities could be:

- Underutilization of guidelines by ;the members of staff who plan and conduct the services. When planning is not adequate or not done at all, the activities planned for will not be carried out which will lead to failure of outreach activities

- There may be inadequate health education to sensitize the people who may not be aware that outreach activities are provided for in their communities.

- There may be inadequate resources to use during outreach activities. Resources such as staff, transport, drugs and money are vital for carrying out outreach activities.

- Inadequate co-ordination between staff and the neighbourhood communities will lead to communication breakdowns which in turn will lead to failure of these activities from taking place.

- Health care providers need to be adequately trained and supervised sufficiently in order to carry out outreach activities well. Lack of in-service training to update their knowledge especially on primary health care will hinder their ability to carry out outreach activities well enough.

Other factors that could lead to failure of outreach activities are:

- Most people in shanty compounds are poor and of low educational levels

- Most women spend more time selling their merchandise in markets and streets and may not appreciate the importance of outreach clinics.

Due to ignorance and inadequate community support, most people in shanty compounds may not be aware of these activities. The health neighbourhood committee may not be very active. The committees should be having meetings with the health center member of staff to plan these activities. Failure to have these meetings often could lead to failure to planning together with the community leading to failure of outreach activities.

Most mothers are of low educational levels and may value their cultural beliefs and prefer them to attending outreach clinics.

There is therefore need to find out why outreach activities are not carried out as expected in Lusaka urban health centers.

1:3 PURPOSE OF THE STUDY

The purpose of the study is to identify areas in the existing service that are contributing to low implementation of outreach activities in Lusaka urban district. This will enable the health workers to revisit the policies and outreach programmes in order to ensure maximum implementation of the service.

1:4:0 OBJECTIVES OF THE STUDY

The objectives of the study are as follows:

1:4:1 GENERAL OBJECTIVES

To identify factors that lead to low implementation of outreach activities in Lusaka urban.

1:4:2 SPECIFIC OBJECTIVES

1. To determine the knowledge of health workers on outreach activities.

2. To determine the level at which health centers are carrying out outreach activities.

3. To establish the socio economic factors that may contribute to the health workers not carrying out outreach activities effectively

4. To make recommendations to all parties on what changes should be made in order to improve outreach activities in Lusaka urban.

1:5 HYPOTHESIS

1. Inadequate knowledge by health workers on outreach activities and primary health care leads to low implementation of outreach activities.

2. Inadequate guidelines on outreach activities in health centers lead to low implementation of outreach activities.

3. Absence of established outreach activities. Programmes in Lusaka urban health centers lead to low implementation of outreach activities.

CHAPTER 2
2.0 LITERATURE REVIEW
2.1 INTRODUCTION

There is very little information on studies conducted on outreach activities in Zambia. This has prompted the researcher to carry out a study to determine factors that affect outreach activities in Lusaka urban.

Lusaka urban District is a densely populated area with several shanty compounds. The District faces an urbanization problem as people move from rural to urban areas in search of employment.

In comparison to other cities of developing nations, Lusaka has become the focus of change and development. It is generally felt that the city has improved health conditions and facilities, it has more job opportunities and better education facilities which has drawn masses of people from rural areas and many parts of the country. The government is unable to keep pace with this rapid growth. The people who have moved from the country have found that they have exchanged lives of rural poverty for lives of urban poverty.

Typically of third world countries, the city growth is concentrated in shanty compounds. Although these areas lack all the basic amenities, they are physically decrepit, highly disorganized and have become centers of squatter poverty, illiteracy, human deprivation and sickness. These areas experience outbreaks of epidemics such as measles, cholera, diarrhoea, upperispiratory diseases and many others. The shanty compounds play an important role of solving the housing shortage and other complex

problems associated with migration from rural to urban centers. Typical examples being shelter, security, and continuity of rural values and ways of living.

2.2 GLOBAL PERSPECTIVE

In Belgium, Robert Kohn in his book, The health center concept (1993) in primary health care writes "outreach of health centers were originally limited to case finding and follow up. These activities are increasingly directed towards health maintenance, primary prevention and expansion of health education activities to serve those purposes."[9] Primary health care (PHC) services are increasingly aiming at achieving health living styles among the population they serve.

Outreach means a change in the basic stance of the medical services, no longer are health workers merely waiting for the people to come to them but take the initiative in taking the knowledge and skill to the population they serve. This implies that the PHC facility assumes responsibility for a defined population.

The definition of the population may be in geographical terms as in countries with strict regionalised health system. The possibility of outreach cover is a very wide spectrum that is from health maintenance of general population through primary prevention among specific risk groups. These have been in existence for many years.

In European countries, there are several dimensions to community orientation by primary heath care as a medical function which presupposes a responsibility for the health care of a defined population including outreach, prevention and health education.

According to World Health Organization "Health for all by the year 2000" based on primary health care implies Health will begin in homes, schools, fields and factories rather than hospitals". [10]

This is to enable health to be accessible to all people and that people will use better approaches for preventing disease and injury instead of relying on doctors to repair damage that could be avoided.

Communities need to be sensitized in order for them to have the knowledge of their right and responsibility to shape the environment so that it enhances health and reinforce individual action for health. Resources for health should be equally distributed and essential health will be accessible to everyone.

In East Bhutan, Bohler E carried out studies in 1984 and 1991 in a traditional agricultural society on Infant and Child Mortality rates. He interviewed mothers regarding births during the preceding 5 years and deaths among these children. A significant fall in Infant Mortality rate (IMR) from "145 to 49" was found.

In 1991, measles was almost eliminated as a cause of death. families with 1 to 3 children, respectively, during the period studied were found to have significantly different IMRs with higher mortality for higher numbers of births. To quantify the effect on mortality from birth intervals, both the possibility of reverse causation and confounding factors such as socio-economic conditions were considered , but the study suggested that the association was partly casual. The living conditions of the people did not seem to have improved so greatly as to have caused the reduction in IMRs. Monthly mother and child health outreach clinics and a network of village health workers had provided the framework necessary for implementation of different health programs. As a result primary health care had improved during the period between 1984 and 1991 and may have contributed considerably to reduce mortality.

In Philadelphia a study was carried by York R. and others (1993) on women who received inadequate prenatal care, to determine the factors that influenced their decisions related to prenatal care. Data was collected from 57 women in an institution that serves neighborhood clinics that offer free prenatal care and can be reached by public transport. Women were interviewed either prenataly or postnataly. The interview questions were drawn form literature on the adequacy of prenatal care. The women identified 32 personal reasons and structural barriers for receiving inadequate prenatal care. the five most-cited reasons were "Had small children at home with no one to look after them, no medical assistant card, did not know reason, were ambivalent about the

pregnancy or just moved to the area" 12. Despite demographic risk and facing similar barriers, some women manage to receive sufficient prenatal care while others did not. At present, the Government and other policy makers often believe that public insurance, Medicaid or socialized medicine is the answer to high infant mortality rates.

However in some geographical areas where financial barriers are not factors, and where services are available that meet pregnant women's needs, some women still do not enter care early and remain in care. Data that sheds knowledge on why women receive inadequate care will be useful in developing community outreach programs, preparing public service announcements and designing prenatal services.

In the United States, a study was carried out in 1993 by Stein L. M. among immigrants and farm workers who constituted a medically undeserved population with many health care needs. Barriers to health care needs among farm worker families included "financial constraints, cultural factors, restrictive labor practices and absence of acceptable clinics in rural areas"13.

The migrant health outreach teams offered primary health care including health maintenance and treatment of acute chronic illnesses. The team served the targeted population of farm workers a successful alternative to traditional medical clinic.

12&13

In Columbia, a study conducted by Walter and others in 1995 concluded that Junior high school based clinics could provide a wide range of primary and preventive health care services for large numbers of medically underserved youths. The provision of mental health services may fill a critical need among inner city adolescents. Outreach clinics are necessary to maximize utilization of health care especially among high risk students.

In Indonesia, Kaye K. and others carried out a study in 1994 among residents in a Jakarta slum which described the use of public and private health care services in relation to socio-economic and health status. As problems associated with urban poverty rapidly increased in developing countries, it was important to study the ethnic and economic diversity which existed in slums. The result of the study was to inform on the development of effective for outreach and service delivery. Through a survey of 690 and 593 children it was found that poorer residents were more likely to rely on local government clinics for primary health care than affluent ones. Only regular local government clinic users were more likely to be fully immunized and use aral rehydration salts correctly. Delivery in hospital was common among all residents but especially the more affluent.

Prevalence of contraception was high and not associated with socio-economic status or type of health care service.

There are varieties of outreach activities being carried out the world over. At Cambridge in the United Kingdom a community health nurse reported different

activities that were carried out in the community. these involved visiting individuals with health problems such as the disabled, post natal mothers as well as the terminally ill. She also conducted child health clinics, school health, antenantal and post natal groups and assisted women to come up with projects such as the Mum Toddler groups with the help of a play group advisor in social services.

Other outreach activities are seen in integrated primary health care units, whose aim of integrating care is to identify gaps in the services being provided. this means finding out people's problems or needs, provide the type of expert care and then integrate it into the mainstream services to fulfill them.

In the United Kingdom, a community health nurse's outreach team called "Annie's Outreach Team" dealt with clients on the margins of society- the homeless, drug users, prostitutes, prison inmates and HIV and AIDS patients. The team boasted of being "the team that reaches parts that others could not", [14] for the purpose of providing comprehensive care.

Other teams prefer one type of activity instead of integrated activities. Regardless of the approach used by a team it is the commitment and determination of the team that will lead to the success of the outreach approach.

In order for the outreach activity to be successful, the communities involved should be willing to take part in the provision of care. Each community reacts differently to outreach programs. In Peru, the Occoran community rejected the program out of sheer

inertia. When visited six times in twelve months by the health team staff, the community came together for consultation only after much persuasion by the local school teacher. Then they asked "What use are these drugs? What will happen to our money? [15] . At first nobody was willing to serve as a health promoter. When, finally, a young man was chosen and trained, he went off to a big city and did not return. Even then the community did not demand for a replacement. They were simply unable to organize themselves sufficiently to utilize the services offered by the health team, let alone demand better services or take initiative to start their own program.

Crushed by poverty, repression and history of shared resistance to outside control and the process of maginalization, the community remained indifferent to the failure of the program. The people's interpretation of health remained traditional, and the health team was unable to help start a process of direct or social participation in health care.

Another example of community reaction is seen.

In Peru, in the Urban community of Villael Salvador, the people faced innumerable hardships. Their flimsy straw and cardboard shacks were in constant danger of going up in flames. Thieves invaded to steal the people's few possessions. Drinking water was an acute problem. Men, women and children had to travel long distances through the burning sand to the main road to buy drinking water. No trained medical care was available as the slum could not be reached by road. The shared hardships motivated the people to organize themselves for survival. Among the first community organizations were common pot communities providing food to groups of people

14&15

during initial stages of the illegal occupancy. Committees for schools and health care followed. Most important, however, was the community's own organization based on blocks of houses which provided local government. The living conditions however still remained poor. As a result of these conditions, health conditions were highly unsatisfactory, such that infant diarrhea, dehydration, tuberculosis, typhoid fever and scabies were frequent. People blamed the government and free enterprise for their own problems. Though they failed in the area of health, they succeeded in organizing other projects that they needed in their community. They built bakeries, banks, shops, a kerosene pump and a pharmacy.

2.3 REGIONAL PERSPECTIVE

In Kisumu, Tanzania, a community based health care survey showed a missed opportunity by Ministry of Health (MOH) and the Kisumu municipality. It showed that most of the units were not oriented towards improving the health of the community around them, and were not supportive of community based activities. Liaison between community health workers (CHW) and traditional birth attendants (TBA) and the unit were slight. Most units had insufficient capacity to provide high quality care for referral from CHW or TBA. Only four could help with a retained placenta while only four could treat anemia, scabies or schistosomiasis. Only five could provide treatment for a moderately dehydrated child while only three carried out outreach activities. Five were functioning as static units for immunizations. However, comment from the staff suggested that the y were prepared and interested to support community based health care and to move out into the community if they could be

given support, resources, encouragement and directives from the supervisors of health services in the district. By 1987 the concept of a dispensary giving out symptomatic treatment for diseases at its door was no longer tenable.

In Tanzania in a village called Ibonjanda, the community based primary health care project helped villagers to identify their own problems and come up with solutions. They were tired of seeing their children die. The under-five mortality rate was "176 per 1000 live births and 14% of their infants had a low birth weight" 16. Their natural government was virtually bankrupt and the state hospitals were barely functioning due to lack of drugs and equipment. In eight years they had gone from building latrines to house surveys carried out by trained volunteers to building a brand new health center. They were assisted by a medical assistant called Sekieta Sekasua who lived in a clean house and a neatly cleaned surrounding. The village comprised mud brick houses with tin or thatched roofs and vegetable gardens dotted with bright red poinsettia bushes. He talked about the affordable, accessible, acceptable and all participatory primary health care system he was trying to encourage in this poor community which is similar to our own communities in Zambia.

He wanted to stop the health center being seen as a disease recycling center where people with worm infestations or diarrhea went for treatment then returned to the same environment where they were re-infected.

16

Working in accordance with the World Health Organization's objective of health for all by the year 2000, he started with a baseline survey of health and the environment in the village. He found out that water holes were being shared by both people and cattle.

The problem of getting water was serious because it was very dirty and hazardous to drink. People were drinking the water thinking there would be no problem. Sekasua called up a meeting in 1987 where they came up with a number of problems, the most prominent of which was water. He gave the community the responsibility of making a decision regarding the problem. The villagers took the responsibility upon themselves since they were the ones affected. The medical assistant contributed by devising strategies and action plans with target dates and set out the training needs, including awareness in the village to help people become more competent at solving problems. With the support of Oxfam, he conducted a seminar which brought together many villagers. he recalled hearing people who used to sit passively while others issued instructions or edicts asking themselves questions such as "Why should we continue with the problem?, we have our hands to dig latrines with as well as shallow wells. Why should we wait for others to make things for us which we can do ourselves?".[17]

They begun by digging two latrines at the health center, one for males the other for females. they also cleared old wells and dug new ones. The meetings to discuss health became a monthly event and demands and expectations rose. Some villagers volunteered to learn how to promote health care in the village. Their role was to

motivate people to help themselves. the village is spread over a span of 16.090 Kms and the community health workers met the people to find out about their problems and how they hoped to solve them. they did not tell them what to do. At first the people found it strange because they were used to being addressed by leaders while they listened passively. the passiveness went slowly, not everyone joined at the same time as some people learnt faster than others.

The five objectives they promoted as they undertook house to house survey were: "

- to build latrines in every house
- to have children vaccinated
- to build draining racks for cooking utensils in every house
- to have women deliver at health centers
- to clean up the water supplies and keeping cattle and humans washing and drinking sources separate" [18]

Five years later they found that 70% of households had latrines. half of the homes had draining racks which improved hygiene because utensils were drained away from where chickens, ducks, dogs and cats roamed. In situations where culture did not allow the use of latrines with in-laws two were built. Other villagers built latrines which they did not use. These were encouraged to change their cultural beliefs and make use of the latrines. It is only the results of a clean environment that has helped others to change. The people in the village now enjoy some form of authority. they have built themselves a health center with support from a small British organization

17 & 18

and volunteers from abroad.

The community continues discussing health projects and health education. They now believe that hospitals are for big and genuine problems and not for small ailments that can be prevented.

2.4 NATIONAL PERSPECTIVE

In Zambia, there is hardly any research done on outreach activities. However, outreach activities were intensified with the introduction of the concept of primary health care in the early 1980s. Like most other countries, Zambia has put in place measure to develop a health care system which does not depend on curative medicine. the system of conventional medicine had failed to make an impact on the Zambian people

The following deficiencies were identified in the conventional medical care system:

(i) Available resources were not adequately distributed. The central hospitals consumed a disproportionate amount of the national health budget

(ii) There was too much emphasis on curative rather than prevention of disease and promotion of good health. Most diseases that caused morbidity and mortality such as measles, malnutrition and anemia, diarrhea, upper respiratory disease and others could be prevented

(iii) Health care was not accessible to the majority of the population, especially in rural areas where people had to walk very long distances to get to a health centers

Outreach activities were perceived to be the way of making primary health care a practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. In Zambia the country aimed at tackling the main health problems in the community with particular emphasis on underserved, high risk and vulnerable groups. Special attention is paid to rural and peri-urban areas where the health needs of the people are greater. The main emphasis being on disease prevention and promotion of good health practices and providing treatment for common illnesses and injuries.

It is necessary to have active community participation, co-orporation and coordination between all sectors engaged in community development in order that outreach activities succeed. Fortunately, these needs have long been recognized in Zambia. The urban organization of outreach programs requires that the views of the people should be represented by the section committee responsible for the organization of primary health care within the section. The urban clinic staff and the section committees will then form the primary health care and outreach teams.

Each section should have a trained community health worker who will concentrate on health education and other activities that promote good health. Treatment of patients is done in the urban clinics since most communities have access to urban health centers unlike in rural areas where villages are far from rural health centers. The staff

at the health center are responsible for the management and delivery of primary health care both at the health center and in the sections. this requires that clinic staff make regular visits to the community. The following services are provided in order to provide comprehensive health care:

- Health education
- Promotion of adequate nutrition and food supply
- promotion and maintenance of safe water and basic sanitation
- Maternal and child health services including family planning
- Immunizations
- Prevention and control of local endemic diseases
- promotion of maternal health
- provision of necessary drugs and equipment
- Collection and maintenance of data
- Treatment of common diseases and injuries

The outreach team includes all those who have the common goal of improving the health of the community. These are , the community health nurse, Clinical officer, Midwives, General nurses, Laboratory Assistants, Environmental Health Technician, Community development workers, Agricultural assistants, teachers and social workers.

There is also a proposal by Ministry Of Health which states that in future there will be health posts in the communities which will be responsible for a population of 500 households (3500 people) in both rural and urban areas. these posts will be

responsible for outreach activities in their catchment areas. They will provide health post package care, and will be staffed with one community health practitioner and will be responsible for the supervision of traditional Birth attendants and community health workers.

Conclusion

Literature review has shown that outreach activities are directed towards primary prevention, health promotion and health maintenance. Health workers will not merely wait for people to come to them but take the initiative in taking the skill and knowledge to the people they serve. Community participation would be encouraged. Communities should be involved in the identifying and solving health problems prevailing in their communities for the purpose of improving their health living styles.

Outreach intensification would stop health centers being seen as disease recycling centers where people are treated for different ailments and went back to their environments only to be re-infected. Team work is also encouraged in order too provide the communities with comprehensive health care.

CHAPTER 3
3.0 RESEARCH METHODOLOGY

3.1 Research Design

The purpose of this study was to determine factors that affect outreach activities in Lusaka urban district. It is imperative that outreach activities be planned and carried out by all health centers in their catchment areas, for the purpose of health maintenance, primary prevention, and expansion of health education in order to promote healthy living styles and prevent diseases. Curative care services alone cannot promote healthy living styles and maintain health. A non experimental descriptive study was chosen to carry out this study. It was designed to identify current practices and making judgments. It also involved a systematic collection and presentation of data. In order to show cause-effect relationship between the dependent variables and independent variables. The variables are:

Dependent

Outreach activities

Independent

Ignorance

Age

Poverty

Community support

Cultural beliefs

Transport

Health education

Co-ordination

Incentives for staff

Planning

Publicity

Guidelines

Resources

3.2 Research Setting

The study was conducted in Lusaka urban district health centers in Lusaka province. The researcher had chosen to conduct the research in Lusaka urban district for various reasons. One of the reasons was that Lusaka urban is a densely populated area which faces problems of outbreaks of diseases like cholera, diarrhoea, Malaria and many others, with an increase in the number of cases every year.

The other reason for sampling from these health centers was to choose from a cross section of health workers in different catchment areas with different backgrounds. some health centers carter for big peri-urban areas and villages, while others cater only for suburb areas. It follows therefore that life styles and health related behaviour would vary in these areas. All health centers provide both out patients and mental child health services.

3.3. STUDY POPULATION

The study population consisted of health workers currently working in these health centers. Data was collected from Registered nurses, clinical officers, environmental technicians, environmental health officers, Registered Midwives, family health nurses, Enrolled Midwives, Enrolled Nurses and Medical Officers.

3.4 SAMPLE SIZE

The sample size comprised fifty health workers from ten (10) health centers. The distribution was five (5) from each health center.

3.5 SAMPLING METHOD

Stratified Random sampling was used to ensure representatives of different groups within the study population. It was important that the sample included representative groups of study units with specific characteristics. The sampling frame was divided into groups or strata according to characteristics. In this study the characteristics were medical officers, community health nurses, Registered midwives, Family Health Nurses, Registered nurses, Enrolled midwives, Enrolled nurses, clinical officers, environmental technicians and environmental health officers. After the population was divided, a simple random sample was taken from each stratum, until fifty samples were picked. This was to ensure representation of each particular segment of the study population. Where some characteristics were not represented, a respondent was picked randomly from the available health workers.

3.6 DATA COLLECTION TECHNIQUE

Data was collected by administering a questionnaire. The questionnaire consisted of both open and close ended questions. Open ended questions were to bring issues not previously thought when planning the study providing valuable new insight in the problem. Closed questions provided for quick recording of data and easy analysis of data. The questionnaire was written in English as the study population was literate.

3.7 DATA COLLECTION

Data was collected in two weeks from 5th to 19th September, 1997. The researcher collected data with the help of one research assistant (a classmate). There was no need to train the research assistant, however, the researcher went through the questionnaire with the assistant. Data collected included, demographic data of respondents, knowledge of health worker of outreach activities, level at which health workers carried out outreach activities, socio economic factors that affected outreach activities and recommendations by the health workers on how best outreach activities can be improved.

3.8 PILOT STUDY

A pilot study was conducted at Chainda health center. It involved a sample of ten health workers randomly chosen from different departments of the clinic. It allowed the researcher to determine the reliability of the instrument used in the study population. More information regarding administration were clarified, such as time it would take to complete the data collection protocol, presence of confusing information and project costs. The researcher also used data collected at this time to evaluate the data entry and analysis methods that were planned in the larger study.

3.9 ETHICAL CONSIDERATIONS

The researcher obtained permission to carry out the pilot study at Chainda health center and to carry out the actual study in Lusaka urban health centers. Permission was obtained from the Director Lusaka Urban District Health Management Team. The researcher explained why Lusaka urban was chosen for the study. Confidentiality, anonymity and privacy was ensured during data collection.

3.10 LIMITATIONS OF THE STUDY

1. Due to time factor, it was not possible to conduct the study on a large scale with a larger sample size.

2. Time for data collection stretched over two weeks because respondents often needed time in which to complete the questionnaire. This resulted in the researcher having to travel to some health centers more than once.

3. The researcher had to travel to 10 health centers by public transport several times which increased the cost.

4. Some respondents were unwilling to fill in the questionnaires for fear of being victimized.

5. Some respondents refused to respond to the questionnaires because they were not being paid for it, despite showing them the permission letters from DHMT and school.

CHAPTER 4

4.0 PRESENTATION OF FINDINGS AND ANALYSIS

4.1 INTRODUCTION

The purpose of the study was to identify areas in the existing service that are contributing to low implementation of outreach activities in Lusaka urban district. Data collected was analyzed into frequency tables and numerical description for each table. The data was analyzed both manually and by using a scientific calculator.

4.2 DATA ANALYSIS

The results presented were obtained from fifty health workers stratified randomly selected and practicing in Lusaka urban health centers. Data were sorted out, edited for consistency, completeness and accuracy. Responses from open ended questions were categorized and coded.

4.3 PRESENTATION OF FINDINGS

TABLE 1
AGE RANGE OF RESPONDENTS

n = 50

AGE RANGE IN YEARS	FREQUENCY	PERCENTAGE
20 - 29	8	16
30 -39	26	52
40 - 49	15	30
50 and above	1	2
TOTAL	50	100

The majority (52%) of the respondents were aged between 30 and 39 years, followed by (30%) aged between 40 and 49 years. Only 2% were aged between 50 years and above

TABLE 2
SEX OF RESPONDENTS

n = 50

SEX	FREQUENCY	PERCENTAGE
MALE	7	14
FEMALE	43	86
TOTAL	50	100

86% of the respondent were female and only 14% were male.

TABLE 3 - showing the marital status of the respondents.

n = 50

MARITAL STATUS	FREQUENCY	PERCENTAGE
Single	4	8
Married	32	64
Separated	7	14
Divorced	1	2
Widowed	6	12
TOTAL	50	100

The majority of the respondents 64% (32) were married, 8% (4) were single, 14% (7) were separated, 12% (6) were widowed and only 2% (1) were divorced.

TABLE 4
RELIGION OF RESPONDENTS

n = 50

RELIGION	FREQUENCY	PERCENTAGE
CHRISTIAN	49	98
OTHERS	0	0
NO RESPONSE	1	2
TOTAL	50	100

98% of the respondents were Christians. Non belonged to other religions.

TABLE 5
EDUCATIONAL LEVEL OF RESPONDENTS

n = 50

EDUCATIONAL LEVEL	FREQUENCY	PERCENTAGE
PRIMARY SCHOOL	0	0
SECONDARY SCHOOL	0	0
COLLEGE	49	98
UNIVERSITY	1	2
TOTAL	50	100

The majority of respondents (98%) attained college level of education. Only 2% attained university level of education.

TABLE 6
DESIGNATION TABLE

n = 50

DESIGNATION	FREQUENCY	PERCENTAGE
PUBLIC HEALTH NURSES	0	0
REGISTERED MIDWIVES	11	22
REGISTERED NURSES	3	6
FAMILY HEALTH NURSES	6	12
ENROLLED MIDWIVES	12	24
ENROLLED NURSES	11	22
CLINICAL OFFICERS	6	12
ENVIRONMENTAL TECHNICIANS	0	0
ENVIRONMENTAL OFFICERS	0	0
MEDICAL OFFICERS	1	2
TOTAL	50	100

24% of the respondents were enrolled midwives followed by enrolled nurses and registered midwives who were 22% each. The smallest number of respondents was 2% for the medical officers.

TABLE 7
DURATION OF TIME SINCE RESPONDENTS QUALIFIED FROM SCHOOL

n = 50

RANGE IN YEARS	FREQUENCY	PERCENTAGE
0 - 5	10	20
6 - 10	10	20
11 - 15	14	28
16 - 20	9	18
21 AND ABOVE	7	14
TOTAL	50	100

This Table shows that 28% have been working from eleven (11) to fifteen (15) years. 20% graduated 6 - 10 years ago and another 20% graduated 0 - 5 years ago. Only 14% graduated over 21 years ago.

TABLE 8

TABLE SHOWING RESPONDENTS WHO TRAINED IN OUTREACH ACTIVITIES WHILE AT COLLEGE

n = 50

TRAINED IN OUTREACH ACTIVITIES	FREQUENCY	
PERCENTAGE RESPONSES		
YES	41	82%
NO	9	18%
TOTAL	50	100

Table 8 shows that 82% of the respondents received training in outreach activities and only 18% did not train in outreach activities.

TABLE 9

TABLE SHOWING RESPONSES WHO RECEIVED INSERVICE TRAINING ON OUTREACH ACTIVITIES

n = 50

HAD IN-SERVICE TRAINING IN OUTREACH ACTIVITIES	FREQUENCY	PERCENTAGE
YES	12	24
NO	38	76
TOTAL	50	100

Table 9 reveals that only 24% of the respondents had trained in outreach activities after they qualified and 76% have not been trained.

TABLE 10
RESPONDENT'S opinion in relation to whether they received adequate training in outreach activities.

n = 50

RESPONSES	FREQUENCY	PERCENTAGE
YES	24	48
NO	17	34
NOT TRAINED	9	18
TOTAL	50	100

The table reveals that 48% of the respondents found the training they received in outreach activities adequate. 34% found the training to be inadequate and 18% did not train in outreach activities.

TABLE 11
Respondents opinion in relation to the areas they thought was inadequate in the training they received at college.

n = 17

AREAS	FREQUENCY	PERCENTAGE
THEORY	0	0
PRACTICAL	4	23.5%
BOTH THEORY AND PRACTICAL	13	76.5%
TOTAL	17	100

The table reveals that the majority of respondents 76.5% feel the area where their training was inadequate is both theory and practical. Where as 23.5% feel it is only practical.

TABLE 12

Respondents opinion on what in-service training would strengthen outreach activities.

n = 50

AREA OF IN-SERVICE TRAINING REQUIRED	FREQUENCY	PERCENTAGE
work shop on outreach activities and PHC	26	52
safe motherhood and cold chain	6	12
EPI and statistics	5	10
Community diagnosis and community health nursing	3	6
Psychosocial counseling	1	2
No training	2	4
No response	7	14
TOTAL	50	100

The table shows that 52% of the respondents need to be trained in primary health care followed by 12% who need training in safe motherhood and cold chain in order to strengthen outreach activities.

TABLE: 13

Table showing the different departments the respondents are working.

n = 50

DEPARTMENT	FREQUENCY	PERCENTAGE
LABOR WARD	13	26
OUT PATIENTS DEPARTMENT	17	34
MATERNAL CHILD HEALTH	17	34
WARD	3	6
TOTAL	50	100

This table reveals that the majority of the respondents 34% work in out patients department and maternal child health department 26% work in labor ward and 6% work in the wards.

TABLE 14
Table showing availability of outreach program in the health centers

n = 50

PROGRAM AVAILABLE	FREQUENCY	PERCENTAGE
YES	49	98
NO	0	0
NOT TRAINED	1	2
TOTAL	50	100

The table reveals that all the health centers in the sample have outreach programs

TABLE 15.
Table showing how frequent the respondents carry out outreach activities.

n = 50

FREQUENCY OF CARRYING OUTREACH ACTIVITIES	FREQUENCY	PERCENTAGE
Every day	4	8
once a week	10	20
Twice a week	13	26
3 times a week	3	6
once a moth	3	6
twice a month	3	6
when necessary	1	2
on immunization days	2	4
irregular	2	4
don't know	8	16
no response	1	2
total	50	100

The table reveals that 26% carryout outreach activities twice a week, 20% once a week 8% every day, 6% three times a week, another 6% once a month and only 20% carry out outreach activities on immunization day and another 4% have irregular outreach activities.

TABLE 16

Table showing when the respondent last carried out outreach clinics.

n = 50

LAST OUTREACH VISIT	FREQUENCY	PERCENTAGE
0-1 Month ago	28	56
2 - 6 months ago	7	14
7 - 12 months ago	1	2
13 months and above	5	10
Does not carry out activities	8	16
No response	1	2
TOTAL	50	100

The table reveals that 56% of the respondents carried out outreach activities a month ago. 14% carried out outreach activities 2 to 6 months ago.

TABLE 17

Table showing who comprises the outreach team of the respondents.

n = 50

OUTREACH TEAM	FREQUENCY	PERCENTAGE
FHN RM RN EM EN	45	90
RN EN RM	5	10
TOTAL	50	100

The table shows that 90% of the respondents states that outreach teams comprise of nurses of different categories most of the time.

TABLE 18

Respondents opinion in relation to whether outreach activities are beneficial.

n = 50

RESPONSES	FREQUENCY	PERCENTAGE
YES	45	90
NO	2	4
NO RESPONSE	2	4
DON'T KNOW	1	2
TOTAL	50	100

The table shows that 90% of the respondents stated that outreach activities are beneficial only 4% said they are not beneficial, 2% did not know.

TABLE 19

Respondents reason as to why outreach activities are beneficial.

n = 50

REASONS	FREQUENCY	PERCENTAGE
Eradicate and control communicable diseases	9	18
Improve FP, ANC, CC coverage and prevent post natal complications	25	50
Follow up of T.B, HIV clients	2	4
Health workers know the community and encourage community participation	3	6
Decongest health centers	5	10
Don't know	1	2
No response	5	10

The majority of the respondents (50%) stated that outreach activities are beneficial for improving family planning antenatal. Children clinic coverage and prevents post natal complications, followed by 18%

TABLE 20

Respondents responses as to whether they experience problems during outreach activities

n = 50

RESPONSES	FREQUENCY	PERCENTAGE
YES	20	40
NO	16	32
DON'T KNOW DOES NOT CARRYOUT OUTREACH	8	16
NO RESPONSE	6	12
TOTAL	50	100

40% of the respondents do experience problems during outreach activities while 32% do not. 16% do not carry out any outreach activities.

TABLE 21

Types of problems faced by the respondents when carrying out outreach activities

when carrying out outreach activities.

n = 20

TYPES PROBLEMS	FREQUENCY	PERCENTAGE
Inadequate resources, staff, money, drugs	4	20
Apathy	5	25
Insufficient publicity	3	15
Insecurity	3	15
Ignorance	3	15
Change of address for T.B patients.	1	5
No proper infrastructure	1	5
TOTAL	20	100

25% of the respondents stated that they face problems of apathy followed by 20% who expressed problems of inadequate resources, such as not having enough members of staff and money. 5% of the respondent expressed problems of change of address and no proper infrastructure for outreach activities.

Table 22
Respondents' opinion in relation to factors affecting their carrying out outreach activities

n = 50

FACTORS	FREQUENCY	PERCENTAGE
Underutilization of guidelines	3	6
Lack of transport	19	38
Inadequate planning	3	6
Inadequate coordination with neighbourhood committees	4	8
Insufficient supervision	5	10
Lack of In-service training	5	10
Not carrying out outreach activities	8	16
No response	3	6
TOTAL	50	100

The table reveals that 38% of the respondents stated transport factor to be affecting outreach activities, followed by 10% who stated insufficient supervision, another 10% lack of in-service training. Other factors stated are under utilization of guidelines 6%, inadequate planning 6% and inadequate coordination with the neighbourhood committees.

CHAPTER 5
5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR HEALTH SYSTEM

5:1 DISCUSSION OF FINDINGS

INTRODUCTION

In this chapter, the findings of the research study are discussed. The general objective of the study was to determine the factors affecting outreach activities in Lusaka urban district. The assumptions before the study were that factors such as underutilisation of guidelines, lack of transport to distant areas,

Inadequate resources such as staff, funds and drugs; insufficient publicity and health education; inadequate in-service training and insufficient supervision could be contributing to the health workers in Lusaka urban not carrying out outreach activities as they ought to. Other factors were poverty, low educational level of the people in shanty compounds, ignorance about outreach activities by the communities, lack of community support, age of mothers such as teenage ;mothers, Negative attitude by the communities, fear of side effects of vaccines, culture beliefs and women preferring to be involved in other activities such as marketeering to outreach activities.

The sample consisted of fifty (50) health workers randomly selected from ten (10) Lusaka urban health centers.

BIOGRAPHIC DATA

The study revealed that the age range of the respondents was between 20 and 50 years. the mean age was 37 . 12 years. The majority of the respondents (52% (26)) were aged between 30 and 39 years, followed by 30%, (15) aged between 40 and 49 years only 2% were aged 50 years and above.

The sample population was both male and female. the majority of the respondents 86% (43) were female and only 14% (7) were male.

Table 3 revealed that 64% (32) of the respondents were married, 14% (7) were separated, 12% (6) were widowed, 8% (4) were single and 2% were divorced.

The majority of the respondents 98% were Christians. Professionally the majority of the respondents 98% (49) had attained college level of education and were mainly nurses. Only 2% attained university level of education.

PROFESSIONAL BACKGROUND/KNOWLEDGE OF OUTREACH ACTIVITIES

Table 6 of the study showed that 24% (12) of the respondents were enrolled midwives followed by enrolled nurses and registered midwives who were 22% (11) each category. The smallest number of respondents was 2% who were medical officers. The sampled health centers had no Community health nurses, Environmental health technicians and environmental health officers. These three categories make important members of an outreach team. They play an important role of identifying health

problems and are specialists in their own fields. The Community health nurse is a professionally qualified member of the health care team who is responsible for the efficiency of all nursing services and sees that their standard of practice is high and up to date. The environmental health officer sees that proper programs of environmental hygiene are established. He is also concerned with meat inspections and market and eating house hygiene. He sees that sanitation improves and encourages the making of pit latrines for every family. He is also in charge of mass disease control campaigns. The environmental health technician is responsible for improving the environment. He goes out into the houses and villages, and stimulates the interests of people in improving their water supplies, latrines, houses and food storage. He often works together with the community nurse. These 3 categories conduct community diagnoses, rapid appraisals and surveys to identify health problems. They work with other members of the health care team and other disciplines to develop strategies of solving the identified problems. As the situation is this aspect is not well catered for in the district.

This could be one of the reasons why outreach activities are not being conducted adequately in the district. 28% (14) of the respondents have been working for eleven to fifteen years 20% have been working for six to ten years and 18% have been working for sixteen to twenty years and another 14% have been working for 21 years and above. Table 7 reveals that 80% of the respondents have gained practical experience and therefore should be able to carry out outreach activities adequately. But this is not the case in this study.

The study in table 8 also reveals that 82% of the respondents trained in outreach activities while at nursing schools and, only 18% did not receive any training in a outreach activities. This is because not all schools of nursing have been conducting outreach activity programs. Lusaka school of nursing for example, just introduced the practical outreach program in January 1997. Students will now be going to Monze district to learn community diagnosis and all the other outreach activities to prepare them adequately to work in the community. 48% of the respondents found the training they received in outreach activities adequate where as 34% found the training they received in outreach activities inadequate.

The respondents' opinion in relation to the areas they felt was inadequate in the training they received in outreach activities are as follows:

The majority 76.5% felt the area where their training was inadequate was both theory and practical. 23.5% felt it was only practical.

The study also reveals that only 24% (12) of the respondents had received training in outreach activities after they qualified from their nursing schools 76% (38) have not had in-service training in outreach activities. The study therefore reveals that there is some degree of deficit of knowledge in outreach activities in about 52% of the respondents. This could be another reason why outreach activities are not being carried out as they should be done. The 34% of the respondent who found their training to be inadequate and the 18% who did not train in outreach activities need to

be adequately trained in order for them to be able to carry out outreach activities effectively.

Table 12 reveals that 52% of the respondent expressed the need to be trained in outreach activities and primary health care, followed by 12% who felt they needed to be trained in safe motherhood and cold chain in order for them to strengthen outreach activities 10% stated that they needed training on Expanded program on immunizations and statistics followed by 6% who expressed the need to be trained in community diagnosis and community nursing. These expressions confirm the need and importance of training these health workers, to equipment them with the necessary knowledge and skills for them to appreciate the need to apply them in the communities they are working.

LEVEL AND PRACTICE OF OUTREACH ACTIVITIES

The respondents for this study were from all the departments of the health centers. There were 34% (17) from out patient department, 34% (17) from maternal child health department, 26% (13) from Labour ward and 6% from the wards.

98% of the respondents stated that they had outreach programs at their health centers, only 2% did not know if there was an outreach program at their health center. Table 16 reveals that all the health centers in the sample are carrying out outreach activities.

Table 16 shows that 26% of the respondents carry out outreach activities twice a week, 20% carry out outreach activities once a week, 16% of the respondents do not know how often outreach activities are carried out because they are not actively involved in outreach activities 6% carried out outreach activities 3 times a week, another 6% carried out outreach activities twice a month and another 6% carried outreach activities once a month. 4% stated that their outreach activities are irregular, another 4% stated that they only carried out outreach activities on immunization days and 2% said they only carried out outreach activities when necessary. This table reveals that 72% of the respondents are carrying out outreach activities regularly and have carried out a number of outreach activities within the last month. These responses seams to be conflicting with the responses in the next table which shows that, only 56% of the respondents carried out outreach activities in the last one month and only 14% carried out outreach activities in the past 2 to 6 months. 2% carried out outreach activities in the past 12 months and 10% carried out outreach activities in the past 13 months and above.

This table still does not correlate with the statistics at the district public health nurse's office. Only six health centers were recorded to have carried out outreach activities in 1996, and even then, some of the outreach activities were carried out on immunization

days only. The respondents may have given what they thought to be ideal which they do not practice or they don't send their statistics to the District Public Health nurse

Table 18 reveal that the outreach team consists mainly of the registered midwives, registered nurses, enrolled midwives, family health nurses and enrolled nurses.

This explains why concentration is directed towards children's clinic, family planning, antenatals and health education. This is because this is the area of their specialization and they are not joined by the other members of other disciplines like the environmental health technicians who would look into the area of sanitation waters and improve the environment. The table reveals that there are no intersectoral collaboration activities. They do not work together with teachers, community health workers, agricultural assistants, and social workers. Outreach activities is about team work which implies working with these people with a team spirit so that all their individual skills are used to the best advantage of the community. There is need of identifying areas that need intersectoral collaboration activities so that other members of other disciplines who can promote the health of the communities can be involved in outreach activities.

Some families in the shanty compounds still do not have pit latrines, refuse pits and access to clean and safe water. Street vending is rampant and food is sold in places that are unhygienic and not covered. These areas when addressed can go a long way in reducing the number of cholera and diarrhea patients that are treated at the health centers every year. It will also reduce the Expenditure of the Ministry of Health as

they will spend less on cholera beds, drugs and protective clothes they buy for health workers who nurse these patients every year.

SOCIO ECONOMIC FACTORS THAT AFFECT OUTREACH ACTIVITIES

Table 19 revealed that 90% of the respondents stated that outreach activities are beneficial to the communities they serve. Only 4 % said they are not beneficial and 2% did not know. the respondents reasons as to why outreach activities are beneficial are as follows:

50% of the respondents stated that outreach activities improve family planning antenatal, children's clinic coverage and prevent postnatal complications. This confirms the study conducted by Stein L. M. which states that the women identified personal reasons and structural barriers for receiving inadequate prenatal care. the five most frequent cited reasons were small children at home, no medical assistant , cards, just moved to the area, sadness about the pregnancy and did not know reason. Despite demographic risk and facing the same barriers some women receive sufficient care and others do not .

18% felt outreach activities are beneficial for eradicating and controlling communicable diseases. This is true in that when the outreach team visits the community they will identify the communicable diseases, identify the source of the diseases, give health education on the prevention f the disease and take other necessary measures to control and eradicate the disease.

10% stated that they are beneficial for decongesting the health centers. This is also important because when diseases are prevented in the community, there will be few people attending the health centers for treatment. Clients who just need weighing or growth monitoring do not have to come to the clinic every month, weighing can be done in the community during outreach activities.

6% said outreach activities are beneficial because they will know the community they are serving and will encourage community participation. This is also important because you can only know the health problems of the community when you visit them. You can only be able to solve the health problems when the community is willing to participate in the solving of their problems. They also have to see and agree that what they are experiencing is a health problem that need to be solved. Sometimes what you perceive to be a problem may not be an urgent problem to them. Your project may fail when they do not favor it.

4% stated that outreach activities are important for follow up of TB and HIV clients. This is important to ensure that these clients comply with the treatment they have been given. These clients need counseling, support and love for them to recover. They sometimes need to receive treatment from their homes as they may be too weak to walk to the health centers for their reviews and supply of drugs.

Table 20 reveals that 40% of the respondents stated that they experience problems during outreach activities while 32% did not. Some of the problems expressed by the respondents are:

25% experience problems of apathy. 20% expressed the problem of inadequate resources such as not having enough members of staff, money an drugs. 15% expressed the problem of insecurity. 5% said their problem was trying to locate TB patients who have changed addresses and another 5% said their problem was not having a conducive place to carryout activities like antenantal and family planning counseling.

It is important to review the problems faced by the outreach teams so that you can discuss how best they can be solved in order to improve your outreach activities.

20% for example have expressed the problem of inadequate resources such as members of staff to carry outreach activities, meanwhile there are other people who said they are not involved in outreach activities and are willing to carryout outreach activities if they are involved. Drawing a time table that involves everyone at the center can solve such a problem.

Table 23 reveals that some of the factors that affect the respondents carrying out outreach activities are as follows:

6% Underutilization of guidelines, 6% inadequate planning for outreach activities, 8% inadequate coordination with neighborhood committees. The majority of the respondents 38% stated lack of transport affected their outreach activities.

Transport is important for carrying out outreach activities because the health workers need to carry equipment to use at the outreach site: without transport they will find themselves with the same problem that their clients who live in faraway areas face, which causes them not to go to the health centers to receive medical care. The population from distance places will continue to be neglected, communicable diseases such as outbreaks of measles will continue, as the population's children will not receive the protection that is required to protect them from these diseases. Some respondents expressed that sometimes they would mobilize the communities in the farms for an outreach activity on a particular day but have failed to honor their appointments due to lack of transport to get to the area. This could be one of the reasons why there is apathy towards outreach activities in the communities that are served by the sample health centers.

It is also important to have clear guidelines that guide the health workers on how they should go about carrying outreach activities. These should be well stipulated so that they have the force of a rule that must be followed. The criteria should be clear to all health workers, so that they are able to follow them adequately.

Adequate planning for these activities is important in order for the health worker to meet the goals of the plan. the plan should include what is to be done, when to be

done, why it should be done, who should carry out the plan and where it will be carried out. This will improve the outreach activities in the area.

Adequate coordination with the neighborhood committee members should be encouraged because they live in the community and can help sensitize the community members, publicize the outreach activities and help solve problems such as insecurity in the community. They will be able to communicate the favorable times for carrying out outreach activities in the community. Inadequate coordination could be the reason why there is negative attitude and apathy in the communities.

Sufficient supervision is also important for monitoring the services that are offered in the communities. I have already discussed that these health centers lack the services of community health nurses responsible for the supervision of community health nursing and ensuring that the standards of outreach activities are high and up to date. This could be another reason why there is apathy in the communities.

In-service training will help the health workers update their knowledge and skills of medical care to be offered in the communities. Lack of in-service training in outreach activities could be one of the reasons why outreach activities are not adequately carried out.

The recommendations given by the health worker on how outreach activities can be improved or strengthened are as follows:

- There is need for knowledgeable staff to carryout outreach activities, that is in-service training should be conducted for the health workers.
- There is need for incentives such as lunch allowances to motivate the members of staff to carry out outreach activities.
- Transport where possible should be provided for outreach activities.
- Those who do not carry out outreach activities would like to be involved in outreach activities so that they can gain some experience. They are calling for rotation of members of staff who carry out outreach activities in order to involve everyone.
- There should be a stable outreach program drawn for every health center, and that planning should involve the community.
- Each zone should have a public health nurse who will monitor the activities of outreach programs.
- Outreach activities should be carried out frequently such as everyday or once a week.
- Health centers should be well staffed and improve on supply of drugs.
- Outreach posts should be clearly stated so that all health workers know which area should have outreach clinics.
- Community diagnosis should be carried out in order to identify the health problems in the community.

There should be clear guidelines on outreach activities. Introduce intersectoral activities especially on sanitation and water. There should be support from policy makers in terms of government involvement in the implementation of certain health activities e.g. control of street vending and sanitation disposal.

5.2 Implication for Health System

Review of literature seem to indicate that, outreach activities are made effective to meet the comprehensive needs of communities by:-

Level of knowledge of health workers on outreach activities. Health workers need to be adequately trained to equip them with the necessary skills, that will enable them to be able to assess, plan, implement and evaluate the health care needed in communities.

Team work which implies working with other professions is necessary for providing comprehensive health care. Multi sectional collaboration is necessary for providing for all the needs of the communities and for community development.

Community participation is essential for outreach activities to be successful, the communities need to be sensitized in identifying their own problems. They should really see the need, it's urgency and benefits for them to be able to comply with the care being given to them.

Programme development. The health centers should have a detailed, large scale plan developed for outreach activities. This will stipulate what is to be done when by who, where why, and should be accessible to all health workers.

Political commitment. The developed policy on outreach activities should create a conducive environment for health workers to carry out their duties.

Continuos evaluation of the developed programme should be done after every planned session for monitoring and replanning according to the needs of the communities.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The study sought to identify factors that led to low implementation of outreach activities in Lusaka urban in (10) ten health centers.

It was established that there was lack of team work in the outreach team. In that the district lacked services of environmental health technician and officers and also community health nurses. These are specialists who deal with the problems of environmental sanitation, food hygiene, prevention of diseases and supervision of nursing activities in the community.

It was also found out that there's some deficit in knowledge of outreach activities in about 52% of the respondents. These had expressed the need for training in outreach activities and primary health care.

The study also reveals that though all health centers have outreach programs. The programs were not in detailed writing and accessible to all health workers. This led to some health workers being ignorant about these services being offered at their working places.

The study also found out that there was less community participation in outreach activities this was established by the response of apathy acknowledged by 20% of the respondents.

The study also found out that the available guidelines on outreach activities may not be accessible to all health workers as 6% of the respondents expressed the problem of inadequate planning for outreach activities.

It has also been revealed that the health workers have a problem with transport for carrying out outreach activities. This was expressed by 38% of the respondents.

Other constraints identified by the respondents are insecurity in the community by 15% of the respondents, insufficient publicity by another 15%, inadequate members of staff by 20% of the respondents. This could also be due to the same people going for outreach activities all the time. Rotation of members of staff going for outreach activities was recommended. This may be a solution to the shortage of staff. 8% expressed inadequate co-ordination with the neighborhood committees. This could also be one of the reasons why community participation is less leading to apathy.

It is therefore worthy to mention that the objective of the study have been achieved.

6.2 RECOMMENDATIONS

1. Team work should be encouraged in all outreach activities. This is to ensure that all areas of promoting healthful living styles are catered for.

2. In-service training should be organized for the health workers that require training on outreach activities and primary health care.

3. There is need to develop outreach programs that are clearly detailed and accessible to all health workers of the health centers so that every one knows what is expected of them during outreach activities.

4. Emphasis on community participation should be encouraged. Sensitization should be carried at all health centers in all departments.

5. Research should be done to find out to what extent outreach activities have been beneficial in Lusaka urban and what still needs to be done.

6. Health workers should be motivated by giving them incentives and provide them with transport for outreach activities.

7. A study should be done to find out the views of the recipients of care in the communities.

FOOT NOTES

1. Gaisie K. (1992) Demographic and health survey. UNZA

2. Byrne & Bennet (1986) Community Nursing in developing countries
A manual for the community nurse pp. 44
Oxford University Press
Oxford

3. Morley Rhode and Williams (1987) Practicing health for all
Oxford Medical Publication
Oxford pp. ix, x

4. MOH (1989 - 1992) Bulletin of health statistics
MOH
LUSAKA

5. Robert Kohn (1983) Health center concept in Primary Health Care
WHO
GENEVA

6. Khonda Tohn (1986) Primary health care
A manual for people from all sectors for the improvement of primary health care

7. Nsemukila G. (1994) Maternal and child mortality in Zambia
Determinants and trends 1965 - 1992

8. Gaisie K. (1992) Demographic and health survey.
UNZA, Zambia

9. Robert Kohn (1983) Health center concept in Primary Health Care
WHO
GENEVA

10. WHO Four decades of achievement
High lights of the work of WHO
Geneva

11. Bowler E (1994) Journal of tropical medicine
Riserboo hospital
Wamnong East Bhytan, Medline

12. York R. (1993) Public health journal
Maternal factors that influence inadequate prenatal care
Hospital of University of Pennslvia
Philadelphia - Medline

13. Stein L. M. (1993) May, June Health care delivery for farm workers in South West. An innovative nursing clinic Journal at the American academy of nurse practitioners - Medline

14. Volume 90, No.6 (Feb. 9-15th) Nursing times. The independent voice of Nursing. pp. 42&43

15. Morley Rhode and Williams (1987) Practicing health for all
Oxford Medical Publication
Oxford pp. 198 - 200

16. Volume 85 No. 45 (Nov. 1989) Nursing times. The independent voice of Nursing. pp. 27&28

17. Volume 85 No. 45 (Nov. 1989) Nursing times. The independent voice of Nursing. pp. 27&28

18. Volume 85 No. 45 Nov. 1989 Nursing times. The independent voice of Nursing. pp. 27&28

BIBLIOGRAPHY (For the research)

1. Banda (1994) — Annotated bibliography of identified and published research activities related to Zambian family. MOCBW . UNICEF- Zambia

2. Byrne & Bennet (1986) — Community nursing in developing countries A manual for the community nurse Oxford University Press. Oxford

3. Corlien M. Varkeviser — Designing and conducting health systems research projects. HSR training series, volume 2, part 2

4. Freeman and Heinrich (1981) — Community health nursing practice W.B. Saunders company, Philadelphia

5. Fromer M.J. (9183) — Community health care and the nursing process C.V. Mosby company

6. Heidemann (1993) — The contemporary use of standards in health care . WHO. Division of strengthening of health services. District health systems

7. Hess Markson and Stein (1988) — SOCIOLOGY Macmillan Publishing company. New York.

8. Joint GRZ/SIDA (1988) — Annual review of the health sector support programme HSSP, Lusaka - Zambia

9. Kaye K and others (1994) — Journal of public health. USA

10. Leahy and Cobbs (1977) — Community health nursing McHill co. New York

11. MOH (1981) — Health by the people implementing primary health care Lusaka, Zambia

12. MOH (1995-1999) National strategic health plan from vision to reality. MOH, Lusaka - Zambia

13. MOH (1982-1997) Bulletin of health statistics major health trends. Lusaka,Zambia

14. MOH (1984) Report of a joint evaluation of primary health care in the republic of Zambia MOH, WHO, UNICEF.

15. Morley, Rhode & Williams (1987) Practicing health for all Oxford medical publications

16. Oakley Peter (1989) Community development in health development An examination of critical issues

17. Republic of Zambia (June 1988) Guidelines for formulation of the 4th national development plan Lusaka, Zambia

18. Seaman H. C. Catherine (1987) Research methods Principle, Practice and theory of Nursing, appleton and lange Los altus California

19. Smith and Bindari-Hammod (1992) Primary Health Care Reviews WHO, Geneva

20. Talbot L. A. (1995) Nursing research Principles and practice of Mosby Co. USA

21. Treece & Treece (1986) Elements of research in nursing c.v. Mosby company St. Louis Toronto, Princeton

22. UNICEF (1983) Community based Primary health care, Kisumu

23. Volume N. (1993) Implementation of the global strategy of health for all by the year 2000 WHO. South east region. East Asia

24. Walter H. J. (1995) Journal of Public health center for population and family health USA

25. Were Mirriam IC (1978) Organizations and management of community health care. Nairobi. Kenya

QUESTIONNAIRE FOR HEALTH WORKERS IN LUSAKA URBAN DISTRICT HEALTH CENTRES ON FACTORS AFFECTING OUTREACH ACTIVITIES IN LUSAKA URBAN

Instructions

1. Do not write your name
2. Answer all questions as instructed
3. Tick in the box next to your answer or write in the space provided
4. All responses will be held in strict confidence

DATE:.....

HEALTH CENTRE:..... .....

QUESTIONNAIRE NO:.....

SECTION A: BIOGRAPHIC DATA

FOR OFFICIAL USE ONLY

1. What was your age last birthday? ..... ☐

2. SEX
(a) Male ☐
(b) Female ☐

3. Marital status
(a) Single ☐
(b) Married
(c) Separated
(d) Divorced
(e) Widowed
(f) Others, specify.....

4. What is your religion?..... ☐

5. Educational level attained
(a) Primary school ☐
(b) Secondary school
(c) College
(d) University

SECTION B

PROFESSIONAL BACKGROUND/KNOWLEDGE OF OUTREACH ACTIVITIES

FOR OFFICIAL USE ONLY

6. What is your designation

(a) PHN ☐
(b) R.M. ☐
(c) R.N. ☐
(d) FHN ☐
(e) EM ☐
(f) EN ☐
(g) CO ☐
(h) EHT ☐
(i) EHO ☐
(j) Others, specify.....

7. When did you qualify?..... ☐

8. What other qualifications do you posses?..... ☐

9. Did you carry out outreach activities during your training?

(a) Yes ☐
(b) No ☐ ☐

10. If your answer to question 9 is Yes,

(a) How many supervised outreach activities did you carry out during training? ☐

.....

(b) How would you describe your experience?..... ☐

.....

11. Do you consider the training you received in outreach activities training as adequate?

(a) Yes ☐

(b) No ☐

☐

12 If your answer to question 12 is No, in what area was the training inadequate?

(a) Theory ☐

(b) Practical ☐

(c) Both ☐

(d) Not applicable ☐

(e) Others, specify.....

☐

13 Have you had any in-service training in outreach activities after you qualified?

(a) Yes ☐

(b) No ☐

☐

14 What additional training do you need in order to strengthen your outreach activities:.....

☐

SECTION C

LEVEL AND PRACTICE OF OUTREACH ACTIVITIES

15 What department are you working in?.....

16 Do you have an outreach programme in your health centre?

(a) Yes ☐

(b) No ☐

☐

17 If your answer for question 17 is yes, how often do you carry out these activities?

(a) Once a week ☐

(b) Twice a week ☐

(c) Once a month ☐

(d) Twice a month ☐

(e) Others, specify.....

☐

18 What activities do you carry out during your outreach activities?.....

☐

19 How many outreach posts do you have in your catchment area?

(a) One ☐

(b) Two ☐

(c) Three ☐

(d) Four ☐

(e) Others, specify.....

☐

20 When was your last outreach visit?

(a) Last ☐

(b) Six months ago ☐

(c) Last year ☐

(d) 2 years ago ☐

(e) Others, specify.....

☐

21 If you do not carry out outreach activities, what are the reasons? .....

22 Who comprises your outreach team?

CHN	☐	FHN	☐
R.M.	☐	E.N	☐
R.N	☐	CO	☐
E.M.	☐	EHO	☐

23 Do you have any intersectoral collaboration activities during your outreach activities?

(a) Yes ☐
(b) No ☐

24 If your answer for question 24 is yes, list these activities

.....
.....
.....
.....

SECTION D
SOCIO-ECONOMIC FACTORS

25. Do you experience any problems from the community you serve during outreach activities?

YES ☐
NO ☐

26. If yes, what are the problems?

.....
.....
.....

27. In your opinion, are outreach activities beneficial to the population you serve?

YES ☐
NO ☐

28. Explain your answer to question 28

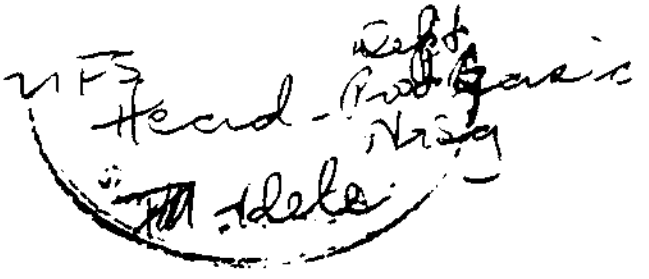
.....
.....
.....

29. What recommendations would you make in order to improve outreach activities in your area?

.....
.....
.....
.....

Mulonda N. Kwaleyela
University of Zambia
School of Medicine
Dept. of Post Basic Nursing
PO Box RW 50110
Lusaka
8th August, 1997

The Director
District Health Management Team
PO Box
Lusaka



Dear Sir,

Ref.: Research Study Request

I am a fourth-year student in the school of medicine, Department of Post Basic Nursing where I am pursuing a Bachelor of Science Degree in Nursing.

As a partial fulfilment for my Degree programme, I am required to carry out a research study. The topic I have chosen for my research is entitled "Factors affecting Maternal and child health outreach activities in Lusaka urban".

I intend to collect data from randomly selected Lusaka Urban health centres within Lusaka District, during the months of August and November, 1997.

I therefore request your permission to conduct the study in these centres.

Thanking you.

Faithfully,

cc Head of Dept. Post Basic Nursing

Telex

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

LUSAKA URBAN DISTRICT HEALTH MANAGEMENT TEAM

17th September,1997

Mrs Mulonda Kwaleyela
University of Zambia
Post Basic Nursing
P.O. Box 50110
LUSAKA.

Dear ~~Sir~~, Madam

Re: RESEARCH PROJECT

Management has looked at your letter dated 8th September,1997 concerning Research Study "Factors Affecting Maternal and Child Health Outreach Activities in Lusaka District". Permission has been granted for you to conduct the study in Lusaka Dis Health Centres.

Kindly see to it that you avail the District your findings in this study.

Good Luck,

Maya

DR S. Bvulani - Malumo
DEPUTY DIRECTOR OF HEALTH PROGRAMMES
FOR/DISTRICT DIRECTOR OF HEALTH.

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

Dear Sir/Madam,

This is to introduce... Nalishebo M. Kwaleyela ...
a Fourth Year BScN student in the School of Medidine, Department of Post Basic Nursing. This student is carrying out a Research study in partial fillfulment of the Degree requirement. The name of the Research Topic is... FACTORS AFFECTING OUTREACH ACTIVITIES ...

... IN LUSAKA URBAN DISTRICT. ...

We shall be most grateful if you could access the student to information on the subject, clients or interviews and any other assistance the student may require.

Yours faithfully,

for Ringoma

Patricia M. Ndelo (Mrs)

ACTING HEAD/RESEARCH LECTURER

/cm