

**FACTORS INFLUENCING ACCESS TO PRIMARY HEALTHCARE SERVICES IN
BEREJENA VILLAGE, GURUVE SOUTH DISTRICT, ZIMBABWE**

BY

MUBAIWA LOICE

UNIVERSITY OF VENDA

2015

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BY

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11605678

**A MINI-DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
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DECLARATION

I, Loice Mubaiwa (11605678), declare that the dissertation titled "Factors influencing access to primary healthcare services in Berejena village, Guruve South District, Zimbabwe" hereby submitted for the degree, Master of Public Health (MPH) at the University of Venda has not been submitted before by me at this or any other University, that it is my own work in design and in execution. All the sources that I have quoted and cited have been indicated, acknowledged and referenced.

Signature

L. Mubaiwa

Date

09/02/2016

L. Mubaiwa

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This research project is dedicated to my parents Mr Mudonhi and Mrs Olicia Mubaiwa for being the pillars of my strength throughout this study. To my precious sisters Miriam and Rumbidzai who have been supporting and encouraging me and to my little sister Diana I say follow in the footsteps of your older sister which have been set before you. An amicable dedication goes to my only brother Pardon for his love, motivation and unwavering support.

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- My special thanks are given to my brothers and sisters in Christ for their undivided moral support and extreme prayers.
- My gratitude goes to the Mubaiwa family for their emotional support during the course of this study; your efforts are highly appreciated and forever cherished.
- I sincerely thank my friends Moline Muzarira, Prillage Mhete, Leah Gwizimba, Anna Mahulo and Rachel Chiyatata for their psychological support and encouragement during challenging times.

Finally, my sincere appreciation goes to the study respondents in Berea village for their assistance and participation that study would not have been successful if they had refused to participate.

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Finally, my sincere appreciation goes to the study respondents in Berejena village for their assistance and participation, this study would not have been successful if they had refused to participate.

ABSTRACT

Background: Accessibility to healthcare services at any healthcare facility is a vital and developmental issue and it as a very crucial aim of many governments globally.

Purpose: The purpose of this study was to investigate factors influencing access to primary healthcare services in Berejena village, Guruve South District, Zimbabwe.

Methods: A quantitative approach using a descriptive cross-sectional survey was employed. A self-reporting questionnaire with closed-ended questions was administered to both males and females respondents between the ages of 18-65 who suited the inclusion criteria. The targeted population was ordinary Zimbabweans. Four hundred and twenty five households were systematically selected and a sample size of 220 respondents randomly selected was used. Permission to conduct the research was sought from the Ethics Committee of the University of Venda and the Office of the District Administrator of Guruve South District. The Statistical Package for Social Sciences version 23.0 was used to analyze data.

Results: The results were presented on frequency tables and graphs. The findings showed that socio-economic and some socio-cultural factors had a negative impact and influence Primary HealthCare Services access (PHCS) in Berejena Village. It was found that sample (96%) regarded travel time, shortage of healthcare professionals (92%) and shortage of essential medication (93%) as factors influencing their access to PHCS. However, respondents showed that decision making (72%) and ethnicity (66%) did not influence their access to PHCS.

Conclusion: Lack of medical aid, unreliability of transport and shortage of essential drugs were recognized as some of the socio-economic factors influencing access to PHCS. Religious beliefs, level of education and age are socio-cultural factors influencing access to PHCS and factors like decision making, ethnicity and marital status do not influence PHCS access in Berejena village.

Recommendations: Introducing mobile clinics, health village workers, implementation and monitoring are some of the strategies that could help address the challenges raised in this study and better access to PHCS in Berejena village.

Keywords: Factors, Access to healthcare, Primary healthcare service

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ACRONYMS

AIDS	Acquired Immuno-deficiency Syndrome
BASNEF	Beliefs, Attitudes, Subjective Norms and Enabling Factor.
EDs	Essential Drugs
FBOs	Faith Based Organizations
HIV	Human Immuno-deficiency Virus
MoHCC	Ministry of Health and Child Care
NHI	National Health Insurance
PHCS	Primary HealthCare Services
THs	Traditional Healers
TB	Tuberculosis
TBAs	Traditional Birth Assistants
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZMPMS	Zimbabwe Maternal and Perinatal Mortality Study
ZNHS	Zimbabwe National Health Strategy

CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.0 INTRODUCTION

Access to healthcare services is regularly an overlooked characteristic of the right to health (Huls, 2008). This right can be achieved or obtained when people have full access to healthcare services whenever it is needed. Over the years many governments globally have thrived to ensure that healthcare services especially primary healthcare are accessible to all the people. However, in most of the developing nations, Zimbabwe included, this is still a difficulty due to a variety of factors. The health for all goal by year 2000 was one of Zimbabwe's target goals during post-independence (Duri, Stray-Pedersen and Muller, 2013). Many years have gone by since the year 2000 has passed and instead of all people accessing healthcare they are dying from easily treated diseases (Zimbabwe Maternal and Perinatal Mortality, 2007). High mortality and morbidity is prevalent in Zimbabwe at an alarming rate, child health deteriorating, HIV prevalence rate among adults is also high (Multiple Indicator Monitoring Survey (2009). Duri et al. (2013) posit that this severe fall in vital health statistics is partially due to the reduced access to healthcare.

1.1 BACKGROUND TO THE STUDY

Healthcare facilities can provide quality and effective services if they are accessible to the people. It is of no benefit if a country has quality primary healthcare services but those services are not accessible to the people. Quality and effective healthcare services can be measured by the use of data to assess the performance of health strategies and healthcare workers against accepted quality principles. Peters, Garg, Bloom, Walker, Brieger and Rahman (2008) posit that access to health services depends on the suitable use of health services rendered to meet the needs of the people. Whenever a health-related need arises, the healthcare services must always be available to meet that need. It also means that every person, irrespective of sex, race or culture should have physical access to good health facilities and services. Access to health services has four dimensions: acceptability, affordability, availability and geographic accessibility (O'Donnell, 2007).

Access to skilled health services is a vital factor in decreasing the mortality rate everywhere in the world (Esen and Sappor, 2013). It is also at the core to be addressed on how to attain the health-related millennium development goals MDGs (Balabanova, Parkhurst, Mckee and

McPake, 2006). Inaccessibility to health services is recognized as a contributing factor of health disparities (Suárez, Gil-González, Vives-Cases, Love, Wimpenny and Ronda-Pérez, 2012).

People use primary healthcare services (PHCS) for various reasons such as to cure illnesses and to prevent or delay future healthcare problems. However, the PHCS are mainly accessible to the rich whereas the masses are suffering. Agere (1990) posits that healthcare is treated as a product; it is obtainable at a price on the market and is procured like food. Agere goes on to suggest that a man who is jobless or on a minimum salary, for example, is unable to buy drugs when given a prescription by a medical doctor. A man who cannot afford the price of drugs has to do without medicine if he is not on medical aid. On the contrary, a man who is in a high income bracket and on medical aid can afford to purchase the drugs. Therefore, the poor have difficulties in accessing PHCS whilst the rich access and enjoy healthcare services, in most parts of the world.

On a global scale, accessibility to PHCS by all people is a burning issue for many governments. Access to PHCS has to be assured to all people all over the world, even though this has not been completely accomplished in unindustrialized countries (Chiang, Labeeb, Higuchi, Mohamed and Aoyama, 2013). This however, does not mean that in a developed country like the United States of America, for instance, all the people have access to healthcare services. For this same reason, President Barack Obama introduced healthcare bills in an effort to make sure that everyone has access to efficient primary healthcare services. Many governments strive to make sure that primary healthcare services are available to all people. The European Union have come up with innovative skills for improved health (European Union, 2009) showing that accessibility of PHCS is important around the globe.

According to Kronfol (2012), the access to and use of health services remain a severe concern to the healthcare systems of the Arab countries. Irrespective of most important developments that have transpired over the previous years in the Arabic nations, some parts of its population are still facing problems using the range of PHCS that are available. It is dreaded that these problems may escalate with the existing trend towards a better level of cost-sharing and co-payment for health care. Ensuring reasonable access to good healthcare constitutes an essential challenge for health systems throughout the Arab world. In spite of changes in health system size, structure and financing, empirical evidence suggests that across the Arabic region, specific sections of the population are excessively affected by obstacles to access PHCS.

Kevany, Murima, Singh, Hlubinka, Kulich, Morin and Sweat (2012) conclude that for many people in sub-Saharan Africa, the choice of healthcare services is inadequate. This means that accessing the already inadequate services might be a challenge for many people. The authors further suggest that the area has 24% of the universal burden of diseases which cause inadequate healthcare services. This implies that accessing the already limited healthcare services is difficult for many people.

Zimbabwe has experienced stringent, harsh and accumulative fiscal hardships. These hardships have resulted in the decline of the health structure, scarcity of medications and health specialists, and so forth (Ministry of Health and Child Care, Zimbabwe, 2009). It has also been observed that many Zimbabweans patients die from easily preventable and curable illnesses such as HIV and AIDS, malaria, TB and hypertension (Multiple Indicator Monitoring Survey, 2009 and Maternal and Perinatal Study, 2007). For example Tren, Urbach, Bate and Ncube (2007) note that by 2007 approximately 3000-3500 people died every week from HIV-related illnesses and 265 people also died due to TB complications and Zimbabwe was rated 17th out of the 22 TB high burdened nations in 2009 (Zimbabwe National Tuberculosis Control Programme, 2012-2017).

Tren et al. (2007) indicate that Zimbabwe is one of the countries with low life expectancy in the world. However, the life expectancy at birth in Zimbabwe is better than that of Mozambique and Lesotho as indicated on the table below

Table: Life expectancy at birth by 2013

Country	Life expectancy at birth in 2013	
	Males (years)	Females (years)
Zimbabwe	56	61
Botswana	63	65
South Africa	57	64
Lesotho	48	52
Mozambique	53	55

Source: World Health Organization

The possible reason for the low life expectancy is that PHCS are only partially accessible or inaccessible to the people needing them. Accessing healthcare services in Zimbabwe hospitals and PHC centres is generally expensive for most of the financially poor patients. Accessing

healthcare services in Zimbabwe has become a serious challenge particularly for critically ill patients who hardly has any source of income to meet the exorbitant costs.

In Zimbabwe, several public health facilities have shut down in recent years and lack of medications and important curative equipment has caused many hospitals and clinics to come close to collapse (Tren et al. 2007). To support this claim Zimbabwe Health System Assessment (2010) notes that 87% of the healthcare infrastructure are poor and needs to improve. This situation has contributed rapid increase in the inaccessibility to healthcare services in hospitals and clinics by the majority of the poor Zimbabwean patients. The Parirenyatwa Group of Hospitals is one of the largest medical centres in Zimbabwe, but it also faces many challenges in ensuring that their healthcare services are accessible to all the people. The fact that major hospitals in Zimbabwe are affected means that rural clinics might be seriously affected leaving the rural people struggling to access PHCS. Ishewokunze, (1981) in Agere (1990) maintains that the mainstream of the rural people have slight, if any access, to well organized primary healthcare or health facilities.

1.2 PROBLEM STATEMENT

The Zimbabwean government has come up with strategies to improve accessibility to PHCS namely recuperation of primary health, renovation of already existing medical facilities and promotion of healthcare material use. Despite all these efforts to make PHCS accessible, people are still facing difficulties in accessing PHCS especially in rural areas, as indicated in the Table 1 below:

Table 1: Number of villagers consulting at Nyakapupu Clinic (2014)

Month	May	June	July	August	September	Total Number of Patients	Total Population
Patients	220	146	189	115	230	900	20 000

Source: Guruve Health Department.

The Zimbabwe Maternal and Perinatal Mortality Study of 2007 notes that only 52% of rural women deliver in health facilities due to the difficulties faced in accessing health facilities. Due to the challenges in accessing healthy facilities some of the women have no option but to give birth at home. Unfortunately, a relatively high percentage of these women die while in labour in homes or on their way to health facilities. A report from Mudhindo Police Station (A Police

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Although the Government of Zimbabwe expected increased access, utilization and affordable PHCS by 2013, this did not materialize due to a number of factors that this study intended to investigate. Statistics from local clinics in Guruve South District show that only 10% of the population is accessing PHC centres. The reasons given for poor access to health facilities in the District are very vague and inconsistent with what was expected. The purpose of this study was to find factors influencing access to PHCS in Berejena village, Guruve District and Zimbabwe as a whole.

1.3 RATIONALE FOR THE STUDY

In Zimbabwe, 70% of the population live in rural areas (Zimbabwe National Health Strategy 2000-2013). In addition, there are few and understaffed healthcare facilities in rural areas. Accessing PHCS can prevent a lot of health-related problems. Therefore it is unacceptable if only a few people are accessing the services. There is a necessity to scale up efforts in ensuring that PHCS are accessible. Reports from Guruve Health Database show that only 20% of the population visit the district hospital. Therefore, it is vital to conduct a study on factors influencing access to PHCS so that recommendations can be made for greater access to district hospitals as well as PHCS centres. To date, no known study has been conducted in Guruve South District investigating factors influencing access to primary healthcare services.

1.4 SIGNIFICANCE OF THE STUDY

This study is important in a number of ways. First and foremost, the study would establish factors that negatively influence access to PHCS in Zimbabwe and the findings would help the District Health Authority to find meaningful ways to enhance primary healthcare accessibility. Secondly, the results emanating from this study may enrich the country with information with

regards to why people in rural areas are not accessing PHCS. Furthermore, results of the study may provide grassroot knowledge that would assist health planners to design effective strategies and policies directed towards dealing with factors influencing PHCS access in rural areas. In addition, the study may also form a data base for further comparative studies on factors influencing access to primary healthcare services in sub-Saharan Africa.

1.5 AIM OF THE STUDY

To determine factors influencing access to primary healthcare services in Berejena village, Guruve South District, Zimbabwe.

1.6 OBJECTIVES

The objectives of this study were to:

- Assess the impact of socio-economic factors influencing access to PHCS.
- Assess the impact of socio-cultural factors influencing access to PHCS.

1.7 DEFINITION OF KEY TERMS

1.7.1 Factors- According to the Oxford Dictionary (2012), factors refer to one of the elements contributing to a specific result or condition. For the purpose of this study, it refers to the elements influencing access to PHCS.

1.7.2 Primary healthcare services - The Medical Dictionary (2014) defines the phrase as a commercial entity that offers inpatient or outpatient testing or cure of human disease and distributes medicines or medical procedures for handling human ailments or dysfunctions. For the purpose of this study, the phrase refers to services given to the patients at a clinic.

1.7.3 Access to healthcare - According to Gulliford, Figueroa-Munoz, Morgan, Hughes, Gibson, Beech and Hudson (2002), this is concerned with assisting individuals to command proper health care resources, in order to preserve or improve their health. For the purpose of this study, the phrase refers to ability to get to PHCS.

1.8 OUTLINE OF THE DISSERTATION

This study is divided into six chapters as follows:

Chapter 1 introduces the study, gives the statement of the problem, purpose, significance, aim, objectives and definition of key terms.

Chapter 2 is centered on literature review, which highlights the overview of healthcare access, socio-economic factors influencing access to PHCS, socio-cultural factors influencing access to PHCS, healthcare system of Zimbabwe, challenges of the healthcare system of Zimbabwe,

health status of Zimbabweans, Zimbabwe national health strategy, Zimbabwe's policy on primary healthcare, strategies of the ministry of health Zimbabwe to ensure healthcare accessibility, health delivery in rural areas of Zimbabwe, importance of accessing PHCS and the theoretical framework.

Chapter 3 outlines research approaches that were used in data gathering, collection, presentation and analysis.

Chapter 4 is the interpretation of the study findings.

Chapter 5 discusses findings of the study.

Chapter 6 presents conclusions and suggested recommendations.

1.9 SUMMARY

The Zimbabwean Government has an obligation of providing quality healthcare services to its population well equipped and accessible health facilities. Currently, most of the health facilities cannot provide the services particularly in rural areas where the majority of the population live. A number of factors seem to be conniving to prevent the Health authorities in Zimbabwe to meet this essential obligation. This Chapter has highlighted important and critical issues that underlies PHCS in Zimbabwe that need to be investigated particularly in the Berejena Village, Guruve South District where the expectations and reality are in total contrast. The next chapter gives the literature review of this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The main purpose of this chapter is to critically analyze, scrutinize and review studies carried out by different schools of thought concerning factors influencing access to primary healthcare services. Since there are many factors influencing access to primary health care services, this review however, is narrowed to the socio-economic and socio-cultural factors that influence access to primary healthcare services among the rural people.

2.2 HEALTHCARE ACCESS: AN OVERVIEW

According to Mwasi (2006), ensuring reasonable access to healthcare services is a worldwide objective of governments and it is one of the Millennium Development Goals. Access to healthcare services is a serious issue in many nations including developed ones. In January and May 2003, Ministers of Health from Chile, Germany, Greece, New Zealand, Slovenia, Sweden and the United Kingdom met for the purpose of forming an International Forum on matters relating to access to healthcare services. During the course of the meeting the ministers agreed that they share a collective belief that their healthcare systems must aim to make sure that their people enjoy global and equitable access to excellent quality healthcare (Oliver and Mossialos, 2004).

Healthcare access can be viewed as the capability, liberty or chance to use healthcare if it is required (Mooney, 2009). Access cannot be mentioned leaving out utilization, thus utilization is a representation for access (Oliver and Mossialos 2004). Access is part and parcel of a good health service delivery which is a very important component of any healthcare system. The degree of accessibility is a good pointer of assessing productivity of any healthcare system (Gatrell and Elliot, 2009).

McPake, Normand and Smith (2001) posit that one billion people everywhere in the world have difficulties or face challenges in accessing healthcare services in rural areas. About half of the globe's population live in rural and secluded regions where healthcare facilities and services are of poor quality (Buchan, Couper, Tangcharoensathien, Thepannya, Jaskiewicz, Perfilieva and Dolea, 2013). The situation is worse in poor and underdeveloped nations and rural areas as these people have partial access to wide-ranging healthcare services. Access to healthcare is a major issue and in developing countries such as Zimbabwe where the majority of the people live

in rural areas and accessing PHCS is a challenge for many. Generally, the health status of the people in rural areas is not as good as those who are in urban areas as rural people are at a more dangerous level of not seeking necessary healthcare (Lin, Brimmer, Boneva, Jones and Reves, 2009). Rural people face serious obstructions in accessing PHCS (Ziller and Lenardson, 2009). Access to PHCS in rural areas is denied by many difficulties such as the physical environment, unsatisfactory health structure, feeble infrastructure and restricted delivery system (Ricketts, 2001).

2.3 SOCIO-ECONOMIC FACTORS INFLUENCING ACCESS TO PHCS

Socio-economic factors greatly influence access to PHCS in rural areas. The definition of socio-economic factors involves the social and economic aspects of peoples' lives. Socio-economic factors affect people in accessing PHCS everywhere in the world.

Socio-economic status of an individual can influence PHCS access. Adler and Newman (2002) observe that lower socio-economic status is connected with higher mortality rate, caused by postponing the timely or early diagnosis, treatment and management of an ailment, access to additional healthcare services which may result in surplus bills by doctors. Similar findings have been reported by Murata, Yamada, Chen, Ojima, Hirai and Kondo (2010). Marrone (2007) posits that low socio-economic status have an impact on a person's ability to access and get hold of indispensable medical services. If a person has a low socio-economic status, his or her chances of accessing healthcare services are very slim compared to a person who has a high socio-economic status. Adler and Newman (2002) suggest that even in nations with adequate or widespread healthcare, socio-economic status driven disparities in health are noticeable. In a study conducted in Canada, the results showed higher mortality among men with less salary, less education, and lower professional position for a variety of reasons of death, all of which were submissive to medical treatment (Adler and Newman, 2002).

Income and occupation is another socio-economic characteristic which influence access to PHCS among many rural inhabitants. Kyriopoulos, Zavras, Skroumpelous, Mylona, Athanasakis and Kyriopoulos (2014) in a study conducted in Greece suggest that income level is a main factor that affects access to healthcare services. Castro-Leal et al. (2000); Carr, (2000) in Muchabaiwa, Mazambani, Chigusiwa, Bindu, Mudavanhu, Navaneetham and Dharmalingam (2012) suggest that a household's fortune has also been found to be a significant cause of maternal healthcare utilization, with the poor being the most disadvantaged. High revenue

patients are able to conquer some if not all of the healthcare access barriers as they can pay for other alternatives, like the private sector (Kyriopoulos et al. 2014). Visagie and Schneider (2014) note that people who reside in rural locations are often poorer than those in metropolitan areas who have funds to spend on healthcare. In developing countries like Zimbabwe, to access healthcare services requires or carries a price tag that a patient has to pay (Kevany et al. 2012). This implies that those who are not employed and do not have an income will face a greater challenges in accessing PHCS. The authors further suggest that, in Zimbabwe the most common reason for not consulting a health care giver is low household income.

In a study in Greece, it was observed that the type of employment has an impact on the barriers to access healthcare services (Kyriopoulos et al. 2014). Many rural people are unemployed and they do not have insurance. The situation is not only in developing countries even in developed countries like the United States of America, rural populations have shortages of insurance coverage. According to Schur and Franco (1999) twenty per cent of the rural population is not insured as equated to sixteen per cent of city occupants. In addition, jobless persons have poorer health than their employed colleagues (Murata et al. 2010). In a study on payment of health insurance conducted in the Kassena Nankana District in Northern Ghana, some of the respondents said that paying money for diseases that are not there was not suitable as that in itself can invite diseases (HRU, May 2005a, in Bashiru, Saeeda, Abdul-Azizb and Zhaoa, 2013). In many countries, especially, the developing ones like Zimbabwe, healthcare services are not for free. This means that if a person is not insured and is unemployed, PHCS access is a challenge. It can therefore be noted that lack of insurance and unemployment in rural populations hinders most, if not all, from accessing PHCS.

Transportation is another factor which influences access to primary healthcare services among many rural inhabitants. In many rural areas, people depend on public transportation and there are a limited number of ambulance services. In some areas where there is no transportation, evacuation of seriously ill or injured people is impossible. Adedini, Odimegwu, Bamiwuye, Fadeyibi and De Wetb (2014) note that in isolated countryside areas transportation is not good; this can greatly influence PHCS access. Watt, Franks and Sheldon (1994) posit that transport to hospitals in rural areas is predominantly problematic for persons who do not own a car, especially in the light of deteriorating rural transport (Gale and Heady, 2013; Liu, Sun, Zhang and Guo, 2007; Awoyemi, Obayelu and Olapuwa, 2011). Visagie and Schneider (2014) confirm that transport is a significant barrier to accessing PHCS in rural areas.

Transportation is a vital issue for accessing PHCS in rural areas where travel distances are great and access to alternative modes of transport is not possible (Mattson, 2010). The author further suggests that long distance travel makes trips to medical care centres burdensome but lack of transportation makes those trips impossible. A study in Japan indicated that access to check-up treatment for cerebrovascular disease was considerably predisposed by access to suitable transport (Tamiya and Araki, 1996). In another study in Zimbabwe, it was suggested that up to 50% of maternal deaths from hemorrhage could be accredited to the nonexistence emergency transportation (Fawcus, Mbizvo, Lindmark and Nystrom, 1996). Therefore, it can be noted that transport is a factor which greatly influences access to PHCS in rural areas.

A study in Iowa City in the United States of America has reported that distance was recognized by patients, workers, and staff as the most crucial barrier for rural veterans' access to healthcare (Buzza, Ono, Turvey, Wittrock, Noble, Reddy, Kaboli and Reisinger, 2011). Access to public healthcare services is greatly restricted by distance (Black, Ebener, Aguilar, Vidaurre and El Morjani, 2004). Henson, Sadler and Walton (1998) define 'distance' as a level of separation among one and many entities and added that the characteristics of that entity might be in cosmos, period or behaviour. It is noted that there is no comprehensively established range of distance for individuals to travel for healthcare. For example, Rovali and Kiivet (2006) put this range at thirty minutes. Hare and Barcus (2007) have projected that societies who reside more than forty-five minutes away from healthcare facilities are more likely to be marginalized. Brabyn and Skelly (2007) consider one hour as a tolerable range. They further note that persons who travel more than one hour are paying a greater price, fiscally and emotionally to visit a hospital. Countless countryside persons are obliged to travel great distances to acquire even the most-simple healthcare services (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich, 2011; Hutchison, Hawes and Williams, 2010). Distance issues are further affected by accessibility of transport.

In addition, distance can be measured in numerous methods, for example, linear distance on a map, road distance or distance to the nearest provider (Arcury, Gesler, Preisser, Sherman, Spencer and Perin, 2005). Nemet and Bailey (2006) observe that elders in Vermont who had to travel 10 miles have a habit of going to medical doctors less often, henceforth long distances to healthcare facilities cause postponements in the decision to seek care (Adedini et al. 2014). A study in Vietnam also found out that distance is a principal determining factor of how long

patients delay before seeking care (Ensor, 1996). In Zambia, 56% of the surveyed rural families professed distance as a hindrance to accessing primary healthcare services (Hjortsberg and Mwikisa, 2002). The Nigerian Central Bank (2004) in Yar'vezver (2013) notes that females who reside five kilometres from the nearest healthcare facility can walk to that facility even when there are in labour.

Long distances to primary healthcare facilities are most common in developing countries like Zimbabwe, where the healthcare facilities are far apart. The European Union (2008) concurs that in rural areas with a great population of senior citizens, distance from the nearest health centre is normally a barrier to accessing full primary healthcare services. Kara and Egressi (2013) note that extensive distance seriously affect the senior citizens and people who are living with disabilities from accessing PHCS.

In a study carried out in Baringo, Kenya, time was found to be one of the strongest barriers to healthcare facility attendance. Many rural residents consider the time they will travel to a health care facility. This hinders access especially when the primary healthcare facility is far. Even when a patient is seriously sick, when time factor is considered that particular patient will not seek medical treatment. Ziller et al. (2009) maintain that the travel time to a healthcare facility or provider can adversely affect an individuals' capability to access that provider, even in the midst of those needing specialty care. In rural areas, the healthcare facilities are sparsely separated and travel time to reach them is greater. In Berejena village, a patient can walk up to one hour thirty minutes to access the nearest healthcare service provider. If villagers decide to go to another service provider, the patient has to also walk a long distance to the bus stop, to get transport to a primary healthcare facility. In such cases, a person may be reluctant to go to a healthcare facility.

Islam and Sheikh (2010) posit that the level of education is connected with health status all over the world, regardless of race and origin. The level of education is also very vital for primary healthcare access in rural communities. Most of the rural people are illiterate; this implies that their level of seeking healthcare services is very limited. Studies by Islam and Sheikh (2009, 2010) on indigenous community in Bangladesh disclosed that education is a considerable component of health. Sometimes when people are not educated they cannot really see the importance of going to a primary healthcare facility to seek diagnosis and treatment. They often do self-diagnosis which is very dangerous. According to McDonough (1999) education is linked

with a sophisticated possibility of looking for medical care. Murata et al. (2010) note that education offers knowledge and life skills that are critical to gain access to information and behaviour that promote health.

The results of a study in Nepal showed that poor and uninformed mothers have a tendency to deliver at home paralleled to knowledgeable mothers who tend to access a health care facility and deliver there (Belam, Khedhiri and Daoud, 2005). A study conducted by Yamagasawa, Oum, and Wakai (2006) indicated that females who have attended at least seven years at school are more likely to deliver at a healthcare facility equated to those who did not attend school at all. It is evident that education can give people a better understanding of the importance of utilizing and accessing primary healthcare services. A study in Australia also showed that a great percentage of indigenous people in Australia never attended school which results in poorer health (Altman 2003).

In Greece Kyriopoulos et al. (2014) found that progressive prevalence in chronic diseases is observed in the population cluster characterized by low education. Well-informed patients have better knowledge about the options of their treatment and are more aware about health promotion and prevention. Adler and Newman (2002) note that education offers consciousness and life skills that permit better-informed people to achieve more access to information and resources to promote health. Muchabaiwa et al. (2012) found that unschooled women are less likely to use maternal healthcare, but found no variances in utilization among the educated women. In rural Zimbabwe, 56% of the uninformed women do not deliver at health care facilities.

2.4 SOCIO-CULTURAL FACTORS INFLUENCING ACCESS TO PHCS

According to Hjortsberg et al. (2002) socio-cultural variables also affect access to primary healthcare services. Socio-cultural issues involve the social and cultural aspects of people's lives. Social and cultural factors play a role in shaping perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being. Oke (1996) in Ajiboye and Abimbola (2012) observe that the usage and non-usage of health services are strongly influenced by individuals' socio-cultural setting, which, in most circumstances, is fashioned by its male-controlled society. Kempe and Stougard (1984) in Gbaden (2014) note that cultural factors often play a leading role in healthcare pursuit, be it at a place of delivery or otherwise.

Frazier and Kleinstein (2009) maintain that race and ethnicity can result in opinions and ethics that cause limitations to access healthcare. Ethnicity is a factor which influences access to primary healthcare services especially among many rural residents (Muhofah, 2010). People might not access healthcare facilities due to ethnic reasons. Islam and Sheikh (2010) report that ethnicity is one of the very important predictors of poor health of aboriginal people around the globe. Islam and Sheikh (2010) reveal that studies show that infant mortality rates between native peoples are way too high than non-indigenous peoples in Canada, New Zealand, Australia, Brazil, India, Uganda and Peru and these variances are more pronounced in unindustrialized nations relative to industrialized nations. In a rural clinic, the employees might be of a different ethnic group from the villagers. Due to that reason, the villagers might not go and access healthcare facility. Some might turn to traditional healers of the same ethnic group.

The marital status of a person also plays a major role in people accessing primary healthcare services in rural areas. In Ethiopia, women tend to use those primary healthcare facilities within mobile distance from their households because of traditional margins placed on their travel outside the community (Kloos, et al. 1987, in Gbaden, 2014). Furthermore, women's mobility is restricted in certain zones as they need approval to travel. Frequently, this approval needs to be given by the spouse or the mother-in-law or next of kin. According to Dia, et al (1989) in Gbaden (2014) in six Senegalese regions, only two per cent of the women interviewed in their study could make the decision themselves to seek medical care in the event of obstetric difficulties whereas for the majority the decision would be made by the husband or another family member (96%). Studies have shown that the choice to seek care in Nigeria, Tunisia, India, Ethiopia, and other republics belongs to a spouse or to elder members of the household. Women do not choose on their own to seek care (Kloos, et al. 1987; Dia, et al. 1989 in Gbaden, 2014). Therefore, marital status is a very crucial aspect of primary healthcare access among many rural populations.

Abyad (2012) notes that in the Middle East, gender of a health provider may impede women utilizing health services in circumstances of male physicians. Gender is more related to the functions, authority and influence societies give to men and women than it is to their natural needs. Hammoud, White and Fetters (2005) note that Muslim and Arab women favour women healthcare providers. According to Gbaden (2014), Purdah forces the women to subject to the will of their spouses even in their health-seeking behaviour as they must get permission from their partners before they attend health centres. Chiang et al. (2013) observe that access to

primary healthcare services is frequently challenging for women in developing countries. For example, in Pakistan gender-based customary beliefs still prevail in the utilization of health services except when the delivered services are traditionally satisfactory in practice. Gender is therefore a socio-cultural characteristic which greatly influences access to primary healthcare services in rural areas.

Armenakis and Kiefer (2007) observe that religion is also a factor which influences healthcare access in urban as well as rural areas. Religion is generally seen as the institutionalization of common ethics and customary practices (Hilbers, 2011). Gbaden (2014) notes that religious beliefs are known to influence access to health. Kronfol (2012) observes that religion plays an important role in health in the Arab countries. The author went on to suggest that although the correlation between religion and other socio-cultural factors are not certainly detectable, health, as a mirror of humanity, is influenced by religion. The utmost influence of religion lies in matters associated to reproductive health such as abortion. Hessini summarizes lawful, religious, medicinal and communal factors that aid to support or hinder women's access to safe abortion services in the 21 predominantly Muslim republics in the Middle East and North Africa.

According to Qidwai, Ashfaq, Khoja, Rawaf, Kurashi and Alnasir (2012), in the Middle East, another noteworthy area of apprehension is patient's religious opinions about sickness. On one hand it may help in improving health results with improved patient contentment. On the other hand, it can act as an obstruction to access. A very good instance is a patient's view about accepting an ailment and its effect as "God's will" or their confidence in the power of prayer in soothing disease prevents them from visiting healthcare providers. This is especially witnessed in those suffering from deadly illness. There is also extensive use of alternative medicine and "religious treatments" that either delay access or compete with mainstream medical care. Gbaden (2014) notes that in Nigeria there is a Purdah religion which influences access to healthcare services by prohibiting women from benefiting from medical services provided by the government for the general public.

Religion can also affect the way people understand health, illnesses, diagnosis and recovery. Religion can make people not to seek, utilize and access primary healthcare services even though such services are desperately needed. In Zimbabwe, religion causes many people to have poor access to PHCS. In a study carried out in the Hwedza and Buhera Districts of Zimbabwe, respondents agreed that some apostolic spiritual or religious groups do not accept

modern medical treatment (Magumbate and Nyoni, 2013). The practice was prevalent among the *Johanne Marange* sect. The skepticism in modern treatment is a doctrine that is maintained by faith healing. It is also encouraged by lack of assurance in modern treatment practices; hence at the end of the day, the people will end up not accessing healthcare services.

Maguranyanga (2011) notes that numerous apostolic sects like the *Johanne Marange*, *Johanne Masowe*, and *Madhidha* have harsh religious and ethical codes, and they are inclined to strong devotion to religious instructions. The above mentioned religious sects frequently scrap off the use of modern treatment and immunization. In addition, in the Apostolic Sects the Holy Spirit (*Mweya*) plays a central role in the spiritual life, beliefs, and faith healing of the apostolic religious community. *Mweya* is thought to predict and forewarn about any approaching epidemic, catastrophe, problems as well as how to treat diseases. *Mweya* works through and leads prophets and other church members who are spirit filled (*maporofita*), and enable them to heal and to prophesy. Therefore, it can be noted that religion is a factor that influences people's access to healthcare services.

2.5 HEALTHCARE SYSTEM OF ZIMBABWE

Nyazema (2010) posits that the health system plays a pivotal role in people's lives and a health system that encourages exceptional health is a fundamental prerequisite of human activity. In Zimbabwe, the public health system is the principal provider of healthcare services (Zimbabwe Network for Health). Many health services are rendered by the public sectors which are of Ministry of Health and Childcare (MoHCC), Ministry of Defence, local authorities and mission health services. The system is divided into four levels, namely, national, provincial, district and ward and the services are also established at four levels, these are primary, secondary, tertiary and quaternary. Traditional healers (THs) also play a pivotal role in the healthcare system and service delivery.

Financial challenges have contributed to diminished healthcare financial plan disturbing the provision at all stages. The loss of competent executives at all levels. The healthcare system, has reduced organization capacity and negatively impacted on basic healthcare. According to the Zimbabwe Global Health Initiative Strategy (2012) since 2009, the Zimbabwe health system has been attaining functionality since its breakdown in 2008, thus the system is in the course of being reconstructed. Zimbabwe's health system has retained many of the structures ever since 1980, although recent exploitation of health workers and inadequate resources for supporting

health processes has restricted the capacity of the decentralized structures (Primary Health Assessment Zimbabwe, 2010).

2.6 CHALLENGES OF THE HEALTHCARE SYSTEM OF ZIMBABWE

Zimbabwe Statistics (2009) maintains that hyper-inflation has harshly affected simple social services particularly the health sector and the sector has experienced major budgetary constraints. Since 2008, the healthcare system of Zimbabwe has faced a number of challenges in giving necessary services to its people. MoHCC, in conjunction with National Tuberculosis Control Programme Strategic Plan (2009-2013) note that the health system faces inadequate human resources due to the exodus of skilled professional during the economic crises of 2008. Health management has also weakened as a result of high attrition rates of experienced health service and programme managers. This has made an impact on supervision and monitoring and is evidenced by reduced quality of service provision. Health professionals cannot provide services without adequate medicines and equipment.

Access to vital drugs and supplies has been greatly reduced with stock availability ranging between 29% and 58% for vital items and 22% and 36% for all groups of items on the essential drugs list in 2008. Vital items should always be 100% accessible. Medical equipment for serious diagnosis and treatment is timeworn, outdated and non-functional. The majority of physical health structures are in an extremely poor condition. Immovable plant and equipment, such as washing machines, kitchen equipment and boilers are also not operating well. As an outcome, a few public health organizations are able to meet the basic hospital principles for patient care and infection control measures. Severe scarcity and disturbance of transport and telecommunications has compromised several programs including patient transfer, immunizations, malaria indoor residual spraying, drug distribution and supervision of districts and rural health centres.

The health system is unacceptably under-funded. The current reviewed financial provision available shows funds are about US\$7 per capita per year against the WHO recommendation of at least US\$34. The system has unsatisfactory currency allocated for service delivery (Zimbabwe Network for Health). Therefore, it can be noted that the healthcare system of Zimbabwe is still recovering from harsh economic hardships and hence it is facing many challenges in delivering healthcare services to its people.

2.7 THE HEALTH STATUS OF ZIMBABWEANS

According to the Zimbabwe National Health Strategy (ZNHS) (2009-2013) in studies carried out by Multiple Indicator Monitoring Survey (2009) and Zimbabwe Maternal and Perinatal Mortality Study (ZMPMS) (2007), Zimbabweans are succumbing to easily controlled, preventable and curable conditions. The main reason for this is that people have partial, if any access to health care services United Nations Children's Fund (UNICEF, 2009), 65% of the population live in rural regions (ZMPMS, 2007) whereas less than half of the population (46%) have access to primary health services (Assessment of Primary healthcare in Zimbabwe, 2009). According to the ZNHS (2009-2013) and Zimbabwe's E Health Strategy (2012-2017), HIV prevalence among adults, among the ages of 15-49 was 13.7% by year 2010, child health is deteriorating with under 5 mortality at 84 per 1000 live births and infant mortality at 57 per 1000 live births and maternal mortality levels are at 960 per 100 000 births.

The nutritional status pointers of children are disappointingly high with stunting escalating from 29.4 in 1999 to 35% among children under 5 years. Occurrences of rabies and anthrax continue being reported in certain areas of Zimbabwe. There is also constant and increasing public health consequence of chronic non-communicable disorders such as diabetes and hypertension (Zimbabwe STEPS survey, 2005). Above 5 million people are greatly exposed to the risk of contracting malaria yearly. Life expectancy in Zimbabwe at birth has dropped from 63 years in 1988 to 43 years in 2005/6, the worlds' lowest (Physicians for Human Rights, 2008-2009) and TB is the main reason of high morbidity with an alarming rate of 434 out of 100,000. The general health status of Zimbabweans is of major concern and the question of healthcare accessibility becomes difficult to answer, especially in rural areas where healthcare services are very limited.

2.8 ZIMBABWE NATIONAL HEALTH STRATEGY

Zimbabwe has a National health strategy, the strategy works as a National Health Policy for the country. The strategy aims to attain equitability in health by directing funds and programs towards the most vulnerable and disadvantaged among the population. Another aim of the strategy is to introduce new methods in management and delivery of services in ways which will increase access, guarantee community gratification and local accountability. Keeping as numerous people as possible in good health in the community through health promotion, protection and disease prevention is also another aim of the strategy. Providing suitable

services for those needing care in the community is also another element of the National Health Strategy of Zimbabwe.

2.8.1 ZIMBABWE'S POLICY ON PRIMARY HEALTHCARE

Zimbabwe's PHC policy entails that there should be free care at clinic stage and there should be health promotion and community mobilization throughout rural community and farms. There should be promotion of wide-ranging and combined healthcare in curative and rehabilitative services. At all service delivery, improvement in treatment and administration, procedure of common health difficulties should be mandatory.

2.8.2 STRATEGIES OF THE MoHCC TO ENSURE HEALTHCARE ACCESSIBILITY IN ZIMBABWE

Even though the health sector of Zimbabwe is facing a lot of challenges in delivering healthcare services, the MoHCC have come up with strategies to ensure that the offered healthcare services are available to all people. Some of the strategies include the Zimbabwean government and UNICEF together with worldwide donors' formulation of a five year strategy, titled, the 'Health Transition Fund' to abolish or eradicate health-care user fees. In November 2011, in the legislative body, the then Minister of Finance, suggested a distribution of US 10 million dollars to aid remove user fees particularly for maternal and child-health care. Another strategy is to recuperate the primary health notion and to expand and renovate the already prevailing medical centres. Providing vehicles and motor cycles acquired in line with transport endowment for each level of care and promotion of health information use, at all levels, is also a strategy to ensure healthcare accessibility in Zimbabwe.

2.8.3 HEALTH DELIVERY IN RURAL AREAS OF ZIMBABWE

According to Magumbate and Nyoni (2013) public health in rural Zimbabwe is systematized by the Ministry of Health and Child Care (MoHCC). At the lower level, the health system includes village health workers who are part and parcel of the primary health care system. These employees work at a primary healthcare facility, typically a clinic run by a nurse who is in charge. At the clinic, a public health nurse, together with an environment health expert manage public health determinations such as awareness and surveillance. Every clinic in Zimbabwe is projected to service up to 10 000 people inside an 8km range. However, this has not been realized as yet, because some patients travel for more than 8km to get health care. This

situation has been worsened by few village health workers and a major decrease in itinerant or mobile clinics.

Magumbate and Nyoni (2013) note that all clinics in rural areas report to a District Hospital commonly positioned at an area of development. The District Hospital serves all clinics in the district. All District hospitals are anticipated to serve up to 140 000 people. The district hospital transfers patients to a provincial hospital which in turn transfers patients to national hospital for serious and fatal cases. Journeys to national hospitals can take many hours, in extreme circumstances nearly close to the whole day. In rural areas, there are inadequate private health facilities and they are usually situated at growth points, but in many cases there are no private sectors. The probability of finding a private healthcare facility in rural areas is close to zero. Other sources of treatment in rural regions comprise faith-based approaches (praying, prophets, *midzimu* and others), customary based techniques (*masvikiro*, *n'angas*, herbalists).

2.9 IMPORTANCE OF ACCESSING PHCS

There are significant documented benefits of PHCS access among rural as well as urban communities. PHCS access reduces infant and child mortality. According to Dutt and Srinivasa (1997), in a study conducted in Pondicherry India, delivery of primary health services comprising home-based care by primary health nurses lessened infant and child mortality by more than sixty-five percent. If people have full access to PHCS, infant and child mortality can be easily controlled. Similar findings were also observed by Rosero-Bixby (2004). The authors observe that accessing healthcare services decreases mortality not in children only but in adults as well. In Mexico, access to primary health care lessened child mortality from sixty-four per thousand live births in 1980, to twenty-three per thousand live births in 2006 as (Sepulneda, Bustreo, Tapia, Rivera, Lazano and Ol'aiz, 2006). Access to PHCS is therefore important in reducing mortality around the globe.

2.10 THEORETICAL FRAMEWORK

This study is anchored on the Model Barriers theory to healthcare access, developed by Frazier and Kleinstein (2009). According to the Model Barriers theory to healthcare access, there are factors which hinder or encourage people to access healthcare services. These factors include socio-cultural and socio-economic. It is observed that in each and every geographical area of a country, the above mentioned factors cause people to either access or not to access healthcare services. Some of the socio-economic and socio-cultural factors which may cause people not to

access healthcare services, be it at primary, secondary or tertiary levels are religion, transportation, level of education, gender and so forth. The Model Barriers theory to healthcare access also notes that if the above mentioned barriers are eradicated there would be good health, healthy behaviours and healthy environments.

The model further indicates that if the barriers are kept to a minimum and the healthy behaviours and health environments are maintained, there would be continuing healthcare which would lead to good health. This model will be applied and used as the theoretical framework for the study looking at the factors influencing access to primary healthcare services in Berejena village. The main reason for using this model is that it explains the barriers which cause people to have difficulties in accessing healthcare services. The model also gives an insight into the positive aspects in eradicating these barriers which would lead to good health for all people. This model was applied in this study because if the model is properly understood and applied it could result in healthcare reforms at the local, provincial and national level. Practitioners can advocate strategies for the removal of these barriers.

2.11 SUMMARY

This chapter was a review of literature. The consulted literature endorses that PHCS is influenced by the socio-economic and socio-cultural factors which in turn greatly affects the health status of people. It is noted that limited access to healthcare services is not only prevailing in developing nations but it is noticeable also in developed countries and that makes it a global burden. Zimbabwe has good policies and strategies to ensure healthcare accessibility but unfortunately the healthcare system is crippled by many challenges and as a result the health status of Zimbabweans is in a bad state. It may be concluded that accessing PHCS is very important and the application of the Model Barriers to access can greatly increase PHCS access. The next chapter is a presentation of the research methodology which will help to realize the objectives of this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the research methodology, namely, research design and approach, population, research sample, sampling technique, research instrument, reliability and validity, procedure for data collection, ethical considerations and data analysis.

3.2 STUDY DESIGN AND APPROACH

The study used a quantitative descriptive cross-sectional survey which describes a phenomenon at one point in time rather than several points in time. A survey is a very traditional way of conducting a research and therefore is particularly useful for non-experimental descriptive designs that seek to describe reality (Mathers, Fox and Hunn, 2009). A cross-sectional survey design is the most appropriate design if the survey is to be carried out at just a single point in time (Mathers, Fox and Hunn, 2009), a case with this study. In this study the quantitative cross-sectional survey enabled the researcher numerates, measures and analyzes data statistically. A quantitative approach was used because it gives a high degree of reliability and the findings of this study would be generalized. The approach also reduces the researcher's prejudice as opposed to a qualitative approach whereby there is direct contact with the respondents in the course of accumulating data. The researcher also used descriptive approach in-order to gather a lot of information through description. Therefore, by relating the responses of respondents in quantities, frequencies or percentages this greatly helped to bring out factors influencing access to primary healthcare services.

3.3 STUDY SETTING

The study was conducted in Berejena village located in Guruve South about 170 kilometres outside the capital city, Harare. Guruve South District has a total of 80 villages. Berejena village is under the leadership of a traditional chief. The Shona language is the most common understood and spoken language. In 2010, a gold mine was opened near Berejena village. This is important because, some people are now employed, and their lives are changing for the better. In the Guruve South District, there are 8 health facilities which comprise seven clinics and one district hospital serving a population of 81996 people. In the district, there are fourteen nurses and one doctor. In Berejena village there is no primary healthcare facility, the only primary health facility the villagers can assess is Nyakapupu clinic located some 15km away in another village.

3.4 STUDY POPULATION

Neuman (2011) notes that population is a group of cases from whom the investigator takes a sample. The target population of this study consisted of males and females aged 18-65 in Berejena village. This age group was used because it is a good representation of all adult population in the village. Berejena village consists of 425 households and 2 020 residents. The households are more arranged in sections as indicated in Table 2.

Table 2: Distribution of residents within Berejena Village

Name of Section	No of household	Number of residents
1. Tawasika	130	620
2. Gomba	125	600
3. Chimanga	100	500
4. Makomo	70	300
TOTAL	425	2020

The population for this study consisted mainly of unemployed rural people of ages between 18 and 65.

3.5 SAMPLING METHOD

Sampling is a procedure of taking a quota or a smaller number of components of a population as representative or having specific features similar to the target population (Mouton, 2009). Systematic sampling was used to select households in this study. The sample size was consistently distributed according to the people of each sub-section or block in the village.

The following was the criteria for inclusion in this study:

- Male and female villagers aged 18-65 were included in the study. The researcher concentrated on this age group because it represents a cross-section of all age groups in the village
- All villagers who were prepared and were willing to sign up the consent form.
- The capability to communicate in Shona or English.

Table 3: The sample frame

Name of block	No of households	No of respondents	Percentage
1.Tawasika	130	67	30.5%
2.Gomba	125	65	29.5%
3.Chimanga	100	52	23.6%
4.Makomo	70	36	16.4%
TOTAL	425	220	100 %

The sample size was calculated using the formula below.

n = sample size of the adjusted population.

N = population size

e = accepted level of error set at 0.05.

$$n = \frac{N}{1 + N(e)^2}$$

$$n = \frac{425}{1 + 425 \times (0.05)^2}$$

$$n = 425 / (1 + 425 \times (0.05)^2)$$

$$= 425 / (1 + 1.13)$$

$$425/2.13$$

Sample size (n) = 200

The sample size was however increased by 10 % in order to cater for non-response, giving us a sample size of 220. The sample size was therefore calculated and found to be 220. The overall household number of every village was divided by the sample size in order to find the K value (sample interval) = $425/220$. Each 2nd household was incorporated in the study on the merit that it suited the inclusion criteria. To begin with the household was randomly selected and in cases where the designated household failed to suit the inclusion criteria the researcher moved to the

next household. The respondents of the study were randomly selected in the households on the merit that they met the inclusion criteria.

3.6 TOOL FOR DATA COLLECTION

This study used a self-reporting questionnaire for collecting data. A questionnaire is a well-established tool within social science research for acquiring information on participant social characteristics, present and past behaviour, standards of behaviour or attitudes and their beliefs and reasons for action with respect to the topic under investigation (Bird, 2009). This study utilized a questionnaire for a number of reasons. These included maintaining participants' privacy as participants were encouraged not to enter their personal details on the questionnaire.

The questionnaire was constructed in line with the study objectives and was divided into four sections: biographical data, socio-economic factors, the use of the PHC facility and socio-cultural factors (see appendix 4). Sections B and D sourced data and assessed the socio-cultural and socio-economic factors influencing access to PHCS. The instrument also revealed the biographical data of the respondents and the use of the PHC facility in Sections A and C. The instrument was initially developed in English and later translated into Shona in order to accommodate those who could not read and understand English. The questionnaire was translated back to English to make sure that there was excellence in translation and precise comprehension. Each respondent was given the option to respond to the questionnaire in either Shona or English. The questionnaires were serialized for easy data capturing and the questionnaires returned before data capturing were kept classified.

3.7 VALIDITY AND RELIABILITY

Attention was paid to validity and reliability in order to ensure quality data was collected.

3.7.1 Validity

Validity refers to the degree to which an observed measure adequately reflects the real significance of the concept under consideration (Babbie, 2010). For the purpose of this study, face validity and content validity were considered to ensure a quality questionnaire. The two methods of validity are briefly described below

3.7.1.1 Face Validity

Face validity is the extent to which the measure or instrument being used appears to measure what it is supposed to measure (Mathers et al., 2009). To achieve face validity in this study, the academic staff from the University of Venda's Public Health Department and the panel of Higher Degrees Committee (HDC) of the School of Health Sciences looked at the questionnaire to ensure its aptness and gave assistance where there were inadequacies. The researcher modified the questionnaire in accordance with constructive comments from the two committees.

3.7.1.2 Content Validity

Content validity is a set of operations or measures which together operationalize all aspects of a concept (Mathers et al., 2009). According to Cresswell (2009), content validity confirms that the contents of the measuring instrument cover what is proposed to be measured by the questionnaire. To ensure content validity in this study, the questionnaire was evaluated by supervisors of this research who went through the instrument, made some corrections where possible before accepting it to be used in accordance with the questions outlined in the research objectives. The questionnaire was then pre-tested and piloted studied with randomly selected respondents to check whether the questions were easy to understand and also measured what they were intended to.

3.7.2 Reliability

Reliability is a positivist principle and an important precondition for validity (Cohen, Manion and Morrisom 2011). In a quantitative research design, reliability is based on the assumption of replicability or repeatability (Voss, Tsikriktsis and Frohlich, 2002). Also, Babbie (2010) regard reliability as a substance of whether a specific method applied recurrently to the same object yields the same result each time. In this study, the reliability of the instrument was bolstered by the test-retest technique. To ensure consistency and accuracy of outcomes, a structured questionnaire was used to collect data from respondents by the researcher. Consistency in responding to the questions was evaluated using test-retest method wherein the similar set of questions were given on different times to a small sample of 11 males and 11 females who did not form part of the study to observe if they gave comparable answers every time. The outcomes of the first responses by each individual were equated to the answers they gave on the second occasion after a period of a week and to see whether there was consistency. Testing of reliability helped the researcher in correcting the instrument to make sure that there is consistency of results.

3.8 PRE-TESTING THE INSTRUMENT

Pre-testing of the research instrument was conducted in Nyandoro which is a village in Guruve South District before the actual data collection took place. The questionnaire was administered to 22 respondents made up of 11 males and 11 females, who were among the age group of 18-65. They were not included in the main study. The questionnaires were administered in Shona or English depending on the language favoured by respondents. The necessary corrections of the research instrument were done on the questions relating to factors influencing access of primary healthcare services.

3.9 DATA COLLECTION

The researcher used a closed-ended questionnaire to gather or collect data. After explaining the aim, the ethical principles to be adhered to and giving the respondents the informed consent form, the researcher gave questionnaires to those who met the inclusion criteria. The researcher explained the format of the questionnaire to the respondents and also urged them to fill the questionnaire honestly and also not to write their names to ensure anonymity. Data were collected by the researcher over a period of 14 days. The respondents were approached in their houses and the questionnaires were given at set appointments according to their choices.

According to Cohen, Manion and Morrison (2007), making respondents fill in the questionnaires as you hand them is useful as it permits any queries or doubts to be addressed immediately with the researcher and it also decreases the rate of non-response. It also decreases information bias through sharing of information if the respondents complete and return the questionnaire instantly. Therefore, in this study, the researcher waited for the respondents to fill in the questionnaires while present and collected the questionnaires on the same day to reduce the non-response rate but ensuring confidentiality.

Shona questionnaires were handed over to those who could not understand English and to those who could not read and write, the researcher helped them to answer the questionnaires. The researcher read the questions to such respondents and would write down their responses. For literate respondents the researcher was not involved in any way in the filling in of the questionnaires. The researcher also ensured the privacy of the respondents who could not read and write, by not probing or forcing the respondents to answer the questions in any way but only wrote down the answers as per their choices.

3.10 DATA ANALYSIS

The collected data was cleaned, coded and captured by the researcher and two research assistants. Data from questionnaires was converted to percentages and was presented in the form of tables. All data from the questionnaire was coded using Microsoft excel. The researcher and two research assistants used codes instead of respondents' names and checked data by frequency in order to find omitted or improper values. For data analysis, the Statistical Package of Social Sciences (SPSS version 23.0) was used. The significant level was set at 0.05. Various descriptive statistics were calculated using the mean, mode and median. Chi square which is a measure to non-parametric investigation was used to analyse the association between the independent and dependant variables. The results emanating from the study were denoted in the form of tables and figures for easy interpretation.

3.11 ETHICAL CONSIDERATIONS

Any research study conducted with human beings as subjects brings about ethical issues that have to be addressed from the onset (Ritchie and Lewis, 2005; Marshall and Rossman, 2006; Babbie, 2007). Resnik (2011) defines 'ethics' as standards for conduct that differentiate between tolerable and intolerable behaviour. Ethics in research are very important because they are values that are essential to collaborative work, such as fairness and mutual respect. It is of paramount importance that researchers incorporate ethics in their research in order to avoid harm to the respondents, as well as to ensure that the respondents participate in the research with full knowledge of the aim, dangers and benefits of the research. For the purpose of this research, the following ethical principles were considered: informed consent, confidentiality, avoidance of harm, maintaining of human dignity and voluntary participation and described below.

3.11.1 Permission to conduct the research

The research proposal was presented to the School of Health Sciences Higher Degrees Committee and University of Venda Higher Degrees Committee for quality control. The researcher sought permission to conduct this study from the University of Venda Research committee for ethical clearance. The permission to collect data in Berejena village was sought from the office of the District Administrator of Guruve South District.

3.11.2 Informed Consent

An informed consent form was drafted and given to the respondents. This detailed the purpose and nature of the study before data collection commenced. The purpose of informed consent is to conduct the study plianly and without deceitfulness (Silverman, 2013). Consent forms were given to each respondent as a means of accepting responsibility to play a part in the study. The researcher ensured that the respondents were conscious of the kind of information required, why the information is required, what purpose it will be put to, how they are anticipated to contribute in the study and how it will openly or ultimately affect them.

3.11.3 Voluntary participation

According to Neuman (2011) in the procedure of conducting an investigation, the researcher must not force anybody into participating. Therefore, the researcher, before engaging the respondents in the research study ensured that they knew that participation would be done at their own free will and that they had a right to withdraw at any time if they feel uncomfortable or endangered in the research procedure. The respondents were not forced in any way to participate in this study.

3.11.3 Confidentiality

The researcher took responsibility to maintain confidentiality of the given information by participants. Bishop (1994) confidentiality is all about protecting a person's private information from unlawful access. According to Canterbury Christ Church University (2006), researchers have a strong obligation to ensure that they know and shield the rights and overall wellbeing of their participants, irrespective of the nature of their research. In this research, respondents were assured anonymity in answering the questionnaires. To achieve this, respondents did not write their names or provide any other form of identification. Every respondent in the research was entitled to privacy about their thoughts, beliefs, ideas and personal understanding. The data was kept classified at all time and was discarded immediately on completion of the study.

3.11.5 No harm to Participants

According to Canterbury Christ Church University (2006), researchers must take specific care to ensure that individuals are not abused or harmed in any way during the course of a research. Shamoo and Resnick (2009) state that when conducting research on people, harm and risks must be reduced while benefits are maximized. Moreover, any ethnic, spiritual, governmental, societal, gender or other variances in a research population should be considerably and

appropriately handled by researchers during the course of the research. The researcher made sure that no harm, be it emotional or physical was caused on the respondents. The researcher constructed questions in an appropriate way to avoid causing uneasiness and emotional distress throughout the course of answering the questionnaire. Additional potential hazards like psychological stress were considered and the researcher safeguarded against them.

3.11.6 Human Dignity

In this study, human dignity was respected and observed all the time. Respect for human dignity is the fundamental aspect underlying research ethics and safeguards the interest, physical, psychological or cultural honour of a person (Canterbury Christ Church University, 2006). The researcher treated all the respondents with utmost respect.

3.12 SUMMARY

This chapter was on research design and methodology which the researcher used in conducting the research. The chapter also outlined the data collection techniques in which the methods were used in order to address the objectives of the study. Population sampling procedures, plans for data collection, instrumentation, ethical considerations and data analysis were also described. After these methods were utilized, data was collected. The next chapter will present the research results.

CHAPTER 4

PRESENTATION OF RESULTS

4.1 Introduction

This chapter presents the results from data processed. The analyses and interpretation of the results will generate findings. The results are presented as descriptive statistics in the form of percentages and frequencies. Tests for associations/relationships and cross tabulations between employment status and socio-economic factors, educational level of the respondents and some socio-cultural factors, demographic variables and responses on the use of PHC facility are also presented. The results will be presented under the sub-headings aligned to the objectives of the study namely: demographic information, socio-economic and socio-cultural factors influencing access to PHCS.

4.2 Demographic characteristics of respondents

Results on demographic variables are shown on Table 4 below and the analysis is given thereafter.

Table 4: Demographic characteristics of respondents

n= (220)

Variables	Description	Frequency	Percentage (%)
Age range	18-25 years	41	19%
	26-33 years	43	21%
	34-43 years	49	22%
	44-54 years	51	23%
	55-65 years	36	16%
Residential address of respondents	Tawasika	66	30%
	Chimanga	53	24%
	Gomba	65	30%
	Makomo	36	16%
Educational level of respondents	Never attended school	52	24%
	Grade 1-7	66	30%
	Form 1-4	63	29%
	Form 4 and above	28	13%
	Diploma/ degree	11	5%

Variables	Description	Frequency	Percentage (%)
Employment status	Employed	52	24%
	Unemployed	168	76%
Marital status of respondents	Married	111	51%
	Separated	29	13%
	Widowed	33	15%
	Divorced	20	9%
	Single	27	12%
Religion	Christianity	162	74%
	Traditional	48	22%
	Baha'I Faith	10	5%
Ethnicity	Korekore	171	78%
	Shangani	2	1%
	Karanga	14	6%
	Varemba	2	1%
	ZeZuru	30	14%
	Alien	1	0.5%

The results in Table 4 show that (23%) of respondents were between the ages of 44 and 54 years. This was followed by 34-43 years (22%), the age group 26-33 years constituted 20% of the study population and the age group 18-25 years had (19%). Lastly the senior citizens constituted (16%). The study setting was divided into four blocks: namely Tawasika, Chimanga, Gomba and Makomo. Thirty percent of the respondents were from Tawasika, (30%) represented Gomba, Chimanga and Makomo constituted (24%) and (16%) respectively.

About their level of education (24%) of the respondents indicated they had never attended school in their life time. Thirty percent showed that they had acquired basic education that is grade 1-7, (29%) stated that they had attended secondary school and fewer respondents had attended advanced level and managed to get a diploma/ degree (13%), (5%) respectively. The results indicate that the majority (76%) of respondents in Berejena village are not employed and only (24%) are employed (Table 4 has details).

The marital status of the respondents indicated that more than half of the study population (51%) respondents are married. Twelve percent are single, while the separated, divorced and widowed are (13%), (9%) and (15%) respectively. Table 4 shows the details. It is of paramount importance to note that marital status plays a significant role in PHCS access. For example married people can seek permission from their spouses first before they access PHCS especially in patriarchal communities or the widowed, divorced and single can also seek permission from other third parties in their families.

The total population $n=220$ showed that they belonged to a specific religious group. The majority of the respondents (74%) indicated that they were Christians, whilst (22%) indicated that they are following their traditional values and principles. The results also indicated that not many people (5%) are Baha'i Faith. Religion plays an essential role in PHCS access. Some religious groups like Apostolic Sects under Christianity religion have strict doctrines and rules which make it difficult for their members to access PHCS. Therefore, religious beliefs of a person can influence PHCS access negatively or positively.

The results indicated that Berejena village is mainly dominated by the Shona Korekore speaking people. The Shona Korekore are the majority with (78%), followed by Shona Zezuru with (14%) and Shona Karanga with (6%), while Varembe and Shangani are both represented by only a percentage. Only one respondent indicated that they are Alien (0.5%). The sample had minimal diverse ethnical groups represented in Zimbabwe. Ethnicity of an individual can influence PHCS access in the sense that some people might feel that they cannot be treated by someone who is not from their ethnical group especially in societies where tribalism exists (See for table 4 for details).

4.3 Socio-economic factors.

In a quest to assess the impact of socio-economic factors in the access of PHCS respondents were requested to fill-in a questionnaire by showing their level of agreement to certain questions. The questions were put on a 5 item Likert scale where 5 represented strongly agree, 4 agree, 3 undecided, 2 disagree and 1 strongly disagree. For the purpose of analysis, strongly agree and agree are merged together and strongly disagree and disagree are also merged together.

Table 5 shows results on socio-economic factors in access of PHCS according to employment status. The results indicate that (65%) of the respondents agreed that lack of medical aid is one of the factor which prevents them from accessing the PHCS, (11%) remained neutral and (24%)

disagreed to this notion. The unemployed respondents (62%) agreed that lack of medical aid prevents them from accessing PHCS, (9%) were undecided and (5%) disagreed. More than three quarters of the employed respondents (19%) disagreed that lack of medical aid prevents them from accessing PHCS, while only (2%) remained neutral and (3%) were in agreement with the assertion. A significant difference was recognized between the employed and unemployed respondents regarding the fact that lack of medical aid is a barrier to PHCS access (χ^2 121.558, $p > 0.000$).

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Table 5: Socio-economic factors influencing access to PHCS by employment status

Item	Unemployed (n=168)			Employed (n=52)			Total for both groups (n=220)			χ^2	P-value
	Agree N (%)	Undecided N (%)	Disagree N (%)	Agree N (%)	Undecided N (%)	Disagree N (%)	Agree N (%)	Undecided N (%)	Disagree N (%)		
Lack of medical aid prevents me from going to the primary healthcare facility when I am sick.	137(62)	2(0.9)	11(5)	6(3)	5(2)	41(19)	143(65)	25(11)	52(24)	121.558	0.000
The primary healthcare facility is very far.	163(74)	5(2)	0(0)	52(24)	0(0)	0(0)	215(98)	5(2)	0(0)	50.852	0.000
I don't go to the primary healthcare facility because I cannot afford to buy the medicine.	141(64)	19(9)	8(4)	10(5)	3(1)	39(18)	151(69)	22(10)	47(21)	117.478	0.000
There is no reliable transport to the primary healthcare facility.	157(71)	10(5)	1(0.45)	51(23)	0(0)	1(0.45)	208(94)	10(5)	2(1)	22.630	0.031
There are shortages of healthcare professionals at the primary healthcare facility.	151(69)	15(7)	2(1)	52(24)	0(0)	0(0)	203(92)	15(7)	2(1)	11.807	0.757
There is a serious shortage of essential medication at the primary healthcare facility.	152(69)	16(7)	0(0)	52(24)	0(0)	0(0)	204(93)	16(7)	0(0)	10.851	0.227
There are shortages of equipment at the primary healthcare facility.	154(70)	14(6)	0(0)	52(24)	0(0)	0(0)	206(94)	14(6)	0(0)	9.652	0.290
There is poor service delivery at the primary healthcare facility.	146(66)	12(6)	10(5)	40(18)	10(5)	2(1)	186(85)	22(10)	12(5)	228.896	0.000
At the primary healthcare facility, patients wait for long periods of time before they are attended.	133(60)	21(10)	14(6)	52(24)	0(0)	0(0)	185(84)	21(10)	14(6)	224.772	0.000
The primary healthcare facility has inadequate carrying capacity.	152(69)	11(5)	5(2)	50(23)	1(0.45)	1(0.45)	202(92)	12(6)	6(3)	11.993	0.744

The majority (98%) of the respondents agreed that the PHC facility from which people can assess the PHCS is very far, the minority, that is only (2%) were undecided and none of the population were in disagreement with the above view. Of the unemployed respondents, only (2%) respondents neither agreed nor disagreed that the PHC facility is very far and (74%) agreed. The total population (24%) of the employed group agreed that the PHC facility is very far. There was a significant difference between the employed and unemployed respondents' views on whether the PHC facility is far ($\chi^2 50.852$ $p > 0.000$).

When asked if the respondents travelled for more than one hour to reach the nearest PHC facility, (96%) of the entire population agreed, none of the respondents disagreed and only (4%) were undecided. Seventy two percent unemployed respondents agreed that they travel for more than one hour to reach the nearest PHC facility, (4%) remained neutral and none of the respondents disagreed. The employed respondents clearly stated that the travel time is way more than one hour to reach the nearest PHC facility (24%) none of the employed respondents remained neutral or disagreed.

On the statement that medication is not affordable at PHC facilities, (69%) of the respondents totally agreed, while (21%) disagreed and (10%) were undecided and unsure about the affordability of medication. Of the 24% employed group, only (5%) agreed with the above notion, (1%) neither agreed nor disagreed and (18%) disagreed. 64% unemployed respondents highlighted or agreed that they do not consult at PHC facilities because the medication is unaffordable, (9%) were undecided and (4%) disagreed. There was a significant difference between the employed and unemployed respondents' views regarding the affordability of medications at PHC facilities ($\chi^2 117.478$, $p > 0.000$).

When asked if there is reliable transport to access the PHCS, almost all the respondents (94%) indicated that there is no reliable transport to PHC facilities, while only (1%) disagreed. However, (5%) of the respondents remained neutral. Unemployed respondents (71%) stated that there is no reliable transport from the village to the nearest PHC facility, (5%) neither agreed nor disagreed and only one person (0.45%) disagreed. Twenty three percent employed respondents agreed that there is no reliable transport from the village to the nearest PHC facility and (0.45%) respondents disagreed. Data shows that there was a significant difference between

the responses of the employed and unemployed respondents on the reliability of transport to the nearest PHC facility (χ^2 22.630, $p > 0.031$)

The respondents were asked if the shortage of healthcare professionals at the PHC facility prevents them from accessing the PHCS. Collected data shows that (92%) respondents agreed that shortage of healthcare professionals prevents them from access PHCS, while (7%) were undecided and (1%) totally disagreed. Unemployed respondents (69%) were in agreement with the above idea, (7%) neither agreed nor disagreed and (1%) disagreed. The employed respondents (24%) also indicated that shortage of healthcare professionals at the PHC facility is a barrier to accessing PHCS.

The respondents strongly agreed that at the PHC facility there is a serious shortage of essential medication. Ninety three percent respondents clearly supported the above notion, none of the respondents disagreed and (7%) were undecided. 69% unemployed respondents agreed that at the PHC facility there is a serious shortage of essential medication and that is a barrier to PHCS access and none of the respondents disagreed. The employed respondents (24%) were in agreement with the assertion and none disagreed or remained neutral.

A shortage of equipment at the PHC facility was indicated by the respondents as an element that prevents them from accessing PHCS. The majority of the respondents (94%) affirmed shortage or lack of equipment at the PHC facility as a one of the factors that made it difficult for them to access PHCS. Respondents (6%) were undecided whether the shortage of equipment at the PHC facility causes them to access PHCS or not and none disagreed. The unemployed respondents (70%) agreed that shortage of equipment at the PHC facility is a barrier to accessing PHCS, (6%) neither agreed nor disagreed and none disagreed. The employed respondents (24%) also indicated that shortage of equipment at the PHC facility is a barrier to accessing PHCS. There was no significant difference between the views of the employed and unemployed respondents on the shortages of equipment as a hindrance to PHCS access (χ^2 9.652, $p < 0.290$)

The majority (85%) agreed with the option that there is poor service delivery at PHC facility and that is why many respondents do not access PHCS. Ten percent of the respondents remained neutral to the above statement. Unemployed respondents (66%) were in agreement with the above claim, (6%) were undecided and (5%) respondents disagreed. Of the employed

respondents (18%) agreed that there is poor service delivery at the PHCS facility, while those who were undecided and disagreed constituted (5%) and (1%) respectively.

Respondents (84%) agreed that at the PHC facility, patients tend to wait for long periods of time before they are attended, n=21 (10%) neither agreed nor disagreed and n=14 (6%) totally disagreed. Unemployed respondents (60%) agreed that the patients wait for long periods of time before they are attended by healthcare professionals and this causes PHCS inaccessibility, n=21 (10%) were undecided and n=14 (6%) disagreed. The total population (24%) of the employed group were in agreement with the above notion, none of the respondents remained neutral or disagreed. There was a significant difference between the employed and unemployed respondents with regards to waiting period at PHC facility (χ^2 228.896, $p > 0.000$).

The respondents (92%) agreed that the PHC facility is inadequate, (6%) were undecided and (3%) disagreed. The unemployed respondents (69%) agreed that the carrying capacity of the PHC facility is inadequate, (5%) were undecided and (2%) disagreed. Employed respondents (23%) agreed that the PHC facility is inadequate, while only (0.45%) remained neutral and (0.45%) disagreed. However, there was no significant difference between the responses of the employed and unemployed respondents on the inadequate carrying capacity of the PHC facility (χ^2 11.993, $p < 0.744$).

4.4 The use of PHC facility.

Access to PHCS is a proxy to PHCS use; these two words (access and utilization) work in cohorts therefore, it is impossible to talk about access to PHCS without mentioning PHCS utilization. In order to have profound knowledge on the use of the nearest PHCS facility in Berejena village, the respondents were asked whether they utilize the PHC facility at all, reasons for their utilization, best place to get treatment and best time to use the PHC facility. Associations or relationships between demographic characteristics and responses on the use of PHC facility are also laid down.

Table 6: Associations/relationship between demographic characteristics and responses on the use of PHC facilities

n = 220

Association	Df	χ^2	p-value	Significance
Use of PHC facility				

Association	Df	χ^2	p-value	Significance
Age and the utilization of the PHC facility	8	10.627	0.224	Ns
Level of education and the utilization of the PHC facility	8	6.362	0.607	Ns
Employment status and the utilization of the PHC facility	8	3.185	0.922	Ns
Marital status and the utilization of the PHC facility	8	11.113	0.195	Ns
Religious beliefs and the utilization of the PHC facility	8	1.658	0.990	Ns
Ethnicity and do you visit the PHC facility	12	25.829	0.011	Sig
Reasons for using the PHC facility				
Age and the reasons for utilizing the PHC facility	12	14.997	0.242	Ns
Level of education and reasons for using the PHC facility	12	25.444	0.013	Sig
Employment status and reasons for utilizing the PHC facility	12	19.700	0.073	Ns
Marital status and reasons for utilizing the PHC facility	12	22.792	0.030	Sig
Religious beliefs and the reasons for utilizing the PHC facility	12	78.779	0.000	Sig
Ethnicity and reasons for utilizing the PHC facility	18	11.759	0.859	Ns
Best place to get treatment when sick				
Age and the best place to get treatment when sick	8	8.479	0.388	Ns
Level of education and the best place to get treatment when sick	8	6.059	0.641	Ns
Employment status and the best place to get treatment when sick	8	22.724	0.004	Sig
Marital Status and the best place to get treatment when sick	8	13.514	0.095	Ns
Religious beliefs and the best place to get treatment when sick	8	149.103	0.000	Sig

Association	Df	χ^2	p-value	Significance
Ethnicity and the best place to get treatment when sick	12	24.165	0.019	Sig
Best time to visit PHC facility	12	7.909	0.792	Ns
Age and the best time to visit the PHC facility				
Level of education and the best time to visit the PHC facility	12	14.540	0.268	Ns
Employment status and the best time to visit the PHC facility	12	36.508	0.000	Sig
Marital status and the best time to visit the PHC facility	12	19.703	0.073	Ns
Religious beliefs and the best time to visit the PHC facility	12	48.883	0.000	Sig
Ethnicity and the best time to visit the PHC facility	18	40.712	0.002	Sig

Sig=Significant difference

Ns=No significant difference

There were no significant differences between all demographic characteristics except ethnicity and the responses on the use of the PHC facility (Table 6). This means that regardless of the social-demographic characteristics of the respondent, the use of the PHC facility is almost the same.

The results indicated that no significant differences existed between age, employment status and ethnicity and the responses of respondents on their reasons for the utilization of the PHC facility. On the other hand religious beliefs, marital status and the level of education indicated significant differences on the subject in question at $p < 0.05$. Therefore, the results showed that there are differences between some socio-demographic variables of the respondents and their reasons for utilization of the PHC facility (See table 6 for further details).

Results on the association between demographic characteristics and the best place to get treatment show that demographic characteristics of respondents cause variances on the best setting of PHC utilization. Significant differences were only recognized between age, level of education and marital status (Table 6 has details). There were no significant differences between age, level of education and marital status and the responses on the best time to visit the PHC facility. This means that, irrespective of these three demographic characteristics, the best time to utilize the PHC facility is similar.

As indicated in Table 6 above, no significant differences existed between most of the demographic characteristics and the use of PHC facility variables. Therefore, much emphasis was given to the associations where significant differences were identified. Table 7 indicates the respondents' views on the use of the nearest PHC facility by demographic characteristics. The results showed that the majority (84%) respondents indicated that they utilized the PHC facility, while (15%) indicated that they do not utilize the PHC facility. The Korekore respondents (67%) indicated that they utilized the PHC facility, (10%) indicated that they do not utilize the PHC facility, whilst (1%) were undecided. The Zezuru affirmed that (10%) utilized the PHC facility, (4%) do not utilize the PHC facility and only one respondent (0.5%) was unsure about utilizing the PHC facility. The Karanga ethnic group (6%) indicated that they utilize the PHC facility, no respondents indicated that they do not utilize the PHC facility and none were unsure. Varembe, Shangani and Alien groups due to low representation in the study sample stated that (0.5%) of all the three groups utilize the PHC facility, (1.5%) do not utilize the PHC facility and only one respondent (0.5%) was undecided.

The majority of the respondents (75%) regardless of their level of education indicated that they utilize the PHC facility because they want to get treatment, (19%) of the respondents indicated that they are forced to use the PHC facility and (6%) highlighted that they use the PHC facility though they sometimes felt it was not necessary. Since many respondents showed that they utilize the PHC facility for treatment, much emphasis is given to the respondents who indicated that they are forced to access or use the PHC facility. The never attended school, those who acquired basic education, Form 1 to 4, the respondents who attended form 4 and above and managed to get a diploma/degree have (6%), (6%), (4%), (2%), (0.5%) respectively.

The respondents were asked to state the reasons why they utilize the PHC facility by marital status. Seventy five percent indicated that they utilize the PHC facility because they need treatment while (19%) showed that they utilize the PHC facility because someone forces them and (6%) showed that they utilize the PHC facility because they are used to it even when occasionally it is not required as indicated in Table 7 above. The married respondents (33%) indicated that they utilize the PHC facility because they need treatment, (13%) showed that they are forced to utilize the PHC facility, whilst (4%) indicated that they utilize the PHC facility because they are used to it. The widowed (10%) indicated that they used the PHC facility because they want treatment, (2%) are forced and only one respondent (0.5%) showed that

they are just used to it. The single, divorced, and separated respondents indicated that (32%) of all the three clusters utilized the PHC facility because of medical reasons, (5%) are forced to use the PHC facility and (1%) are just used to utilizing the PHC facility.

The association between religion and reasons why respondents utilize the PHC facility (χ^2 78.779, $p > 0.000$) is such that (61%) of the Christianity group regarded treatment as the motivation for utilizing the PHC facility, while (9%) highlighted that they are forced and (4%) are used to it. Thirteen percent of the traditional respondents indicated that they are forced to use the PHC facility, while only (1%) utilize the PHC facility because of treatment and (7%) are used to it. The Baha'i Faith showed that no one forces them to use the PHC facility, neither are they used to utilizing the PHC facility when sometimes it is not necessary but (6%) utilize the PHC facility because they will be in pursuit of treatment.

The majority of the respondents, (75%) believed that the PHC facility was the best place to get treatment, while (11%) indicated that the church was the best place to get treatment and others (14%) showed that the traditional setting was the best place to get treatment. Fifty three percent (14%) showed that the traditional setting was the best place to get treatment, unemployed respondents indicated that the PHC facility was the best place to get treatment, (10%) felt that the church was the best place to get treatment and (14%) respondents were convinced that treatment was better at the traditional setting. Of the employed respondents (22%) indicated that the PHC facility was the best place to get treatment, while those who showed that the church or traditional setting is the best place to get treatment constituted (1%) and (0.5%) respectively.

The respondents were asked to state the best place to get treatment when sick by religion. Sixty seven percent of the respondents suggested the PHC facility was the best place to get treatment, (10%) indicated the church while (22%) showed that the traditional setting was the best place to get treatment. The Christian respondents (63%) indicated that the PHC facility was the best place to get treatment, (8%) said that the church was the best as far as treatment was concerned, whilst (2%) specified that the traditional setting was the best. 20% from the traditional group indicated that the traditional setting was the best for treatment, none preferred the church and only (2%) desired the PHC facility. Of the Baha'i Faith cluster (2%), (2%) and (0.5%) indicated the PHC facility, church and traditional setting as the best place to get treatment respectively.

The relationship between ethnicity and the best place to get treatment was (58%) of the Korekore group mentioned the PHC facility as the best place, while (7%) indicated the church and (12%) preferred to be treated at a traditional setting. Two percent of the Zezuru respondents indicated the church as the best place for treatment, (9%) highlighted the PHC facility and (3%) opted for the traditional setting. None of the Karanga respondents showed that the traditional setting was the best place to get treatment, some indicated the church (1%) and (5%) selected the PHC facility. Varembe, Shangani and Alien (1%) indicated that PHC facility was the best when accessing treatment, no respondents from all the three groups indicated that the church was the best place and only (1%) indicated the traditional setting as the best place.

A significant difference was recognized between the employed and unemployed respondents on the best time to visit the PHC facility (χ^2 36.508, $p > 0.000$). The unemployed respondents (27%) believed that the best time to use PHCS was when seriously sick, (36%) showed that the best time was when sick and (14%) were unsure about the best time to utilize the PHCS. The employed respondents (20%) indicated that the best time was when sick, others (3%) mentioned that PHCS can be used when seriously sick and (1%) were unsure.

The respondents (54%) highlighted that the best time to get treatment was when sick, whilst (33%) indicated that they wait until they are seriously sick to get treatment, whereas (14%) were unsure. The traditional respondents (14%) strongly suggested that the best time to get treatment was when seriously sick, (4%) felt that one has to get treatment when they are sick, still others (5%) were not really sure about the best time they can get treatment when sick. The Christianity group indicated that the best time to get treatment was when sick, seriously sick and unsure with (49%), (16%), (9%) respectively. One respondent (0.5%) of the Baha'i Faith was unsure about the best time to get treatment, (1%) indicated that the best time was when sick and (3%) indicated that the best time was when seriously sick.

The Korekore (45%) indicated that they get treatment when sick, (21%) indicated that they get treatment when they are seriously sick, while (12%) were unsure. Zezuru respondents (5%) indicated that they get treatment when they are seriously sick, (7%) get treatment when they are sick and (2%) were unsure. The Karanga ethnic group showed that they get treatment when seriously sick, when sick and others were unsure with (2%), (4%), (1%) respectively. The Varembe, Shangani and Alien groups indicated that (1%) of all the three groups get treatment when they are seriously sick, (1%) get treatment when they are sick and (0.5%) were unsure.

Table 7: Views on the use of the nearest PHC facility by demographic characteristics

Variable	Description	Question	Views			
			Yes	No	I don't know	
Ethnicity		Do you utilize the PHC facility	n=184	n=32	n=4 (2%)	
	Korekore		148 (67%)	21 (10%)	2 (1%)	
	Zezuru		21 (10%)	8 (4%)	1 (0.5%)	
	Karanga		14 (6%)	0 (0%)	0 (0%)	
	Varemba		0 (0%)	1 (0.5%)	1 (0.5%)	
	Shangani		1 (0.5%)	1 (0.5%)	0 (0%)	
	Alien		0 (0%)	1 (0.5%)	0 (0%)	
Level of education		Reasons for using the PHC facility	To get treatment			
	Never attended school		n=165 (75%)	Forced		
	Grade 1-7		n=165 (75%)	n=42 (19%)	n=13 (6%)	
	Form 1-4		31 (14%)	13 (6%)	8 (4%)	
	Form 4 and above		49 (22%)	14 (6%)	4 (2%)	
	Diploma/degree		53 (24%)	9 (4%)	1 (0.5%)	
			22 (10%)	5 (2%)	0 (0%)	
Marital Status		Reasons for using the PHC facility	10 (5%)	1 (0.5%)	0 (0%)	
			n=165	n=42 (19%)	n=13 (6%)	
	Married		73 (33%)	29 (13%)	9 (4%)	
	Divorced		17 (8%)	3 (1%)	0 (0%)	
	Single		28 (13%)	3 (1%)	1 (0.5%)	
	Widowed		22 (10%)	4 (2%)	9 (4%)	

Variable	Description	Question	Views					
			25	(11%)	4	(2%)	0	(0%)
Religion	Separated	Reasons for using PHC facility	n=151	(69%)	n=42	(19%)	n=27	(12%)
	Christianity		136	(61%)	19	(9%)	8	(4%)
	Traditional		3	(1%)	29	(13%)	16	(7%)
	Islam		0	(0%)	0	(2%)	0	(0%)
	Baha'i Faith		10	(6%)	0	(0%)	0	(0%)
	Other		0	(0%)	0	(0%)	0	(0%)
Employment status		Best place to get treatment	Clinic		Church		Traditional	
	Employed		n=165	(75%)	n=24	(11%)	n=31	(14%)
	Unemployed		48	(22%)	3	(1%)	1	(0.5%)
Religion		Best place to get treatment	117	(53%)	21	(10%)	30	(14)
	Christianity		n=148	(67%)	n=23	(10%)	n=49	(22%)
	Traditional		139	(63%)	18	(8%)	5	(2%)
	Islam		5	(2%)	0	(0%)	43	(20%)
	Baha'i Faith		0	(0%)	0	(0%)	0	(0.5%)
	Others		4	(2%)	5	(2%)	1	(0.5%)
Ethnicity		Best place to get treatment	0	(0%)	0	(0%)	0	(0%)
	Korekore		n=161	(73%)	n=24	(11%)	n=35	(16%)
	Zezuru		128	(58%)	16	(7%)	27	(12%)
	Karanga		19	(9%)	5	(2%)	6	(3%)
	Varemba		11	(5%)	3	(1%)	0	(0%)
	Shangani		2	(1%)	0	(0%)	0	(0%)
Ndebele	1	(0.5%)	0	(0%)	1	(0.5%)		
	0	(0%)	0	(0%)	0	(0%)		

Variable	Description	Question	Views					
Employment status	Alien	Best time to visit the PHC facility	0	(0%)	0	(0%)	1	(0.5%)
			When seriously sick n=65 (30%)	When sick n=123 (56%)	Unsure n=32 (15%)			
Religion	Employed	Best time to visit the PHC facility	6	(3%)	44	(20%)	2	(1%)
	Unemployed		59	(27%)	79	(36%)	30	(14%)
	Christianity	Best time to visit the PHC facility	n=72	(33%)	n=118	(54%)	n=30	(14%)
	Traditional		36	(16%)	107	(49%)	19	(9%)
	Islam		30	(14%)	8	(4%)	10	(5%)
	Baha'1 Faith		0	(0%)	0	(0%)	0	(0%)
Other	6	(3%)	3	(1%)	1	(0.5%)		
Ethnicity	Korekore	Best time to visit the PHC facility	0	(0%)	0	(0%)	0	(0%)
			n=62	(28%)	n=124	(56%)	n=34	(16%)
	Zezuru	46	(21%)	98	(45%)	27	(12%)	
	Karanga	10	(5%)	16	(7%)	4	(2%)	
	Varemba	4	(2%)	8	(4%)	2	(1%)	
	Shangani	0	(0%)	2	(1%)	0	(0%)	
	Ndebele	1	(0.5%)	0	(0%)	1	(0.5%)	
	Alien	0	(0%)	0	(0%)	0	(0%)	
			1	(0.5%)	0	(0%)	0	(0%)

4.5 Socio-cultural factors influencing access to PHCS

On the assessment of the impact of socio-cultural factors influencing access to PHCS the respondents were requested to provide information on decision making when accessing PHCS. The respondents were also asked to give their level of agreement to questions regarding the socio-cultural factors.

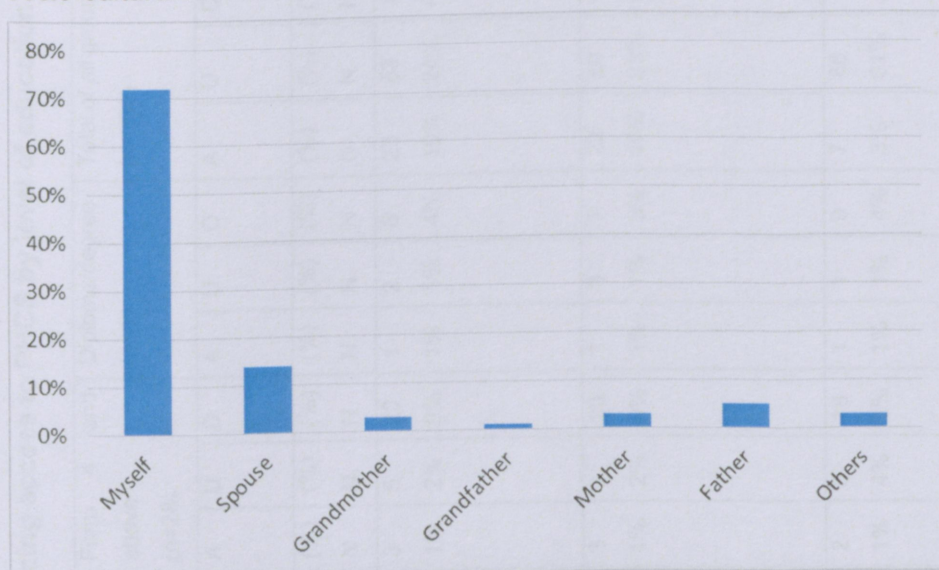


Figure 1: Decision making regarding PHCS access

The respondents were requested to state the person in their families who makes decisions pertaining to PHCS access. The majority (72%) showed that they make their own decisions regarding PHCS access, followed by (14%) who mentioned that the decision lay with their spouses. Some respondents indicated that their grandmother, grandfather, mother and father make the decision, with (3%), (1%), (3%) and (5%) respectively. The last group (3%) indicated that there are other people who are decision makers when PHCS access is concerned, as shown on figure 1 above.

Table 8 below shows the socio-cultural factors influencing access to PHCS according to the level of education of the respondents.

Table 8: Levels of agreement about socio-cultural factors influencing access to PHCS by level of education

Item	Never attended school (n=52)			Grade 1-7 (n=66)			Form 1-4 (n=63)			Form 4 and above (n=28)			Diploma/degree (n=11)			Total of all groups (n=220)			χ ²	P Value
	A (%)	U (%)	D (%)	A (%)	U (%)	D (%)	A (%)	U (%)	D (%)	A (%)	U (%)	D (%)	A (%)	U (%)	D (%)	A (%)	U (%)	D (%)		
My church doctrine does not allow me to visit the PHC facility whenever I'm sick	5 2%	16 7%	31 14%	6 3%	13 6%	47 21%	8 4%	17 8%	38 17%	3 1%	5 2%	20 9%	1 1%	2 1%	8 4%	23 10%	53 24%	144 65%	7.555	0.819
I do not go to the PHC facility because whenever I'm sick I get treatment from church.	6 3%	9 5%	37 17%	5 2%	18 8%	43 20%	7 3%	15 7%	39 18%	3 1%	5 2%	20 9%	1 1%	3 1%	7 3%	22 10%	50 23%	146 66%	8.136	0.945
I do not go to the PHC facility because the healthcare professionals are not Shona speaking people.	0 0%	18 8%	34 15%	4 2%	21 10%	41 19%	0 0%	20 9%	43 20%	2 1%	8 4%	18 8%	1 1%	1 1%	9 4%	7 3%	68 31%	145 66%	18.118	0.580

Key: A represents agree, U is undecided and D represents disagree

Sixty five percent of the respondents disagreed when asked if their church doctrine prevented them from using PHCS, while (24%) were undecided and only (10%) agreed. Fourteen percent of the never attended school respondents disagreed that their church doctrine prevented them from accessing, PHCS, (7%) were undecided and (2%) agreed. Those who acquired basic education (21%) were in disagreement with the above claim and (3%) agreed. Four percent of the respondents who attended form 1-4 agreed with the statement that the church doctrine is a stumbling block when using PHCS, (8%) were undecided and (17%) strongly disagreed. The respondents who attained O' level or a better educational qualification, disagreed that the church doctrine was a factor that prevented them from using PHCS, others were indecisive and some agreed, (4%), (1%), (1%) respectively.

When respondents were asked whether they did not access the PHCS because whenever they were ill they got treatment from the church, (66%) disagreed, while (23%) were undecided and (10%) agreed. Seventeen percent of the never attended school disagreed that they were not prevented from accessing PHCS because of the treatment they always got from the church, (5%) were undecided and (3%) agreed. Those who acquired basic education (20%) disagreed with the above notion and (8%) were undecided. Three percent of the respondents who attended form 1-4 agreed with the claim that they did not access the PHCS because they get treatment from the church, (7%) were undecided and (18%) disagreed. Nineteen percent of the respondents who attended form 4 and above disagreed that they did not access the PHCS because they got treatment from the church, others (2%) were undecided and others agreed, (1%). On the degree/diploma group (1%), agreed, (1%) were undecided and (3%) disagreed with the above statement.

Sixty six percent totally disagreed that they did not access PHCS because the healthcare professionals were not Shona speaking people, (31%) remained neutral and (3%) agreed. Fifteen percent of the respondents who indicated that they never attended school disagreed that they do not access PHCS because of the ethnicity of healthcare professionals, (8%) were undecided and none agreed. Seventeen percent of the respondents who acquired basic education were in disagreement with the above claim, while (10%) were undecided and (2%) agreed. None of the respondents who attended form 1-4 agreed with the assertion that they do not access the PHCS because the healthcare professionals were not Shona speaking people, (9%) were undecided and (20%) totally disagreed. Eight percent of the respondents who attended form 4 and above disagreed that they do not access the PHCS because of the

ethnicity of the healthcare professionals, others (4%) were neutral and some agreed (1%). The respondents who hold a degree/diploma (1%), agreed, (1%) were undecided and (4%) disagreed with the above statement.

4.7 SUMMARY

This chapter was a presentation of the study results. The results showed that though the Berejena villagers (75%) do visit the PHC facility, their visits are greatly crippled by the socio-economic factors. Socio-economic factors cause the visits to the PHC facility difficult especially for the (76%) unemployed respondents. The results highlight that the main reason why respondents visit the PHC facility is for treatment. However, others (19%) indicated that they are forced and some respondents felt that the best place to get treatment is at the traditional setting (14%) and the church (11%). The results also show that (72%), (66%) respondents are not influenced by others in decision making and ethnical reasons when accessing PHCS respectively. The next chapter discusses the results in more detail.

CHAPTER 5

DISCUSSIONS

5.1 Introduction

This chapter presents the discussion of the study findings in relation to the aim, objectives as well as the reviewed literature. The previous chapter laid the foundation for this discussion. The discussion is presented according to the following sections; demographic variables, socio-economic factors, the use of the PHC facility and socio-cultural factors influencing access to PHCS.

5.2 Demographic variables

According to the findings of this analysis, age as a demographic characteristic plays a major role in health seeking behaviours, healthcare access and healthcare use. In a similar study conducted by Macassa, Hiswåls, Ahmadi, Alfredsson, Soares and Stankunas (2014) age was statistically considerably associated with utilization of health care services and the highest odds were observed between the age groups 36-45 and 46-55 with odds ratios of 2.15 (CI 1.67-2.76) and 2.34 (CI 1.84-2.97). The implication of age to PHCS access is that the elderly people are the most affected group as indicated by the results of this study. The theoretical framework of this study indicated that healthcare requirements increase with age. The elderly people have greater needs for healthcare, however, they faced many obstacles when accessing PHCS. Syed, Gerber and Sharp (2013) maintain that the elderly people may face a lot of challenges when accessing healthcare services because of disabilities, illness and are more likely to have a greater need for repeated visits to the medical professionals.

Literacy level plays a pivotal role in healthcare seeking and healthcare access of individuals as observed by Lam, Broaddus and Surkan (2013). The sample of this study showed that 24% of the respondents never attended school in their life time. This means that the way they viewed healthcare and accessed it was completely different from the (5%) respondents who have attended school and got degrees. According to Sunkanmi and Olufunsho (2013) having some form of education is greatly associated with a higher probability of seeking healthcare. The model used in this study showed that access to modern medication is regularly restricted by lack of knowledge. People with necessary knowledge are able to access healthcare services. Olayinka, Achi, Amos and Chiedu (2013) also indicated that people with higher educational level and knowledge are more likely to use healthcare. A study in Nepal by Lam et al. (2013) indicated that only 38.7% of uneducated women versus 61.2% of well-educated women sought

care for Sexually Transmitted Infections-related symptom. The results of this study, also showed that the majority of respondents have lower levels of education, considering that only 5% have a diploma or degree. Common Wealth Australia (2008) indicates that people who live in rural and remote communities tend to have lower levels of education, partly because there is limited variety of professions in the local area or limited access to resources and higher education.

The results of this study revealed that many respondents in Berejena village are not employed and only 26% are employed. The results of the high unemployment rate in Berejena village are not shocking considering that Zimbabwe is one of the countries which records the highest rate of unemployment in the world. The high level of unemployment could be a result of the fact that in rural areas, there are few industries and the majority of the people rely on subsistence farming and illegal gold panning. In terms of healthcare access the unemployed are the most disadvantaged group compared to their employed counterparts. The unemployed have to deal with the user fee costs and at times the money will not be available, considering the user fees burden the unemployed end up not accessing the PHCS. Kyriopoulous, Zavras, Skroumpelous, Mylona, Athanasakis and Kyriopoulos (2014) note that unemployment is one of the features which cause financial constraints in accessing healthcare services. Giving reference to the theoretical framework used in this study on employment status as a barrier to PHCS access, the people who have a job or have fiscal means, are able to access healthcare.

The sample highlighted that there are few single, separated and widowed people while the married constitute the larger percentage. A few respondents are divorced, therefore, signifying how the people still up-holds the sacred principles of marriage. Marital status of an individual can have a positive or negative impact on PHCS access especially when the decision to access the health services lies with other people. Gbaden (2014) indicated that the women of Purdah religion sought permission from their spouses and other family members when accessing PHCS.

The findings also showed that Christianity was the dominant religion in Berejena village. Some respondents indicated that they are Baha'i Faith; others showed that they were still following their traditional values and beliefs, whilst the Islamic religion was not picked in the sample. Religious beliefs especially the Christian-apostolic religion commonly known as *mapositori* play a significant role on one's decision to access PHCS or not. The way the *mapositori* seek and perceive health care is completely different from other religious groups. A study on the Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe

(Maguranyanga, 2011) concurs with this as some respondents indicated that medical treatment is not from health centres but from the church and sicknesses are caused by demons and evil spirits, therefore, it is not necessary to visit health centres because God is the ultimate healer.

Owumi, Raji and Aliyu (2013) articulate that in Nigeria, general practitioners have admitted that there is an interwoven correlation between medicine and religion and can be seen from the sticky labels on doors with the phrase “Doctors care but God heals” engraved. In Nigeria, the use of religion to treat sicknesses is a well-known point. Just like Nigerian doctors, Zimbabwean medical professionals do admit that God heals because at Parirenyatwa Group of Hospitals stickers like “Doctors care but God heals” are also pasted on doors and walls. Zimbabwe medical practitioners at times when they do not detect the real cause of their patients’ sicknesses, sometimes encourage them to seek religious remedies also. In Zimbabwe, people are seeking healing and treatment from the Prophets and there are many people who give testimonies that they have been healed. It is very vital to note that religion is significant and can influence the health-seeking behaviours, utilization and PHCS access of individuals. The theoretical framework used in this study identified religion as a barrier to access healthcare services. The eradication of this barrier can result in many people accessing PHCS.

The results of this investigation, showed that Berejena village is mainly dominated by the Korekore speaking people as they cover (78%) of the study population. These findings are not surprising because the Mashonaland Central Province is largely inhabited by the Korekore people. However, the sample also reflected diversity in the village because the sample picked Zezeru, Karanga, Shangani Varembe, and Alien people. This study is similar to the study carried out by Shapiro and Benatar (2001) in which their respondents were from several geographical and culturally representative settings from all over Botswana. People are no longer limited to one place but in each and every area there is diversity, a mixture of different languages, beliefs, customs, norms and traditions.

5.3 Socio- economic factors

The theoretical framework used in this study states that many people lack access to healthcare services because of the socioeconomic barriers that are prevalent in this era. The framework further indicated that insurance status can significantly influence access and utilization of health care services. The study findings suggest that lack of medical aid is a socio-economic barrier to PHCS access and this was most common among the unemployed respondents. The employed respondents clearly disagreed that lack of medical aid prevents them from accessing PHCS.

This is obviously because they are employed and can afford to cover health insurance costs. Those who are not insured are likely to be the most disadvantaged when accessing PHCS. Wilper, Woolhandler, Lasser, McCormick, Bor and Himmelstein (2009) posit that the uninsured are in many ways likely to be deprived of required care than the insured and absence of health insurance is linked with as numerous as 44789 deaths per year in the United States of America. Tsawe and Susuman (2014) observed that in South Africa (90%) of the women who have medical aid, accessed maternal health services more compared to 31.0% of the women who do not have medical aid. Wilper et al. (2009) in Shi, Lebrun-Harris, Daly, Sharma, Sripipatana, Hayashi and Ngo-Metzger (2013) note that the uninsured patients in the United States of America also had lesser odds of reporting access to care and contentment with general care, in comparison with privately insured patients. Therefore, it can be argued that lack of insurance is a hindrance when accessing PHCS.

The respondents, both the employed and unemployed stated that the PHC facility is very far from their respective homes. The physical distance they have to walk sometimes prevents them from accessing PHCS. Visagie et al. (2014) reported that in Africa and in South Africa, travelling distances are worsened by poor roads, insufficient or non-existent public transportation. In Berejena village there, is no public transport to facilitate access to PHCS and the villagers have to walk and when the patient is seriously sick, they use oxen-driven carts. According to Rapakwana (2009) PHCS should be geographically accessible meaning that they should be within a walk-able distance. It is believed that PHC is the principal level of care and therefore ought to bring its services to the people. The consumers must not incur an expense when they obtain PHCS. Distance that people walk seems to be the main factor in the access and utilization of PHCS in Berejena village as supported by the framework used in this study which indicate that travelling for long distances to receive care is a barrier that is very apparent in rural areas.

Sapru, Cassidy and Sibbald (2014) maintain that an extensive travel time to acquire medical services is a challenge rural people face when seeking medical attention. Supporting these above findings Tsawe and Susuman (2014) maintain that travelling time to healthcare facilities is considered a major barrier to healthcare utilization, specifically in rural South Africa. The findings of this study specified that the majority of the respondents articulated that they walk for more than an hour to reach the nearest PHC facility and this is a barrier to accessing PHCS. No significant difference was recognized between the employed and unemployed respondents regarding the great travel time to reach the nearest PHC facility. In another study conducted by

Nteta, Mokgatlé-Nthabu, Oluwafemi and Oguntibeju (2010) time taken to reach the facility has been established to influence health service use.

Furthermore, studies conducted in Hlabisa Health Sub-district, Kwa-Zulu Natal Province, South Africa, showed that the median travel time to the nearest clinic was 81 minutes, and that people travel for 1 hour or more to get to the nearest clinic. This in itself is a challenge to accessing PHCS, because a patient has to think about the distance they have to walk to access the PHCS. Kuwana (2014) also indicated that in Namibia many rural respondents walked to the nearest PHC facility and this generally takes up to an hour to reach to the nearest health center. Giving reference to the theoretical framework of this study, it is important to note that the removal of this socio-economic barrier can cause many people to have access to PHCS.

The findings of this study indicated that the majority agreed that medication is unaffordable. The respondents who intensely indicated that medication is unaffordable are the (64%) unemployed respondents. The employed respondents begged to differ as only (5%) concurred with the unemployed respondents that medication is unaffordable and a significant difference was noticed. If people do not afford medications, they have to do without medications and this leads to more health-related complications. The findings of this study are not reasonable as many people around the globe concur that medication is not affordable and very expensive. In a study conducted by Watal (2010) in Abiye, Tesfaye and Hawaze (2013) it is believed that medicines are unaffordable for many people of the general population and it is a major problem for governments. In another study by Abiye et al. (2013) almost half of their total population showed that the drugs are not affordable. Abiye et al. (2013) further indicated that once drugs are unaffordable patients turn to traditional medicine and religious medications which they can get on lower prices. Another study in Malaysia showed that people regarded medicines as expensive and assumed that the prices of the drugs would one way or the other influence their decision to buy medicine or not (Baber *et al.*, 2003 in Abiye et al., 2013).

The unemployed are the most deprived people when the affordability of medication is in question. Therefore, the findings of this study are in correlation with the results of Idzerda, Adams, Patrick, Schrecker and Tugwell (2011). Their findings indicated that the Roma people in Serbia do not afford to pay for health services and are not able to purchase medications. The Roma people are believed to be the poorest people in Serbia as most of them are not employed. Idzerda et al. (2011) also indicates that the Roma people did not use health services because they were too expensive for them. Therefore, it can be noted that unaffordability of

medications causes a negative impact on PHCS access and the poor or unemployed people are the most affected compared to their employed counterparts. The barriers to access model used in this study specified that if any barrier that hinder access to healthcare can be removed they would be great access to healthcare. Therefore if medications are affordable people can have access to PHCS.

The respondents', both the employed and unemployed, said that the unavailability and unreliability of transport influences access to PHCS. Rapakwana (2009) notes that transportation to access health services should be freely available. When transport is unreliable and unavailable people can walk for great distances to access PHCS. Nteta et al. (2010) showed that walking is the second most common mode of transport. This study sample reflected that unreliability of transport is a factor which influences access to PHCS, others disagreed and some remained neutral. In conjunction with the above findings, other studies conducted on transportation as a barrier to access PHCS have found that lack of transport is becoming a challenge in accessing healthcare services in rural areas. Humphreys and Wakerman in a discussion paper about the PHC in rural and remote Australia concluded that lack of transport is gradually becoming a hindrance to accessing health services in rural and secluded areas. In a report by the KwaZulu-Natal Provincial Health Consultative: A community Durban Consultation (24-25 May 2010) transport to health service points was also identified as a challenge in rural and isolated areas. The barriers to access model also support the claim that unreliability of transport is a challenge for accessing healthcare services as it shows that healthcare services barriers are caused by lack of public transportation for people who do not have their own automobiles or who are unable to drive.

Sapru et al. (2014) conducted a study in Northern Ontario and the results indicated that in rural areas, persons who seek medical care face numerous barriers, including a short supply of healthcare workers. Their findings are similar to the findings of Kuwana (2014) who showed that the shortage of health workers act as a major barrier in assessing PHCS. In this study, no significant difference was noticed between the employed and unemployed respondents' opinions regarding the shortage of healthcare professionals at the PHC facility as a barrier to PHCS access. The findings of this study shows that (92%) respondents said that the shortage of healthcare professionals prevents them from accessing PHCS. These findings are constant with the findings of Toyin and Kayode (2014) which show that lack of medical doctors in many PHC facilities stop people from utilizing the facility. The findings of this study also agree with those of Brundisini, Giacomini, DeJean, Vanstone, Winsor, and Smith (2013) which showed that

accessibility of healthcare workers clearly influenced access to health care, treatment, and therapy for chronic conditions in the rural setting.

Shortage of healthcare professionals at PHC facilities is a serious challenge as it can lead to major health complications. This is shown in a study conducted by Tsawe and Susuman (2014) on the determinants of access to and use of maternal health care services in the Eastern Cape, South Africa. The authors indicated that shortages of healthcare staff can have severe repercussions for the use of maternal health services. The shortage of healthcare workers is not experienced in developing nations only but also in developed countries and this makes it a global problem. Swartz (2009) notes that the shortage of doctors and nurses is experienced by many poor areas of the United States of America. Sapru et al. (2014) say that in Northern Ontario, the scarcity of medical specialists is a well-known problem. This problem has given rise to massive waiting time at healthcare centres as noted by Sanders (2013) who cites that emerging PHC physician shortage has steered the cumulative wait times for ordinary Americans. Lastly, availability of health workers is a good pointer of a good healthcare service delivery system as it is very crucial in rendering quality services to the people (Kuwana, 2014). The theoretical framework of this study showed that the shortage and poor distribution of medical providers is a barrier to healthcare and frequently occurs in rural areas. Therefore, it can be argued that shortage of healthcare professionals at PHC facilities has a negative impact on PHCS access.

The results of this study suggest that shortage of Essential Drugs (EDs) causes respondents not to access PHCS. These results are not surprising as shortage of EDs is a global problem, prevalent in public sectors and most severe in rural areas. According to Abiye et al. (2013) lack of access to (EDs) is still a severe international public problem and 90% of the people in low and middle income nations purchase medication from their pocket. A study in Bangladesh, Brazil, Malawi, Nepal, Pakistan and Sri-lanka shows that of all the countries excluding Brazil and Sri-lanka, less than 7.5% of the EDs are accessible in public sector (Mendis et al., 2007 in Abiye et al., 2013). Shortage of EDs is also mainly predominant in rural areas as indicated in the report by KwaZulu-Natal Provincial Health Consultative workshop conducted on 24-25 May 2010. The report showed that there is great shortage of sufficient medication at the PHC facilities and hospital in rural areas.

Lack or unavailability of EDs at PHC facilities is a threat to public health and it causes people to seek other alternatives to treat their illnesses and conditions. Maswanganyi, Lebese, Mashau,

and Khoza (2014) indicated that shortages of Tuberculosis (TB) treatment at PHC facilities caused TB patients in Giyani Municipality, Mopani District to seek other forms of treatment from traditional healers (THs) simply because when patients go to them, the treatment is always available. In another study by Mbwanyo et al. (2013) people visited THs because healthcare centres did not have medication and only pain killers were available.

It is believed that lack of qualified health workers to manage the medications supply chain is one of the causes for persistently low access to medicines (Lubinga Jenny, Larsen-Cooper, Crawford, Matemba, Stergachis and Babigumira, 2014). The authors further proposed that swift access to EDs can greatly increase health results, including the saving millions of lives in developing countries. Access to EDs permits people to acquire treatment for health conditions which are persistent and chronic (Sambala, Sapsed and Mkandawire, 2010). The barriers to access model proposes that the removal of socio-economic barriers can escalate access to healthcare services, therefore the eradication of shortages of ED can increase PHCS access in rural as well as urban areas.

The results of this investigation confirm the assertion that shortage of equipment negatively influences access to PHCS. The respondents both employed and unemployed (94%) indicated that shortage of equipment at the PHC facility prevents them from accessing PHCS. Oshi, Chukwu, Nwafor, Aguwa, Onyeonoro, Meka, Ikebudu, Anyim, Ekeke, Omotowo, Ogbudebe and Madichie (2014) note that PHC facilities often times do not have radiology services, therefore the patients needing such services are regularly transferred to tertiary levels of healthcare. If the people are aware that they are always referred to a hospital they will end up not going to the PHC facility. It is important to have enough equipment at PHC facilities because it saves lives.

In addition, Tsawe and Susuman (2014) notes that various healthcare facilities are not sufficiently equipped to properly support the healthcare desires of their inhabitants particularly in rural areas and some of these facilities are far from providing the healthcare services that are expected of them. The above mentioned inadequacies have the power to contribute to the less or marginal utilization of healthcare services. Some facilities do not have the equipment at all, but if the equipment exists they are in a very unfavorable state. Abdulraheem, Olapipo and Amodu (2012) conducted a study on PHCS in Nigeria and the results indicated that most PHC facilities were in different conditions of dis-repair, both equipment and infrastructure being either absent or obsolete. This in itself can prevent people from accessing PHCS. The eradication of the shortage and provision of enough equipment raises the use and access of PHCS.

The sample reflected that there is poor service delivery at the PHC facility. The provision of good quality healthcare help people access PHCS which is indicated in the theoretical framework. Most respondents agreed that there is poor service delivery at the PHC facility. Poor quality in service delivery is a hindrance to PHCS access as indicated by Kuwana (2014). The use and access of health services is determined by providing and improving excellence in quality services and obtaining good results at PHC facilities. Some of the elements that guide the provision of quality of care are compassion, dignity, confidentiality and informed choice. According to a study by Coomer (2012) in Kuwana (2014) the undesirable experiences at the healthcare centres stretched from the absence of a reliable doctor and being treated by a student nurse instead and repeatedly explaining the child's health history many times to the health staff. The above two assertions are very good indicators of poor service delivery at healthcare facilities. Therefore, poor service delivery has a negative impact and can cause people not to access and utilize PHCS.

The results obtained from a small scale investigation piloted in 2011 evaluating the utilization of healthcare services by the Roma people in rural districts of Greece, conveyed that the most recurrent barriers regarding access to healthcare services were high waiting time in medical facilities (Charalapos, Kaitelidou, Katsikas, Siskou, National and Kapodostrian University of Athens, Zafiropoulou and European Commission, 2014). These findings are similar to the results of this study which reflect that that long waiting period at the PHC facilities hinders PHCS access. When patients wait for a very long time at healthcare facilities they become dissatisfied by the available services as indicated by Tsawe and Susuman (2014). The findings of this study are also consistent with those of Sollenberger (2014) which indicate that at healthcare facilities patients may have to wait a long time before they are attended to by medical professionals and this is a barrier to PHCS access. In another study conducted by Bamidele, Hoque and Van der Heever (2010) the people were dissatisfied with the time they spend in the healthcare facilities. It can be noted that long waiting periods at PHC facility can be fatal and the removal of this barrier causes people to have access to much needed PHCS

The study results showed that (92%) of the respondents agreed that the PHC has inadequate carrying capacity and that it is a hindrance for them from accessing PHCS. Studies done by various authors indicated that the inadequate carrying capacity of a health centre can be a major challenge when accessing healthcare services. Sheiman, Shishkin and Markelova (2013) point out that if the capacity of the providers is low, this results in becoming an additional major barrier for patients' options and access to the preferred providers. When the carrying capacity is

inadequate, it gives rise to long queues and patients will end up waiting for long periods of time as indicated by The KwaZulu-Natal Provincial Health Consultative: A community Durban Consultation workshop report (24-25 May 2010). The above mentioned problems make accessing healthcare services difficult particularly for people with disabilities, epilepsy and the aged. In another study in Northern Honduras by Pearson, Stevens, Sanogo and Bearman (2012) healthcare facility crowding and low carrying capacity is a very big challenge for healthcare access. Therefore, it is of great significance to note that the carrying capacity of a PHC facility can have a negative impact and hinder patients from accessing PHCS. The removal of this socio-economic barrier will greatly increase PHC access in Berejena village.

5.4 The use of the PHC facility

The sample of this study was $n=220$ and out of that sample (15%) respondents regardless of their ethnic backgrounds indicated that they never visit or consult at the PHC facility. The reasons for their not consulting at the PHC facility might be that they have other avenues they explore like the traditional setting and the church whenever they are in need of PHCS. Mbwana et al. (2013) showed that in many developing republics, close to 80% of the population depend on the traditional remedies to assist them meet their healthcare requirements. Furthermore, in this study, some respondents were unsure whether they visit the PHC facility or not. The reason for their uncertainty might be accredited to the fact that they hardly visit the PHC facility.

The study results illustrates that many respondents utilize the PHC facility because they want to get treatment for their ailments. However, there were significant differences between the level of education, marital status, religion and the reasons for accessing PHCS. A fifth of the respondents articulate that they utilize the PHC facility because someone forces them. This is insinuating that on their own they cannot visit a PHC facility and access PHCS, they only go when they are forced by circumstances beyond their control. This means that circumstances can cause people to access PHCs. To support this, in a study by Maguranyanga (2013), one of the respondents indicated that their children were forcefully immunized at the school. Some people only access PHCS and other healthcare services because they are encouraged by other family members as noted by Agnus and Horiuch (2012). Therefore, it can be noted that people can access PHCS due to various reasons.

The majority said that the best place to access the PHCS or treatment is at the PHC facility though there are some significant differences between employment status, religion and ethnicity. In contrast to that some respondents felt the best place they can get treatment is at

the traditional setting. The reasons why some respondents prefer traditional setting is that they believe THs are cheaper compared to PHC facilities and they can pay in installments and in kind and payments are made when patients are getting better (Mbwayo et al., 2013). Another reason why people especially women might opt for traditional settings rather than PHC facility is that THs are believed to be caring, easygoing and loving as noted by Agnus et al., (2012). Some people reflect that health workers have a negative attitude towards patients. This in itself can push people away from accessing the PHCS.

Some respondents prefer traditional settings over healthcare facilities because they believe that if a person has spiritual problems and sicknesses they cannot be solved or cured at the PHC facility as indicated by Mbereko and Mahlatini (2014). In a similar study by Toyin et al., (2014) people believed that witchcraft related-diseases do not require hospital treatment. People believe and perceive that witchcraft related complications cannot be cured at the healthcare facilities hence they prefer traditional settings. Others prefer traditional settings because they are told that diseases like HIV and AIDS are not only manageable but are treatable as well by traditional herbs and medicines (Mbereko and Mahlatini 2014).

A tenth of this study population said that the best place a person can get treatment is not the PHC facility neither is it the traditional setting but showed that the church is the best place to get treatment. The reason why some people prefer the church over the traditional setting and the healthcare facilities is that when visiting them they do not recover from their ailments. In Zimbabwe, some people rely so much on the church and the prophets whenever they fall sick and many claim to be healed instantly.

Few respondents (27%) enunciated that the best time to visit a PHC facility and access PHCS is when seriously sick. Some diseases are better treated at the early stages. Therefore, delaying early diagnosis of a disease may be fatal because sometimes health professionals might fail to curb the illness. Some people do self-diagnosis and only visit the PHC facility when they think it is necessary. Findings from previous studies Pearson, Stevens, Sanogo and Bearman (2012) are in agreement with this study finding, which shows the majority respondents feeling that the best time to visit the PHC facility is when sick or ill. Nevertheless, (16%) of this study population were unsure about the best time to visit the PHC facility.

5.5 Socio-cultural factors.

The theoretical framework of this study indicated that socio-cultural factors play a pivotal role in the access of care and the removal of barriers can increase access to healthcare. As far as

decision making is concerned when accessing the PHCS, the study shows that almost three quarters of the entire population make their own decisions. The results are similar to those of Situ (2013) who conducted a study on women's autonomy and maternal healthcare utilization in Nepal where the findings showed that the majority of women had autonomy in determining health care. Thirty (14%) respondents in this study indicated that their spouses make that decision and others showed that the decision lies with other family members. These results are also parallel to those established by Gbaden (2014) which highlighted that women of Purdah religion sought permission from their spouses and other family members when accessing PHCS. Gender is also indicated in the model barriers to access as a factor that can influence access to healthcare as women are in an unfavourable position in this patriarchal society.

The results also indicated that despite the level of education, the respondents disagreed that their church doctrine prevents them from accessing PHCS, whilst (24%) were undecided. The rest indicated that their church doctrine prevents them from accessing PHCS. This is mainly common among Christian-apostolic sects' members (*mapositori*). They believe that God is the healer of all diseases and ailments. In a study conducted by Amanze (1994) in Kgwatalala, (2009), it was observed that members of African Gospel church or *mapostori* are not allowed to use professional healthcare services rather they prefer laying hands on the sick at home and they practice their peculiar treatments according to their church doctrine. Even though *mapositori* recognize the modern healthcare system, they have a very strong belief that God is the healer and this can be achieved through prayer and they do not believe in immunization for their children. They believe that ancestral spirits, God, witches and sorcerers influence health and illness. They view illnesses as unnatural and are accredited to the anger of God or the discontentment of the ancestral spirits. They also believe that illness is caused by enchantment and demonic powers. Therefore if people have such beliefs and perspectives they do not seek PHCS but rely on prophets and the church for treatment.

Furthermore, in the Shona culture, people believe that witches still exist and they strongly consider that witches and lizards can send a goblin to their enemies. If a person is struck by a goblin (*kurohwa ne zvinhu*) they believe that person must not be taken to a PHC facility rather to a traditional healer or to a church or prophet depending on the beliefs of that person or family. In a study carried out by Maguranyanga (2011) the results indicated that religious philosophy and church doctrine of the several Apostolic Faith groups profoundly shapes the healthcare seeking behaviors of individuals. The author further suggested that the *mapositori* strictly believe in faith healing and stringent obedience to church doctrine and they challenge the modern healthcare-

system. The use of modern treatment is often associated with the defilement of the church doctrine and is an offence and the offenders are normally punished by confession or *kureurura*, asked not to wear church regalia or *kubviswa gemenzi*. Faith healing and healing ceremonies amongst the mapositori is often related to the works of The Holy Spirit or *Mweya*, prayers, consecrated holy water (*mvura yakayereswa*) and consecrated stones (*nhombo*). Ailments are believed to have spiritual and religious connotations as observed by Maguranyanga (2011) and therefore they strongly spiritualize even complicated medical conditions. Therefore, it can be noted that the church doctrine of individuals can be a stumbling block to accessing PHCS. The theoretical framework of this study supports this notion as it stipulates that the beliefs of an individual can cause them to access healthcare services or not.

The results of this study indicate that people in Berejena village are not influenced by ethical reasons to access the PHCS. This is evident in the results gathered whereby (66%) of the respondents completely disagreed that they do not access PHCS because the healthcare workers are not Shona speaking people. However, these findings are contrary to the study results of Jatrana and Crampton (2009) which highlight that with regards to the correlation between ethnicity and the postponement of primary care, the Asian and Maori ethnic groups were significantly adversely associated with the odds of postponing a doctor's visit. The findings of this study regarding ethnicity as a barrier to PHCS access are also in parallel to those reported in the theoretical framework of this study which highlights that ethnicity can result in opinions and principles that limit access to care.

5.6 SUMMARY

This chapter discussed the results of the study. The theoretical framework of this study was used as a reference point in the discussion of the findings. The removal of barriers according to the framework can increase access to care. The discussion was focused on the socio-economic and socio-cultural factors influencing access to PHCS. It can be concluded that socio-economic and socio-cultural factors have a negative impact on PHCS access in Berejena village. The next chapter will present summary, conclusions and proposed recommendation.

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CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the summary of the study, conclusions and suggested recommendations based on the study objectives.

6.2 Executive Summary

The purpose of the study was to investigate factors influencing access to primary healthcare services in Berejena village, Guruve South District, Zimbabwe. A questionnaire was used by the researcher to collect data and the questions were formulated in line with the objectives of this study, hence much knowledge was gathered. Research conclusions have been out-lined and it has been indicated that the socio-economic and some socio-cultural factors have a negative impact on PHCS access in Berejena village. The results emanating from this study could form a database for further comparative studies. Necessary recommendations have been drafted and given with regards to the objectives of the study.

6.2.1 Socio-economic factors

One of the objectives of this study was to assess the impact of socio-economic factors influencing access to primary healthcare services in Berejena village. Access to primary healthcare services is very beneficial as it reduces morbidity and mortality rate and increases life expectancy around the globe. However, attaining access for all is still a huge problem for most countries in sub-Saharan Africa especially in Zimbabwe where the healthcare system is greatly affected by financial hardships. This study was conducted in one of the rural areas of Zimbabwe and for many rural people healthcare is unavailable, not affordable and inaccessible and this results in major challenges to leading a good quality life.

The results showed that the Berejena villagers are greatly influenced by socio-economic factors when accessing PHCS especially those who are not employed. However, the respondents both employed and unemployed highlighted that socio-economic factors like the shortage of healthcare professionals, unreliability of transport and shortage of essential drugs greatly

influence their to access PHCS. Therefore, it can be noted that socio-economic factors have a negative impact on PHCS access and can influence the health seeking behaviours of the people.

6.2.2 Socio-cultural factors

Another objective of this study was to assess the impact of socio-cultural factors influencing access to PHCS access in Berejena village. The reviewed literature indicated that socio-cultural factors can be dangerous and be stumbling blocks when accessing healthcare services. The age of an individual as well as their gender can determine their access to PHCS. In many rural settings, Berejena village included, the PHC centres are very far, therefore, for an elderly person or a child to walk to a PHC centre is a challenge and this makes PHCS inaccessibility. The marital status and educational level of individuals also intensify the probability of rural people not utilizing healthcare services. In this study, the results indicated that some people in Berejena village are not educated, so the level they seek and access PHCS is very different from well-informed people, as education comes with awareness and understanding of the intensity of diseases.

In this study, religious affiliations have been identified as the reasons why some respondents do not access PHCS. The respondents specified that they are better treated at church and the traditional setting rather than at a PHC centre. Failure to seek PHCS in time and relying on other alternatives is very detrimental to health and can continually cause the morbidity rates to escalate. However, it has been noted that Berejena villagers are not affected by decision making, ethnicity and marital status when assessing PHCS. The main reasons for this might be accredited to the fact that the village is mainly dominated by the Shona people and the position women have nowadays, they are now involved in decision making.

6.3 CONCLUSIONS

Described below are the realized conclusions

6.3.1 Socio-economic factors

Factors such as lack of medical aid, distance to the PHC facility and travel time were indicated as the major challenges for accessing PHCS. Medication expense and transport unreliability are some of the main worries of the study respondents which challenge them when accessing PHCS. The researcher also noted that shortage of healthcare professionals and shortage of essential drugs at the PHC facility caused respondents to have difficulties when accessing PHCS. In addition, shortage of equipment, poor service delivery, long waiting periods and the carrying capacity of the PHC facility influence PHCS access in Berejena village.

6.3.2 Socio-cultural factors

Socio-cultural factors such as religious affiliations, age and educational level affect PHCS access and socio-cultural factors like ethnicity, marital status and decision making do not affect PHCS access in Berejena village.

6.4 Recommendations

The following recommendations were made:

6.4.1 Recommendations for the Zimbabwe Department of Health

The study indicated that the PHC facility is far, the travel time as well as the distance is great, therefore, in Berejena village mobile clinics must be erected in order to reduce the travel distance and time.

MoHCC should employ more healthcare personnel since the study revealed that there is a serious shortage of healthcare professionals, this is causing patients to wait for long periods of time before they are served.

The introduction of health village workers is also a very important point to consider. The health village workers can act as a bridge between the villagers and the PHC facility and they can also educate people more about seeking PHCS in time and other health related issues.

Improving implementation and monitoring. The Zimbabwean government has plans on paper which detail that in remote areas and farming communities the PHCS must be given free of charge. The plans are not regularly implemented because of inadequate monetary provisions showing both lack of proper fiscal planning and commitment. The development and monitoring of user fees abolishment in rural and farming communities should include the government ministries, the public as well as the private sector.

6.4.2 Recommendations for Policy makers

The analyzed data indicated that people pay for their healthcare services from their own resources. Therefore, it is recommended that the country needs to consider or adopt other evidence based types of healthcare system such as the Beveridge Model, the Bismarck Model and the National Health Insurance. The application of these models will curb the socio-economic factors that are preventing people from accessing PHCS.

Shortage of essential drugs, shortage of necessary equipment and PHCs' low carrying capacity are some of the highlighted factors influencing access to PHCS, therefore, the policy makers should come up with strategies to reduce these factors.

In order to address the socio-cultural factors influencing access to PHCS highlighted in this project, the BASNEF model is recommended and can be applied through health education and promotion to improve PHCS access in Berejena village.

The analyzed data indicated that the majority of the respondents showed that drugs are unaffordable and expensive. Therefore, there is a need to come up with a drug pricing policy to increase the obtainability and affordability of medications.

6.4.3 Recommendations for practice

Healthcare facilities should also ensure that there is enough medication for the people as the shortage of medication can cause people to seek dangerous alternatives.

The medical personnel should also try to treat their patients with honour and dignity as sometimes the negative attitudes of medical professionals cause people to search for additional means of care such as the traditional healers.

It is also recommended that medical professionals should improvise and economically utilize the available scarce resources.

6.4.4 Recommendations for community

Since some respondents revealed that they prefer the traditional setting and the church over PHC centres, it necessary to involve the traditional, cultural and religious leaders in delivering and promoting PHCS access as these people have great influence in communities.

It is also recommended that the community work hand in hand with the medical professionals from the local clinic as well as the District hospital, so as to eradicate factors recorded in this study which are preventing access to PHCS.

It is recommended that the Berejena community as a whole should come together through community meetings and write down challenges they are facing when accessing PHCS and forward them to the relevant authorities and organizations.

6.4.5 Recommendations and Suggestions for further research

The researcher would like to recommend that the healthcare model that Zimbabwe is using should be evaluated in order to enable easy access to PHCS.

The researcher noted that there is no single research previously conducted on the PHCS access in Berejena village, or Guruve District, therefore, it is necessary to conduct a similar

study on the same subject as it will bring out more factors influencing access to PHCS that are not noted in this study.

Further research is needed to evaluate the relationship between religion and PHCS access.

Research should be conducted to assess the reasons for seeking medical attention late.

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APPENDICES

APPENDIX 1: REQUEST TO CONDUCT RESEARCH

University of Venda
P.O Box X5050
Thohoyandou 0950
24 April 2014

Guruve South District
P.O Box
Guruve

Dear Sir/Madam

RE: REQUESTING PERMISSION TO CONDUCT RESEARCH IN BEREJENA VILLAGE ON FACTORS INFLUENCING ACCESS TO PRIMARY HEALTHCARE SERVICES

I am a Masters student at the University of Venda. In order to complete my degree I am expected to conduct a research project of my choice.

In many rural areas there is reduced access to primary healthcare services as observed by many respected researchers, my study is, therefore, aimed at investigating factors influencing access to primary healthcare services in Berejena village.

A questionnaire will be used for data collection and the information gathered will be treated with utmost confidentiality. The summary of results will be made available to Guruve District Department of Health.

I am therefore asking for your permission to conduct the study.

I hope this study will help to identify factors influencing Berejena villagers accessing primary healthcare services and come up with strategies to overcome them.

Your help in facilitating this research will be highly appreciated.

Yours faithfully

.....
Mubaiwa Loice
Student
loicemubaiwa@gmail.com (+27734039170)

APPENDIX 2: CONSENT LETTER

I Loice Mubaiwa hereby, invite you to participate in this study. Please note that any information you will provide will be handled with utmost confidentiality and will not be revealed to anybody without your consent. Please note that your participation is voluntary. This means you are free to pull out at any time should you feel uncomfortable or threatened during the study.

Signature of researcher..... Date.....

I have read and understood the contents and terms of this invitation to participate in this study. I hereby proclaim that I am voluntarily participating in this research.

Respondent's signature..... Date.....

For more information contact Mubaiwa L (Researcher)-0734032170 or loicemubaiwa@gmail.com

APPENDIX 3: INFORMATION SHEET

My name is **Mubaiwa Loice**. I am a student at the University of Venda registered for the Master of Public Health Management degree (MPH). My research focuses on **factors influencing access to primary healthcare services in Berejena village, Guruve South District, Zimbabwe**. You are kindly requested to take part in this study because your participation can make a great difference.

In this research, the data will be collected by the researcher. Before data collection the researcher will explain the purpose, the ethical principles to be adhered to giving the respondents the informed consent form, the researcher will give questionnaires to those who meet the inclusion criteria. Data will be collected at set appointments and places as to the choices of the respondents. The researcher will allow the respondents to fill in the questionnaire during her presence but will ensure privacy at all cost. This is to help those who cannot read and write clarify were there are uncertainties and reduces the level of non-responses.

The researcher is going to handle the gathered data in utmost confidentiality, meaning that no unauthorized people are going to handle the data in any way. The data will be kept classified at all times and will be discarded after the completion of the study

The researcher will explain the format of the questionnaire to the respondents and also urge them not to write their names or any form of identification to ensure anonymity. Instead, the researcher will use codes rather than participants' names.

In this research, participation is free and voluntary. Participants will be able to withdraw from the project at any time should they feel uncomfortable or threatened in any way.

The researcher will ensure that the benefits supersede the risks. The researcher will ensure that no physical, psychological or emotional harm is inflicted on the respondents. Other possible dangers will be looked at and the researcher will guard against them. In addition, in case the respondent is harmed, the researcher will do follow up and refer the respondent for treatment, such as counseling. The respondent's positive response to participate in the study will enable the researcher to draw conclusions from the findings and give recommendations that could be helpful to the Guruve District.

APPENDIX 4: QUESTIONNAIRE

The information gathered herein will be solely used for academic purposes to partially fulfilment the requirements of the Master of Public Health (MPH) at the University of Venda. The data will be held in utmost confidentiality.

CONTENTS AND INSRUCTIONS

This questionnaire comprises of section A, B, C & D. Kindly fill in the necessary information requested.

1. Do not enter your personal details like names and identity number to ensure anonymity and confidentiality.
2. Do not tear any page.
3. Please answer all the questions
4. Please do not hold any conversation with any one concerning this questionnaire and its content.

SECTION A: DEMOGRAPHIC INFORMATION

Indicate by marking/ticking which is appropriate to you and answer on the provided space

1. Age

18-25yrs	1
26-33yrs	2
34-43yrs	3
44-54yrs	4
55-65yrs	5

2. Which section you come from?

1. Tawasika	1
2. Chimanga	2
3. Gomba	3
4. Makomo	4

3. Highest standard passed

Never attended school	1
Grade 1-Grade 7	2
Form 1-Form 4	3
Form 4 and above	4
Diploma/degree	5

4. Employment status

Unemployed	1
Employed	2

5. Marital Status

Single	1
Divorced	2
Widowed	3
Married	4
Separated	5

6 Are you a member of any faith or religious group, e.g. church or denomination?

Yes	No	Unsure
-----	----	--------

7 If yes, which religion do you belong to?

Christianity	
Islam	
Baha'i faith	
Traditional	
Other	

8 Which ethnic group are you?

Shangani	1
Varemba	2
Korekore	3
Zezuru	4
Karanga	5
Ndebele	6
Alien	7

SECTION B : SOCIO-ECONOMIC FACTORS

KEY

SA	A	U	D	SD
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

	SA	A	U	D	SD
9. Lack of medical aid prevents me from going to the primary healthcare facility when I am sick.					
10. I don't go to the primary healthcare facility because I don't have a monthly income.					
11. I don't go to the primary healthcare facility because I'm not employed.					
12. The primary healthcare facility is very far.					
13. I travel for more than 1 hour to reach the primary healthcare facility.					
14. I travel for more than 10km to get to the primary healthcare facility.					
15. I don't go to the primary healthcare facility because I cannot afford to buy the medicine.					
16. There is no reliable transport to get to the primary healthcare facility.					

17. There are shortages of healthcare professionals at the primary healthcare facility.					
18. There is a serious shortage of essential medication at the primary healthcare facility.					
19. There is shortage of equipment at the primary healthcare facility.					
20. There is poor service delivery at the primary healthcare facility.					
21. At the primary healthcare facility, patients wait for long periods of time before they are attended.					

22. The primary healthcare facility has inadequate carrying capacity.					
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SECTION C: USE OF THE PHC FACILITY

23. Do you go to a primary healthcare facility?

Yes..... No..... Don't know.....

24. If yes, what are your reasons for going?

- (i) To get treatment
- (ii) Someone forces me
- (iii) Used to it

25. Where do you think is the best place to get medical treatment?

- (i) Clinic/ hospital
- (ii) Traditional setting
- (iii) Church

26. When do you think it is necessary for a patient to visit a primary healthcare centre?

- (i) When sick.....
- (ii) When seriously sick.....
- (iii) Unsure

SECTION D: SOCIO-CULTURAL FACTORS

27. Who makes decision regarding getting primary healthcare services?

- (i) My father
- (ii) My mother
- (iii) My grandfather

(iv) My grandmother

(v) Myself

(vi) My husband/wife

(vii) Other, specify.....

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

RESEARCH INVESTIGATOR:
M. L. MASHAYI

	SA	A	U	D	SD
28. My church doctrine does not allow me to go to the primary healthcare facility whenever I'm sick.					
29. I do not go to the primary healthcare facility because whenever I'm sick I get treatment from church.					
30. I do not go to the primary healthcare facility because the healthcare professionals are not Shona speaking people.					

RESEARCHER(S)/ CO-INVESTIGATOR(S)

NAME AND DEPARTMENT	ROLE
Prof. G. C. Ekoto	Supervisor
Prof. G. C. Ekoto	Co-Supervisor
Prof. G. C. Ekoto	Investigator - Student

APPROVED BY:

RESEARCH ETHICS COMMITTEE

Research Committee Granted

Signature of the Committee:

Signature of the Committee: Prof. G. C. Ekoto

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms L Mubaiwa

Student No:
11605678

PROJECT TITLE: Factors influencing access to primary healthcare services in Berejena Village, Guruve South District, Zimbabwe.

PROJECT NO: SHS/15/PH/06/1903

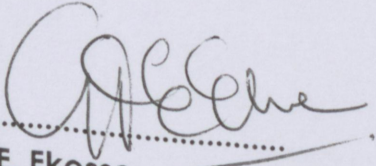
SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof AM Amosu	University of Venda	Supervisor
Dr NS Mashau	University of Venda	Co-Supervisor
Ms L Mubaiwa	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: March 2015

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. G.E. Ekosse