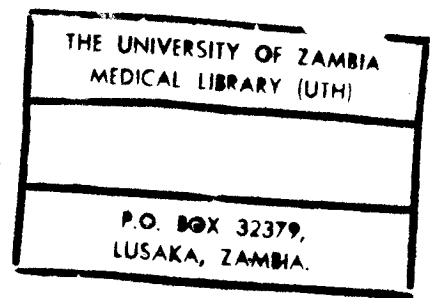


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Department of Post Basic Nursing

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**FACTORS CONTRIBUTING TO  
UNDERUTILIZATION OF HOME BASED CARE  
SERVICES AT MACHA HOSPITAL.**

**BY**

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## **LIST OF ABBREVIATIONS**

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>HIV</b>	Human Immune Virus
<b>WHO</b>	World Health Organisation
<b>HBC</b>	Home Based Care
<b>MOH</b>	Ministry of Health
<b>CMAZ</b>	Churches Medical Association of Zambia
<b>ARC</b>	Acquired Related Complex
<b>TB</b>	Tuberculosis
<b>FGD</b>	Focus Group Discussion
<b>CBOH</b>	Central Board of Health
<b>NGO</b>	Non governmental organisation
<b>UNAIDS</b>	United Nation's Agency for AIDS

**DECLARATION**

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

Sign----- V Mhango

Approved----- 

**STATEMENT**

I hereby certify that this is entirely, the result of my own independent investigation.

The various sources I used, to whom I am indebted are clearly indicated within the text and in the references.

Signed V. Mhango

Candidate V. Mhango

## **DEDICATION**

I dedicate this piece of work to my wife Judith who has been so supportive and taking care of the children at home.

I also dedicate the study to my children Mbachi, Thomas and Kamozaawa who have been waiting patiently for dad at home.

## ACKNOWLEDGEMENTS

I would like to express my sincere thanks to my supervisor, Mrs Jumbe for her patience and her constructive guidance without whom, this study could not have been successful.

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## ABSTRACT

The purpose of the study was to determine factors contributing to underutilisation of the home based care services at Macha hospital. A descriptive explanatory and non-intervention type of study was used. The general objective of the study was to determine factors contributing to the underutilisation of home based care services at Macha hospital.

The review of literature on relevant studies done in other countries and within Zambia revealed that there are influencing factors on the topic under study and the factors include; training of staff, supervision of staff and incentives from management, community co-operation, availability of resources, knowledge about significance of HBC, professional qualification and cultural-beliefs.

The study was conducted at Macha mission hospital. The population under study was fifty (50) health care providers of which 40 were nurses, 3 clinical officers, 4 pastors and 3 environmental technologists.

The respondents were selected using a non-probability sampling method (convenience method). Data was collected using self-administered questionnaires and two focus group discussions from the community. Data was analysed manually and findings presented in frequency tables, bargraphs and pie chart.

The study revealed that the majority of respondents 41(82%) did not receive any training in home based care. Resources for use in HBC services are not available and health personnel are demotivated because of inadequate incentives. The study also revealed that, the majority of the respondents 37(74%) stated that there are no community volunteers involved in HBC programme. Sexual cleansing after death of a spouse was the

cultural belief affecting ~~HBC~~ activities. Going by the above findings, the researcher concluded that the home-based care service is being underutilised.

## **1.0: BACKGROUND INFORMATION**

Zambia is a sub-Saharan African country with an area of 753,000 square kilometres and a Total population of 10.3 million. About 62% of the population reside in rural areas, while 38% are in the urban areas. The country has a relatively young population with about 45% aged between 0 and 14 years (CSO, 2000).

From 1984 to 1993, a cumulative total of 29,734 HIV/AIDS cases were reported in Zambia (MOH, 1998). From 1992 to 1994, AIDS-related illnesses have been the most Common cause of death in hospitalised adults. Reported incidence of tuberculosis which was on the decline up to 1974 and static up to 1984, has been continuously increasing, on average by 20% per annum in absolute numbers since 1985 (MOH, 1998).

In 1998, the estimated HIV prevalence rate for the entire country was 19.7%. In urban areas, the prevalence rate among 15 to 49 years old was more than 28%; in rural areas it was 13.6% (MOH/CBoH 1999). The overall rate is exceedingly high and shows that Zambia is undergoing one of the worst HIV/AIDS epidemics in the entire world.

By 1999, an estimated 1,009,000 persons were infected with HIV in Zambia (MOH/CBoH 1999). However only about 9% of these had actually progressed from HIV to AIDS.

During the late 1980's, Zambian non-governmental organisations began to respond to the mounting AIDS crisis by developing home-based care programmes for people with HIV/AIDS. One of the first programme was the Salvation Army hospital at Chikankata in the Southern province, which started its home care programme in 1987. On the

Copperbelt, Ndola central-hospital established a Home-based care unit in 1992. In Lusaka, the university teaching hospital Home-based care programme started in 1988,

with six part time volunteers, and was taken up by the Family Health Trust in 1997.

Home based care was promoted enthusiastically by the churches Medical Association of Zambia (CMAZ) and endorsed by the ministry of health aided by foreign donor agencies. According to the ministry of health, the number of home-based care projects in the country had increased up to 100 by 1996 (MOH 1998). The non-governmental sector began to respond to the AIDS health crisis by developing Home-based care programmes.

By the early 1990's, home care programmes for chronically ill patients in Zambia included most of the following activities:

- a. Basic medical and nursing cares.
- b. Emotional, social and spiritual support to patients and family members.
- c. Explaining to family members how to provide chronically ill patients with nursing interventions within the home.
- d. Awareness raising and education within the family and the community to reduce stigma against people with HIV/AIDS and to promote behavioural change for HIV prevention (Blinkhoff, p.etal 1999).

The home-based care programmes have been implemented in two ways;

- a. Hospital-Initiated outreach programmes, or Vertical programmes, reaching out to communities. Activities are integrated into the community by the hospital staff concerned about the quality of care for people with chronic illnesses.
- b. Community-initiated programmes or horizontal programmes, started by the Community, religious groups and NGO's such as the family Health trust (WHO 2000)

**TABLE 1: TOTAL NUMBER OF AIDS AND ARC CASES REPORTED IN ZAMBIA FROM 1984-1997.**

<b>YEAR</b>	<b>AIDS Cases.</b>	<b>ARC</b>	<b>Cumulated Totals</b>
1984	0	1	1
1985	1	3	4
1986	241	1,347	1,588
1987	709	4,741	5,450
1988	1,693	8,234	9,927
1989	2,803	11,757	14,565
1990	4,201	15,066	12,267
1991	5,847	18,684	24,531
1992	7,123	20,784	27,907
1993	8,304	22,497	30,801
1994	9,406	23,358	32,764
1995	12,741	25,973	38,714
1996	14,566	27,881	42,447
1997			44,000

Source; MOH 1997 National AIDS/ STD, TB and Leprosy programme.

### **1.1. STATEMENT OF THE PROBLEM**

Macha hospital is a 208-bed capacity rural hospital located 70 kilometres by gravel road from Choma town in Southern province. A registered (missionary) nurse started providing health care services at Macha mission hospital in 1924. The first missionary doctor arrived at Macha Hospital in 1954. A new hospital was opened in 1957 at the present site and has expanded over the years to its current 208-bed capacity.

The population of the catchment area for Macha Hospital is primarily of the Tonga tribe with the primary livelihood being that of subsistence farming. The hospital's catchment area is a radius of approximately 40kilometres with an estimated population of 70,000.

The home-based care programme started as far back as 1991. Since its inception, the

home based care programme has not yet developed like other Home-Based Care programmes in the country.

The idea of a home-based care programme came from the Christian environment.

Initially home-based care was concerned with spiritual aspects only,

where by Clients were followed up in their homes for spiritual care. At that time clients were those patients diagnosed with tuberculosis only, but with the advent of HIV/AIDS, Clientele increased and were camouflaged under the diagnosis of tuberculosis for fear of stigmatisation.

Todate the home based care register has only 66 clients. Medical records at the health institution show that some patients that are discharged and re-admitted require home-based care. The quarterly statistics of the year 2000 at the hospital show an increase of 6.7% in chronically ill patients who need home care.

**TABLE 2. CHRONICALLY ILL PATIENTS ADMITTED AT MACHA HOSPITAL**

DIAGNOSIS	OCTOBER		NOVEMBER		DECEMBER		TOTAL
	Male	Female	Male	female	Male	female	
TB	49	31	53	47	60	52	292
HIV	2	4	3	7	10	9	35
HIV SUSPECTED CASE	8	6	8	2	21	43	88
<b>TOTAL</b>	<b>59</b>	<b>41</b>	<b>64</b>	<b>56</b>	<b>91</b>	<b>104</b>	<b>415</b>

Source: Macha Hospital quarterly statistics 2000.

Observations and records reviewed at the hospital show that the home-based care services for chronically ill patients are not provided for as expected, because efforts to provide home-based care services have been made only for a few clients and these services are irregularly provided. Despite the existence of the home-based care programme at Macha

hospital, most of the beds are occupied by patients with chronic illnesses who are not on any medication.

This trend has led to congestion on the wards, making it difficult for nurses to offer quality-nursing care to clients. It is with this assumption that the researcher felt the home-based care services are under utilised at Macha hospital. The researcher would therefore want to address the question of what could be the contributing factors to under utilisation of home based care at Macha hospital.

There are existing assumptions on the factors that may contribute to under utilisation of the home- based care services at Macha hospital.

**A. COMMUNITY BASED FACTORS**

- i. Fear of stigmatisation of clients, by the community to be labelled as “AIDS” Patients.
- ii. High poverty levels among communities due to inadequate income.
- iii. Lack of volunteerism among the community.
- iii. Lack of sensitisation on Home-based care activities.
- iv. Lack of incentives.
- V. Fear of contracting diseases.
- vi. Primary care givers are busy with other chores.

**B. HOSPITAL BASED FACTORS**

- i. Shortage of qualified staff to undertake activities and supervise volunteers:
- ii. Lack of training programmes in Home-based care for health service providers.
- iii. Lack of resources to use and to give to families for use during care.

iv. Lack of incentives to home base care providers by the management.

## **JUSTIFICATION**

Long-term care is an integral part of health and social systems. It includes activities undertaken for people requiring care by informal caregivers (family, friends and neighbours), by formal care givers, including professionals and auxiliaries (health, social and other workers) and by traditional caregivers and volunteers (Polnary, etal 1990).

The goal of long term care is to ensure that an individual who is not fully capable of long-term self care can maintain the best possible quality of life, with the greatest possible degree of independence, autonomy, participation, personal fulfilment and human dignity (Zulu, etal 1997).

Like most of other countries in the sub-Saharan Africa, Zambia faces the problem of how (with severely limited economic resources) to provide basic care and support to every one affected by the dual epidemic of HIV and Tuberculosis.

There has been no study undertaken to look at the home-based care services at Macha hospital. At the moment there is scanty information on home-based care services done at Macha hospital since its inception.

The congestion on the ward with chronically ill patients who may benefit from home-based care services is increasing. The researcher would therefore like to establish factors contributing to the underutilisation of home-based care services. The data collected from the study will provide information to stakeholders on how to formulate strategies and implement home-based care services appropriately.

### **1.3 OBJECTIVES**

#### **GENERAL OBJECTIVE.**

To determine factors contributing to the underutilisation of home based care services at Macha hospital.

#### **SPECIFIC OBJECTIVES**

1. To determine the knowledge on the management of home based care services by health care providers.
2. To determine whether giving incentives to health care providers in the home based care programme will improve the utilisation of home based care services.
3. To determine factors that influences utilisation of Home based care services.
4. To determine factors that will improve home based care services.
5. To determine the accessibility of home based care services to clients.

### **2.0 OPERATIONAL DEFINITION OF TERMS**

HOME BASED CARE:	Care given to patients in their homes.
PRIMARY CARE GIVER:	A person providing the nursing care to the patient in their home.
HEALTH CARE PROVIDER:	A trained health worker involved in the provision of Health care services.
NEED	The lack of something useful.
VOLUNTEER:	A person who provides an activity without a reward.

INCENTIVE:	Factors that will increase workers morale such as providing an allowance, workshop, praise and others.
UNDER UTILISATION:	Not fully used to the required standard.
VERTICAL PROGRAMME:	Services integrated into the community by the Hospital staff concerned about the quality of care for People with chronic illnesses.
HORIZONTAL PROGRAMME:	Services started by the community, religion groups and NGO's for people with chronic illnesses.

## **2.1 LITERATURE REVIEW**

The HIV/AIDS epidemic has become a number one and a serious health and developmental problem in many countries around the world. The joint United Nations programme on AIDS, estimated the number of HIV infections world-wide at about 33.4million by the end of 1998,of which 22.5million would be found in sub-Saharan Africa (MOH/CBoH 1999). According to UNAIDS and WHO, almost 13.9 million people world-wide have died of HIV/AIDS since the start of the epidemic (UNAIDS/WHO 1998). Another 31 million people, many of which are chronically ill, are living with the virus.

The impact of HIV/AIDS is greatest in sub-Saharan Africa, where 83% of AIDS deaths world-wide have occurred and nearly 21 million people are currently living with

HIV (UNAIDS/WHO 1998).

The second epidemic is caused by the Tuberculosis (TB) germ, which already has killed 3 million people worldwide annually, more than any other infection. Among people living with HIV, TB dramatically reduces the quality of life and shortens survival rate (MOH/CBoH 1998).

Africa now faces a devastating dual epidemic of HIV and TB, with Zambia in the front line of the countries most severely affected (MOH 1997). A report by MOH/CBoH (1998) shows that, one in five adults in Zambia is infected with HIV and an estimated 90,000 people develop AIDS every year. The number of people in Zambia who fall sick with Tuberculosis has increased from 7,000 new cases a year in 1984 to nearly five-fold, to over 500 per 100,000 population in 1996. The number of reported TB cases was over 40,000 in 1996, more than 100 each day ( MOH/CBOH 1999).

The true number of cumulative AIDS cases in Zambia is officially estimated at over 400,000, of whom more than half have already died (MOH/CBoH 1997). According to the ministry of health it was estimated that by the year 2000, the cumulated totals of AIDS cases in Zambia would probably reach 700,000 (MOH/CBoH, 1997).

The HIV adult prevalence by province in Zambia in 1997 is as follows:

**Table 3: HIV prevalence estimates by province in adults' aged 15years and above.**

<b>Province</b>	<b>HIV+ve urban</b>	<b>HIV+ve rural</b>	<b>Cumulative total</b>
Central	43,299	57,271	100,570
Copperbelt	186,614	20,474	207,088
Eastern	18,407	72,980	91,337
Luapula	14,918	58,475	73,393
Lusaka	165,201	15,580	180,782
Northern	23,232	81,826	105,058
North Western	9,208	20,468	29,674
Southern	41,921	51,644	92,936
Western	10,756	54,700	65,516

Source- MOH/CBoH 1997.

In the late 1980's, Zambia saw the emergence of a new strategy for the care of HIV/AIDS patients, known as Home-based care. This strategy was not confined simply to medical treatment and nursing care, but also took a more comprehensive approach to the needs of individuals, families and communities affected by the HIV epidemic. Home care programmes in Zambia and in other African countries have generally achieved only limited coverage and are relatively expensive to operate (Chela and Shankanga 1994). Home based care programmes were initially financed by church organisations, non-governmental organisations (NGO's) and well wishers. Of late home based care programmes have been facing declining donor support and overwhelming increase in the number of patients (MOH/CBoH 1998). Generally in Zambia, staffing of home based care programmes has been a significant challenge with frequent shortages of health personnel in health institutions (Chela and Shankanga, 1994). It has further been noted that, health workers experience conflicting work demands because the same people who go to see patients in their homes are the very ones who are supposed to meet the needs of the patients on the wards. This has lead many health workers to resign from home-based care programmes due to continued over exposure to overwhelming demands as opposed to rewards (Reijer 1996).

According to Reijer.p. (1996), lack of encouragement from superiors, lead to low staff morale and lack of commitment to home-based care programme.

The key reason identified for low staff morale in home-based care programme is a perceived lack of monetary gain and intrinsic incentives to stay within the programme (Chela and Shankanga, 1994). In their study, the respondents stated that they did not receive adequate allowances for the efforts they made to try and meet the needs of

HIV/AIDS patients in their homes. On the other hand the administration never gave them the support and encouragement for services provided to the programme.

In Zambia, Chikankata home based care is one of the successful home based care programmes in the country. It trains health workers in home management of AIDS patients and equips them with counselling skills for them to work effectively in the community. The programme owns a vehicle and receives resources from donors.

Chikankata home-based care has implemented an integrated approach to AIDS management. The concept of integrated AIDS management incorporates pastoral care along side with medical and nursing care, counselling and education. When a patient dies, a member of the home based care team provides pre-burial counselling to the family and attends the funeral (Blinkhoff, etal 2000). The members of the home based care team are drawn from various disciplines.

**TABLE 4: FOUR SELECTED HOSPITAL-INITIATED HOME-BASED CARE PROGRAMMES IN ZAMBIA**

	<b>Chikankata</b>	<b>Lusaka</b>	<b>Monze</b>	<b>Ndola</b>
Year started	1987	1988	1989	1993
Area served	Rural, 10 zones 7,400sq,km	Urban, 6 zones 5,200sq,km	Rural, 6 zones. 6, 7 00sq,km	Rural, 970sq,km
Population served	100,000	1,200,000	197,000	300,000
Type	Vertical	Vertical	Horizontal and Vertical	Horizontal
Affiliation	Protestant church mission	Philanthropic NGO	Catholic church mission and designated government agents.	NGO, Catholic church.
Home visits per week	3	5	3	3
Number of vehicles	1(rent)	1(own)	1(own)	2(rent)
Patients currently registered	214	214	244	244

**Source;** (MOH, 1994)

Another Zambian successful home-based care programme is the one on the Copperbelt in Ndola, which is run by the catholic archdiocese. The sisters from the catholic congregations set up a small clinic in the office of the local Catholic Church. The sisters realised that many chronically ill people were unable to walk to the clinic and would have to be visited at home. The home care programme does not operate from a health institution, but works in partnership with various departments of the Ndola Catholic archdiocese, local NGO's, community groups, district health management team, government and private hospitals, the victim support unit of the Zambian police, the World Food Programme, a small number of local businessmen and individuals. The programme focuses on people exclusively adults who have been ill for at least one month, most of whom have symptoms of HIV/AIDS or TB. Small proportion (less than

25%) of the people registered with the programme have been tested for HIV (Veldhuizen 1998). The home-based care programme in the 12 townships around Ndola is helping to relieve staff at Ndola central hospital some pressure of work. (Blinkhoff, etal 1999).

A study by Polnary on home based care in 1990, concluded that an effective home based care programme involves the provision of preventive services, detection of illnesses and other social factors in the environment that contributes to the ill health, instituting collective management strategies, recognising the need to mobilise appropriate resources, provision of health education and advise in periods of stress. With an effective home care service, the bulk of problems could be dealt with, within people's own environment, leaving hospitals to adequately attend to a manageable number of patients.

In Great Britain, the Home –based care concept was recognised way back in 1946 when the need for home-based care was expressed in the 1946 National Health Service Act. A ruling was made that every local authority should make provisions for visiting the sick in their homes, to give advice to women on child care and how to prevent diseases (Dhillon, etal 1994). This was important in empowering people with health information so that, they are able to make choices and take positive health actions in their own environment.

Home-based care is important in that, the service provides a better chance for patient's recovery because during a home visit the health worker makes sure that the patient is supervised and provided with the time, knowledge, motivation and resources.

In Kenya, the general complaints of home based care staffs are that, they receive insufficient vertical communication from their superiors; lack of job orientation from administrators and their roles in home-based care programme were not clearly defined (Smart, and Finchman, 1996). In some countries home based care health personnel are provided with incentives to motivate them so that they can meet needs of HIV/AIDS patients in their homes (Hampton, 1994).

In Malawi home based care programmes have incorporated all workers in the health care system so that their efforts can be combined to meet the needs of HIV/AIDS patients in their homes. The burden of AIDS patients is not thrown to health institutions alone, but also to the community and other government sectors such as Agriculture (Jackson, 1996). The health personnel undergo some training and know how best they can teach people the basic principles of caring for chronically ill patients. Proper counselling is given to primary care providers and patients so that they know what to do and how to give and seek emotional and practical support from the community and health personnel.

Ghana has a self-help group that provides home visits for HIV/AIDS patients. The group that is made up of people with HIV, offers encouragement and support to each other. This has helped to reduce their feelings of guilty and isolation, giving them purpose and meaning for life (Polnary, et al, 1996).

Blinkhoff, et al (1999) stated the following as advantages of home based care services:

- a. Good basic care in the home enables the ill person to be as active and productive as possible.
- b. Family support for the sick person is strengthened.

- c. Very sick or dying people often prefer to stay at home, especially if they know they cannot be cured in hospital or cannot derive any further benefit from in-patient care.
- d. Relatives are able to carry out other duties more easily if the sick person is at home rather than in hospital.
- e. Home care can help to relieve the pressure on hospital, so that staff can give better care to those who really need to be in hospital.
- f. Home care is usually less expensive for families than hospital care, requiring visits and food to be provided by the family members.
- g. Sometimes hospital care is not possible or is simply unavailable.
- h. Being in their homes and communities comforts sick people, with family and friends around.
- i. Home care is an effective entry point for support to the survivors of the sick person, especially the widowed spouse and orphaned children.
- j. Home care offers opportunities for educating families and communities about HIV prevention and can help destigmatise HIV/AIDS and TB patients.

In Uganda mission hospitals such as Nsambya in Kampala and Kitovu in Masaka developed home care programmes providing thousands of people with HIV/AIDS and their families with basic health care and social support (WHO 1993).

In Zambia, the most important problems encountered by the home-based care team is a problem of money and food for patients (Zulu, 1997). Despite some achievements, home based care programmes are still unable to reach most of the HIV/AIDS patients in

need of care and support. It is estimated that the proportion of patients receiving home care services was between 2% and 5% of the total number in need of care and support (MOH/WHO, 1993).

Zambia is experiencing a “home care gap”. This situation is similar to other African countries (WHO 1993).

In early 1994, the Southern African network of AIDS service organisation (SANASO) organised an international meeting on home-based care at Chikankata hospital in southern province of Zambia, representatives from eight southern African countries concluded that the only realistic means of closing the widening “home care gap” is increasing community involvement (Blinkhoff, et al. 1999).

Home-based care has been shown to be an effective alternative complement to hospital care for people living with AIDS (PWA). It supports and builds on the strength of the family and community while providing care often not available within hospitals, such as emotional, spiritual and social support.

Home based care programmes provide some relief on over burdened hospitals. Providing services within a community also provides a unique opportunity to reduce the fear and stigma associated with HIV/AIDS and to implement health and HIV prevention services.

### 3:0. **METHODOLOGY**

#### 3:1. **RESEARCH DESIGN**

The purpose of the study was to determine the factors contributing to Under utilisation of home based care services at Macha hospital. A descriptive explanatory non-intervention study design was used to get the accurate description of the factors contributing to under utilisation of home based care services.

The descriptive research design was used because it provided data about the current situation within a relative short period of time and it enabled the description of variables.

#### 3.2. **RESEARCH SETTING**

The study was done at Macha mission hospital because it was cheaper and easier for the researcher to conduct it there considering the limited resources available to under take the study. The respondents were the health workers at Macha hospital and the community. This included nurses, clinical officers, environmental health technologists, hospital pastors, and the community. Macha hospital has 73 Nurses of which 56 are enrolled nurses, 12 are enrolled midwives, 2 Registered midwives and 3 Registered nurses. There are 4 clinical officers, 3 environmental health technologists and 2 hospital pastors.

#### 3.4. **SAMPLING METHOD**

“Sampling is the process of selecting the sample or subjects from the population” (Polit and Hungler 1995).

The non-probability sampling method was used. This method was cheaper and

quick considering the limited resources and time. Specifically, a convenience sampling method was used. This was done by the use of the most conveniently, available people as subjects in the study. Convenient samples do not necessarily comprise of individuals known to the researcher, however it should be noted that convenience sampling is the weakest form of sampling, but it is also the most commonly used sampling method in nursing studies.

### **3.5. SAMPLING SIZE**

The sample size was 50, (n=50). The sample was drawn from health care providers, pastors and the community. This number of the sample was considered reasonable, taking into account the limited resources and time.

### **3.6. PILOT STUDY**

To ensure validity and reliability, the questionnaire was pre-tested. This was done on 5 health care providers at Macha hospital, and these were excluded from the main sample used in the study.

### **3.7 DATA COLLECTION TOOL**

The researcher used semi-structured questionnaire as the tool to collect data. The questionnaires comprised of both open-ended and closed ended –questions. This was considered suitable because the respondents were literate. It also permitted anonymity and resulted in more honest responses. To control for anticipated low response rate and ambiguity, the questions in the questionnaire were simple and straightforward. A Focus group discussion was

also used to collect data from the community. This helped in answering questions on how people behave as they do and to objectively compare the results from the FGD and the structured questionnaires.

### **3.7. ETHICAL CONSIDERATION**

The right of privacy was observed by obtaining direct consent for participation from the respondents and measures were taken to ensure informed consent and confidentiality. The respondents were informed of the purpose and the benefit of the study. To ensure anonymity, the researcher omitted the names of the respondents. The researcher got permission from the director of Macha hospital to conduct the study. Permission was also sort from the village headmen to conduct interviews and Focus Group Discussions.

### **3.8. VARIABLES**

Variables identified in this study were both dependent and independent variables. Independent variables were as follows:

Age, sex, marital status and professional qualification.

Community cooperation and social support.

Availability of resources, staff supervision, incentives, training and staff level.

Values, norms and religion.

Dependant variables: Uderutilisation of home based care services.

### **4.0. DATA ANALYSIS**

To ensure quality control the questionnaires were checked for completeness and

mistakes. Data was then cleared in readiness for coding. The qualitative data was categorised and coded on the data master sheet. Data from closed-ended questions was analysed manually using a calculator and presented in the form of frequency tables, bar graphs and pie chart. Significant and non-significant results have also been reported.

#### 4.1: PRESENTATION OF FINDINGS

The objective of the study was to determine factors contributing to under utilisation of Home Based care at Macha Hospital. The data collected was presented in tabular, graph and pie chart form, which made it easier to summarise the findings.

TABLE 5: DEMOGRAPHIC INFORMATION OF THE RESPONDENTS

Characteristic	Frequency	Relative frequency
<b>1. GENDER</b>		
Male	19	38%
Female	31	62%
<b>TOTAL</b>	<b>50</b>	<b>100%</b>
<b>2. AGE</b>		
21-30	28	56%
31-40	16	32%
41-50	6	12%
<b>TOTAL</b>	<b>50</b>	<b>100%</b>
<b>3. MARITAL STATUS</b>		
Single	25	50%
Married	21	42%
Divorced	3	6%
Widowed	1	2%
Separated	0	0
<b>TOATL</b>	<b>50</b>	<b>100%</b>

The table shows that, there were more female respondents 31 (62%) than the male respondents 19 (38%), while the majority of the respondents were between the ages 21-30years, 28 (56%). The majority of the respondents 25 (50%) were single.

**TABLE 6: PROFESSIONAL QUALIFICATION OF RESPONDENTS**

<b>Qualification</b>	<b>Frequency</b>	<b>Relative Frequency</b>
ZEN	28	56%
ZEM	9	18%
ZRM	1	2%
ZRN	2	4%
Clinical officer	3	6%
Pastor	4	8%
Doctor	0	0
EHT	3	6%
<b>Total</b>	<b>50</b>	<b>100%</b>

The table shows that, the majority of the respondents 28(56%) were Zambia Enrolled nurses.

**TABLE 7: CONDITIONALITY FOR JOINING HBC PROGRAMME**

<b>Condition of joining HBC</b>	<b>Frequency</b>	<b>Relative Frequency</b>
By choice	19	38%
By directive from Hosp.	5	10%
Not involved	26	52%
<b>Total</b>	<b>50</b>	<b>100%</b>

The table above shows that, the majority of the respondents 26(52%) were not involved in HBC activities.

While 19 (38%) joined by choice and 5 (10%) joined by directives from Macha hospital.

**TABLE 8: YEARS OF SERVICE IN HBC PROGRAMME**

<b>Years of service</b>	<b>Frequency</b>	<b>Relative Frequency</b>
0--2	36	72%
3—5	9	18%
More than 6	5	10%
<b>Total</b>	<b>50</b>	<b>100%</b>

The table shows that, the majority of the respondents 36(72%) were in the range of 0—2 years in HBC programme.

**TABLE 9: RESPONDENTS THAT RECEIVED TRAINING IN HBC**

Respondents	Frequency	Relative Frequency
Received training	9	18%
Did not receive training	41	72%
Total	50	100%

The table shows that, the majority of respondents 41(72%) did not receive any training in HBC.

**FIGURE 1: KNOWLEDGE ABOUT THE SIGNIFICANCE OF HBC PROGRAMME IN RELATION TO PROFESSIONAL QUALIFICATION.**

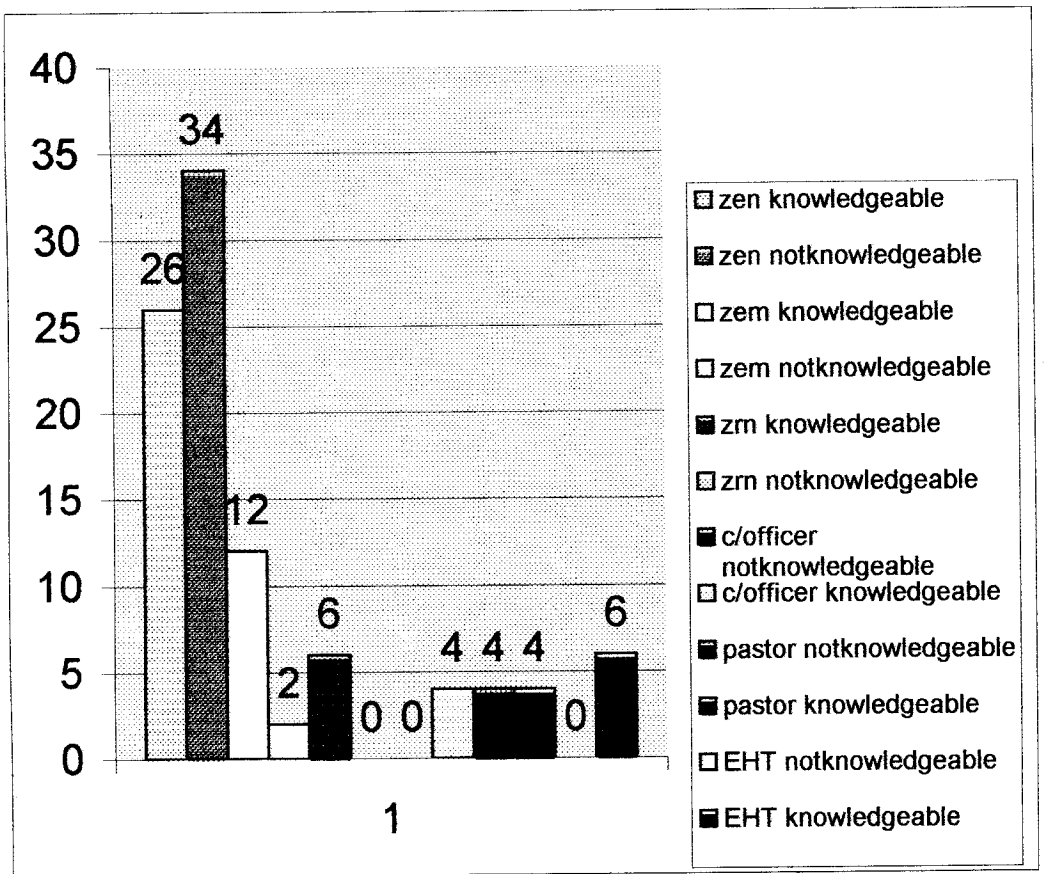


Figure 1 shows that, the majority of the respondents 17 (34%) stated that they did not know the significance of HBC programme.

**TABLE 10: TYPE OF TRAINING RECEIVED IN HBC**

Type Of Training	Frequency	Relative Frequency
Management of patients with HIV/AIDS	7	14
Counselling	2	4
None	41	82
Total	50	100%

The majority of the respondents 41(82%) had not attended any training in HBC, while 18% received training in HIV/AIDS management and counselling.

**TABLE 11: WORKSHOPS ATTENDED IN HBC PROGRAMME**

Workshops	Frequency	Relative Frequency
0-1	4	8
2-3	2	4
MORE THAN 4	4	8
NONE	40	80
Total	50	100%

Majority of the respondents 40(80%) did not attend any workshop in HBC programme. while 10 (20%) attended some workshops.

**TABLE 12: SUPERVISION IN HBC ACTIVITIES**

Supervised	Frequency	Relative Frequency
Yes	13	26
No	37	74
Total	50	100%

The majority of the respondents 37(74%) stated that, they are not supervised in HBC activities.

**TABLE 13: RESPONSE ON AVAILABILITY OF INCENTIVES IN HBC PROGRAMME.**

Response	Frequency	Relative Frequency
Yes	21	42
No	29	58
Total	50	100%

29(58%) Of the respondents stated that, there were no incentives given in the HBC programme, while 21(42%) receive incentives.

**TABLE 14: HBC ACTIVITIES CARRIED OUT**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
Home visit	27	54
Counselling	13	26
Health education	10	20
<b>Total</b>	<b>50</b>	<b>100%</b>

27(54%) Of the respondents stated that, they carried out home visits as an activity in HBC programme.

**TABLE 15: AVAILABILITY OF TRANSPORT**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
Not available	42	84
Available	8	16
<b>Total</b>	<b>50</b>	<b>100%</b>

Majority of the respondents 42(84%) stated that transport was not available, while 8 (16%) stated that transport was available.

**TABLE 16: NUMBER OF CLIENTS IN THE HBC REGISTER BOOK**

<b>Number</b>	<b>Frequency</b>	<b>Relative Frequency</b>
0-50	36	72
51-100	12	24
ABOVE 100	2	4
<b>Total</b>	<b>50</b>	<b>100%</b>

Majority of the respondents 36(72%) stated that, the number of clients in HBC register was in the range of 0-50.

**TABLE 17: AVAILABILITY OF TRAINING PROGRAMME FOR COMMUNITY VOLUNTEERS.**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
AVAILABLE	13	26
NOT AVAILABLE	37	74
<b>Total</b>	<b>50</b>	<b>100%</b>

The majority of the respondents 37(74%) said there was no programme to train community volunteers.

**TABLE 18: AVAILABILITY OF RESOURCES**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
AVAILABLE	2	4
NOT AVAILABLE	48	96
Total	50	100%

The majority of the respondents 48(96%) stated that, there are no resources in the HBC programme.

**TABLE 19: COOPERATION FROM THE COMMUNITY**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
Cooperate	31	62
Not cooperating	19	38
Total	50	100%

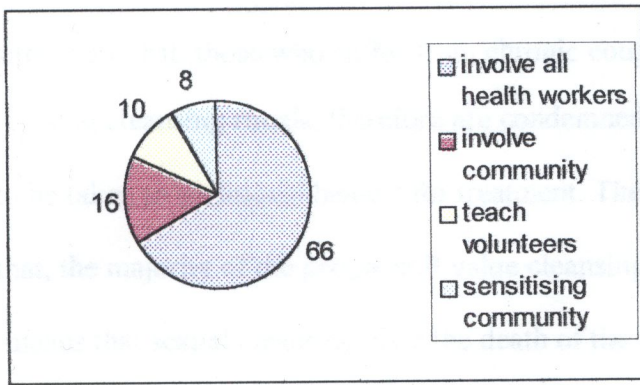
The majority of the respondents 31(61%) stated that, the community does cooperate in HBC activities, while 19(38%) do not cooperate.

**TABLE 20: CULTURAL-BELIEFS AFFECTING HBC ACTIVITIES**

<b>Response</b>	<b>Frequency</b>	<b>Relative Frequency</b>
Cleansing	8	16
Polygamy	0	0
none	42	84
Total	50	100%

The majority of the respondents 42(84%) stated that, there are no cultural-beliefs affecting HBC activities, while 8(16%) agreed to cultural-beliefs having an effect on HBC activities.

**FIGURE 2: SUGGESTIONS ON IMPROVEMENT OF HBC SERVICES.**



Majority of the respondents 33(66%) stated that, all health workers should be involved in HBC programme.

#### 4.2: DISCUSSION OF FINDINGS

Out of the fifty- (50) respondents 62%(31) were females and 38%(19) were males. The mean age of the respondents was 32 years and the majority of the respondents 56%(28)

were in the age range of 21-30 years as shown in table 6. Most of the respondents

56%(28) were Zambia enrolled nurses, 18%(9) were Zambia

enrolled midwives, 8%(4) were Pastors, 6%(3) were clinical officers and Environmental health technologist, 4%(2) were registered nurses and 2%(1) was a registered midwife.

Out of the 50 respondents, 50%(25) were single, 42%(21) were married, 6%(3) were divorced and 2%(1) was widowed. This data was significant in determining whether sex,

age, professional qualification and marital status can affect the activities of HBC programme.

Majority of the respondents 84%(42) stated that there were no cultural beliefs that affected the delivery of care to patients in their homes, while 16%(8) stated that there are

some cultural beliefs that affect the delivery of home care. Some of the cultural beliefs sited were that, those who suffer from chronic cough or AIDS, are affected as a result of refusing cleansing rituals, therefore are condemned by their ancestors and were supposed to be taken to traditional healers for treatment. The Focus Group Discussion revealed that, the majority of the people still value cleansing after the death of a spouse, which means that sexual cleansing after the death of the spouse is likely to spread HIV to a partner who is not infected. This indicates that there are cultural beliefs responsible for the spread of HIV/AIDS and hence the need to continue sensitising the community on HIV/AIDS.

The majority of the respondents 62%(31) stated that the community does not support the HBC activities, while 38%(19) stated that, the community does support the HBC activities. On the type of support offered, 32%(16) stated that, the community offers social-economic support to HBC patients and 6%(3) stated that, the community gives material support.

The FGD results showed that, the community is willing to work with the HBC team if they are provided with the knowledge on home care. This is in line with table 21, which shows that 62%(31) of the respondents, said that the community is willing to cooperate with HBC activities. Others showed concern that they could probably be paying for the services offered by the HBC team. This implies that HBC programme is not fully understood by the community and not fully appreciated. Jackson, M (1996) agrees that, the burden of AIDS patients should not be thrown to health institutions alone, but also to the community and other government sectors and churches in giving holistic care to the chronically ill at their homes, meaning that the community should be fully involved in

HBC activities.

62%(31) of the respondents stated that, the community does not give support to the HBC programme. This may indicate the high poverty levels among the community as revealed by the FGD where all of the participants stated that, they did not have resources to care for the sick in their homes, hence prefer to take them to the hospital for the provision of care. This may be one of the reasons as to why HBC is being underutilised at Macha hospital.

The study revealed that, most of the respondents 52%(26) were not involved in HBC programme, while 48%(24) were involved in HBC programme on a part time basis, and these are more committed to the work that they are paid for, than the HBC activities to which they get less incentives. Out of the 48%(24) respondents who stated that, they were involved in HBC activities, 38%(19) joined the programme by choice while 10%(5) joined by directives from Macha hospital. This implies that, those who joined by directive may be working with low morale because they already have overwhelming work demands, or were not interested to work in HBC. This is supported by Chella, C and Shankanga, Z (1994) who stated that the same people who are involved in HBC programme are the ones who are supposed to meet the needs of the patients on the wards. Out of the 30 respondents, 34%(17) stated that, they did not know the significance of HBC programme while all the registered nurses 6%(3), clinical officers 6%(3) and environmental health technologist 6%(3) stated that they knew the significance of HBC programme. This may mean that there is a difference in the level of understanding about HBC in these categories of health providers. This is explained in table 11, which shows that, the majority of the respondents 41(82%) did not receive training in HBC and

40(80%) stated that they did not attend any workshop in HBC programme, meaning that even if they are involved in HBC programme, they do not fully understand it. These findings are supported by a report made by WHO (1993) which stated that, for HBC to be fully appreciated one needs to be knowledgeable and should be receiving constant training about the trends in HBC.

Further more the study revealed that, the majority of the respondents 74%(37) stated that, they did not receive any supervision while carrying out HBC activities. This could be a demotivating factor to the health care provider who is not supervised, because they will relax, retarding activities of the programme. Chella, C and Shankanga, Z (1994) had similar findings in their study on cost and impact of HBC programmes. They stated that health care providers who are not supervised and not remunerated will have low morale and lack of commitment to work.

The majority of the respondents 36(36%) stated that, they had worked for 0-2 years of service in home-based care programme. This implies that a number of them are inexperienced in HBC activities. This may also answer why the majority of the respondents 72%(36) who stated that the number of clients in the HBC register book was in the range of 0-50, implying that there is no proper record keeping. In line with the number of clients, only 66 clients are registered since the inception of the programme. This may also mean that there could be an increase in the number of patients in the community who are not accounted for. Results obtained from the FGD revealed that at 3 households, they had patients admitted in the hospital with tuberculosis, but were not reflected in the register book, meaning that the number of patients in the villages could be more than that may need HBC services. The FGD also revealed that the community

is willing to initiate HBC activities given the knowledge about care and the necessary resources.

The majority of the respondents 42(84%) stated that transport was not available, however it was noted that at the end of data collection a vehicle was donated by CMAZ for HIV/AIDS activities. The study also revealed that resources for HBC programme were not available as stated by 48(96%) of the respondents. This implies that, the health care provider may be frustrated because they are not able to meet the needs of the clients. These findings are consistent with those of Chela, C and Shankanga, Z (1994) who stated that general burn out signs of health care providers in HBC programme will continue due to exposure to overwhelming needy patients and families, inadequate resources to satisfy their needs, and the amount of uncomfortable travel involved with home visits.

From these findings one would suggest that there is need to train health care providers in HBC activities in order for them to participate actively in the programme. Similar findings were alluded to by WHO (2000), who stated that training health care providers in HBC programmes make the programme successful. In Chikankata, health care providers undergo some training before they start providing care in the HBC programme, in order to equip them with knowledge and skill.

Further more the study revealed that, majority of the respondents 66%(33) stated that all health workers should be involved in identifying patients who need HBC services. The FGD also revealed that, the community suggested that every health care provider should be involved in teaching patients and relatives about the existence of HBC programme and also to train community volunteers who will be working hand in hand with health workers. Blinkhoff, P. etal (1999) reports that, in Chikankata the HBC programme

involves the community more than the health workers and are provided with basic medical supplies to use on patients in their homes.

#### 4.3: **IMPLICATIONS TO HEALTH SYSTEMS**

The study revealed that there is still a need to provide knowledge and skill in the management of HBC activities to health workers and the community, in order to offer quality service to chronically ill patients in their homes.

Health policy makers should consider ways of motivating the home based care providers for effective operation of the programmes. The health care provider must be provided with resources to enable them meet the needs of patients and be rewarded for the extra efforts to ensure that the programme succeeds. Provision of transport must be given the first priority to enable successful home visit.

Effective establishment of HBC programmes demands that the role of the health care providers be expanded as they are also expected to work in the community.

Training schools such as schools of nursing are challenged to incorporate content on HIV/AIDS Counselling skills in the curriculum so that nurses can be able to meet demands of HIV/AIDS patients even as they graduate.

#### 4.4 **CONCLUSION**

The study sought to determine factors contributing to underutilisation of home-based care at Macha hospital and the findings suggest that, the programme should involve the community by training community volunteers. More health care providers should be recruited on voluntary basis and be given training in HBC services before they start the actual activities. It is almost impossible to have permanent workers in HBC programme,

so recruitment should be widened to include teachers and agriculture workers social workers and many more interested parties.

To keep the health care provider's morale high, incentives should be given not in form of money but also to provide training, workshops and positive feedback from the supervisors.

#### 4.5 **RECOMMENDATIONS**

Based on this study, the following recommendations were made;

1. The district health management board should consider integrating HBC programme at Macha hospital as part of its activity.
2. Training the health personnel in HBC activities is the answer to meet the overwhelming needs of patients in the homes.
3. Support of trained health personnel in HBC activities, should be done so that they feel cared for by their supervisors.
4. The Zambian government should consider increasing budgetary allocation to the health sector in order to provide continuous training in HBC activities.
6. The community should be involved in identifying patients who need HBC services.
6. Volunteers, should be trained to work within the community.

#### 4.6 **LIMITATIONS**

1. The major limitation in undertaking the study was the limited resources and the time frame in which the research programme was to be completed considering other courses being done during the course of the study.
2. The researcher had difficulties in collecting information on HBC programme at Macha hospital, as the records were frequently inconsistent or incomplete.

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## APPENDEX II

### FOCUS GROUP DISUSSION GUIDE

#### INSTRUCTIONS

1. GREET THE PARTICIPANTS.
2. INTRODUCE YOUR SELF AND THE TOPIC.
3. EXPLAIN THE PURPOSE OF THE DISCUSSION.

#### FOCUS GROUP DISCUSSION GUIDE

1. WHAT DO YOU KNOW ABOUT HOME BASED CARE?
2. HOW DO YOU THINK HOME BASED CARE ACTIVITIES SHOULD BE IMPROVED?
3. WHAT PROBLEMS DO FACE IN CARING FOR THE SICK AT HOME?
4. HOW DO YOU CARE FOR A PATIENT WITH A CHRONIC ILLNESS AT HOME?
5. WHAT HELP WOULD YOU WANT TO RECEIVE FROM THE HOME BASED CARE PROGRAMME?

**THE END.**

**Thank you very much for your co-operation.**

APPENDIX I

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING.

**Self- administered questionnaire on the factors contributing to underutilization of Home-based care at Macha Hospital**

Date...

Questionnaire no...

**INSTRUCTION TO INTERVIEWEE**

1. Please do not write your name on this questionnaire.
2. Kindly tick[ ] the appropriate response.
3. Answer all the questions.
- 4.** Answer all the questions in this questionnaire.
5. Information will be held in confidence and utilised for the purpose of the study.

**SECTION A. DEMOGRAPHIC DATA**

- |    |                             |                        |                     |
|----|-----------------------------|------------------------|---------------------|
| 1. | SEX.                        |                        | OFFICIAL USE<br>[ ] |
|    |                             | A.MALE. [ ]            |                     |
|    |                             | B.FEMALE.[ ]           |                     |
| 2. | AGE.---                     |                        | [ ]                 |
| 3. | MARITAL STATUS.             |                        |                     |
|    |                             | A.SINGLE. [ ]          |                     |
|    |                             | B.MARRIED. [ ]         |                     |
|    |                             | C.DIVORCED. [ ]        | [ ]                 |
|    |                             | D.WIDOWED. [ ]         |                     |
|    |                             | E.SEPARATED. [ ]       |                     |
| 4. | WHAT IS YOUR QUALIFICATION? |                        |                     |
|    |                             | A.ZEN [ ]              |                     |
|    |                             | B.ZEM [ ]              |                     |
|    |                             | C.ZRN [ ]              | [ ]                 |
|    |                             | D.ZRM [ ]              |                     |
|    |                             | E.CLINICAL OFFICE. [ ] |                     |
|    |                             | F.PASTOR. [ ]          |                     |
|    |                             | G.DOCTOR [ ]           |                     |
|    |                             | H.EHT. [ ]             |                     |
| 5. | RELIGION.                   |                        |                     |
|    |                             | A.CHRISTIAN. [ ]       | [ ]                 |
|    |                             | B.ISLAM.. [ ]          |                     |
|    |                             | C.HINDUISM. [ ]        |                     |
|    |                             | E. OTHERS.. [ ]        |                     |

**SECTION B. WORK EXPERIENCE**

6. HOW DID YOU JOIN THE HOME-BASED CARE PROGRAMME?
- |                                      |  |  |     |
|--------------------------------------|--|--|-----|
| A.BY CHOICE. [ ]                     |  |  |     |
| B.DIRECTIVE FROM MACHA HOSPITAL. [ ] |  |  | [ ] |
| C.OTHERS.....                        |  |  |     |
- 7a. DO YOU KNOW THE SIGNIFICANCE OF HBC PROGRAMME?
- |            |  |  |     |
|------------|--|--|-----|
| A. YES.[ ] |  |  |     |
| B. NO.[ ]  |  |  | [ ] |
- 7b. IF YES,  
EXPLAIN.....
- .....

8. HOW LONG HAVE YOU BEEN INVOLVED IN THE PROGRAMME?  
 A.0-2YEARS. [ ] [ ]  
 B.3-4YEARS. [ ]  
 C.5-6YEARS. [ ]  
 D.MORE THAN 6 years. [ ]
- 9a. DID YOU RECEIVE ANY TRAINING IN HBC?  
 A.YES. [ ]  
 B.NO. [ ] [ ]
- 9b. IF YES, EXPLAIN.
- 9c. IF NO,  
 EXPLAIN.....  
 .....
10. HOW MANY WORKSHOPS HAVE YOU ATTENDED IN HBC?  
 A.0-1. [ ]  
 B.2-3. [ ]  
 D.MORE THAN 4.[ ] [ ]  
 E.NONE. [ ]
- 11a. DO YOU GET ANY KIND OF SUPERVISION IN HBC ACTIVITIES?  
 A.YES. [ ] [ ]  
 B.NO. [ ]
- 11b. IF YES,  
 EXPLAIN.....  
 .....
- 11c. IF NO EXPLAIN...
- 12a. ARE THERE ANY INCENTIVES FOR CARRYING OUT HBC ACTIVITIES?  
 A.YES. [ ] [ ]  
 B.NO. [ ]
13. WHAT SORT OF HBC ACTIVITIES DO YOU DO?  
 .....  
 .....
14. IS TRANSPORT AVAILABLE?  
 A.YES. [ ] [ ]  
 B.NO. [ ]
15. HOW MANY PATIENTS (CLIENTS) DO YOU HAVE IN HBC REGISTER?  
 A.0-50. [ ]  
 B. 51-100. [ ]  
 D.ABOVE 100. [ ] [ ]

16. DO YOU HAVE VOLUNTEERS IN HBC? A PROGRAMME TO TRAIN COMMUNITY  
 A. YES. [ ] [ ]  
 B. NO [ ]
17. DO YOU HAVE ENOUGH RESOURCES FOR HBC PROGRAMME?  
 A. YES. [ ] [ ]  
 B. NO. [ ]
18. WHERE DOES THE PROGRAMME GET THE FUNDS?  
 A. HOSPITAL GRANT. [ ] [ ]  
 B. DONORS. [ ]  
 C. OTHERS.....
19. DOES THE COMMUNITY COOPERATE WITH YOU IN HBC ACTIVITIES?  
 A. YES. [ ]  
 B. NO. [ ]
20. WHAT TYPE OF SUPPORT DO YOU GET FROM THE COMMUNITY?  
 A. SOCIAL-ECONOMIC. [ ] [ ]  
 B. SPIRITUAL. [ ]  
 C. MATERIAL. [ ]  
 D. NONE. [ ]  
 D. OTHERS.....
- 21a. ARE THERE ANY CULTURAL BELIEFS THAT AFFECTS YOUR HBC ACTIVITIES?  
 A. YES. [ ] [ ]  
 B. NO. [ ]
- 21b. IF YES EXPLAIN.....
22. DO YOU HAVE ANY SUGGESTIONS IN ORDER TO IMPROVE THE HBC PROGRAMME?  
 A. YES. [ ]  
 B. NO. [ ]
- 22b. IF YES, EXPLAIN.....

**THE END.**

**THANK YOU VERY MUCH FOR ANSWERING THE QUESTIONNAIRE**

## APPENDEIX II

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THE END.

Thank you very much for your co-operation.

UNIVERSITY OF ZAMBIA,  
SCHOOL OF MEDICINE,  
DEPARTMENT OF POST BASIC NURSING,  
P O BOX 50110,  
LUSAKA.

THE EXECUTIVE DIRECTOR,  
MACHA MISSION HOSPITAL,  
P.O. BOX.630340,  
CHOMA.

UFS HEAD OF DEPARTMENT

(H/M) WSA  
17/07/01

Dear Sir,

RE: Health system research

I am a student at the school of medicine, department of post basic nursing, university of Zambia.

In partial fulfillment of the course requirements, I'm required to submit a research study. My topic is FACTORS CONTRIBUTING TO THE UNDERUTILIZATION OF HOME-BASED CARE SERVICES AT MACHA HOSPITAL. This requires getting information from health workers at Macha hospital using questionnaires.

The purpose of this letter is to request for permission to collect data from health workers at Macha hospital.

If permission is granted, data collection will commence in August 2001.

I would be grateful to receive a favorable response.

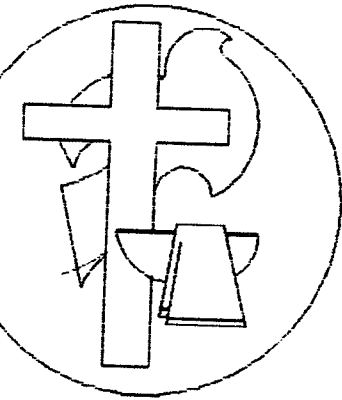
Thanking you in advance.

Yours faithfully,

Vincent M'hango.



CC: Manager clinical care.



# MACHA HOSPITAL

P.O. BOX 630340  
CHOMA, ZAMBIA.

TEL: (032)20778

FAX: (032)20127

Email: [mhmri@maf.org](mailto:mhmri@maf.org)

21 September, 2001

The Head of Dept  
UNZA School of Medicine  
PBN  
P.O. Box RW 50110  
LUSAKA.

Dear Sir/Madam,

**RE: MR. V. M'HANGO**

I write to acknowledge that Mr. V. M'hango a PBN student at your institution has successfully conducted a research project in Home Based Care, at our Institution.

I trust that the information gathered will assist him in his programme and at the same time be used by stake holders to further promote Home Based Care activities in the various communities.

Thank you for allowing him to come to our Hospital during his recess.

Sincerely,

**S. Zulu**  
Manager Clinical Care  
for/Executive Director.

*"All correspondence should be addressed to the Executive Director."*



**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF POST BASIC NURSING**

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P.O. Box 50110  
Lusaka, Zambia

16<sup>th</sup> May 2001

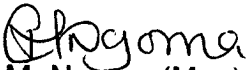
Dear sir/Madam,

This: serves to introduce Mr/Mrs/Ms. VINCENT M'HANU,  
a Fourth Year BSC (Nursing) student in the Department of Post Basic Nursing,  
School of Medicine, University of Zambia. The student is undertaking a  
Research Study in partial fulfilment of the above mentioned degree.

The Research Topic for study is TO DETERMINE FACTORS CONTRIBUTING  
TO UNDERUTILIZATION OF HOME BASED CURATIVE SERVICES  
IN MACHA

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

Yours faithfully

  
C.M. Ngoma (Mrs.)  
**COURSE CO-ORDINATOR**  
**DEPARTMENT OF POST BASIC NURSING**

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