

An Equity-Focused Approach to Health Services and Its Influence on Health-Seeking Behaviour Patterns in Peri-urban Communities: A Study of Matero, Lusaka, Zambia

Flint Kenna Zulu^{1*}, Lazarous Mbulo²

¹Department of Public Health, Texila American University, Lusaka, Zambia

²Centers for Disease Control and Prevention (CDC), Global Tobacco Control Branch, Office on Smoking and Health, Atlanta, Georgia, United States of America

***Correspondence to be addressed:** E-mail - zuluflint@yahoo.com

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Abstract Health equity remains a central concern in achieving universal health coverage in Zambia. Despite reforms such as the abolition of user fees and the introduction of the National Health Insurance Management Authority (NHIMA), disparities in healthcare access and utilisation persist. This study examined the influence of an equity-focused approach to health services on health-seeking behaviour among residents of Matero Township in Lusaka, Zambia. A cross-sectional comparative design using mixed methods was employed, involving 252 respondents from public and private health facilities. Findings revealed that while 58.3% of respondents reported access to healthcare services, 41.7% still lacked access, indicating persistent inequities. Systemic barriers were reported by 65.5% of participants, while 57.4% perceived inequalities in service delivery. Key determinants of health-seeking behaviour included distance to health facilities (25.6%), availability of medication (23.3%), and cost of services (22.0%). Although 70.4% expressed confidence in local health services, utilisation remained irregular. The study concludes that while equity-focused reforms have improved access, structural barriers continue to limit optimal utilisation.

Keywords Health Equity, Health-Seeking Behaviour, Healthcare Utilization, NHIMA, Peri-urban Health, Zambia.

Introduction

Health-seeking behaviour plays an important role in determining health outcomes and the utilisation of available healthcare services. In Zambia, health sector reforms have aimed at enhancing equitable access through initiatives such as the removal of user fees and the establishment of the National Health Insurance Management Authority (NHIMA) [1, 2]. These reforms were intended to address inequities and improve healthcare delivery across populations.

Despite these efforts, disparities remain evident, particularly in peri-urban settings such as Matero Township. These disparities are influenced by socio-economic differences, system inefficiencies, and accessibility challenges. Understanding how equity-focused approaches influence health-seeking behaviour is critical for improving health outcomes and system performance [3, 4].

Background

Zambia is a landlocked country in Southern Africa with a population of about 21 million people and abundant natural resources. It is divided into ten provinces and 116 districts, with a largely rural population, which creates challenges in accessing healthcare due to long distances to health facilities [2].

Since gaining independence in 1964, Zambia has maintained political stability and introduced major health sector reforms in the early 1990s aimed at improving equity, access, and quality of healthcare. These reforms included decentralization, community participation, and financing changes such as user fees, later partially removed, and partnerships with donors and private providers [1, 2].

Despite progress, healthcare equity remains a challenge due to reduced donor support, socio-economic inequalities, and geographic disparities. Factors such as poverty, education, and location continue to influence access to healthcare services [5]. While public facilities

serve the majority and policies like free primary healthcare and national health insurance aim to improve access, barriers such as cost, infrastructure limitations, and cultural beliefs persist [1].

Matero Township reflects these broader challenges, with high population density and mixed use of public and private healthcare. Health-seeking behaviour in this area is influenced by service quality, availability of medicines, waiting times, and provider attitudes, highlighting the need for continued efforts to improve equitable healthcare delivery [2, 5].

Statement of the Problem

The literature shows that healthcare access and health-seeking behaviour (HSB) are influenced by multiple interconnected factors, including socio-economic status, education, geographic location, and systemic health system constraints [5]. Individuals in high-density and low-income areas often face overcrowded facilities, limited resources, and significant financial barriers, which hinder access to care.

Zambia has made significant steps towards improving the health of the population, including the introduction of a national health insurance scheme. However, health inequalities continue to persist, and many people do not have the same opportunities to attain optimal health [1].

Health system challenges such as long waiting times, inadequate staffing, and unequal distribution of resources further contribute to disparities in healthcare utilization. In addition, patients' perceptions of service quality, as well as cultural beliefs and norms, strongly shape decisions about when and where to seek care [3, 5].

The review draws on both theoretical models and empirical evidence, particularly from sub-Saharan Africa, due to similarities in health system contexts. It highlights the importance of social determinants of health such as living

conditions, income, and policy environments in shaping health outcomes and reinforcing inequities [7]. Concepts such as the inverse care law demonstrate that populations with the greatest health needs often have the least access to services [7].

Two major approaches to understanding HSB are discussed:

1. **Pathways Models**, which describe the stages individuals go through when seeking care [8].
2. **Determinants Models**, such as Andersen's model, which explain how predisposing, enabling, and need factors influence healthcare utilization [9].

However, these models have limitations in African contexts, where healthcare systems are pluralistic and individuals often use a mix of public, private, and traditional providers.

Study Objectives

General Objective

To examine the influence of an equity-focused approach to health services on health-seeking behaviour in Matero Township.

Specific Objectives

1. To assess access to healthcare services among residents.
2. To identify barriers affecting healthcare utilization.
3. To determine factors influencing health-seeking behaviour.
4. To evaluate perceptions of equity in healthcare delivery.

Literature Review

The literature shows that healthcare access and health-seeking behaviour (HSB) are influenced by multiple interconnected factors, including socio-economic status, education, geographic location, and systemic health system constraints [5, 11, 12]. Individuals in high-density and low-income areas often face overcrowded facilities, limited resources, and

significant financial barriers, which hinder access to care.

Zambia has made significant progress in improving population health through reforms such as the introduction of a national health insurance scheme. However, health inequalities continue to persist, and many people do not have the same opportunities to attain optimal health [1, 21].

Health system challenges such as long waiting times, inadequate staffing, and unequal distribution of resources further contribute to disparities in healthcare utilization. In addition, patients' perceptions of service quality, as well as cultural beliefs and norms, strongly influence decisions about when and where to seek care [13, 15].

The review draws on both theoretical models and empirical evidence, particularly from sub-Saharan Africa, due to similarities in health system contexts. It highlights the importance of social determinants of health such as living conditions, income, and policy environments in shaping health outcomes and reinforcing inequities [6, 7]. The inverse care law suggests that populations with the greatest health needs often have the least access to healthcare services [7].

Two major approaches to understanding HSB are frequently discussed:

1. **Pathways models**, which describe the stages that individuals go through when seeking healthcare services [8].
2. **Determinants models**, such as Andersen's Behavioural Model, which explain how predisposing, enabling, and need factors influence healthcare utilization [9].

However, these models have limitations in African settings where healthcare systems are pluralistic and individuals often utilize a combination of public, private, faith-based, and traditional healthcare providers [16].

Empirical evidence from sub-Saharan Africa shows that healthcare utilization is shaped by cost of care, accessibility, quality of services,

cultural beliefs, and social factors such as stigma [11, 14, 15, 22]. Patients frequently choose providers based on perceived quality and convenience and may delay seeking care because of financial constraints or fear of discrimination [12, 17].

Overall, the literature emphasizes that improving health equity requires addressing not only healthcare services but also broader socio-economic and structural determinants that influence health-seeking behaviour [6, 7].

Concept of Health Equity

Health equity refers to the absence of avoidable or remediable differences in health among populations. Health equity exists when everyone has a fair and just opportunity to attain their optimal health [1]. It emphasizes fairness in access, utilization, and outcomes.

Health-Seeking Behaviour

Health-seeking behaviour (HSB) refers to any action undertaken by individuals who perceive themselves to have a health problem or illness for the purpose of finding an appropriate remedy [3]. HSB is situated within the broader concept of health behaviour, which encompasses activities intended to maintain good health, prevent illness, and respond to health problems when they occur [11, 12].

Factors influencing health-seeking behaviour include:

1. Socio-economic status
2. Cultural beliefs and practices
3. Accessibility of healthcare services
4. Availability of medicines and healthcare personnel
5. Perceived quality of care
6. Health insurance coverage
7. Educational level and health literacy [5, 11, 18, 19].

Andersen's Behavioural Model

The study is guided by Andersen's Behavioural Model, which categorizes determinants into:

1. Predisposing factors (age, gender, education)
2. Enabling factors (income, access, insurance)
3. Need factors (perceived and actual health status)

These factors collectively influence an individual's decision to utilize healthcare services [9].

Equity-Focused Health Reforms in Zambia

Zambia has implemented key reforms through:

1. Abolition of user fees (2006 in rural areas, 2012 in urban areas)
2. Introduction of NHIMA
3. Expansion of primary healthcare services

These reforms were intended to improve access and equity in healthcare utilization [1, 2]. However, disparities persist due to systemic inefficiencies and resource constraints.

Empirical Evidence

Evidence from sub-Saharan Africa indicates that:

1. Distance to healthcare facilities remains a major barrier to service utilization [12, 22].
2. Costs associated with healthcare continue to limit access, despite fee-removal policies [17, 20].
3. Drug shortages undermine confidence in public healthcare facilities [13, 14].
4. National health insurance schemes improve access but may not fully eliminate inequities [18, 19].
5. Informal and traditional healthcare providers remain important sources of care in many communities [16].

These factors continue to shape patterns of health-seeking behaviour across low- and middle-income countries.

Conceptual Framework

The study adopts a framework linking:

1. Equity-Focused Policies → Access to Services → Health-Seeking Behaviour → Health Outcomes
2. Moderating variables include:
3. Socio-economic status
4. Geographical accessibility
5. Healthcare system efficiency

Materials and Methods

Study Design

Mixed methods design was adopted in the study [10]. A cross-sectional comparative study design was used, incorporating both quantitative and qualitative approaches. Data was collected from respondents using structured questionnaires. The sample included individuals from different residential areas, occupations, and demographic groups.

Data analysis was conducted using descriptive statistics, including frequencies and percentages. Variables analyzed included age, gender, marital status, household size, occupation, income, access to healthcare, and perceived barriers.

Study Area

The study was conducted in Matero Township in Lusaka, a peri-urban area characterised by high population density and mixed socio-economic conditions.

Study Population and Sample Size

The study sample consisted of 252 respondents:

- 148 from public health facilities
- 104 from private health facilities
- Participants were aged 18 years and above.

Data Collection Methods

Data were collected using multiple methods to ensure comprehensive and reliable information. A **structured questionnaire** was administered to respondents to gather quantitative data on demographic characteristics, healthcare access, utilization patterns, and perceptions of health services. In addition, **key informant interviews** were conducted with selected healthcare providers and community stakeholders to obtain in-depth qualitative insights into health service delivery and health-seeking behaviour. Furthermore, a **document review** was undertaken to examine relevant policy documents, health reports, and existing literature, providing contextual information and supporting the triangulation of findings from the primary data sources.

Data Analysis

Quantitative data was analysed using SPSS and Microsoft Excel. Descriptive statistics were presented in percentages, tables, and charts. Qualitative data were analysed thematically.

Results

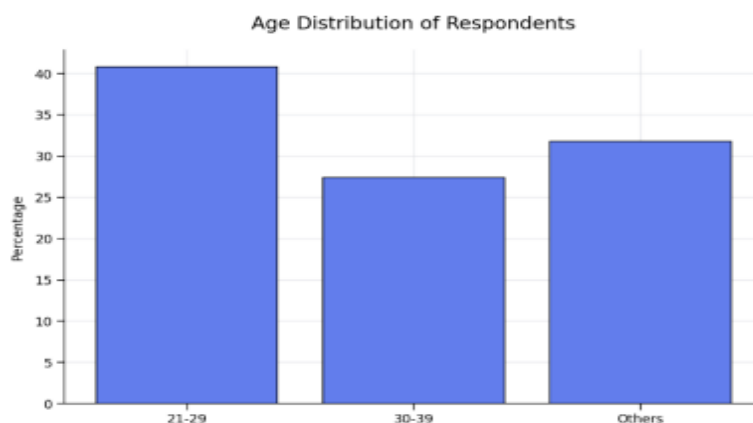


Figure 1. Distribution of Respondents by Age Group

The majority of respondents were aged 21–29 years (40.8%), followed by 30–39 years (27.4%), indicating a predominantly young adult population (Figure 1). Most respondents were female, and nearly half were married

(49.8%), with a substantial proportion being single (39.9%). All respondents identified as Christian. In terms of residence, most participants lived in high-density areas (49.8%), suggesting potential.

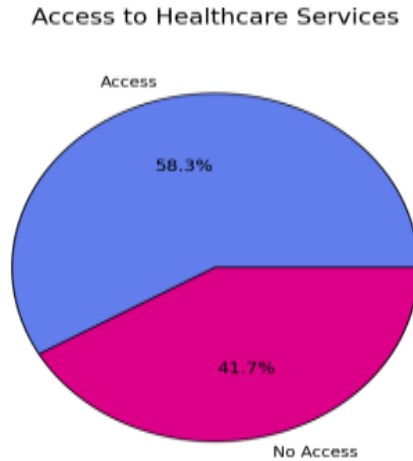


Figure 2. Proportion of Respondents Reporting Access and Lack of Access to Healthcare Services in Matero Township

Pressure on healthcare resources. Household sizes were moderate, with most households comprising 3–5 members. Occupationally, the majority were businesspersons (35.0%) and employed individuals (30.9%), indicating varied income sources. However, income distribution showed variability, suggesting

potential financial constraints among respondents.

Access to healthcare services was reported by 58.3% of respondents, while 41.7% lacked access, highlighting a significant service gap (Figure 2). A majority (65.5%) reported systemic barriers, and 57.4% observed inequalities in healthcare services.

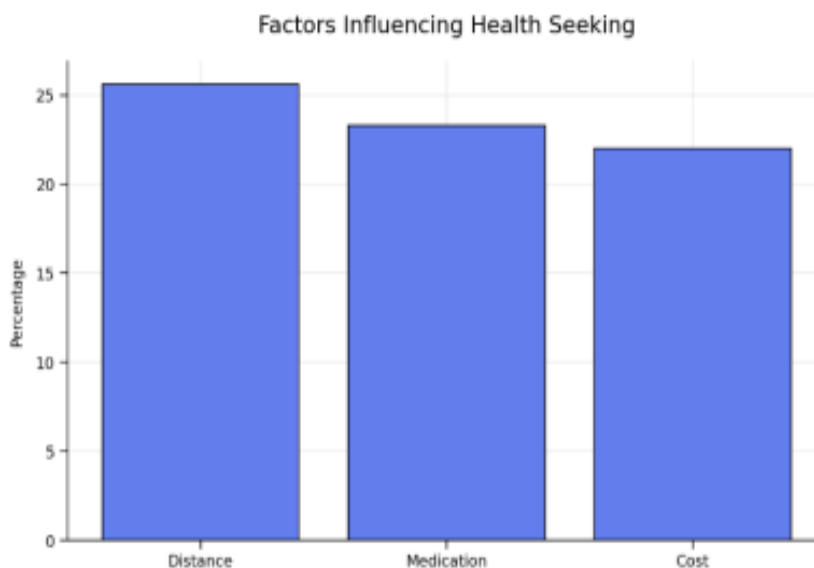


Figure 3. Major Factors Influencing Access to Medical Care

Despite these challenges, 77.6% of respondents reported that healthcare services were culturally appropriate, and 70.4% expressed confidence in local health services.

Healthcare utilization patterns indicated that most respondents visited facilities occasionally (44.8%), while fewer attended regularly (22.4%). Key factors influencing access

included distance to healthcare facilities (25.6%), availability of medication (23.3%), and cost of services (22.0%) (Figure 3).

Affordability was a concern, with 60% indicating services were affordable, leaving a significant proportion experiencing financial constraints.

Combined Results Table

Domain	Key Findings	% / Statistics	Statistical Significance	Interpretation
Access & Barriers	Access to healthcare	58.3% Yes/41.7% No	$\chi^2 = 12.84$, $p = 0.0003$	Access strongly linked to systemic barriers
	Systemic barriers	65.5% Yes	Significant	Structural issues limit effective access
	Observed inequalities	57.4% Yes	—	Inequities widely perceived
Utilization Patterns	Occasional visits	44.8%	—	Care mostly non-routine
	Emergency-only visits	23.3%	—	Reactive health-seeking behavior
	Distance barrier	25.6%	—	Main access constraint
	Medication availability	23.3%	—	Supply limitations affect care
	Cost barrier	22.0%	—	Financial constraints persist
Geographic Inequality Perceptions	Residential area vs access	—	$\chi^2 = 9.67$, $p = 0.008$	High-density areas face greater barriers
	Confidence in services	70.4%	—	Trust remains high
	Affordability	60.4%	$\chi^2 = 14.21$, $p = 0.003$	Affordability influences utilization
	Cultural appropriateness	77.6%	—	

Discussion

Findings indicate that while healthcare services are physically accessible in Matero, financial and systemic barriers limit utilization. Cultural practices still influence healthcare choices, particularly among older residents. The results align with existing literature showing that affordability and service quality are key determinants of care-seeking behavior.

These findings suggest that while confidence in healthcare systems exists, structural and systemic barriers continue to limit access and utilization, which directly relates to the study objectives on equity, utilization, and barriers. The study findings demonstrate that equity-focused health reforms in Zambia have improved access to healthcare services but have not fully eliminated disparities. The presence of a substantial proportion of respondents lacking access (41.7%) highlights ongoing inequities consistent with the inverse care law.

Although cultural acceptability and confidence in healthcare services were relatively high, utilisation remained inconsistent, suggesting that access alone does not guarantee use. Persistent systemic barriers such as drug shortages, long waiting times, and cost-related challenges continue to influence health-seeking behaviour.

The study also confirms the relevance of Andersen's Behavioural Model, where utilisation is shaped by enabling factors such as income, accessibility, and service availability. The findings further align with regional studies in sub-Saharan Africa, which show that individuals often navigate multiple healthcare options based on cost, quality, and convenience.

Conclusion

Equity-focused healthcare policies in Zambia have improved access to services in peri-urban areas such as Matero. However, inequities persist due to structural, financial, and systemic barriers. Addressing these challenges is essential for achieving equitable

healthcare utilisation. The study concludes that socio-demographic factors and systemic barriers significantly influence access to healthcare services. Although a majority of respondents have some level of access and confidence in health services, gaps remain due to cost, distance, and inequalities.

The findings support the study objectives by demonstrating that inequities, financial constraints, and structural barriers shape health seeking behaviour and service utilization. Efforts should therefore focus on improving service availability, strengthening equity-focused policies, and reducing financial and geographic barriers to achieve equitable healthcare access for all populations.

Recommendations

The Zambia government need to looking into improving medicines supply; strengthen service delivery; expand NHIMA; increase outreach; and reduce cost barriers.

Declaration

The author declares that this study is original and has not been submitted elsewhere. Ethical approval was sought, and informed consent was secured from all participants. No conflict of interest is declared.

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Ethical Approval

Ethical principles were strictly observed throughout the study. Permission to conduct the research was obtained from the relevant authorities and participating health facilities. All participants were informed about the purpose of the study, and written informed consent was obtained before participation. Participation was voluntary, and respondents were informed of their right to withdraw from the study at any time without any consequences. Confidentiality and anonymity were maintained by ensuring that no personal identifiers were recorded and that all data were used solely for research purposes.

Author Contributions

Flint Kenna Zulu conceived and designed the study, developed the research instruments, collected and analyzed the data, interpreted the findings, and prepared the manuscript. The supervisor provided academic guidance, methodological support, and critical review of the manuscript. The author read and approved the final version of the manuscript.

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Conflict of Interest

The author declares that there are no conflicts of interest regarding the publication of this study. The author has no financial, professional, or personal relationships that could have influenced the conduct, analysis, or reporting of the research.

Data Availability

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request. Data are not publicly available to protect the confidentiality and privacy of study participants.

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