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SOCIOECONOMIC, GEOGRAPHIC, INSTITUIONAL FACTORS AFFECTING ACCESS TO PRIMARY HEALTH CARE IN GIMBOKI, ZIMBABWE.

BY

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Abstract

The World Health Organization state that access to primary healthcare is beyond just providing medical treatment services to people. However, the world health organization also states that access to primary healthcare remain a challenge in developing countries. This is mostly the case in rural areas and informal settlements of developing countries. The aim of this study was to investigate the socio-economic, institutional, and geographic factors that affect access to primary healthcare in Gimboki. For data collection, questionnaires were given to some participants, and the researcher conducted interviews with other participants. According to ZIMSTAT, Gimboki has approximately 700 households and 60 households were selected as a sample for this study. The findings show that the factors that limit access to primary healthcare in Gimboki include irregular supply of necessary medications, high cost of primary healthcare services, long distance to the clinic, and lack of permanent transportation system. Among the recommendations, participants also recommended the purchasing of an ambulance because they consider it as a necessity for smooth referrals. The study concludes that improving healthcare infrastructure, reducing the cost of primary healthcare services, and purchasing an ambulance for smooth referrals are strategies that will help improve access to primary healthcare in Gimboki.

Key words: Access, access to primary healthcare, primary healthcare, Gimboki.

Declaration

I declare that this dissertation is my original work except where sources have been cited and acknowledged. The work has never been submitted, nor will it ever be submitted to another university for the award of a degree.

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Dedication

This work is dedicated to my parents, papa Kabange Numbi, and maman Brigitte Mwamba for their unwavering support, love, and encouragement throughout my academic journey.

List of acronyms

PHC	Primary Healthcare
UHC	Universal Health Coverage
NHS	National Health Strategy
ZIMSTAT	Zimbabwe National Statistics Agency
MoHCC	The Zimbabwean government through the Ministry of Health and Child Care
GHS	Ghana Health Service
WISN	The Workload Indicators of Staffing Needs
NHIS	National Health Insurance Scheme.
CHPS	Compounds in hard-to-reach areas
CHPS	Ghana's Community-Based Health Planning and Services
AAAQ	Availability, Accessibility, Acceptability, and Quality
WHO	World Health Organization
SDG	Sustainable Development Goals
CESCR	Committee on Economic, Social and Cultural Rights
PHS	Public Health Services
GLS	General Living Standards
UNICEF	United Nations Children's Fund

CHW	Community Health Worker

Definition of key terms

Access: Ribot and Peluso define access as the ability to derive benefits from thing. This definition emphasis both the users' demand and the producer's supply (Ribot & Peluso, 2003).

Access to primary healthcare: Access to primary healthcare is a dynamic interaction between the five dimensions of accessibility. These dimensions include approachability, acceptability, availability, accommodation, affordability, and appropriateness (Levesque, 2013). Levesque, Harris, and Russell (2013) also added that access to primary healthcare includes five abilities of populations. These include ability seek, pay, reach, and engage, and perceive (Levesque, 2013).

Primary healthcare: The world health organization defines primary health care as a cost effective, comprehensive, and equitable approach to health. This approach focuses the needs of families, individuals, and communities.

Gimboki: Gimboki is an informal settlement found in the province of Zimbabwe known as Manicaland. It falls under the jurisdiction of the Mutare District.

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CHAPTER 1 INTRODUCTION

1.1 Introduction

In its constitution, the World Health Organization((WHO) states that access to primary health care is a basic human right and a pillar of well-being for society in its totality. Primary healthcare is an important concept in health policy and health services research (WHO, 2023). This means that no one should face challenges to access primary healthcare no matter their age, gender or ethnicity. Primary health care (PHC) is meant to provide affordable, accessible, and community-based services. This is done in order to meet the majority basic health needs of the people. However, access to primary health care remains one of the persistent global issues. This is the case especially in rural areas, and in informal settlements of developing countries like Zimbabwe.

According to the World Health Organization's 13th General Program of Work, there are many persistent limitations to accessing primary healthcare. Those limitations are the reason many people still struggle to access PHC, which continues to slow the advancement of Universal Health Coverage (UHC). The World Health Organization's 13th report further stated that access to primary healthcare in informal settlements can be affected by various factors. The factors mentioned include geographical and financial factors, workforce shortages, infrastructure deficiencies, cultural and social factors, political factors, and lack of health literacy (World Health Organization, 2023).

In Zimbabwe particularly, literature reveals that accessing primary healthcare remains a significant topic of concern in policy discourses and academic research in many informal settlements like Gimboki (ECID, 2021). The Zimbabwean government has implemented several strategies and policies in order to ensure that even those in informal settlement can have access to primary healthcare. One of the strategies

implemented includes the National Health Strategy 2021–2025 (Zimbabwe Ministry of Health and Child Care, 2021)? The National Health Strategy (NHS) was established to strengthen the health system and ensure equitable, quality, and accessible health services for all Zimbabwean citizens (Government of Zimbabwe, 2022). However, access to primary healthcare remains a challenge, particularly in informal settlements like Gimboki (Zimbabwe Ministry of Health and Child Care, 2021).

Gimboki is an informal settlement in Mutare, Zimbabwe that provides an important context that allows to understand the factors that affect access to primary healthcare in informal settlements. Little to no research has been done specifically focusing on how the Gimboki residents perceive access to primary healthcare system, despite the growing population. This forms a knowledge gap that could prevent policymakers and practitioners from intervention-building that speaks to the near social realities faced by the people in informal settlements. Hence, this study aims to determine the factors affect access to primary healthcare in Gimboki. By identifying the factors, the study aims to recommend strategies that will help to improve access to health care in Gimboki.

1.2 Background of the study

Access to primary healthcare is a key that ensures national development, and allows to achieve the health-related Sustainable Development Goals. (World Health Organization,2023). Hence, governments and international partners put strategies in place to strengthen health systems and the Universal Health Coverage. In Zimbabwe, the National Health Strategy 2021–2025 (Ministry of Health and Child Care, 2021). was among the strategies that set the ambitious priorities to build a resilient, equitable, and people-centered health system (Mistry of Health & Child Care, 2023). Even though the national planning exists, the operational realities about how residents in informal settlements experience access to primary healthcare is still a topic of

discussion. There is need for local evidence for policies that are befitting to the place-specific needs. Studies done in Mutare and in other Zimbabwean locations have looked at availability of primary healthcare services, maternal and child health service utilization, and experiences of groups such as people with disabilities. The majority of those studies' results showed that access to primary healthcare is conditioned by the interactions between health systems, local infrastructure, and social context. (Ndhlovu-Ncube, 2022)

During the official handing over of the mobile clinic in Gimboki in 2019, the Manicaland Provincial Affairs Dr Ellen Gwaradzimba stated: "during the last year's cholera outbreak, five of the seven cases recorded by Mutare city, came from the Gimboki area." (The Herald, 2019). This declaration shows how access to primary healthcare in Gimboki is a topic that needs more research. Zimbabwe has come a long way in developing its healthcare policies in alignment with Universal Health Coverage (UHC). However, disparities in effective implementation are noticeable.

Access to primary healthcare refers to the individuals' ability to obtain basic necessary medical care in a timely, affordable, and appropriate manner (World health organization, 2015).

Access to primary healthcare is crucial and beneficial to the people. It promotes health equity and ensures that all people, regardless of their income, age, or gender can receive essential basic medical services. Primary health care helps to prevent and cure various diseases, which helps to reduce mortality, and improving health outcomes. Additionally, access to primary healthcare ensures that even the marginalized and less privileged receive quality medical care (Smith, 2018).

There are several stakeholders that involved when it comes to access to primary healthcare. These stakeholders have distinct responsibilities in ensuring that access to

primary healthcare is not a challenge to anyone. These include governments that fund programs in the health sector, policy officers who formulate and design policies regarding access to primary healthcare in public sectors, health care providers who provide direct medical services, and the public requiring these services (Rosery., 2019). On the other hand, international organizations and NGOs such as the World Health Organization, and United Nations play crucial roles in reinforcing access to primary healthcare. They fund, advocacy, and conduct research to strengthen public health systems. Private sectors are also included among the stakeholders through pharmaceutical companies and medical equipment suppliers. Finally, community leaders and local advocacy groups are also among the stakeholders as they ensure that public health policies respond to the specific needs of their region.

The geographical focus of this study is Gimboki. Gimboki is an informal settlement found in the province of Zimbabwe known as Manicaland. It falls under the jurisdiction of the Mutare District. According to the Zimbabwe National Statistics Agency (ZIMSTAT), Gimboki has around 700 households. Located near Dangamvura, Gimboki is now part of the informal settlements around Mutare the fourth largest city in Zimbabwe. Gimboki has been a site for various development projects aimed at enhancing living standards of the residents (Brenda P.C).

It is crucial to have a clear understanding of factors that impact access to primary healthcare in Gimboki. This understanding will allow policy makers to develop inclusive policy recommendations that consider the specific needs of the residents of Gimboki.

1.3 Statement of the problem

Access to primary healthcare is a fundamental human right. The World Health Organization ensured to emphasis this through the by establishing the Universal Health Coverage. The WHO further states that, limited access to primary healthcare in forms

of immunization and treatment can aggravate diseases, health conditions, and lead to the spread of diseases that could have been prevented by the presence of well-equipped health care facility (World Health Organization, 2020). The absence of primary healthcare is life threatening because diseases that are preventable result in death due to challenges in accessing medical care in a timely manner (World Health Organization, 2020).

The Zimbabwean government through the Ministry of Health and Child Care (MoHCC) has applied strategies to ensure universal health coverage across the country. One strategy that stands out is the National Health Strategy (NHS) 2021–2025. This NHS has specific objectives (Zimbabwe Ministry of Health and Child care, 2021). The objectives are to ensure all citizens of Zimbabwe have access to primary health care, and to strengthen primary healthcare services. It Also aims to increase access to healthcare services for the previously marginalized communities.

Despite these efforts, disparities in accessing primary healthcare are still significant, especially in rural areas, and in informal settlements. Literature indicates that a number of places, especially informal settlements like Gimboki still face challenges to access primary healthcare. This implies that access to primary healthcare services in such areas is still limited. (Mangundu, 2023). It is important to mention that literature has shown that there is a healthcare facility in Gimboki, precisely a clinic. (Zimunya, 2022). According to ZIMSTAT, Gimboki has 700 households that are meant to be accommodated by that one clinic (ZIMSTAT, 2022). The clinic has limited operational hours, it does not operate during the nights, and it is not well equipped in terms of medications and other clinics equipment (Zimunya, 2022). This situation makes it challenging for people who might have health complications during night hours, and those who many need medications that are not available in the stock to receive the medical attention needed. This results in limited access to primary healthcare being

the problem in this study because the single clinic struggles to accommodate all residents due to reasons mentioned above (Zimunya, 2022).

The WHO emphasizes the need for countries to align with the universal health coverage to avoid such health outcomes. This study aims to determine factors that affects access to primary healthcare in Gimboki.

1.4 Research objectives

1. **Objective1:** To examine availability and accessibility of primary healthcare in Gimboki.
2. **Objective2**: To determine the affordability of primary healthcare in Gimboki.
3. **Objective3**: To explore community acceptability regarding the available primary healthcare.
4. **Objective4**: To provide recommendations to improve access to primary healthcare in Gimboki.

1.5 Research questions

1. How available and accessible are primary healthcare in Gimboki?
2. How affordable are primary healthcare services for the residents of Gimboki?
3. How do residents of Gimboki perceive the acceptability of available primary healthcare services in terms of quality, cultural relevance, and responsiveness?
4. What are the recommendations to improve access to primary healthcare in Gimboki.

1.6 Assumptions

1. The researcher assumes that low-income limits access to primary healthcare services
2. The researcher assumes that long distances to health facilities reduce utilization

3. The researcher assumes that higher education levels improve healthcare-seeking behavior

1.7 Hypothesis

- **H0**. Access to primary healthcare is not limited in Gimboki.
- **H2**. Access to primary healthcare is limited in Gimboki.

1.8 Significance of the study

This study is crucial because it provides insight into the factors that limit access to primary healthcare in Gimboki. This study is significant also because it allows to examine the socio-economic, institutional, and institutional factors affecting access to primary healthcare in Gimboki. Given that Gimboki is an informal settlement, the findings allow to determine whether other informal settlements experience the same limitations when it comes to accessing primary healthcare. Research findings are beneficial to policymakers as they allow them to formulate policies based on concrete, evidence-based recommendations. This allows to improve healthcare policies in informal settlements. The study also helps healthcare administrators and NGOs to design interventions meticulously targeting improved access to quality primary healthcare. Moreover, the research further grows the academic literature concerning primary healthcare accessibility informal settlements. This study is important because it informs future research and advocacy efforts. Ultimately, this research aims at bridging access to primary gap in Gimboki and making sure that the vulnerable receive appropriate medical care.

1.9 Delimitation of the study

The research is specifically focused on informal settlements, specifically on Gimboki. Therefore, its findings may not be generalized to other areas of Zimbabwe and outside of the country. Data collection only occurred for a predetermined period of the study

that might represent access to primary health care at one point in time. However, it may not capture the changes in health policies and dynamics of community health afterward.

1.10 Limitations of the study

2 **Generalizability:** This research will be done in Gimboki. Therefore, the results may not be fully generalizable to other places in Zimbabwe that may have different dynamics of access to primary healthcare.

3 **Respondent Bias:** If the residents of Gimboki have personal or institutional interests that could potentially interfere with their response, the data collected from such participants would be considered biased.

4 **Qualitative Data Subjectivity:** The use of qualitative methods such as interviews and focus groups introduces the possibility of bias or subjectivity. This is because responses may depend on individual's perceptions and experiences, which may differ from that of the entire Gimboki community.

1.11 Summary

This chapter introduced the study by presenting the background, the problem statement, objectives, and the significance of the study. Specific objectives and questions regarding the research were outlined as well. The chapter also highlighted the main issues that the study addresses, and stated why it is necessary to investigate the issues of limited access to primary healthcare in Gimboki. Furthermore, the chapter defines the scope and delimitation of the research.

CHAPTER 2 REVIEW OF RELATED LITERARATURE

2.1 Introduction

This chapter will focus on studies that are related to access to primary healthcare locally, nationally and internationally. The chapter will also present the theoretical framework that was chosen for the study.

2.2 Theoretical framework

The Penchansky and Thomas Access to Care framework is the theoretical framework that was used for this study. The Penchansky and Thomas for Access to Care framework is a widely used framework when it comes to access to healthcare in general (Primary, secondary and tertiary healthcare). It facilitates the understanding of the concept of access to healthcare, and goes further to explore different factors that influence access to healthcare. (Penchansky & Thomas, 1981)

2.2.1 Definition of the framework

The Penchansky and Thomas Access to Care Framework is a conception of access to healthcare in a multi-dimensional view. According to the framework, access to healthcare is defined as the degree of "fit" between clients and the healthcare system. The framework states that access to healthcare is a multi-dimensional concept that comprises a number of factors. Those factors condition the opportunities for healthcare providers to procure necessary health care, and the people to receive the said care. The dimensions of this framework are five: Availability, Accessibility, Affordability, Accommodation, and Acceptability (Ricketts, 2009).

The Penchansky and Thomas Access to Care Framework is applied in a wide range of fields. It applies to public health, health policy, and health services research. This framework also serves the practical applications within them. The framework is useful

in assessing the factors that affects access to primary healthcare in Gimboki. It allows the researcher to determine which factors constitute a limitation for the people to access primary healthcare, as well as providing strategies to overcome those limitations. The Penchansky and Thomas Access to Care Framework is mostly applied in research and Analysis. In research and analysis, the framework helps researchers assess accessibility issues and health inequalities within populations and guides studies that measure access barriers (Nguyen, 2022). Furthermore, the framework is applied in Policy Development. Policymakers can use the Penchansky and Thomas access to care framework to identify gaps in healthcare systems and develop access initiatives, especially for communities that are underserved. The Penchansky and Thomas access to care framework is used in Health Care Planning as well. In this field the framework allows health care providers and organizations to evaluate how accessible services are, their availability, and acceptability against specific criteria (Nguyen, 2022).

2.2.2 History of the Theoretical Framework

Penchansky and Thomas's yr Access to Care Framework is a theory that gives a solid foundation to comprehend access to primary healthcare. The framework was first proposed back in 1981. It was during that time that creasing recognition was given to multidimensional, interrelated factors connected to accessibility rather than just immeasurable health facilities (Penchansky & Thomas, 1981). The model was made due to many disparities in accessing primary healthcare, as those disparities relate to economic divisions, geographical, and sociocultural barriers. Penchansky and Thomas came up with a multidimensional description that went beyond earlier models. The earlier models had generally followed an overly simplistic approach toward access healthcare. The work of Penchansky and Thomas promotes a much more extensive analysis of the interrelationships or interaction of different limitations to an individual seeking health care service. The framework therefore bestows upon the potential

notion to consider in access issues as well as create interventions toward reducing the disparity in the provision of health care services. (Penchansky &
Thomas, 1981)

2.2.3 Explanation of the theoretical concepts

According to the Access to Care Framework by Penchansky and Thomas, access to healthcare needs to consider several dimensions that are interconnected instead of viewing it as a single concept. The framework includes five dimensions that are interconnected. These include availability, accessibility, affordability, accommodation and acceptability. The framework establishes a structured approach for analyzing healthcare access, and as such, it has become the foundation for public health research. It considers both theoretical and action-oriented interventions that are necessary to address healthcare disparities in communities (Penchansky & Thomas, 1981).

2.2.3.1 Availability

Availability is the first key dimension of the framework. This dimension refers to healthcare services and resources required to serve the demand required by the population. Availability indicates the extent and variety of healthcare facilities, health services, and whether the number of providers is enough to treat the health demands of a particular community. Facilities are not limited to those that are physically present: the reference is to preventive, acute medical services, chronic disease care, and specialized services.

Availability of targeted programs such as mental health or maternal health care is crucial in burdened regions for specific health conditions. An evaluation tree on availability allows one to identify gaps in provision and ensures that the healthcare system can adequately respond to the needs of populations in disease action.

2.2.3.2 Accessibility

The other dimension is accessibility. This dimension refers to all the logistical issues that people face when they want to access healthcare services. Accessibility is described in several terms: geographical distance, available means of transport, and the barriers to accessing care such as space for wheelchair access or public transport routes. This dimension focuses on how easy or difficult it is for a person to obtain necessary healthcare, depending on an individual's locality or the available means of access. Accessibility problems tend to be more evident in informal settlements and underserved places. This is because in these places, facilities may be distanced or transport may not be easily available. An analysis of accessibility could point out systemic barriers making people not seek healthcare on time, and would inform whether to develop specific interventions to improve access in the physical domain (Reoch & Thomson, 2018).

2.2.3.3 Affordability

The third dimension is affordability. This dimension considers the financial implications of obtaining healthcare services. The financial implications include the costs of care, the coverage offered by health insurance plans, and the economic resources available to an individual. Affordability is an important dimension of access to healthcare because high out-of-pocket costs or lack of insurance can be a barrier that stops people from seeking medical care on time. Furthermore, the affordability dimension signals it is important that we look at how socioeconomic status and health expenditures affect patient choices in engaging with the healthcare system. When we assess affordability, it allows to identify groups that are at risk who may under-utilize healthcare services because of financial constraints. Assessing affordability allows indicate the need for policies that help improve financial access to health services (Reoch & Thomson, 2018).

2.2.3.4. Accommodation

Accommodation is the fourth dimension of the framework. The accommodation dimension assesses how adequate the health system is in order to ensure that it can address community's health needs. This dimension focuses on how healthcare services can be made to align with patient preferences, scheduling practices, or operational features that facilitate and restrict patient access to care. For example, accommodating care may include extended clinic hours, easier appointment scheduling, and culturally competent and responsive services to community needs. Only when the healthcare system is organized by patient preferences and logistical challenges will patients face barriers to receiving timely care. An assessment of such accommodation within the framework will highlight inefficiencies and chances for improvement in the delivery of health services (Reoch & Thomson, 2018).

2.2.3.5. Acceptability

Acceptability is the last of the five dimensions. It is concerned with factors like culture, society level of acceptability, and willingness to use healthcare services. The acceptance dimension focuses on perceptions, attitudes, and beliefs individuals and communities may have about healthcare services and health care providers. Cultural factors, such as stigma attached to certain health conditions, and professional trust play an important role in the health-seeking behavior of the public. An exploration of acceptance shows how social context and cultural dynamics may influence health-seeking behavior. It also includes issues with creating a strategy to build trust and engage communities with health services (Reoch & Thomson, 2018).

2.2.4 Scholars Who Have Used the Framework

Penchansky and Thomas's Access to Care Framework has been used by various scholars around the world. Kullgren and McLaughlin (2012) used Penchansky and Thomas's theoretical approach in 2012 to understand barriers that are not financial to

healthcare for the U.S. adult population. The study showed how medical needs that are not met or delayed care corresponded to the original five dimensions. It also discussed issues like schedule availability, travel difficulties, and provider attitudes, as particular barriers to access, as well as others that would be beyond purely financial lines. The authors showed that access to primary healthcare cannot only be improved by attempting to reduce costs. He showed that one must also address logistical and social obstacles (Kullgren, McLaughlin, & Armstrong, 2012).

The Penchansky and Thomas's Access to Care Framework has been modified a number of times by deferent scholars in recent years. Scholars have refrained the applicability and dimensions of the framework to ensure that it captures better the complexities regarding access to healthcare. For example, Emily Saurman (2015) first announced the sixth dimension of the framework, which is "awareness". She argues that when patients are aware of the existence of healthcare services, this awareness constitutes an important determinant of whether they will seek and use the health services. Saurman further argued that availability, accessibility, and affordability of healthcare services do not guarantee that people healthcare services because these factors can remain unknown to individuals. Focusing on information about service existence, eligibility criteria, and navigation through the health system are pertinent for such an extension of the model. It is very important especially in studies related to rural health, where awareness very often appears to be a major barrier (Saurman, 2016).

The scholar Jenkins (2023) also added the seventh dimension which is accountability. It is widely known as "7 As of Access", making them 7 dimensions of the Penchansky and Thomas's Access to Care Framework. Accountability is considered to be a major factor in Jenkins' model (Jenkins, 2023). It emphasizes the responsibility of healthcare systems and providers to ensure equitable access to quality care. This framework aims

to tackle the underlying issues of inequities by holding the institutions responsible for systemic inequities. This makes it all the more relevant in discussions about racial and economic disparities in healthcare access. These 7 As include awareness, affordability, acceptability, accessibility, availability, accommodation, and accountability. Accountability is considered to be a major factor in Jenkins' model because the responsibility of healthcare systems and providers to ensure equitable access to quality healthcare (Jenkins, 2015)

research in healthcare continues to demonstrates how relevant the Access to Care Framework is because researchers have broadened and applied this framework several times. Scholars are redefining this model with the aim to broaden the its dimensions or to focus on specific populations. This will allow us to have a deep understanding of factors that limit access to primary healthcare, and provide solutions accordingly.

2.2.5 Relevance of the theoretical Framework to the study

The choice of Penchansky and Thomas's Access to Care framework as a theoretical framework for this study is purposeful. Given that the study focuses on access to primary healthcare in Gimboki, the Penchansky and Thomas's Access to Care Framework will offer the possibility to investigate the multilayered factors that limit access to primary healthcare for residents of Gimboki. In this way, using this framework enabled the researcher to pursue a systematic assessment of all the five dimensions: availability, accessibility, affordability, accommodation, and acceptability.

Given that is the area of the study, can be understood as an analysis of the limitations that residents of Gimboki go through when seeking primary healthcare services. In this instance, the researcher examined the availability of factors such as public transport, the state of the roads leading to health facilities, presence of healthcare institutions in

the area, and their distance from different communities within Gimboki. The aim of the detailed analysis was to determine all the factors limiting access to primary healthcare for the residents of Gimboki. The researcher carefully the factors with the aim to contribute meaningfully to the effort of expending access to primary healthcare to all.

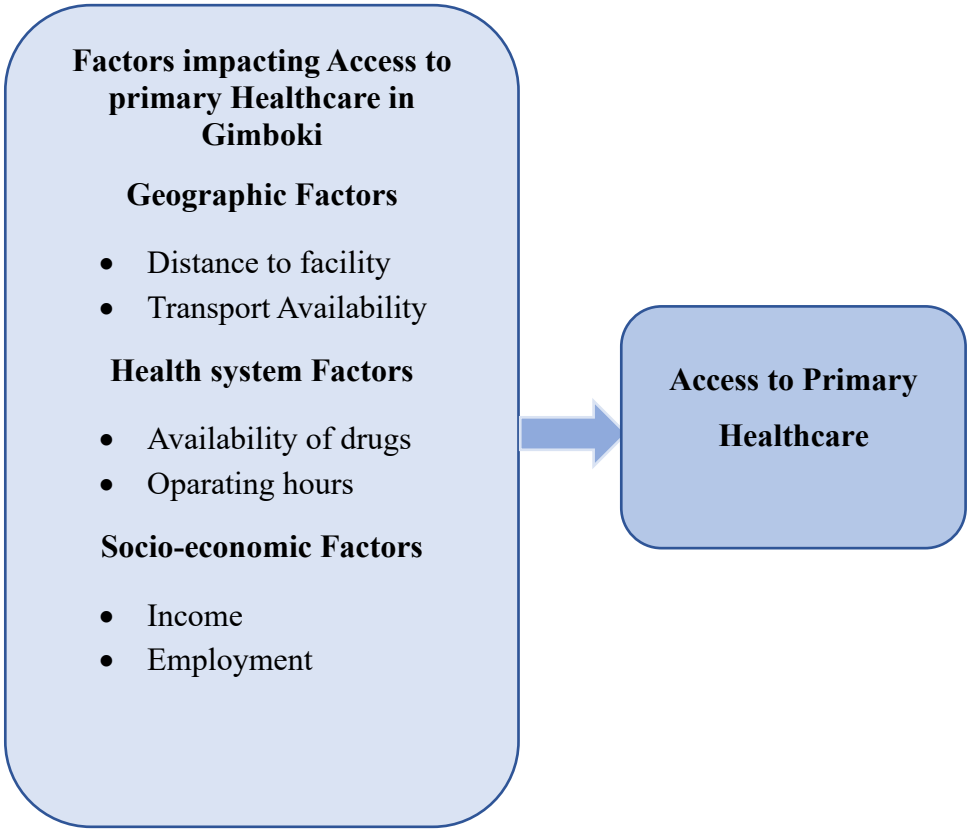
The research also focused on affordability. Affordability is particularly relevant because financial limitations might force people to delay in seeking primary healthcare. Under the financial aspect, the researcher analyzed the financial barriers that residents of Gimboki could be facing. The researcher explored various financial aspects such as high out-of-pocket costs for medical services, and lack of insurance coverage. These also can include prevailing economic conditions such as income levels and employment rates. Understanding the effects of these factors on the utilization of primary healthcare helped to identify certain demographic groups that are disproportionately affected by financial limitations.

The research further focused on the acceptability dimension. Acceptability concerns the community's attitudes and cultural beliefs toward seeking primary healthcare. The researcher ensured to engage with residents of Gimboki through different methods of data collection to obtain accurate information regarding any stigmas associated with seeking primary healthcare. The researcher also considered cultural norms that may discourage people from seeking primary healthcare in Gimboki. On one hand, this dimension allowed the researcher to point out systemic barriers; on the other hand, it allowed the researcher to provide ideas and strategies on how to build community trust in primary healthcare service provided in Gimboki. The ultimate aim is to enhance health-seeking behavior. The focus on availability, accessibility, affordability, and acceptability allowed the study to nuance the challenges related to access to primary healthcare that the resident of Gimboki could be facing. This approach allowed the

researcher to identify specific factors that limit access to primary healthcare in Gimboki, and recommend interventions that will help improve accessibility to primary healthcare in Gimboki.

2.2.6 Conceptual framework

Figure 1 Conceptual Framework



2.2.6.1 explanation of the conceptual framework

Table 1 Explanation of the conceptual framework

Dimension	Description	Example Indicator
Availability	Extent to which health services physically present	Number of doctors/nurses, clini infrastructure, medici stock
Affordability	Cost of health services relative to users income	Consultation fees, medication costs, transport costs
Accessibility	Ease of reaching health services geographically	Distance to facility, trav time, road conditions
Acceptability	How well health services align with socio-cultural expectations	Gender of providers, anguage, cultural sensitivity
Accommodation	Degree to which services are organized accommodate users	Clinic hours, appointm systems, wait time

2.3 Review of literature

2.3.0. Access to Primary Health Care in Ghana

The access to primary health care (PHC) in sub-Saharan Africa is not influenced only by national policies. It is also influenced by local realities such as availability of transport, geography, facility readiness, affordability, and social dynamics (Lokotola, 2024). Based on a growing body of empirical research, there are many factors that impact access to primary healthcare to primary healthcare being studied. These factors are being studied in the Ghanaian metropolitan and municipal contexts. The studies provide nuanced insights into how limitations and facilitators differ between informal settlements and formal settlements (Lokotola, 2024). Local studies are very important.

They highlight the intersection between terrain, infrastructure, and community vulnerabilities, and thus provide lessons directly amenable to sub-national settings like Gimboki in Zimbabwe. This section uses district-level evidence from Ghana to show multi-dimensional factors availability, accessibility, affordability, and acceptability. This section also highlights policy responses to enhance primary healthcare.

2.3.1 Availability, facility readiness, and supply constraints

The researcher Acquah-Hagan (2022) conducted a large-scale study in the Kumasi metropolis (Ashanti Region). The aim of that research was to assess availability and affordability of primary healthcare for vulnerable populations. These included old people, pregnant women, head porters, disabled people, sex workers, and the homeless. The findings of that study revealed that the distance in access was of the order of 5 km. moreover, respondents also mentioned stock outs of medicines, limited hours of operations, and limited-service offerings undermined access in practice (Acquah-Hagan et al., 2022). This urban-district example shows that even in a big city is like Kumasi that is considered well, supply challenges and uneven service readiness can be a barrier to accessing primary healthcare services.

The researcher Korah also conducted accessibility analyses across Ghana's health facilities in 2023 (primary, secondary, tertiary). Many urban and informal settlements districts show that the distance and network challenge were serious challenges to accessing primary healthcare. This was mostly the case in peripheral sub districts. Another example of district-level geospatial considerations is that of Kpandai District (Northern Ghana). The researcher Amoah-Nuamah (2023) conducted a study where he mapped health facility distribution in Kpandai using GIS. The author discovered that 50.5% of the population lives outside of Ghana Health Service threshold distances for Community-based Health Planning and Service (CHPS). This included health

centers implying the distant travels of over 5 km to access primary care. Many communities also reported poor roads conditions regarding their distance from the health facility. (Amoah-Nuamah, 2023).

A qualitative study was conducted in urban areas as well. The aim of the study was to determine how providers cope with facility challenges. The study was conducted across three Ghanaian districts which are Bongo, Kintampo North, Juaboso. According to Bawontuo (2021), health facilities suffer supply shortages, lack of staff, and logistical challenges. To counter threats, providers resort to mechanisms such as borrowing supplies from other facilities, sharing information among levels of care, and multitasking to keep the services going (Bawontuo, 2021). Such coping mechanisms speak of the fragility of the primary healthcare systems in informal settlements districts, and shows why it is necessary to measure not just facility presence but facility readiness as well (staff, supplies, service scope).

2.3.2 Accessibility: Geographic access, distance, and transport

District and municipal studies that were conducted in Ghana always mention distance and transport at the top of all limitations to accessing primary healthcare access, especially in informal settlements. During the study, nurses and other caregivers were interviewed in the Nkwanta South Municipality (Oti Region) on child health services. Care givers and nurses noted that long distances, poor road conditions, and lack of transport options are the most important physical access limitation they face. This limits services either through delay or through complete lack of access (Nyande, 2025). The same authors highlighted that indirect costs limits people from seeking care (such as transport fares and time lost).

In Pru District (Rural Ghana), the researcher Sulemana did his case study in 2014 on the rural community's access to primary healthcare. After conducting and analyzing

the data, he found that those in rural areas are "highly disadvantaged in terms of physical accessibility". This is because of the long distance to the healthcare facilities and low visibility of transport routes, plus seasonal impassable roads. As a results, residents delay seeking medical attention, or prefer to self-medicate. That rural district work shows that one has to consider terrain, road quality, and seasonal variation (Sulemana, 2014)

The researcher Acquah-Hagan states that in Kumasi Metropolis, for many vulnerable respondents, the distance to the primary healthcare facility was beyond 5 km. The researcher Acquah-Hagan states that the majority of the people who participated in his study reported that distance discouraged them to utilize primary healthcare services. They stated that even though services were available in their areas, the distance discouraged them a lot. (Acquah-Hagan, 2022).

The district-level examples go to show that geographic access challenges are different depending on the settings. These settings included urban slums in Kumasi, rural communities in Pru or Kpandai, and mixed rural/forest landscapes in Bongo and Kintampo.

2.3.3 Affordability, insurance, and financial limitations

Acquah-Hagan conducted a study in the Kumasi Metropolis. When the study was broken down by vulnerability group, it showed that approximately 37.9% of the people who participated in the study mentioned that their financial challenges were their main limitation. This was followed by staff attitude and stigma. The participants reported that among vulnerable groups, head porters and persons with disabilities considered primary healthcare services less affordable than older adults. Over 95% of the people surveyed reported that they were being insured by the National Health Insurance Scheme of Ghana (NHIS). But, perceived acceptability of services and hidden costs

such as transport and informal payments restricted their effective access distances (AcquahHagan, 2022). An additional study on access to primary healthcare in the same Kumasi context found that pregnant women, head porters, and other vulnerable groups had lower prevalence of access like to medications, than older adults in crude models' distances (Acquah-Hagan, 2022). According to the researcher, financial limitations continue to exist despite the fact that many people have already enrolled in the National Health Insurance Scheme of Ghana.

More broadly, regarding the subsidized health insurance program at national scale, important lessons arise. The researcher Asuming and his colleagues conducted a field experiment in Ghana with varying subsidy levels to enroll people into NHIS. After the study, their findings revealed that one-time subsidies did increase long-term enrollment. On the other hand, the utilization increased only in some groups (partial subsidy group). This implies that insurance alone does not guarantee access to primary healthcare (Asuming, 2019). That finding shows that in any given district, insurance uptake is not totally helping the situation. That is why they must be supported by measures to lower other financial limitation that people may be experiencing. Those other limitations can include transport, informal payments, supply-side subsidies. (Sokey, 2018).

2.3.4 Acceptability, stigma, staff attitudes, and perceptions

The researcher Dassah interviewed health care providers in informal settlements in Ghana in order to determine the challenges of providing primary healthcare services to persons with physical disabilities. Providers acknowledged that the negative attitudes, lack of communication, poor infrastructure of the facility, and poor trust from the community minimized the utilization of such services by disabled persons, even when services were available (Dassah, 2022). Such district-level qualitative insight

shows that the fields of factors acceptability and provider behavior are not merely abstractions but find their ways into daily interaction and facility design in specific localities. In Kumasi, the Acquah Hagan study that focused on the urban setting found that 25.9% of the people who participated in the study cited attitude of staff as a barrier. They also said that stigma was among the limitation with 18.6% of participants affirming this claim. This goes to show that people face challenges or limitations to access primary healthcare even in those better-placed urban districts (Acquah-Hagan, 2022).

2.3.5 Policy responses

In Ghana, district- and national-level studies reveal many policy responses to improve access to primary healthcare. One of the policy responses deals with health personnel planning. In Ghana, the Ghana Health Service (GHS) has faced large staffing deficits. In 2018, the Ghana Health Service recorded a national vacancy rate of 41%. This means that the staff available is not enough in health facilities to offer healthcare to people (Sokey, 2018).

In response to this issue, the workload Indicators of Staffing Needs (WISN) method was thus put in place to set staffing norms on an evidence basis. This was to allow a fair distribution of health workers to districts that are in need. As it stands, the slow pace of implementation is such that the worst shortages still grip distant areas. While largely policy frameworks exist for human resources for health strengthening, in practice, these responses are undermined by financial constraints. This situation results in many health professionals leaving the field, and weak enforcement mechanisms care (Sokey, 2022).

Another policy response is the National Health Insurance Scheme (NHIS). The goal of the NHIS is to lessen out-of-pocket payments among people, and to enhance

financial access to healthcare. Research suggests that being enrolled in NHIS increase utilization of antenatal care, facility-based deliveries, and skilled birth attendance. This shows potential benefits to maternal and child health (Christmals, 2020). Apart from human resource requirements and health insurance, infrastructure and geographic issues have also been the center of many policy discussions.

Studies from Northern Ghana show that the long distances to healthcare facilities are among the main factors that stop people in informal settlements, and in rural areas from accessing primary healthcare (Amoah Nuamah, 2023). To address this limitation, policy discourse has focused on erecting compounds in hard-to-reach areas (CHPS). Interspersed between these are poor road networks with few transport choices, further compounding the accessibility problem and thus making location an insufficient consideration when discussing actual access. This in turn shows that policy toward infrastructure must reference not just facility siting but roads' connectivity improvements, either through the provision of transport vouchers or through outreach services, thereby cutting down significantly on the patient's indirect costs of seeking care.

2.3.6 Coping Strategies

Health institutions together with communities have put strategies in place to address the issues of access to primary healthcare even though limitations still persistent. changes in medicines management and prescribing practices are the first coping strategies that they applied. This means that when an essential medicine is out of stock in some facilities, providers simply reduce dosages, or ask the patients to go and buy medicines themselves from pharmacies or other hospitals (Kuupiel, 2018). This seems to be a solution for now but continuing with this strategy can compromise equity. This is because poorer patients may see it as a burden on top of an already existing financial

challenge. Therefore, paying for medicines outside of the NHIS coverage is not a solution to the poorer population. In addition, the majority of these facilities rely on outreach clinics and mobile services across the remote communities. However, on an irregular basis, they depend on donor or district-level support (Kuupiel, 2018). This shows that the coping strategies that they have adopted are just temporary solutions that mitigate the real issues, rather than permanently addressing them. These strategies fill immediate gaps while the structural weaknesses in the healthcare system remain.

In many districts such as Bongo, Kintampo North, and Juaboso in Ghana, many health workers reported that most of the time, they opt for practices such as borrowing medicine or other medical tools from other, sharing knowledge, and multi-tasking. They do all this because they try to sustain the delivery of clinical services in shortages (Kuupiel, 2018). The borrowing mostly happens through informal arrangements between one facility and another. They share equipment, medicines, or even staff when there is shortage. They share knowledge mostly situations where an absent specialist is replaced by another healthcare worker. While the above-described methods appear to be innovative, they are not sustainable for the longer term because they increase work pressure and fatigue on staff. They may even end up compromising the quality of healthcare services being delivered (Ohemeng-Tinyase, 2023).

They also involve local-level coping strategies in helping shape access to primary healthcare. In some informal settlements or rural district, local communities mobilize volunteers to support health facilities. They support healthcare facilities through actions like providing transport during emergencies, and undertaking health promotion activities. Social capital, such as community solidarity, acts as an informal cushioning against gaps in the health system (Agyei, 2024).

However, such emergency coping mechanisms rely heavily on local willpower and cannot be compared to sustainable policy interventions that address the root cause. These coping strategies shows local adaptability and strength. But they do not address the fragility of Ghana's health system in providing equitable, consistent, and quality primary healthcare.

2.4. World Health Organization (WHO) and Global Evidence on Access to primary healthcare

Access to primary healthcare is still a global health policy issue (Organization, 2024). There is a big argument that primary healthcare can be considered as the most equitable and cost-effective heart in achieving universal health coverage. According to the World Health Organization, primary healthcare is a community-oriented approach that is there to assure that people receive health services from the promotion of good health throughout their lives (Organization, 2024). However, studies have shown that even if primary healthcare is considered highly important for people and governments, access to it is varies across regions. People always experience limitations in accessing primary healthcare in terms of availability, affordability, acceptability, and quality of healthcare (Khatri, 2024). This section focuses on the World Health Organization's key contributions regarding access to primary healthcare. This section also reviews research-based evidence on factors that impact access to primary healthcare according to WHO, then aligns those factors with studies that have been conducted around the world. This is done to discover the progress made, policy responses, and remaining challenges that still need attention.

2.4.1 World Health Organization's Conceptualization of Access to Primary Healthcare

The world Health Organization state that access to primary healthcare is beyond just providing medical treatment services (World Health Organization, 2021). Access to

primary healthcare is also the ability of one to obtain the healthcare that they need, and to benefit from it without facing financial hardship (World Health Organization, 2021). Access to health care in general is often discussed according to the framework of five dimensions which are availability, accessibility, affordability, acceptability, and quality (Saurman, 2016). According to reports by the world health organization, the inequalities in accessing primary healthcare are more apparent in low- and middle-income countries.

These countries are mostly underfunded, have weaker health systems, and most importantly, human resources hinder healthcare service delivery. For example, the Global Monitoring Report of universal Health Coverage shows that financial protection is highly inadequate, even if essential health services have expanded in coverage, with nearly half of the world's population being rendered full access to healthcare services that they need (World Health Organization, 2023). This conceptualization is the main foundation of contemporary research into systemic and contextual factors that promote or limit equitable access to primary healthcare.

2.4.2 Availability of primary healthcare

Among the most widely discussed obstacles to primary healthcare, the availability of services is mentioned repeatedly. The world health organization noted that there are still remarkable inequalities in healthcare facilities in most African and Asian countries. It is even worse in rural areas and in informal settlements. Most of the time, healthcare facilities are absent to serve the people in these areas. (World Health Organization, 2022). For instance, a multi-country study in sub-Saharan Africa found out that most of the healthcare facilities are found urban areas while informal settlements and rural areas do not have any. (Kruk, 2018). Also, shortages tools to diagnose with, medicines, and skilled health workers significantly affect service

availability. There are many evidence that affirmed the results of the studies conducted in sub-Saharan Africa. Those studies show that gaps in facility readiness and staffing impact directly patients' outcomes, especially among maternal and child health (Hemmeda, 2023). This lack of infrastructure and necessary supplies also limit access to primary healthcare services with an impact on trust in the PHC systems.

2.4.3 Financial Barriers and Affordability

Affordability has always been a major factor that determine whether or not people will have access to primary healthcare. According to world health organization, out-of-pocket expenditures are a major limitation to accessing primary healthcare. This mostly the case I, many low- and middle-income communities. As a result, household delay seeking medical attention or do not seek it at all when they mostly need it (WHO, 2021). The world health organization and world Bank conducted analysis to measure out of pocket expenditures. The analysis found that there are 930 million people worldwide whose health expenditures account for more than 10% of their household incomes. They found out that in sub-Saharan Africa, and in South Asia, out of pocket spending are very high compared to other parts of the world (World Health Organization, 2025).

According to the findings of the world health organization and the world bank's analysis, even very small user fees significantly negatively influenced how people sought primary healthcare services in poor households. The researcher Fadlallah as conducted more recent research in order to examine to the impact of financial burden in accessing primary healthcare. The research showed that high out of pocket limited access to primary health care, especially in poor communities. The study revealed the importance of financial risk protection through schemes such as national health insurance to enhance access to primary healthcare (Fadlallah, 2018).

However, the world health organization warns that insurance coverage does not necessarily equate to equitable access to primary healthcare. The world health organization justifies the above claim with the fact that hidden costs, such as informal payments and transportation can still limit access to PHC. This shows that financial limitations are very complex. That is why addressing financial limitations requires comprehensive policy solutions (World Health Organization, 2021).

2.4.4 Acceptability and Sociocultural Barriers

The world health organization adds that when accessing access to primary healthcare, availability and affordability are crucial factors to consider. This is because these two factors play an urge role in determining whether people will sick healthcare services or not. But they also state that sociocultural factors play an important role when it comes to accessing primary healthcare. This is because sociocultural factors determine whether communities will accept the health care or not. Acceptability accesses the degree to which health services are compatible with patients' culture, values, beliefs, and expectations (World Health Organization, 2022).

According to Khumalo (2021), in many African contexts, gender norms, religious beliefs, and stigma attached to certain diseases strongly interfere with care-seeking behaviors (Khumalo, 2020). For example, research in West Africa has indicated that majority of women do not seek maternal health services. The findings of the research highlight that the reason women do not seek maternal health services is limited decision-making power. in West Africa, the findings have shown that women are considered not capable to make important decisions. Therefore, they do not have the power to decide whether to seek necessary maternal healthcare or not.

In a nutshell, the findings suggest that sociocultural limitations need to be addressed. This is because they usually intersect with systemic inequities. Therefore, these

limitations must be addressed using community-sensitive approaches whenever providing primary healthcare services (Ganle, 2016). Likewise, the WHO goes further to explain that discrimination against marginalized groups, including people with disabilities, migrants, and persons living with HIV, still continues to limit their equitable access to primary healthcare (World Health Organization, 2022).

2.4.5 Quality of Care and Perceived Effectiveness

Increasing access to primary healthcare is the world health organization's central goal. However, the world health organization emphasizes that the quality of care that is provided to the people is an important factor to consider. Poor-quality of healthcare is a greater barrier that prevent governments and health workers from reducing mortality. Therefore, nit using health services is not the only or major barrier. (World Health Organization & World Bank Group, 2018).

The Lancet commission report and the World Health Organization released a report that showed that an estimated 8.6 million deaths occur annually throughout low- and middle-income countries. The report states that these deaths are merely caused by poor access to primary healthcare; they are rather a result of poor quality of care (Lancet commission Report& WHO, 2018). The researcher Kruk also discovered that Patients tend to avoid seeking PHC because they perceive the services offered there to be ineffective. Healthcare facilities are perceived as poorly staffed, or simply lack necessary medicines (Kruk, 2018).

World Health Organization insists that it is important to reinforce the quality assurance systems. Furthermore, it is important to establish continuous training of health workers, better supervision, and protocols of care. Evidence from research conducted in Tanzania and Kenya shows that patient trust and satisfaction determine service utilization. Therefore, it is crucial to treat the issue of quality improvement as a barrier to accessing PHC, rather than treating it as only as a clinical barrier (Bergh, 2022).

2.4.6 Health Workforce Distribution and Retention

According to World Health Organization, human resources availability and equitable distribution are also important factors that impact access to PHC. The world health organization states that 18 million health workers around the world are in short supply. (World Health Organization, 2016). Affording these means disproportion in low- and middle-income countries. In sub-Saharan Africa, informal settlements and rural areas continue to be the most degradable. This is because maximum health professionals are working in bigger cities (World Health Organization, 2016).

Keshvari and Shirdel's research reviews this notion. They cited there are various factors that stops healthcare workers from working in informal settlements and rural areas. Among the factors, they cited malpractices, lack of incentives, and poor infrastructure (Keshvari, 2018). The World Health Organization further recommends interventions like offering financial incentives to retain staff, task-shifting, and investing in rural training programs. (World Health Organization, 2016). Evidence for community-oriented primary healthcare models is shown by the Ethiopian experience. The Health Extension Worker program shows that community-level workers can make an important difference in improving maternal and child health (World Health Organization, 2016).

2.4.7 Policy Responses and Global Initiatives

The WHO has been involved in launching global initiatives. These initiatives aim to strengthen primary healthcare, and to address inequities in accessing it. The 2018 Astana Declaration reconfirmed that if countries commit to making primary healthcare accessible to all, it will make it easy to achieving universal health coverage and sustainable development (World Health Organization, 2019). World health organization encourages integrated service delivery models. In these models, primary

healthcare is linked to wider reforms of the health system. They place high importance on equity, financial protection, and community participation (Walraven, 2019).

National responses have varied but there is noticeable improvement for countries that have adopted certain strategies. For example, countries such as Rwanda and Ethiopia that have implemented strong PHC strategies, such as community-based health insurance have shown greater progress when it comes to increasing access to PHC (Assefa, 2019).

2.4.8 Remaining Challenges and Research Gaps

According to the world health organization, there are broader factors that worsen the disparities that already exist when it comes to access to PHC. The WHO mentions four main factors which are: poverty, geographic location, and education. The WHO asserts that these factors are never adequately taken into account in many health policies. On WHO notes a lack of reliable data concerning the quality and usage of services, especially in communities affected by conflicts. This is the case even though global monitoring frameworks are in place (World Health Organization, 2020). Further gaps occur in regard to studying digital health interventions and community-based financing mechanisms to improve access to PHC. WHO advocates for research that are more specific to particular countries and research that are context-sensitive. The aim of such research is to inform policy decisions based on evidence (World Health Organization, 2020). It is important to use interdisciplinary approaches in order to bridging these gaps. This means combining public policy, social science perspectives, and health systems research.

The world health organization is more focused on research and policy advocacy activities. According to the review on world health organization, access to primary health care is influenced by many other factors. These include quality, accessibility,

availability, affordability, acceptability, as well as health workforce distribution. Research conducted in specific countries have shown that inequalities when it comes to accessing PHC remain. These studies specify that this is the case in low- and middle-income nations because these inequalities are related to the entire system.

The world health organization has been committed to addressing this issue. As part of its effort, the world health organization has initiated policy reforms. These policy reforms include the universal health coverage and the community-based approaches. These reforms have contributed a lot in making primary healthcare accessible. But still, the world health organization main goal is universal equity. Literature backs the world health organization's proposal to adopt inclusive strategies that will cover training programs to empower people, financial protection, and community engagement. In order to reach the for “health for all”, it is critical to focus on the above-mentioned areas.

As the world health organization literature as shown, inequalities in accessing primary healthcare are still a pertinent issue. This is the case most in low- and middle-income countries where systemic weaknesses are glaring. Literature review according to WHO shows that WHO identifies five main factors that influence access to primary healthcare. These are: availability, accessibility, affordability, quality, and sometimes places where healthcare workers live. I some communities, the implantation of certain policies has helped a lot. These include policy interventions like approaches that are based on communities’ needs, and as universal health coverage reforms. Literature shows that of the world health organization endorses call for comprehensive strategies that include financial protection strategies, training for healthcare workers, quality community engagement, and assurance, and community engagement. Focusing in these aspects will make it easy to achieve the vision for health for all.

2.5 The Sustainable Development Goals (SDGs) and the promotion of Access to Primary Healthcare (PHC)

The Sustainable Development Goals (SDGs) establish a framework that was globally accepted in 2015. The Sustainable Development Goals framework was established with clear goals. Among the goals of this framework we can mention, eradicating poverty, establishing prosperity and peace by 2030, and protecting nature. The goal that mostly resonate with this study is goal number three. The vision of SDG number 3 is to "Ensure healthy lives and promote well-being for all at all ages". This goal aligns with the universal health coverage mission because it is about promoting access to quality healthcare services while also protecting citizens against financial risk (United Nations DPI, 2017).

According to World Health Organization, primary health care is a backbone that allows to achieve goal number 3 of the SDGs (World Health Organization, 2024). Literature from around the world in different specific regions has shown that when access to primary healthcare is improved, it contributes to reducing poverty. Literature also shows that enhancing primary healthcare play a remarkable role in improving health outcomes. This goes to show that access to primary healthcare is the backbone that helps to resolve various issues, and thereby promoting sustainable development (Hone, 2018). This section of literature review discusses studies that link primary healthcare to the SDGs.

2.5.1 Primary Healthcare and SDG 3: Universal Health Coverage

In 2019, the world health organization published a report that highlighted how important is it to adopt systems that focus on access to primary healthcare. WHO sated that systems that focus on making primary healthcare accessible to the people can help address most health needs of communities, and they are cost-effective. The WHO's monitoring report further states that half of the population around face challenges to

access PHC, and some do not have access to it at all. It also specifies that About 930 million people obtain healthcare services through out-of-pocket spending, which make it difficult to achieve goal 3 of the SDGs. (World Health Organization, 2019).

The researcher Croke (2024), highlights that access to primary healthcare can help improve people's lives, especially health outcomes. The researcher Croke argues that when communities have strong primary healthcare systems, it increases equity in health, reduces mortality, and provide more financial protection to people. The researcher's findings imply that it is not possible to achieve the SDG 3 without investing in access to primary care. serious investment in PHC are mostly important middle-income countries because health systems in this country are often weak. (Croke, 2019).

2.5.2 Primary healthcare and SDG 1: Ending Poverty

SDGs1 is about ending poverty across the world. This goal relates to issues regarding access to primary healthcare because poverty reduction will result in people having easy access to the said care. Considering the fact that millions of households use out-of-pocket health expenditures each year, the poverty reduction SDG can play huge role in improving access to primary healthcare (World health organization, 2023).

The researcher Wang, (2015), found that poorest households are the most affected by high health expenditure (Wang, 2015). These spending keep them in different cycles of poverty. According to research in low- and middle-income countries, introducing PHC interventions that are community-based, health insurance or essential service packages is important. This is because it helps reduce financial barriers and therefore improving health outcomes of communities. (Wang, 2015). For instance, Rwanda implemented a community-based health insurance scheme. According to literature, this investment has increased the use of PHC across the country. Beside increasing access to PHC, is has also reduce high out of pocket spending among people, which

helps to achieve both SDG 1 and SDG 3 (Nyandekwe, 2020). This literature reveals that affordable PHC is both a health intervention, and a mean of dealing with poverty.

2.5.3 Primary healthcare and SDG 10: Reduced Inequalities

Another SDG that is linked to access to PHC is SDGs is SDG 10. SDG10 is about reducing inequality within and among countries. World health organization has always advocated against health inequities in terms of distribution, asserting that those inequalities present the maximum barriers to achieving universal health coverage (World Health Organization, 2025). Dew, Murad, and Smith, (2025) added to this this by arguing that it is only when people can reach, seek, and use PHC that primary healthcare can be considered accessible.

Literature has shown that communities in rural and informal settlements face disproportionate barriers to the access of PHC, compared to those in urban areas. These barriers include shortage of qualified health workers, inadequate infrastructure, financial constraints, and sociocultural inhibitions (Wolrd Health Organization, 2021) Furthermore, extending access to PHC in these areas would reduce poor-health-outcome. This in return reduces differences among the rich and poor, and among informal settlements and urban areas. For this reason, PHC's equity vision is precisely aligned with SDG 10's commitment to addressing structural inequalities that are related to access to PHC.

2.5.4 Primary healthcare and SDG 5: Gender Equality

Another SDG that relates to access to primary healthcare is SDG 5 “Gender Equality”. According to WHO, in order to improve access to PHC, we must first achieve gender equality by empowering all women and girls. The world health organization specifies women's health outcomes have been largely shaped by systemic inequalities in access to services (World Health Organization, 2024). For example, in Ghana, research has shown that financial constraints, and gender norms limit women in many low- and

middle-income households from accessing maternal and reproductive health services (Ganle., 2014).

Studies also show that in order to reduce maternal mortality, governments must build strong primary healthcare systems with a gender perspective. This ensures increased use of skilled birth attendance, family planning, and preventive services, which ensure gender equality (Campbell et al., 2016). Additionally, PHC systems serve as an entry point to address gender-based violence. Primary healthcare systems can also help address sexual and adolescent health issues, which allows to link women to broader social support systems. This shows that access to PHC contributes to achieving SDG 5 while securing health and reducing.

2.5.5 Cross-Cutting Impact of primary healthcare on Other SDGs

Access to primary healthcare reinforces several other SDGs. Access to PHC is directly linked to SDGs 1, 3, 5, and 10 but also indirectly reinforce other SDGs. For instance, primary healthcare enhances child health and school readiness. This enhancement plays a remarkable role when it comes to strengthening SDG 4. SDG 4 is about ensuring that everyone has access to quality education (World Health Organization, 2020). Additionally, improving access to PHC helps achieve SDG 13. This SDG is about climate action and access to quality primary healthcare can help sustain resilience against climate-sensitive diseases and disasters. Moreover, systems with programs for sanitation, nutrition, water, and sanitation help to achieve SDG 2 and SDG 6. SDG 2 is about zero hunger and SDG 6 is about clean water, and sanitation (World Health Organization, 2020). This crossing influence of primary healthcare is proof that equitable access to primary health-care can help improve several other domains, and help achieve sustainable development. According to World Health Organization, (2020), access to primary healthcare has to be as both a health sector responsibility, and as a multispectral strategy to meet all the SDGs.

2.5.6 Policy Responses and Global Commitments

The world health organization's attempt to linking primary health care with the SDGs can be seen in the Declaration of Astana 2018 (Walraven, 2019). In 2018, The declaration of Astana reaffirmed all countries 'commitment towards strengthening primary healthcare. This Global commitment is crucial to strengthen primary healthcare because it is the pathway toward Universal health coverage, and sustainable development. Many countries are now focused on pursuing primary healthcare-centered reforms. Countries now pursue PHC-centered reforms under the support of WHO frameworks that aim at equity, people-centeredness, and financial protection (WHO, 2019).

Ethiopia's Health Extension Program and Ghana's Community-Based Health Planning and Services (CHPS) have been cited as models to strengthen access to PHC. These are effective, especially in settings that have limited resources (Banteyerga, 2011). Recent reports, however, warn that many strategies seem to be effective only on papers. On the ground, there are facing huge challenges related to financing, governance, and accountability. Therefore, some of these strategies are less effective on the ground (WHO, 2019). Thus, while policy-level commitments have strengthened, significant implementation gaps are underscored by the literature. These gaps require investment, enhanced political will, and systems to support the monitoring of progress toward the SDGs.

The literature above is proof that primary health care is a major contributor to the achievement of SDGs, particularly SDG 3 on health and well-being. That is because beside helping to achieve the SDG 3, it also promotes poverty reduction (SDG 1), gender equality (SDG 5), and reduced inequalities (SDG 10). WHO and empirical literature assert that access to primary healthcare promotes health equity, reduces financial barriers, and generates multiple benefits that go beyond the health sector.

Financial limitations, unequal distribution of the workforce, sociocultural barriers, and quality of care continue, however, to remain unresolved challenges that require more attention. Therefore, to realize the SDGs, it is important to improve of PHC reforms, and to close equity gaps. It is also important to ensuring political and financial commitment sustain themselves. Hence, access to PHC leads to sustainable development, and leads to drawing the interest of researchers, policymakers, and development partners.

2.6 The United Nations Committee on Economic, Social and Cultural Rights (CESCR) and Access to PHC

Access to health care in general (primary, secondary, tertiary) has globally been accepted as an objective of public health and as a fundamental human right. The Committee on Economic, Social and Cultural Rights (CESCR), through General Comment No. 14 (2000), describes the right to the highest attainable standard of health within the broader human rights framework. This description is found in the International Covenant on Economic, Social and Cultural Rights, (Coomans, 2011). The CESCR insists that it is mandatory for countries to ensure they provide health care services in a way that meets the standards of availability, accessibility, acceptability, and quality (the AAAQ framework). In the AAAQ framework, primary health care forms a vital component (Lougarre, 2016). This section reviews literature on access to primary healthcare according to human rights perspective. This section also brings to light the CESCR principles and empirical studies in relation to policy implications and implementation gaps when it comes to access to PHC.

2.6.1 CESCR and the Right to Health

CESCR General Comment No. 14 forms the legal and ethical basis concerning access to health care (primary, secondary, and tertiary levels). The CESCR defines access

healthcare as a human right that must be realized progressively and without discrimination. Through this comment, we understand that primary healthcare services are not simple services that are provided at healthcare facilities. Primary healthcare in this sense becomes a rights-based obligation of the state that emphasizes that governments have a legal obligation to ensure equitable access to PHC services (Economic, 2000).

Gostin and Meier (2019) state that a rights-based conception establishes inadequate access to PHC as a weakness in a health system, and as a possible human rights violation (Gostin, 2019). There are several empirical evidence that supports the above claims. For example, studies in sub-Saharan Africa exhibit rural and informal settlements' populations violating this right because healthcare facilities do not have enough resources. Other reasons include lack of trained personnel, and severe financial limitations (Walker, 2025). That is reason the CESCR framework acts as a normative standard by which actual access to PHC can be measured. It guides both research and policy interventions.

2.6.2 The AAAQ Framework: Availability

Availability is the first pillar of the AAAQ framework. The AAAQ framework is a framework that considers availability, accessibility, acceptability, and quality of healthcare. This implies that adequate amounts of working health facilities, goods, and services are all required in order to meet the needs of the population (Economic, 2000). The world health organization and the CESCR published a report that shows important information. The report shows that low- and middle-income countries lack infrastructure for health and essential medicines (WHO, 2018). For instance, in 2018, the researcher Ouma identified that facility density across sub-Saharan Africa was inadequate for preventive and curative services. This situation disproportionately affected women and children (Ouma, 2018). We also have researchers like Munga and

Maestad (2009) who observed that rural health posts in Tanzania often exist with few staffing and intermittent supplies of medicines. Thus, failing the right to health in terms of availability. This literature indicates that maintaining availability of primary healthcare requires systematic investment into infrastructure, medicines, and human resources, in line with CESCR obligations (Munga, 2009).

2.6.3 Accessibility and Non-Discrimination

CESCR affirms that everyone must be able to access primary healthcare without being discriminated. There are a number of factors that should be considered when referring to Accessibility. These include consideration of physical, economic, and informational factors (Economic, 2000). Physical accessibility means that health facilities are reachable under safe conditions for all populations, including those in informal settlements and rural areas.

Economic considerations are about how affordable healthcare services are. According to the AAAQ framework, economic considerations are about affordability. This is to ensure that economic limitations do not stop people from seeking care, specifically primary care. Informational accessibility must demand that individuals be informed about their right to decide on health-related choices. Reports suggest inequalities in primary healthcare access are still persistent (Economic, 2000). For example, the research Fadlallah, 52018) found that the need for out-of-pocket payments limits the poor from receiving vital care. In West Africa, he pointed to cultural norms restricting women's decision-making and mobility (Fadlallah, 2018). These researches are taken into consideration, and that is why the CESCR's insists on that discrimination based on gender or other factors if prohibited. This prohibition suggests the need for special measures to ensure that vulnerable groups such as women, children, persons with disabilities, and ethnic minorities are able to realize their right to health.

2.6.4 Acceptability and Cultural Appropriateness

Acceptability is another important dimension of the AAAQ framework. This dimension is about how people perceive the available healthcare services. It is concerned with ensuring that primary healthcare services match the community's values, and beliefs in order to be accepted. The acceptability dimension emphasizes on the idea that health services should be respectful of medical ethics, but should also be culturally appropriate (Economic, 2000). The CESCR literature shows that there are a number of factors that can stop people from utilizing PHC services. These include cultural insensitivity, gender-based discrimination, and stigma. For instance, studies done in Ghana and Ethiopia suggest that women avoid the maternal health services due to various factors. These include perceived disrespect, lack of privacy, or other cultural incompatibilities with how those services are usually given to them (Ssenyonjo, 2016).

Additionally, an increasingly marginalized community becomes more subjected to discriminatory attitudes from health personnel. For this reason, they refuse to engage with primary healthcare services. Based on studies, in order effort to ensure acceptability among people, one should consider people's perspective of the available healthcare services. It is also important to consider the training of health workers on culturally sensitive care, and the engagement of local leaders in PHC planning, as guided by CESCR recommendations (WHO, 2020).

2.6.5 Quality of Care

The quality dimension requires health facilities to provide scientifically and medically appropriate service. This can be understood as providing good quality healthcare services. Achieving this aspect of the AAAQ frame work, requires services requires training of personnel, safe equipment, and essential medicines. The sicknesses of poor-

quality health cause bad health. A health service that is technically available and accessible with poor care is also an infringement of human rights under the right to health (Economic,2000). The researcher Kruk (2018) showed that in many low-income and middle-income communities, avoidable deaths occur because of weak quality assurance mechanisms, inadequate training of personnel, and inconsistent supervision processes (Kruk, 2018).

World health organization conducted a Service Availability and Readiness Assessment. This assessment reveals that many healthcare facilities fail to meet at least basic quality standards. This has a strong impact on maternal and child health outcomes (WHO, 2022). The CESCR literature declares that governments must ensure that they monitor and improve healthcare services quality. Once they ensure quality, it will be considered as a mechanism for accountability and the beginning of the process of progressive realization of health rights.

2.6.6 Policy Implications and Global Commitments

The human rights framework of the CESCR has had impact on policies and continues to impact policies at both the international and national levels. Countries that have incorporated the right to health within their legislation and policies towards access to primary healthcare tend to attain better health outcomes (Gostin, 2018). In South Africa, the constitution states that access to healthcare services is a fundamental right, and programs aimed at expanding PHC have improved service coverage. (El Kout, 2020). Also, CESCR monitoring suggests that governments prepare national health plans with the goal to achieve equity, financing, workforce distribution, and quality assurance.

Literature from CESCR and associated studies considers access to primary health care as its own human right.it has always been considered legally and ethically binding. The AAAQ framework is the best way to really evaluate access to PHC services and

to formulates policymaking reforms. Evidence from various research show that there are still inequities when it comes to accessing in PHC services. It is for that reason the CESCR policy responses emphasize to make health plans that are rights-based, equitable financing, quality assurance, and cultural sensitivity. Including CESCR principles in the PHC analysis deepens the human rights perspective within health policy. This helps emphasizing access as both a moral and legal imperative.

2.7. The agenda 2063

The agenda 2063 is an integral part of the strategic framework that was initiated by the African Union (AU). The major aspirations and goals of this framework are sustainable development. Universal access to healthcare is among top priorities. The AU's development framework is a pillar of socioeconomic transformation and healthcare under Aspiration 1. Aspiration 1 of the framework is about a prosperous Africa based on inclusive growth and sustainable development. The aim of that framework is to provide universal health coverage. It also focuses on investing more in the health sector, and the elimination of communicable diseases through funding. The agenda envision a future where all Africans will be able to receive quality primary, secondary, and tertiary healthcare. This will recognize access healthcare as a human right providing for economic and social development (African Union, 2016).

Nevertheless, literature show that the situation in many countries is still alarming when it comes to access to primary healthcare. In Cambia for example, challenges regarding access primary healthcare in informal settlements and rural areas are still persistent. This persistence is due challenges like to infrastructural, social, and cultural factors (Rees, 2016). These are the barriers that agenda 2063 seeks to address. The agenda 2063 considers health infrastructure and human resource development very essential elements that allow to build sustainable healthcare systems. Furthermore, the agenda 2063 focuses on training, retaining, and to distribute equitably of health workers. But

the researcher Tsegaw pointed out that The Gambia has serious infrastructural problems such as ill-equipped health centers, low availability of essential medicines, and a limited number of skilled health professionals (Tsegaw,2023). He further state that working towards addressing the mentioned gaps in The Gambia's healthcare workforce and infrastructure is crucial. This will help achieve the health outcomes outlined in agenda 2063.

Furthermore, the situation surrounding the traditional medicine of The Gambia is related to Agenda 2063. Most people in Gambia prefer to use traditional medicine than professional medical care. This aspect plays a significant role in determining whether or not people will seek primary healthcare. The agenda 2063 encourages integrating traditional knowledge systems into modern health systems. However, the heavy reliance on traditional medicine in Gambia upon traditional medicine stops people from seeking primary healthcare. This results in situations whereby, instead of seeking primary healthcare at the first sign of sickness, people prefer to consult traditional healers (Sidibeh, 2015). It is true that Agenda 2063 recognizes traditional medicine as part of a holistic approach to sensitive cultures in healthcare. However, always depending on traditional medicine is a barrier to accessing modern health facilities, which results in late diagnosis and treatment.

In rural areas, many people prefer to seek traditional healers for malaria symptoms, and childbirth complications (Sidibeh, 2015). This behavior is also observable in urban areas but it is more frequent in informal and rural areas. It is true that some traditional practices are culturally important and give minor relief. However, they are dangerous are applied to grave situations like infections, cancers, or HIV/AIDS. For instance, an individual suffering from malaria might choose herbal remedies, which delays treatment with antimalarial drugs. Such reliance on traditional medicine might

also serve to propagate misconceptions and reduce people's trust in the modern health care system.

Several initiatives and policies have been put in place in The Gambia to deal with issue of traditional medicine interfering with modern treatments. These initiatives also focus on improving access to primary healthcare in order to align with Africa's Agenda 2063. The main initiatives are free primary healthcare Initiative and the Health Financing Strategy. Launched in 2012, the Free Healthcare Initiative provides free maternal and child health services.

This initiative has It has now reduced maternal and child mortality rates. The strategy was put in place to ensure sustainable funding for the health sector but it also led to improved infrastructure and access to essential medicines, which enhances access to primary healthcare. These initiatives align with Africa's Agenda 2063 because they aim to promote universal health coverage. (Ministry of Health Gambia, 2023). These steps have been taken to close the gap, build better infrastructure, and improve accessibility of health to the general population.

2.7.1 Agenda 2063's policy response

The agenda 2063 is very broad. That is why African Union needed sector strategies according to specific sectors. Therefore, the African Union developed the Africa Health Strategy (2016–2030). This strategy was developed the goal of giving practicality to the health components of Agenda 2063.

The Africa Health Strategy (2016–2030) puts primary health care at the center of the response (African Union, 2016) This allows to strengthen health systems, build social protection to minimize inequities, invest in health workforce capacity at the community and primary level. It also allows to scale-up digital health (eHealth) to connect informal settlements and peri-urban populations to services. (African Union,

2015). The Strategy explicitly connects strengthening primary healthcare with attaining universal health coverage.

Implementation mechanisms that are suggested under Agenda 2063 allow to bridge the rural/urban access gaps. There are a number of recommendation measures that aim to the rural/urban gaps. These include: budgeting public funds toward the provision of primary and preventive care, and setting-up and strengthening national health insurance to curtail cost barriers.

Mobilizing concessional finance and public-private partnerships for facility expansion, and fast-tracking community health/CHW programs in are also among the recommendations (African Union, 2015). These remedies appear in the First Ten-Year Plan and its associated policy briefs. More recent African Union roadmaps and declarations reaffirm primary healthcare as being at the heart of health security and resilience. (consider, for example, the AU Roadmap to 2030 & beyond that mentions strengthening primary healthcare and hitting the targets for UHC). These documents present a consistent African Union policy position which include the vision that Agenda 2063 sets, the Africa Health Strategy and AU implementation plans provide the specific PHC-oriented strategies to end the urban–rural access to PHC gaps. These PHC gasp can be in terms of workforce, financing, service delivery models, eHealth, and social protection.

2.8 National Review

In Zimbabwe, Access to primary healthcare has been a subject of research for several decades. In the last two decades of economic shocks in Zimbabwe, many health workers have migrated, and the fluctuation in donor support have played a big role regarding access to primary healthcare. These have determined who can access to PHC services, and who cannot. They have also determined the quality of healthcare people

receive, and how well the available healthcare services have met their needs (Mudzonga, 2022). When the 2021-2025 National Health Strategy was being craft, the Ministry of Health & Child Care highlighted that they have I big ambition. Their big ambition was to work toward achieving the Universal Health Coverage.

The NHS has four main pillars. These include: strengthening primary health care across Zimbabwe, improving infrastructure, increasing domestic financing, and boosting the workforce in the health sector. (Government of Zimbabwe, 2021). Additionally, the government of Zimbabwe will soon release the National Health Insurance (NHI) scheme for 2026. Under the 2026 NHI, the Zimbabwean government plans for health services to be universally covered for every Zimbabwean citizen. The main goal is to fill a major healthcare access gap by introducing the 2026 NHI. Currently, only 13% of the population is covered by private medical insurance (Social Health Protection NetWork, 2025).

The reason why these strategies are being put in place is because the government recognize inequalities in accessing to primary healthcare between big cities and informal settlements. Thus, the government trough the ministry of health and child care is attempting to prioritize investment into district and local authority clinics in order to achieve equitable health services. Despite all these efforts, the implementation of equity policies in health is challenged by several trends and features of the health care system. These challenges became worse in the economic stagnation period after 1983 (Loewenson, 1991). The challenges included the reduction in allocations to local authorities, increasing the pressure for fees, and the static nominal level of the free health care limit despite inflation. Aside these challenges, all financial resources, the higher cost manpower and other resources where all in urban areas. Central and private

sector health care where also among major challenges. Another challenge included the lack of effective systems that aims to refer patients to other hospital.

According to the Ministry of Health and Child Care's report (2021), Limited funds, bad infrastructure system, and inequalities between urban and informal settlements are among the major factors that limit access to PHC in Zimbabwe. The report was also clear on the fact that informal settlements around Zimbabwe struggle a lot access primary healthcare (Ministry of Health and Child Care, 2021)

2.8.1 Physical accessibility and infrastructure

In 2020, the researcher Roets and his colleagues mentioned many determinants that affect access primary healthcare in informal settlements. The findings of that research reveal the following factors: physical distance, transport costs, and infrastructure quality. People located in rural and informal settlements have to walk or spend extra many in order to afford transportation to reach clinics. (Roets, 2020). The study also revealed that water and power were also intermittent at facilities, which reduces hours of services and limits the types of services that healthcare facilities can provide. According to local accounts, basic services such as piped water have been sporadic in parts of Gimboki too. However, improvements have been undertaken recently to address this issue (Mutetwa 2020). These geographic and infrastructural limitations, go hand in hand with household poverty, which limit people from accessing PHC.

2.8.2 Health workforce, service availability and quality

shortage of healthcare workers is one of the challenges that the country has been facing for the past decades. This shortage contributes heavily to limiting access to primary healthcare because less healthcare workers mean too much workload on the few healthcare workers that are available. A shortage of staff combines with the

unequal distribution workers who are already in the healthcare field between urban and informal settlements limit people from accessing primary healthcare.

In 2022, United Nations Children's Fund (UNICEF) published a report that emphasized the issue of shortage of staff in the health sector. The report showed that there was a critical shortage of healthcare workers around Zimbabwe and that the shortage played a big role in determining how accessible primary healthcare would be to the people (UNICEF, 2022). The report showed that the vacancy rate was 57,543 health professionals based on need.

Research and the media have chronicled various episodes of nurse attrition, recruitment freezes, and a 'mass exodus' of health workers that render municipal and council clinics seriously under-resourced. When a clinic operates with limited staff or with irregular hours, it usually leads to decline in service quality. This decline is due to real long waits, short clinical hours, and scant availability of essential drugs. This situation can discourage people from seeking primary healthcare, and may push them to seek informal or traditional care. The NHS targets workforce strengthening in training, retention incentives, and decentralized staffing. However, implementing these interventions requires long-term funding and huge management capacity.

2.8.3 Financial factors

In 2018, a study by Zeng and his colleagues conducted a study about financial factors. The study was about finding out service utilization and financial protection from risk in Zimbabwean health systems. The findings showed that out-of-pocket expenditure contributes to roughly a quarter of the total health expenditure in the country (Zeng, 2018). Also, there were 7.6% of households who paid high health expenditure. This poses a financial barrier to accessing PHC services. Economic-level shocks such as inflation and devaluation of currency translate rapidly into diminished effective access at the household level, and consequentially, delayed care. (Zeng, 2018).

2.8.4 Socio-Cultural Factors and Health-Seeking Behavior

Socio-Cultural factors are among the major factors that impact access to primary healthcare. Cultural beliefs, values, and trust in providers influences whether or not a person will seek Primary healthcare services. In Zimbabwe, many studies have shown on that people get discouraged to seek primary healthcare services and prefer self-medication or traditional medicine because of gender norms that surround decision making.

Moreover, stigma such as for HIV and mental illness also discourage the patronizing of formal services (Ray, 2017). In informal settlements and in rural areas around Mutare (Dangamvura and interface areas with Gimboki), focus groups and household surveys reveal that social networks and traditional healers act as support systems. They sometimes considered as alternative options, especially when people think public clinics are under-resourced or workers are disrespectful (Tsonga 2020). Interventions that promote acceptability (community health workers, respectful care training, engagement with traditional healers) should therefore be considered.

2.9 Local review

A study was conducted by the researcher Chikwature in 2019 in order to assess the challenges that are associated with health services delivery. This study's findings show many health service delivery challenges in Mutare Urban. These include very high doctor-patient ratios, health facilities that are not well equipped, and limited number of healthcare workers. These challenges contribute to poor health outcomes in communities. They lead to high infant and maternal mortality rates and other disease that are infectious. Corruption, poor health systems, and bribery are also mentioned among systemic issues. They recommendations was that authorities should consider

to adjusting the existing health strategies and policies for improving service delivery in the city. (Chikwature & Chikwature, 2019)

In 2015, the researcher Dabale (2015) conducted a study that focused that on client satisfaction with health services in public clinics of Mutare. The findings revealed that there are a number of factors that contribute to low client satisfaction when it comes to healthcare services. These included long waiting time, inadequate facilities, and perceived poor quality of healthcare services. The study went on to state that many patients reported that they prefer to use private healthcare providers because they provide them with better quality service. Moreover, in those private healthcare facilities, there are no long waiting time. Therefore, private healthcare facilities in Mutare becomes a challenge to the public health system in Mutare because patients prefer private over public hospitals (Dabale, 2015).

In 2022, Scott and his colleagues conducted a study on health service utilization in the Makoni and Mutare rural districts during the COVID-19 pandemic. The findings showed that people living in these districts had less chances to seek and obtain health service on time. However, those in urban areas could easily obtain medical attention because facilities were near them, which eliminated challenges like long distance walk. When people are close to the healthcare facilities, if the services are available to the people, and if there are any community health interventions, these are some factors that will encourage people to seek and use health services in rural districts. The findings show that there is a need for interventions that can target rural and informal settlements in order to enhance access to primary health care (Scott, 2022).

Kamusoko et al. (2021) mapped urban and peri-urban land cover of Mutare. The study brought out issues of rapid informal settlements and rural areas. These issues played a huge role because they negatively health service delivery. The findings also underlines

that in informal settlements, there is a huge need for planning and infrastructure development to enhance access to primary healthcare (Kamusoko, 2021).

There are some strategies or responses put in place to address the issue of limited access to primary healthcare in informal settlements. These include the Telemedicine initiatives. As reported by Gavi (2024), patients from informal settlements, and rural areas remote areas use the BatsiHealth platform to consult from doctors located in big cities like Mutare. The goal of these telehealth initiatives is to enhancing access to primary health services in informal settlements and rural areas (Gavi, 2024)

2.10 Summary

The literature review focused on studies conducted in other countries, and by different organization regarding the issue of limited access to primary healthcare. The review discussed studies from Ghana, South Sudan, and The Gambia. It also focused on world health organization's literature, the agenda 2063's, the SDGs', and the CESCR's literature. Furthermore, this section reviewed national and local reviews. The main limitations primary healthcare services that came out of the various literature include workforce shortages, poor infrastructure, financial constraints, and long walking distances to healthcare facilities. Overall, in order to address these inequalities, literature review stated there is need for policy reforms, increased investments, and proper healthcare models that involve the focus on community-based approach.

CHAPTER 3 METHODOLOGY

3.1 Introduction

This chapter presents the research methodology that the researcher used in conducting the study. It presents the research design, the population and sample size, sampling methods, data collection instruments, data collection procedure, as well as analysis that were implemented.

3.2 Research design

An exploratory-descriptive case study is the research design that was used to identify the factors that affect access to primary health care in Gimboki. The reason for choosing this design is that it facilitates an in-depth understanding of the community members lived experiences. The exploratory aspect of the design allows to reveal the economic, social, and institutional factors that are not always visible but do influence access to primary care. The descriptive part of the design, on the other hand, gives a detailed account of how the people living in a specific area experience access to primary health services.

The researcher used a mixed-method approach that included both qualitative and quantitative methodologies.

The qualitative aspect: The qualitative of the study was used to understand the lived experiences of the Gimboki residents in regard to accessing primary healthcare. Capturing personal narratives and perceptions of the Gimboki residents allowed the researcher to discover and understand the limitations that people experience wen seeking PHC.

The quantitative aspect: the quantitative aspect allowed the analysis of statistical data. This mixed approach provided an insight on healthcare access issues in Gimboki.

3.3 Population and Sampling

This study targeted the residents of Gimboki. The research applied stratified simple random sampling. The stratified random sampling allows the researcher to divide the population into different subgroups (strata) based on common characteristics. Simple random samples are then taken proportionately or equally from each stratum. This representation of all major subgroups enhances accuracy and minimizes sampling bias (Keith, 2023). The stratified simple random sampling is beneficial given that it provides equal chances of participation to residents. Gimboki 700 households and these are divided into 7 different cells. The stratified simple random technique allowed the researcher to select 8 samples from each cell to have a total of 60 samples. This is to ensure that all the cells are represented.

The following formula was applied: Sampling fraction = (60 / 700) × 100 = 8.6%

3.4 Data collection instruments

The research will use surveys to collect data. Surveys are data-gathering instruments used for collecting information from respondents through questionnaires. The researcher will also conduct interviews in order to gather data. These instruments consist of structured or semi-structured questions which can be open-ended or close-ended in nature. These data collection tools allowed the researcher to present systematic analytical data such as trends, opinions, or behaviors (Willimack, 2013).

- **Interviews:** the researcher will apply a semi-structured interview in order to gather qualitative data regarding the experience and perception of Gimboki residents about access to primary healthcare. With a set of predefined questions by the researcher, the semi-interview allows flexibility. A variety of measures were taken in order to ensure the validly and reliability of this instrument. The researcher recorded each session and took detailed notes,

which allowed them gather significant information. After the interviews are recorded, the researcher listened to them and captured important details. This allowed the researcher to analyze and understand data. Additionally, the researcher ensured to compare the data collected to check for similarities and differences in participants' responses.

- **Questionnaire:** questionnaires allowed the researcher to collect quantitative data. The questionnaire contained a set of closed-ended questions such as multiple-choice questions, and open-ended questions on broader perspectives concerning access to primary healthcare. To ensure the validly and reliability of this instrument, the researcher ensured to draft questionnaires in a language that resident understood to ensure clarity and relevance.

Moreover, experts such as the researcher's supervisor will be consulted to validate the content.

3.5 Data Collection Procedure

The data collection procedure included the following steps:

- **Preparation: the researcher gave** participants were provided with consent forms. These forms outlined the objectives of the study and conditions of confidentiality. A pilot test was done to be able to fine-tune the interview and questionnaire formats.
- **Data collection:** the researcher conducted the interviews and distributed questionnaires to participants, while maintain neutrality to avoid bias in the responses that they gave.

3.6 Analysis and Organization of Data

The data analysis for this research was done systematically targeting to obtain insight from both qualitative and quantitative data.

Qualitative data: The researcher analyzed and transcribed qualitative data through thematic analysis to identify themes, patterns, and insight regarding access to primary healthcare in Gimboki. The Nvivo Software was used for qualitative analysis. For quantitative data analysis, software, such as SPSS or Excel, were used to analyze answers to closed-ended questions from the questionnaires.

Quantitative data: Descriptive statistics like frequency distributions, means, and percentages were then calculated to describe the data and discern trends regarding access to primary healthcare. To explore relationships between demographic factors (for example: age, gender, location) and cross-tabulation were applied in order to spot patterns in and correlations among the data.

3.7 Ethical Considerations

In the whole research process, the researcher ensured to align with ethical considerations. Africa University Research Committee (AUREC) approved the study, participants were given their informed consent. They were aware of the study purpose and their right to withdraw from the study at any time. The researcher-maintained confidentiality and ensured that participants were anonymous, and that the data was stored securely. Ethical approval was obtained from relevant institutional review boards.

3.8 Summary

In summary, this chapter focused on methodologies that were applied in the study. It presented survey as the research design, the residents of Gimboki were the population,

and sample size was 60. The sampling technique was stratified random sampling, data collection instruments included interviews and questionnaire. It also highlighted data collection procedure and the analysis that were implemented.

CHAPTER 4 DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The previous chapter focused on outlining the methodology for this study. It outlined the research design, data collection tools, sample size and sampling techniques, analysis of methods used, and research approach. This chapter will focus on presenting, analyzing, and interpretation of the data collected in Gimboki.

4.2 Data Presentation and Analysis

4.2.1 Biographic characteristics of participants

Data were collected using two methods: questionnaires and interviews. A total of 70 participants were involved in the study, consisting of 15 respondents who completed questionnaires and 45 respondents who participated in interviews. The combination of these methods allowed the researcher to obtain both quantitative and qualitative insights regarding access to primary healthcare services in Gimboki.

4.2.1.1 Response Rate

15 questionnaires were distributed to residents of Gimboki and all 10 were returned and completed. Additionally, 45 residents participated in interviews conducted by the researcher.

Table 2 Response rates

Data collection Methods	Number
Questionnaire distributed	15
Questionnaire returned	15
Interviews conducted	45

Total participants	**60**

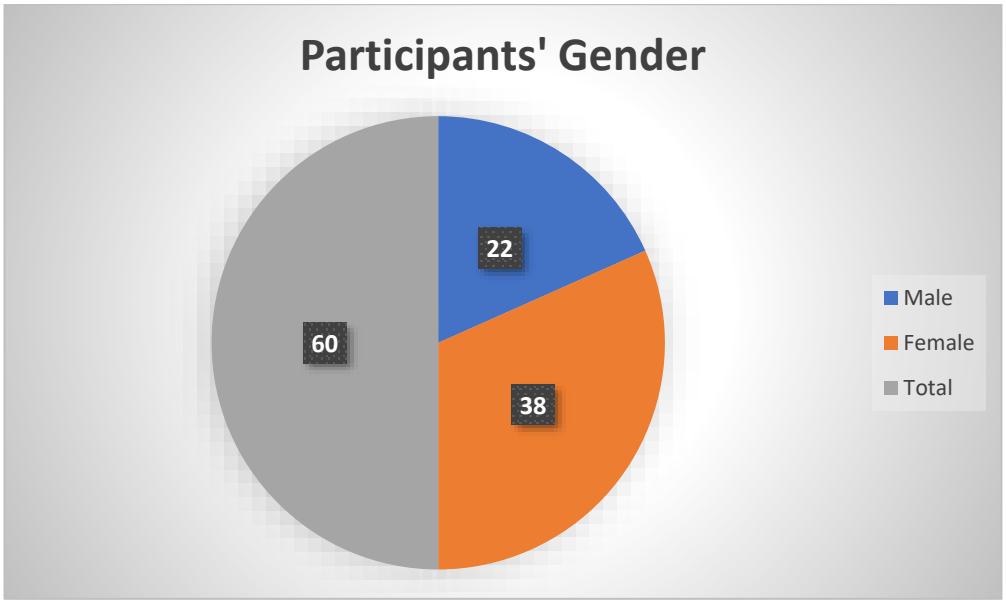
The 100% response rate for the questionnaires, and the 45 completed interviews provided the researcher with enough data for analysis. Combining both of interviews and questionnaire allowed the researcher to gather detailed explanations from participants.

4.2.1.2 Demographic Characteristics of participants

This section presents the demographic information of the participants including gender, age, and education level.

4.2.1.2.1 Participants' gender

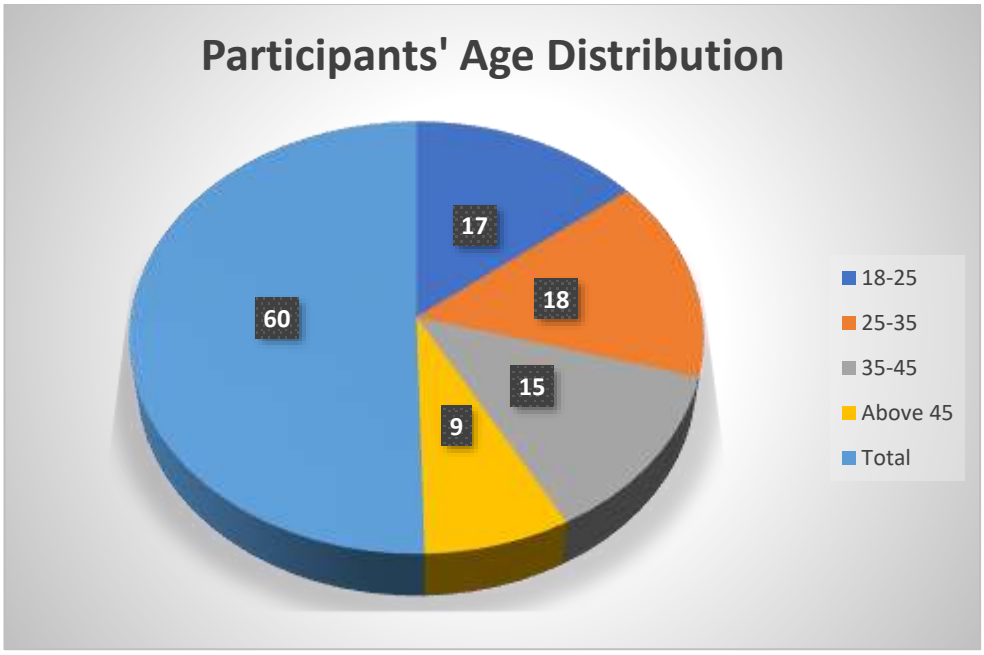
Figure 2 Participants' Gender



According to the findings, 37% of respondents were female, and 67% were male. This shows that women participated more in this study.

4.2.1.2.2 Age Distribution

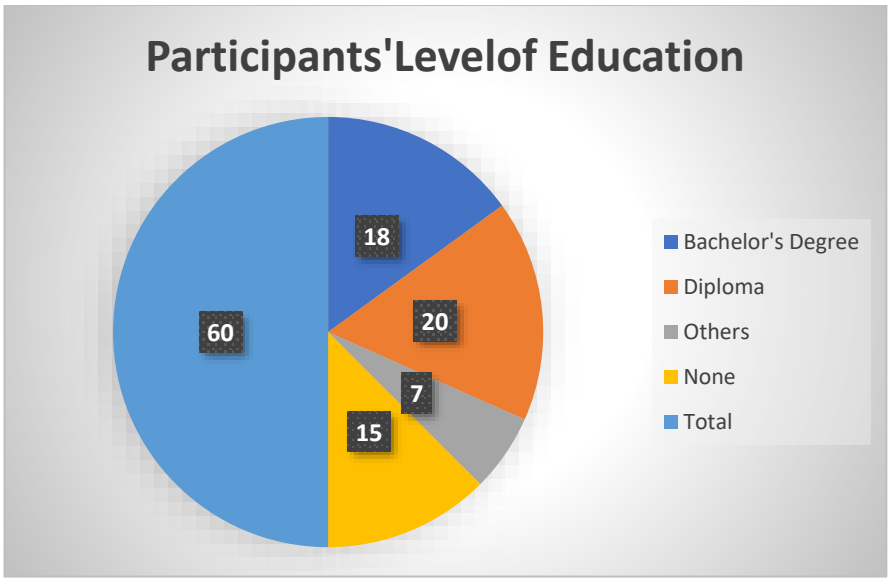
Figure 3 Participants' Age



The majority of participant (18) were between 25 and 35 years. 17 participants were aged between 18 and 25 years, and 15 participants where aged 35-45. finally, 9 was the lowest number for participants aged above 45. This goes to show that most respondents were young adults who are likely to utilize primary healthcare services frequently.

4.2.1.2.2 Level of Education

Figure 4 Participants' Level of Education



The findings indicate that 20 participants had a diploma, 18 participants had a Bachelor's degree, followed by 15 participants with no education. Finally, 7 participants indicated others. This suggests that a significant number of people who participated in this study possess formal education. This is important because their education may influence their awareness and perception of primary healthcare services in Gimboki.

4.2.3 Findings According to Research Objectives

4.2.3.1 Objective1: To examine availability and accessibility of primary healthcare in Gimboki

Participants were asked whether they have a healthcare facility that provide primary healthcare services in Gimboki, and whether they have access to primary healthcare services.

Availability

Table 3 Objective1: Availability

Response	Frequency	Percentage
Yes	**49**	**90%**
No	**6**	**10%**
Total	**60**	**100%**

According to the findings, 90% of participants reported the presence of a healthcare facility in Gimboki, precisely a clinic.10% stated that there is no healthcare facility in the area.

Accessibility

Table 4 Objective1: Accessibility

Responses	Frequency	Percentage
Yes	**27**	**45**
No	**33**	**55**
Total	**60**	**100**

55% of participants reported that they do not have adequate access to primary healthcare service. 45% indicated having access to Primary healthcare services. This suggests that although there is a clinic in the Gimboki, some residents still experience challenges to access primary healthcare services.

4.2.3.1 Challenges in Accessing Primary Healthcare

Participants who reported challenges identified the following:

Table 5 Challenges in Accessing Primary Healthcare

Challenges/Barriers	Frequency	percentage
Long Distance to Clinic	**11**	**18**
Lack of Medication	**10**	**17**
Lack of transportation	**10**	**17**
Poor Roads	**2**	**3**
No Challenges/Barriers	**27**	**45**

18% of participants reported that long distances to the clinic is one of the challenges they face. 17% reported that lack of medication is the challenge that they face, while 17% reported transportation challenges, followed by 3% of participants who reported poor road conditions. Notably, 45% of participants reported that they do not face any challenges accessing primary healthcare services. Overall, these findings reveal that both geographical and systemic factors can influence how accessible primary healthcare are in Gimboki.

4.2.3.2 Objective2: To determine the affordability of primary healthcare in Gimboki

The researcher asked participants whether they had ever avoided seeking healthcare because of the cost.

Table 6 Objective2: Response rate

Responses	Frequency	Percentage
Yes	31	52%
No	27	48%
Total	60	100%

According to the findings, 52% of participants have avoided seeking primary healthcare services because they could not afford them. 48% reported that PHC services are affordable to them. This demonstrates financial constraints could be a factor that impact access to primary healthcare in Gimboki.

4.2.3.2.1 Perception of Primary Healthcare Costs

Table 7 Objective2: Perception of Primary Healthcare Costs

Responses	Frequency	percentage
Healthcare is costly	38	63
Healthcare is affordable	22	37
Total	60	100

A majority of participants (63%) think primary healthcare services are expensive. This suggests that consultation fees and medication costs could be reason residents hesitate to seeking medical attention. 37% of participants reported that PHC services are totally affordable.

4.2.3.2.2 Alternative Treatment Options

Table 8 Objective2: Alternative Treatment

Responses	Frequency	Percentage
Self-medication	**25**	**42**
Traditional medicine	**18**	**30**
Pharmacy drugs	**13**	**22**
No treatment	**4**	**7**
Total	**60**	**100**

The findings show that 42% of respondents opt for self-medication, and 30% use traditional medicine. 22% of participants said that they but medication at a pharmacy, while 7 % reported not seeking medical treatment at all.

4.2.3.3 Objective3: To explore community acceptability regarding the available Healthcare primary

Table 9 Objective3: Level of Acceptability

Satisfaction level	frequency	Percentage
Dissatisfied	**24**	**40%**
Satisfied	**19**	**23%**
Neutral	**3**	**5%**
Somewhat Satisfied	**14**	**32%**
Total	**60**	**100%**

The results show that 40% of participants were dissatisfied with the quality of primary healthcare. 23% of participants reported that they were satisfied with the quality of primary healthcare services provided to them, while 32% of participants reported being somewhat satisfied. Only 5% of the participants was neutral.

4.2.3.4 Objective4: To provide recommendations to improve access to primary healthcare in Gimboki

Participants provided various strategies to improve access to primary healthcare in Gimboki.

Table 10 Recommendations

Recommendations	Frequency	Percentage
Regular Supply of Medications	**21**	**35**
Reduce Primary Healthcare Cost	**16**	**27**
Improve roads and transportation	**13**	**22**
Purchasing an Ambulance	**10**	**16%**
Total	**60**	**100**

Regular supply of medications is the recommendation that many participants provided. 35% of participants insisted that in order to improve accessibility to primary healthcare in Gimboki. This was followed 27% of participant recommending reducing healthcare costs, and 22% recommending improving transportation systems. 16% of participants even added that there is need to purchase an ambulance for the clinic of Gimboki. These suggestions highlight the need for policy interventions aimed at improving medical supply, affordability, and purchasing an ambulance.

4.3 Discussion and Interpretation

The discussion and presentation of the findings follow the study objectives that aimed to assess the following factors: availability, accessibility, affordability and acceptability of primary healthcare services in Gimboki. The results will be discussed and presented according to the experiences of participants.

4.3.1 Availability and Accessibility of Primary Healthcare

After data collection and analysis, the findings show that a healthcare facility of primary healthcare is available in Gimboki. This is because the majority of participants admitted that there is indeed a clinic where they can access basic healthcare services. Of the 60 participants enrolled in the study, there were 49 respondents (90%) who reported the availability of a health care facility in the area. However, 6 participants (10%) reported that there are no healthcare facilities in Gimboki. It implies that the primary healthcare services are designed for a physical presence in the community. This suggest that a healthcare facility for primary healthcare is physically available in Gimboki.

Despite the availability of a clinic in Gimboki, the findings suggest that accessibility continues to be a major barrier for a lot of residents. Just 27 (45%) said that primary healthcare services are easily accessible, while 33 respondents (55%) reported that it was difficult to access primary healthcare services. The findings suggest that although there a clinic in Gimboki, it does not secure access to primary healthcare services for the residents.

Furthermore, after data collection and analysis, findings brought to light other major barriers to accessing primary healthcare services in Gimboki. Long distance (11 reporters, 18%) was the most commonly reported challenge. This challenge was mostly reported by people stayed far from the clinic rather than those who were staying

within walking distance to the clinic. This implies that some people must walk long distances from their homes to reach the nearest medical facility.

Also, additional responses of lack of medication were reported by 10 respondents (17%), reflecting logistical, and supply issues in the healthcare system in Gimboki. Only 2 (3%). participants mentioned poor road conditions. According to the findings, distance, in combination with limited means of transport and insufficient medical supplies are major barriers/challenges that residents face in Gandoki. Although there is a clinic in Gimboki, such infrastructural obstacles remain.

4.3.2 Affordability of Primary Healthcare Services

The other objective of this study was to find out whether Primary healthcare services in Gandoki are within reach for residents' financial abilities. In Gimboki, the affordability of primary healthcare services remains a challenge to many people. After data collection and analysis, the results show that 52% of participants claimed that most of the time, they avoid seeking medical services because they are too expensive for them. On the other hand, 48% claimed the cost of primary healthcare services has never stopped them from seeking medical treatment from the Gimboki clinic. Moreover, 63% of participants said that services are costly; while 37% stated that services are not expensive. These findings suggest that the cost of primary health care services is a barrier that stops the community of Gimboki from accessing Primary Healthcare.

The data illustrates the impact of the financial difficulties and access obstacles to primary healthcare in Gimboki. The data reveals that residents who face the mentioned challenges seek out other means of medical treatment. Self-medication was the most prevalent and cost-affording alternative treatment option, with 42% of participants. This means that some people who cannot afford medical treatment at the Gimboki

clinic treat themselves using medications that they obtain at pharmacies. This means that they have not sought the advice of a qualified medical practitioner. Traditional medicine is the next most prevalent option for alternative treatment at 30%. This also shows the extent to which traditional healing practices are still utilized in Gimboki. Furthermore, 22% of the participants treat themselves using drugs they obtained at a pharmacy, and 7% said they never seek treatment even when they are sick.

According to these findings, financial challenges limit primary health care accessibility for residents of Gimboki. This in turn influences the health care seeking behavior of the residents of Gimboki. When the cost of accessing primary health care services is considered to be high, residents of Gimboki tend to avoid seeking professional services. They prefer to rely on other forms of treatment which can be unsafe.

4.3.3 Acceptability of Primary Healthcare Services

In order to obtain the acceptability of primary healthcare services in Gimboki, the researcher evaluated the satisfaction level of participants. The results show diverse opinions regarding the quality and acceptability of primary health services in Gimboki. Notably, 40% of participants reported that they were dissatisfied with the primary healthcare services provided at the clinic. This goes to show that some residents are not completely happy with what services the Gimboki clinic provides. However, some participants reported that they have positive experiences with the primary healthcare services provided at the clinic. Approximately 23% of participants said that they were satisfied with the services. 32% of participants reported being somewhat satisfied. Only 5% of participants expressed a neutral opinion.

The researcher also sought to understand the level of satisfaction with the primary healthcare services provided at the Gimboki clinic in order to assess the acceptability

of primary healthcare services. Mixed perceptions of the level of quality and acceptability of healthcare services in the area exist. Many participants reported that they are concern about the quality of primary healthcare services being provided at the clinic. 40% of participants reported dissatisfaction. The 40% of dissatisfaction indicates that a significant portion of the Gimboki population was found the primary health services questionable. However, some positive perceptions towards the primary healthcare services provided were reported by some participants. 23% of respondents reported satisfaction and the same was closely trailed by 32% of respondents who reported satisfaction at some level. A very small proportion of respondents (5%) reported no opinion. The fact that many participants expressed dissatisfaction can be linked to issues that have been previously identified. These include lack medications at the clinic, costly treatments, and long distanced. These factors may influence how residents perceive the overall quality and effectiveness of healthcare services in Gimboki.

4.3.4 Recommendations for Improving Access to primary Healthcare in Gimboki

Respondents also offered various suggestions for improving healthcare access in Gimboki. The most highly suggested recommendation was access to medications on a regular basis (35% of respondents). This reveals that although there is a clinic in Gimboki, it is regularly in short of essential medicines.

27% also suggested reducing primary healthcare costs as another key recommendation. This means that if the cost for PHC is low, residents will be more likely to seek professional medical services when needed. Also, 22% recommended a need to improve roads and transport systems so that it became easier for people to reach different health institutions. Lastly, 16% of participants recommended an ambulance purchase to improve emergency response and allow quick transport for

those in need of timely care. Looking at these recommendations, they suggest there is need to improve in healthcare infrastructure, affordability, and service delivery. This would help enhance access to primary healthcare services in Gimboki.

4.4 Summary

Access to a better primary health care in Gimboki is influenced by several major factors as the study has revealed. Geographical barriers including distance to the clinic, which plays a significant role in accessing primary healthcare services. Many residents do not seek primary healthcare when needed because of economic barriers. Moreover, some residents reported that they are satisfied with the primary healthcare provided at the clinic. But there are challenges pertaining service delivery and customer experience.

Lastly, although some participant reported that they were able to afford PHC services, others said that there is need to lower PHC services fees. They also stated that it is important to stock medicine on a regular basis, and to strengthen transport infrastructure to enhance access to primary healthcare in Gimboki.

CHAPTER 5 SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter will focus on the discussion, implications, recommendations, and conclusions. In order to provide more knowledge on access to primary healthcare in informal settlements like Gimboki, this chapter will also focus on giving suggestions on areas that need further research.

5.2 Discussion

In developing communities such as Zimbabwe, access to primary healthcare services is still a topic that requires researchers' attention. Hence, this study intended to explore factors that impact access to primary health care services in Gimboki. Governments have not been trying to address to ensure that primary healthcare services are accessible to everyone. However, challenges still remain especially in informal settlements.

The main aim of this study was to evaluate accessibility to PHC services in Gimboki. The study included aspects of availability, accessibility, affordability and acceptability for primary healthcare services in Gimboki. A better understanding of these variables and their dimensions is essential for recognizing factors that stops residents of Gimboki from receiving timely and adequate medical treatment.

Questionnaires were distributed, and interviews were conducted on 60 participants. This allowed the researcher to collect information regarding residents' experience with primary healthcare services in Gimboki.

The results showed that despite the presence of primary healthcare services in Gimboki, some residents still have limited access to those services. Many reported barriers to accessing the healthcare facility. For example, due to long distances and

limited transport options, residents choose not to seek primary healthcare services, which limits their access. When residents are in need of primary healthcare services, they these factors stop them from accessing it to get it.

Another other key finding of this study was lack of medication at the Gimboki clinic. Many of those surveyed said that most of the time, the clinic does not have medicines and other essentials. Therefore, it becomes almost useless to go to the clinic to sick primary healthcare services. Because of this challenge, residents of Gimboki are often forced to buy medications from pharmacies or have other forms of treatment.

Inability to afford primary health care is also a significant barrier that the study found. The cost barrier to accessing primary healthcare facilities ranged from 54 to 65 percent among the participants. According these findings, financial constraints prevent some residents of Gimboki from accessing primary healthcare services.

These challenges are the reason the majority of residents in Gimboki reported that they rely on other methods than going to the clinic when they are sick. The findings have revealed that common alternative solution for some residents is self-medication. Residents also opt for other options like traditional medicine or not seeking any medical hoping for the situation to get better. This goes to show that, when they cannot access primary healthcare, residents of Gimboki opt for other forms of treatments that seem easy to them.

The study also found that satisfaction levels regarding primary health care services in Gimboki are mixed. Some participants were happy with the primary healthcare services at the clinic. They stated that they are satisfied because the clinic is not very far from where they stay, and that the primary healthcare services provided at the clinic are affordable. However, many were not satisfied with it. According to the findings,

the dissatisfaction that some participants expressed is linked with issues like medication shortages, access challenges, and high cost of primary healthcare services.

Finally, the results suggest that residents feel healthcare access can be increased with several steps. Ensuring a steady supply of medicines, reducing the prices of healthcare facilities, updating road and transport systems and providing ambulances for emergencies are among the most frequent recommendations for improvement.

5.3 Conclusions

This study aimed to fulfill four key objectives associated with access to primary healthcare services in Gimboki. The first aim was to examine the availability and accessibility of primary healthcare services. The study also highlighted some challenges that residents face despite the presence of health care facility in the area. For example, there were cases where people had to walk long distances or had transportation issues given that there is not regular mean of transportation. The second goal was to explore the affordability of healthcare services. The study found that health care costs are a major barrier for many residents. Some do not go for medical help because of the costs involved. The third aim was to assess the acceptability of healthcare services among residents. The findings show that residents have mixed views about healthcare services. They clearly indicated areas of satisfaction, and also reported areas of dissatisfaction. Residents who expressed dissatisfaction stated that their dissatisfaction was due to shortages of medication and how difficult it is to access medications.

The fourth goal was to find measures for bettering healthcare access in the community. Residents stated that healthcare services could be improved by ensuring consistent supply of drugs, reducing healthcare costs, improving transportation network and upholding emergency medical services. In summary, the findings indicate that

Gimboki has basic primary healthcare services; however, there are several structural, economic and logistical hurdles which limit residents' ability to access and consume health service.

5.4 Implications

After analyzing the findings, this study revealed many important implications regarding how primary healthcare services are delivered, and regarding how policies are implemented. According to the findings, there is a gap between how available are healthcare facilities, and how accessible primary healthcare services are to the Residents. These findings suggest that having a healthcare facility in the area is not enough because it does not give certainty that residents will have access to it. A healthcare facility can be physically present but residents do not have easy access to it. In this situation, it is important that policy makers broaden their focus. Instead of only focusing on ensuring that informal settlements like Gimboki have a healthcare facility, they can also focus on addressing broader issues. These can include issues like transportation development, and even poor infrastructure

Moreover, the findings suggest that financial constraints are among the major challenges that residents are facing. This challenge has a strong impact on how resident of Gimboki seek primary healthcare services, and how they utilize them. Therefore, this goes to shows that residents will continue to seek formal health treatment when the cost is low. But when the cost of primary healthcare is constantly high for the residents, they choose to find other informal ways to treat themselves, delay to seek, and even avoid seeking primary healthcare care. As a result, health conditions of residents get worse. Also, this situation can have long term negative impact on the healthcare system in the sense that the healthcare systems might have a lot of pressure in the future.

Furthermore, findings the healthcare facility is always in short of medication. According to residents, this is a weakness in the healthcare supply system that discourage residents from seeking medical treatment. This results in residents feeling as if there are no healthcare facilities even if there is one in the area. This is because without a consistent supply of essential medicines, healthcare facilities become unable to meet the needs of residents in an effective way.

Finally, when resident cannot access primary healthcare, they opt for other easy yet dangerous options like treating themselves or seeking traditional medicines. Truly, some of these alternative options provide healing. But that healing could be temporary because there is no professional intervention, which can cause serious health problems in the future.

5.5 Recommendations

Based on the findings of this study, several recommendations can be made to improve access to primary healthcare services in Gimboki.

5.5.1 Recommendations to the Government and Ministry of Health

The government must maintain a steady supply of lyophilized drops in vaccines and medicines in hospitals. The overall reliability of health care would then improve, and the frequency with which drug shortages occur would decrease.” The government is also advised to formulate policies focusing on primary healthcare services' affordability for low-income and poor citizens. Eliminating healthcare unaffordability would incentivize more residents to pursue medical care when necessary. If the government makes primary healthcare affordable, residents will seek medical care without any reservation. In addition, improving transportation infrastructure would be a durable solution for the residents. Many people reported they get discouraged to seek primary healthcare because of transportation challenges. Improving road conditions, having

permanent means in informal settlements like Gimboki would help address the issue of transportation.

5.5.2 Recommendations to Local Health Authorities

Based on this study's findings, there are some recommendations that are directed to local health authorities. It is important that local health authorities consider to strengthen community health education programs. This is important because when residents have health education, they will priorities seeking professional medical treatment rather than relying on other unprofessional options that can be dangerous and even cost their lives. Moreover, in order to be able to respond to the health needs of residents, local health authorities should primary healthcare services in clinics that are in informal settlement. This will encourage residents to seek professional medical treatment because will be convinced of the high quality of health services at local healthcare facilities. Improving patient communication can also encourage residents to seek professional medical healthcare.

5.5.3 Recommendations to Local Authorities

Local authorities in general should work in collaboration with health institutions. Local authorities should also collaborate with government agencies. This collaboration is important because it will help improve emergency healthcare services. Improving emergency healthcare services can include providing informal settlements with ambulance for emergency cases. Some participants reported that not having a permanent ambulance limit their access to primary healthcare. To enhance healthcare accessibility for residents, local authorities should consider prioritizing initiatives that aim to improve transportation systems.

5.6 Suggestions for Further Research

The aim of this study was to assess how accessible primary healthcare is in Gimboki. This study brought to light suggestions for future research. Future researchers could add to this work by assessing the accessibility of primary healthcare in other informal settlements around Mutare city. This can include investigating whether healthcare facilities are present in other informal settlements, how easily residents can access primary healthcare services, and examining different challenges that they could be facing. Expending this study in that way would be very meaningful because it will help to determine whether similar patterns exist in other informal settlements around Mutare. Also, future research can focus on investigate how often healthcare facilities in these areas face medication shortages, and how their impact on healthcare seeking behaviors. Such studies can help us understand more about the challenges that residents in informal settlements face, and effective policy intervention that can bring positive change.

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APENDIX 1 Questionnaire

APPENDIX 1: QUESTIONNAIRE FOR RESIDENTS

PART A: BIOGRAPHIC DATA

SECTION A: A BACKGROUND INFORMATION

1. What is your gender?

○ Male ○ Female

2. What is your age?

○ 15-18 years ○

18-25 years ○ 25 - 35 years ○ 36 - 45 years ○ Above 45

years

3. What is your level of education?

○ None ○ Diploma ○

Bachelors Masters

PHD ○ Other

(specify…… …….

SECTION B: RESEARCH OBJECTIVES

OBJECTIVE ONE 1: To examine availability and accessibility of primary healthcare in Gimboki.

1 Do you have access to primary healthcare?

○ Yes

○ No

2. Have you ever faced any challenge accessing primary healthcare?

○ Yes

○ No

1. have you ever faced challenges to access the healthcare facility?

- Yes
- ○ No

If your answer to the question above is yes, please select the challenge that applies:

○ It is too far

○ Poor Road quality

○ No transportation available

OBJECTIVE 2: To determine the affordability of primary healthcare in Gimboki.

- Have you ever decided to not seek primary healthcare because it was too costly for you?
- Would you consider primary healthcare costly?
- What option of treatment do you opt for when you think primary healthcare are too costly?

OBJECTIVE 3: To explore community acceptability regarding the available primary healthcare.

○ How satisfied are you with the quality of primary healthcare provided at the clinic?

○ Do you feel comfortable and respected when receiving care from healthcare providers?

OBJECTIVE 4: To provide recommendations to improve healthcare accessibility in Gimboki.

1. According to you, what should be done to improve healthcare in Gimboki?

APENDIX 2 AUREC LETTER

AFRICA UNIVERSITY
"Investing in Africa's future"
AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE (AUREC)

P.O. Box 1320 Mutare, Zimbabwe, Off Nyanga Road, Old Mutare-Tel (+263-20) 60075/60026/61611 Fax: (+263 20) 61785 Website: www.africau.edu

Ref: AU4039/25

29 October, 2025

MWAMBA KYUNGU GRACIA
C/O Africa University
Box 1320
MUTARE

RE: FACTORS AFFECTING ACCESS TO PRIMARY HEALTH CARE IN GIMBOKI, ZIMBABWE

Thank you for submitting the above-titled proposal to the Africa University Research Ethics Committee for review. Please be advised that AUREC has reviewed and approved your application to conduct the above research.

The approval is based on the following.

a) Research proposal

- **APPROVAL NUMBER** AUREC 4039/25
  This number should be used on all correspondence, consent forms, and appropriate documents
- **AUREC MEETING DATE** NA
- **APPROVAL DATE** October 29, 2025
- **EXPIRATION DATE** October 29, 2026
- **TYPE OF MEETING**: Expedited
  After the expiration date, this research may only continue upon renewal. A progress report on a standard AUREC form should be submitted a month before the expiration date for renewal purposes.
- **SERIOUS ADVERSE EVENTS** All serious problems concerning subject safety must be reported to AUREC within 3 working days on the standard AUREC form.
- **MODIFICATIONS** Prior AUREC approval is required before implementing any changes in the proposal (including changes in the consent documents)
- **TERMINATION OF STUDY** Upon termination of the study a report has to be submitted to AUREC.

AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE (AUREC) APPROVED P.O. BOX 1320, MUTARE, ZIMBABWE

Yours Faithfully

MARY CHINZOU
FOR CHAIRPERSON
AFRICA UNIVERSITY RESEARCH ETHICS COMMITTEE