

**IMPACT OF USER FEES ON ACCESS TO QUALITY HEALTH SERVICES FOR WOMEN  
IN SOLWEZI DISTRICT**

**By**

**Dr. Simon Kunda**

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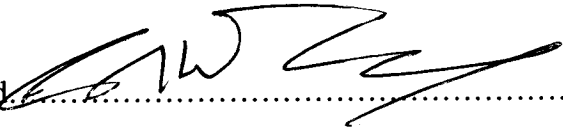
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**DECLARATION**

I hereby declare that the works presented in this study for the Master of Public Health has not been presented whether wholly or in part for any other study programme and is not being submitted for any other Masters programme. The result is entirely the result of my own independent investigation. The various resources to which I am indebted have been acknowledged.

Signed  .....

Date 21/01/09 .....

## APPROVAL

This dissertation of Dr. Simon Kunda has been approved as fulfilling the requirements for the award of the Master degree in Public Health by the University of Zambia.

1. Name..... Dr. L. N. Litawa.....

Signed..... [Signature].....

Date..... 21/01/09.....

2. Name..... Dr. G. B. SILWANBA.....

Signed..... [Signature].....

Date..... 21. 01. 09.....

## ABSTRACT

User fees are generally used in government institutions as a means of alleviating pressure on constrained budgets. In 2006, the Zambian Government abolished user fees in all rural areas except urban areas and municipalities like Solwezi. The Government took this position because of the overwhelming poverty levels in the country, the high cost for accessing health care services and the desire to ensure that a base for improving health outcomes was firmed up through the formation of the fundamental elements for attaining universal access. 0277169

The purpose of this study was to determine the impact of user fees on the quality of health services for women in Solwezi District. The study was conducted at three health facilities: Solwezi General Hospital, Urban Clinic and Kimasala Clinic. The study population included all women aged 15 to 55 years. Data was collected using a structured questionnaire administered to 428 women and a focus group discussion guide administered to 20 women.

Data was analysed using Epi-info computer software package. The Chi-square ( $\chi^2$ ) test was used to test for significant associations. Statistical significance was achieved if  $P < 0.05$ .

The results revealed a significant association between non affordability of user fees and person responsible for intra-household decisions on finances. Most decisions were made by both wife and husband but the later had the final say (42.76%). Almost all the respondents agreed to be paying user fees. Non affordability was also closely associated with how much was paid for user fees. The charges were mostly less than K5, 000 (67.92%). These charges were unaffordable to most women because 44.39% of them were unemployed. Furthermore, a significant association was observed between women turned away and the amount paid. At least 61.45% of the women reported to have been sent away at one time.

Another significant association was observed between women turned away and the selling of household goods ( $p < 0.001$ ) and borrowing of money ( $p < 0.001$ ).

Consequently, we conclude that user fees have a negative impact on women's access to quality health care. The major factors contributing include unemployment, low education levels, amount charged for health services, cultural factors and the person responsible for intra-household decision on finances. We can, therefore, recommend that user fees be abolished completely. The Government should increase funding to the health sector to offset the loss of income from the removal of user fees.

## **DEDICATION**

This research work is dedicated to my wife Emeldah Chisamu Kunda who gave me support and encouragement and without whose love, patience and prayers my studies would not have been possible.

To my beloved children Bwale, Lisa and Simon Kabwela Kunda Junior who were denied adequate fatherly love at the time when they needed it most and without whose understanding and patience my studies would not have been possible.

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## **ABBREVIATIONS**

AIDS	– Acquired Immunodeficiency Syndrome
CRIHB	-California Rural Indian Health Board
DFID	- Department for International Development
HIV	– Human Immunodeficiency Virus
IMF	– International Monetary fund
MDGs	- Millennium Development Goals
MSL	- Medical Stores Limited
NGOs	- Non Governmental Organisations
OPD	– Out Patients Department
PHC	– Primary Health Care
REPOA	- Research for Poverty alleviation
UNDP	– United Nations Development Plan
UNICEF	– United Nations International Children’s Fund
WHO	– World Health Organisation
ZDHS	– Zambia Demographic Health Survey

## **CHAPTER ONE**

### **INTRODUCTION**

Zambia is a landlocked country with a mixed economy consisting of a modern urban area that lies along the line of rail and rural areas that predominantly practice subsistence farming. Poverty is more prevalent in rural areas and currently about 73 percent of Zambians are classified as poor according to the Zambia Demographic Health Survey (ZDHS) of 2001-2002.

According to the United Nations Development Plan (UNDP) of 1998, 85% of Zambians earn and live on less than US\$1 per day. The rising cost of health care coupled with the lower incomes present in rural areas hence makes it difficult for more and more families to afford acute, chronic and preventive health services as illustrated in Table 1 on page 18.

Zambia has a total population of 10.3 million people with a growing rate of 2.9 percent per annum (Census, 2000). Of the nine provinces in Zambia, Copperbelt Province has the highest population followed by Lusaka. Northwestern Province has the lowest population. The majority of the people in Northwestern Province live in Solwezi District. Until recently, the town of Solwezi had seen very little activity in terms of economic and infrastructural development. This has all changed with the reopening of the Kansanshi Mines. This has attracted a good number of both local and foreign investors (Census 2000).

## **1.1 Background: Health Financing and User fees Situations**

According to UNDP report of 1998, the Government of Zambia through Ministry of Health is the main source of funding for the health sector, contributing 57 percent, with the cooperating partners contributing 43 percent. The contribution from the community through user fees is therefore very minimal.

These user fees are gaining widespread use in government Health Programs as a means of alleviating pressure on constrained budget as demand for services increases. In reality user fees generate only a small portion of budgets while disproportionately disadvantaging the poor. The World Health Organisation (WHO) has reported that user fees generally provide only a very small portion of health budgets, rarely more than 5%, yet they disproportionately impact poor people by reducing their access to vital services. United Nations International Children's Emergency Fund (UNICEF) has concluded that user fees collect very modest amounts of money compared with the budgetary resources allocated to basic social services. User charges frequently result in sharp reduction in the access of health services particularly among the poor.

User fees have been aggressively promoted by the World Bank and International Monetary Fund (IMF) for over a decade, and are often a condition for receiving desperately needed loans and debt relief. In Zambia, the user fees were introduced with pressure from IMF and World Bank in the early 1990's. Young girls and women in rural areas were the main victims of the policy as their families were rarely willing or able to pay for their treatment (Oxfam, 2006). In 1998, internal review of the World Bank's health lending, the World Bank's operation Evaluation

Department reported that a shocking 75% of projects in sub-Saharan Africa included the establishment or expansion of user fees.

Because user fees reduce access to quality health services among the poor, they are widespread promotion of fee exemption criteria in order to protect those unable to pay. However, these mechanisms may not effectively ensure access among the poor. The impact of user fees greatly tends to affect women in developing countries because in the majority of countries, women tend to be poorer than men (UNDP, 1990).

In Zambia, a number of factors contribute to the poor status of women. The 2001 – 2002 ZDHS provides information on the status of women in Zambia. Overall, 12% of women aged 15 – 49 have no education and are generally less educated than men. Four in ten women in Zambia are illiterate.

Public sector health resources are often excessively concentrated in large urban tertiary hospitals. This pattern of resource allocation is both inefficient and inequitable. It is inefficient because most health needs can be met by services provided in Primary Health Care (PHC) facilities. These PHC facilities tend to have no staff and supplies; leading to the provision of poor health care. The concentration of resources in urban areas is inequitable because the urban population will have easier access to health services and people there usually tend to have higher incomes than those living in the rural areas. This disparity and inequity in health services provision affects everyone but mostly women in both settings.



The Government of Zambia, through its commitment of improving the quality of life for all Zambians, has demonstrated in its health care package of effecting health reforms by moving from a centralized health system to a decentralized system as a means of addressing the health problems of individuals, the family and the community through Primary Health Care (PHC) programs. The responsibility of planning, implementing, monitoring and managing PHC programs has been vested into the District Health Management Teams. Policy goals like this have therefore demonstrated a link for equity and access. These goals involve efforts not only to make health services available to the whole population, but also remove barriers that may prevent the poor from using health services they need.

In April 2006, the government of Zambia in its effort to remove barriers that may prevent the poor from using health services introduced free health care for people living in rural areas, scrapping off the fees which for years had made health care inaccessible for millions. This move was made possible using money from the debt cancellation and increased aid agreed upon at the G8 meeting in Gleneagles, July 2006. This removal of user fees was only implemented in rural areas. Urban areas and municipalities like Solwezi District have continued to charge. With the scrapping off of user fees, experience from other countries shows that there will be a surge of patients accessing health clinics across the country. Many of these people would not have been able to afford care previously (Oxfam International, 2006)

According to Oxfam, Zambia's next challenge will be the chronic shortage of health workers and medicines in the health institutions. There is currently only one doctor per 14,000 people in Zambia (ZDHS, 2001-2002). The number of nurses in the country is also not sufficient. Human

Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/ AIDS) have also brought disruptions and changes in social networks and support systems due to vastly increased burden of care in the health sector, communities and households. Women carry a much greater burden of care brought about by this HIV and AIDS pandemic as well as being vulnerable to both physiological and social reasons (Velepi et al, 2001).

## **1.2 Statement of the Problem**

Many governments and donor organizations have promoted the introduction of charges in government health facilities for several reasons. Witter and others (2000) state reasons used as arguments for the introduction of user fees:

- i) By charging by-pass fees at higher levels of the system, more people will be encouraged to use the Primary Health Care facilities rather than going to the hospitals straight and overcrowding them.
- ii) By letting health facilities keep some or all the revenue collected, they should become more responsive to patients' needs.
- iii) The revenue collected can provide the health facilities that collect the money to improve overall quality of health services and availability of medicines.
- iv) If exemptions or reduced charges are implemented in parallel for the poor, then those who can afford to pay will cross – subsidize those who cannot, thus promoting equity.

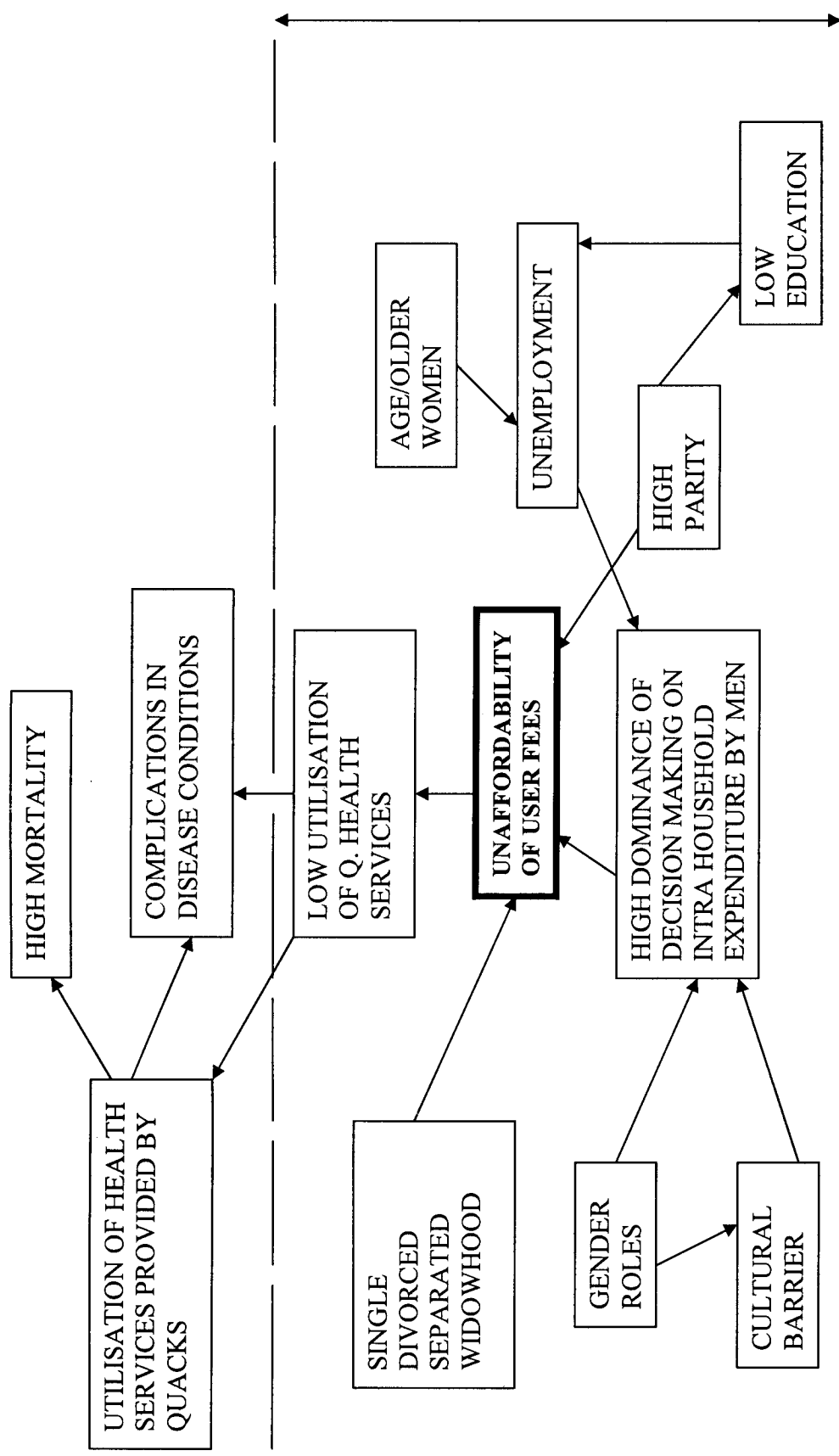
The reasons above are all important health policy objectives. Yet user charges have the unattractive feature that they must be paid at the time of illness, which can create problems of access. The impact of user fees on access can be catastrophic if not addressed well. The user fees were introduced with a view of improving quality of health services in the country.

A recent UNICEF paper (January 2000): Absorbing social shocks, protecting children and reducing poverty quotes a study in Zambia. A researcher witnessed the arrival of a 14 year old boy at a hospital suffering from acute malaria. His parents were unable to pay the registration fee of K300 and the boy was turned away. The report added that within two hours the boy was brought back dead. This evidence highlights the problems that user charges can create.

Another study by Gertler and Van der Gaag (1990) found that user fees deterred poorer persons from seeking care to a greater extent than they deterred richer persons. User charges if not well done have a negative impact in the provision of preventive care. People tend to demand curative rather than preventive services such as immunizations and ante-natal care.

This shows that the vulnerable groups especially women find it difficult to access health services due to financial constraints.

FIGURE 1: Factors contributing to non affordability of user fees



### **1.3 Problem Analysis**

Figure 1 shows the problem analysis chart demonstrating the factors contributing to the non affordability of user fees by the women. Some of these factors include marital status, cultural factors, low education, unemployment, age, high parity and person responsible for making intra-household decisions. Non affordability of user fees may in return also lead to low utilization of quality health services and delays in seeking treatment. Some may be forced to utilize quacks and other sources of substandard health services.

### **1.4 Justification of the Study**

The study will investigate and try to bring out the impact which user fees have on access to quality health services for women in Solwezi district. There are several implications for user fees:-

- i) Their effects on both health and economic status could mean that they act as a barrier to poor individuals remaining healthy, becoming more educated or eating well.
- ii) Ill people have lower productivity and so generate less income and are more likely to stay poor.
- iii) Treatment for women and children suffering priority diseases may be delayed or not happen at all.
- iv) Payment for drugs will mean that fewer are consumed than is necessary, especially for more expensive drugs (such as drugs for malaria, HIV and AIDS).
- v) All the above points may lead to the failure to meet the human development Millennium Development Goals (MDGs).

## 1.5 Definitions

### Quality Health Care

Quality health care is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (CRIHB Health Systems Development, 2004). Quality health care should be:-

- i) **Safe-** avoiding harm to patients from care that is intended to help them.
- ii) **Effective-** A health system that is working well and producing the intended results.
- iii) **Patient centred-** Providing care that is respectful of and responsive to individual patient preferences, needs and ensuring that patients' value guide all clinical decisions.
- iv) **Timely-** Reducing waiting time and sometimes harmful delays for those who receive and for those who give care.
- v) **Efficient-** Avoid waste, including waste of equipment, supplies, ideas, and energy.
- vi) **Equitable-** Providing care that does not vary in quality because of personal characteristics such as age, gender, ethnicity, geographic location, and socioeconomic status.
- vii) **Access-** The service should be within reach and can easily be obtained. This can be in terms of physical (e.g. distance) , financial or attitude of health personnel

## **1.6 Objectives**

### **1.6.1 General Objective**

To determine the impact of user fees on access to quality health services for women in Solwezi District

### **1.6.2 Specific Objectives**

1. To determine the affordability of user fees by the women of Solwezi.
2. To determine the differences in the quality health services between women who pay user fees and those who do not.
3. To determine the socioeconomic and cultural factors that may have an influence on women's access to quality health care.
4. To determine the extent of male dominance on intra-household decision-making concerning expenditure.
5. To determine whether exemption and waiver systems are enabling women to access quality health care or not.
6. To find out the availability of requisites needed for provision of quality care in the health facility.
7. To make recommendations to the Ministry of Health through the Provincial Health Office for action to increase women's access to quality health care.

### **1.6.3 Hypothesis**

User fees are a barrier affecting access to quality health services for women in Solwezi district.

#### **1.6.4 Research Questions**

- i) Are poor people or specific categories of women excluded from public health facilities due to costs and other barriers?
- ii) Are exemption and waiver systems enabling access to health care for the women and most vulnerable? If not what are the main reasons?
- iii) What are the various scenarios for improving access for the poor especially the women and most vulnerable? If not what are the main reasons?
- iv) What are the options, the costs and the benefits should user fees be reduced or abolished all together or at certain levels?



## **CHAPTER TWO**

### **LITERATURE REVIEW**

The user fee debate is full of controversies. The alleged positive and negative impact of user fees on efficiency, quality and sustainability have led to heated debates among health workers and health sector stakeholders. The IMF and World Bank have traditionally promoted user fees, although their official policy is more careful nowadays. They considered charges at the point of use as needed to deter unnecessary use and help bring money into cash strapped health systems (Schwersel and others, 2004). Towards the late 1990s, however other donors started to change their position regarding the desirability of user fees (WHO, 2000).

Equal access and utilization of health services according to need can be interpreted narrowly, as in equal geographic proximity to health facilities or more broadly to include quality of services and their affordability. There are two indicators of hospital utilization. These are hospital percentage by pass first attendances and hospital percentage referred first attendances. The purpose of these indicators is to help reduce the congestion of hospitals in order to make them function as health centre referrals only. If there is over utilization of the hospital Outpatients Departments (OPD), measures need to be taken to improve the quality of services at health centres and accessibility for the general public. Health centre utilization is defined as the number of attendances by the catchments population in a period of time.

#### **2.1 User Fees Situation in Cambodia**

User fees were introduced in public health facilities in Cambodia in order to inject funds into the health system to enhance the quality of service. In a research by Khun and Manderson, (2006),

continued high rates of hospitalization and mortality from viral infections among infants and children made women face extreme difficulties in finding sufficient money especially in cases of emergency resulting in delays in diagnosis and treatment. In-depth interviews were conducted with mothers of children with viral infections in eastern Cambodia. The following were the main findings:

- i) The direct cost of health care and added indirect costs deterred poor women from presenting with their sick children.
- ii) Those who eventually sought care often had to finance health spending through out of pocket payments and loans or sold property, goods or labour to meet the costs. If the family had no money, then they had no option but to keep their children at home and try home remedies.
- iii) The costs were often catastrophic, exacerbating the extreme poverty of those least able to pay
- iv) The Cambodia Demographic and Health Survey in 2005 had indicated that the direct costs of treatment were high. The calculations, including transportation, food, medication and administration, pathology and other fees, indicated that the average cost of a single illness episode was \$15.52 for public facilities, \$18.62 for private and \$6.25 for non medical services (e.g. purchasing local drugs, visiting fortune tellers and traditional healers). People were able to meet these health care costs from wages (39.1%), savings (39.6%), loans (13.3%) and friends (7.8%).

## **2.2 User Fees and Equity Implications in Tanzania**

In 2004, Research for Poverty Alleviation (REPOA) commissioned ETC crystal of Netherlands to examine the equity implications of the health sector user fees in Tanzania.

The following were the main findings of the research:

- i) The study team found that reliable transparent user fee income data were difficult to obtain. The team concluded that revenue raised from user fees at the health facilities was lower than projected.
- ii) The study team found limited positive evidence that user fees in Tanzania had in general achieved the original objective of sustainability, drug availability, quality of care, equity and access for the poor. Government run health facilities faced severe shortages of drugs and supplies. In addition, user fees were not always retained at PHC level.
- iii) The study team concluded that the user fees in Tanzania were regressive and contributed to substantial exclusion, self exclusion and increased marginalization.
- iv) The team collected evidence which showed that user fees had disproportionately affected access to quality health care for the poor and vulnerable population groups, more specifically pregnant women, under five children, orphans, widows, people older than sixty years and AIDS patients
- v) At the PHC level, the study team found that fees had negatively impacted on the use of health care by the rural poor population, particularly children and women.

### 2.3 User Fees in Uganda

All fees at first level government health facilities in Uganda were removed in March, 2001. In 2006, a study was conducted by K. Xu and others to explore the impact of the removal of user fees on health service utilisation and the catastrophic health expenditure using data from National Household Surveys undertaken in 1997, 2000 and 2003. The surveys also included responses from households and individuals in Uganda. Catastrophic health expenditure was defined in relation to a household's capacity to pay. The following were the main findings:

- i) Utilisation increased for the rich but at a lower rate than it had in the period immediately before fees were abolished.
- ii) However, utilisation among the poor increased more rapidly after the abolition of user fees than before hand.
- iii) Unexpectedly, the incidence of catastrophic health expenditure among the poor did not fall. The most likely explanation was found to be frequent unavailability of drugs at government facilities after 2001 which forced patients to purchase from private pharmacies.
- iv) Education was not correlated with the use of public services but people living in households where the head was poorly educated were less likely to use private facilities.
- v) Income was weakly correlated with the use of public services and significantly correlated with the use of private services for the poor.
- vi) The sex of the household head was also tested but did not reach statistical significance.

The practical lesson from this study in Uganda was that the elimination of use fees could have unintended consequences, even in cases where the government seeks to compensate districts for lost revenue.

Lucy Gilson and Di McIntyre, 2005, looked at the analysis from the Universities of Witwatersrand and Cape Town on experiences of removing user fees in Uganda and South Africa. The analysis indicated that this policy change of the removal of user fees had problems because of the following reasons:-

- i) Policies were pushed through too quickly due to political pressure without sufficient analysis and planning.
- ii) Ministries of Health directly intervened to support or oppose specific policies without reference to relevant evidence.
- iii) Technical analysts, with expertise necessary to support decision making, did not have the power or the links with government to push through the policy.
- iv) Governments did not communicate enough with the public or health workers about the new policy.
- v) Not enough drugs or staff were put in place to cope with increased demand
- vi) They did not monitor how the new policies affected clinics, staff and patients.
- vii) Governments should learn from the lessons of the past experience in planning for fee removal.

#### **2.4. Utilisation of Health Services in Zambia**

Zambia Annual Health Statistical Bulletin (2003) shows a general under utilization of health services at lower levels in the country. The bulletin gives a high Hospital OPD percentage by-pass first attendance, at an average of 31 percent. The ideal is that there should be no by-pass if the referral system was working well. The literature clearly indicates health organization system problems in the referral system. These observed high by-pass rates may be explained by:

- i) Preference to seek services of a doctor
- ii) The poor administration of by-pass fees at hospitals.
- iii) Poor services at lower levels

Studies that measure utilization as an indicator of access to health services miss out on crucial aspects relating to financing. Witter and others, 2000, show that access generally has two components, physical access (distance to a given health facility of a given quality) and financial access (payments made in order to obtain services) They further gave an example of a study done in Vietnam in which it was found that the poor, especially the women, generally delayed treatment longer than the rich, and made less use of government health facilities and paid more per episode.

In the 2001 – 2002 Zambia Demographic Health Survey (ZDHS), two questions as part of the household questionnaires were included to ascertain difficulties faced by people in accessing quality medical care due to financial constraints. Table 1 shows the numbers and percentage of households who answered the questions.

**Table 1 : Inability to pay for Medical Services**

<b>Background Characteristic</b>	<b>Denied Care from a Health Facility for nonpayment of user fees</b>	<b>Could not afford medicine</b>	<b>Number of Households</b>
<b><u>RESIDENCE</u></b>			
Urban	22.1	32.5	2,437
Rural	20.0	17.2	4,689
<b><u>PROVINCE</u></b>			
Central	15.2	23.0	490
Copperbelt	23.5	27.7	1,221
Eastern	22.9	19.0	990
Luapula	17.8	19.8	652
Lusaka	23.2	39.8	976
Northern	15.6	12.8	1,028 <sup>a</sup>
North-Western	17.6	11.2	371
Southern	19.2	17.0	734
Western	26.	21.0	656
<b>TOTAL</b>	<b>20.7</b>	<b>22.5</b>	<b>7,126</b>

**Source: Zambia Demographic Health Survey 2001/2002:24**

The table shows that 21 percent of households reported that a household member was denied care from a health care facility because they were unable to pay (22 percent in urban areas and 20 percent in rural areas)

In 23 percent of all households, members could not obtain medicine because they could not afford to pay (33 percent in urban areas and 17 percent in rural areas).

Likwa ( 2005), in a study of the quality and responsiveness of health services to women in a crisis setting in Zambia, shows very little contribution made by women in rural areas to household health schemes when compared to those in the urban areas. The study also shows that non compliance to user fees charges had resulted in failure to access quality medical services by mostly the rural women affected by poverty. It further showed that user fee payment and penalties reflected as “chased away” from clinic and “no treatment” due to non-payment of medical fees was high (67.5%)

Women were also asked to state persons making decision on family expenditure. The purpose was to determine the extent of women’s involvement in financial decision making. Findings showed that 50% of women’s decisions were made by their husbands. Among those who made own decision as ‘self’ showed 33.8% while those with joint decisions, but empowered to make final decision were few at 7.5 % (Likwa, 2005).

Priya Nanda (2002) had almost similar findings to Likwa. Lack of access to resources and inequitable decision making power meant that when poor women face out of pocket costs such as user fees when seeking health care, the cost of care may become out of reach. The lack of hard evidence on the impact of user fees on women’s health outcomes reminds us of the urgent need to examine how women cope with health care costs and what tradeoffs they make in order to pay for health care. Nanda further argues that a review of cost recovery policies in sub Saharan Africa shows a narrow emphasis on raising revenue without explicit equity objectives. The study shows that user fees do not influence improvements in quality of health care or availability of



medical or surgical supplies. The net revenue raised is insufficient to address the existing quality and weakness in coverage of the health system as whole.

## **CHAPTER THREE**

### **METHODOLOGY**

The purpose of the study was to determine the impact of user fees on women’s access to quality health services in Solwezi District. The discussion in this section is about research methods and includes among others study design, study sites, sample size determination, sampling procedures, data collection procedures and ethical considerations.

#### **3.1 Conceptual Framework**

The table below shows the dependent and independent variables in relation to their operational indicators. The dependent variable is a measure of the problem under study and the independent variables describe the factors assumed to cause or influence the problem. The relationship between the dependent and independent variables is illustrated further in conceptual framework diagram in Appendix D.

**TABLE 2: Operational Indicators of the Dependent and Independent Indicators**

VARIABLES	OPERATIONAL INDICATORS
Dependent Variable Quality of health services	Proportion of women unable to access quality health care due to user fees.
<b>INDEPENDENT VARIABLES</b> 1. Demographic characteristics (a) Age  (b) Marital Status  (c) Educational status  (d) Parity  (e) Occupation   2. Decision Making   3. Affordability of user fees   4. Attitudes towards user fees payment   5. Attitude of health workers	 (a) As indicated  (b) - Married - Single - Divorced - Widowed (c)- Never been to school -Primary -Secondary -Secondary -University  (d) Number of children as indicated.  (e)- Employed - Unemployed -Housewife -Farming -Business  - Self(wife) - Husband alone - Both wife and husband but husband with final decision. - All family members - Proportion of women affected by cultural norms of decision-making. - The amount the woman can afford to pay at a health facility. - Exemption criteria  - Responses to user fees payment (both positive and negative).  -Category of heath worker -The services patients pay for -Use for user fees

**TABLE 2: Operational Indicators of the Dependent and Independent Indicators**  
**Continued...**

6.Accessibility to quality health	<ul style="list-style-type: none"> <li>- Distance</li> <li>- Transport cost</li> <li>- Attitude of Health Workers</li> <li>- User fees</li> <li>- Waiting time</li> <li>- User fees</li> </ul>
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### 3.2 Study Design

It is a Cross Sectional study that aims at determining the impact of user fees on the access to quality health care services for women in Solwezi district.

### 3.3 Study Sites

The study was conducted in Solwezi district. The assessment of the impact of user fees on quality health services for the women of Solwezi district was conducted at three health facilities namely; Solwezi General Hospital Outpatient Department, Solwezi Urban Clinic and Kimasala clinic.

#### 3.3.1 Solwezi District

Solwezi is the provincial headquarters for North Western Province. It has a population of about 300,000 people. The district has four constituencies and five wards.

### 3.4. Study Population

The study population included women 15 to 55 years old attending a health facility either for preventive or curative services in Solwezi District at the three health facilities.

### **3.5. Sampling Methods**

Non-probability sampling procedure was used in the selection of health facilities purposively. Solwezi General Hospital is the provincial hospital and attends to referrals from within the province. Kimasala and Urban Clinics are the only two clinics in Solwezi urban under the Ministry of Health catering for the 1<sup>st</sup> referral cases in Solwezi. The other health facilities in the district are very remote, difficult to reach and only service small sparse populations.

#### **3.5.1 Respondents**

Probability sampling procedure was used in the selection of women to ensure that every woman was chosen on the basis of chance. Systematic sampling, which is the selection of women at regular intervals, was used to select the respondents. The first respondent was selected randomly. The researcher then interviewed all women who met the inclusion criteria in the selected health facilities. This method was chosen for it gave equal chance to all women in the district to participate in the study thereby eliminating biasness.

### **3.6 Eligibility Criteria**

#### **3.6.1 Inclusion criteria**

The sample units included all women from 15 to 55 years old attending a health facility either for curative or preventive services and were willing to participate in the study. These were women who were able to undergo a 30 minutes interview

**3.6.2 Exclusion Criteria**

The sample excluded all women who were not attending a health facility for either curative or preventive services and not in the age group 15 to 55 years. Women who were not willing to participate in the study were not included in the sample.

**3.7 Sampling Procedure**

The researcher used non-probability sampling to sample the health facilities

The researcher also used systematic sampling to select the study respondents.

The researcher then interviewed all women who met the inclusion criteria in the selected health facilities.

**3.8 Sample Size**

Sample size was determined by the formula;

$$N = \frac{Z^2pq}{d^2}$$
  
$$Z = 1.96 \text{ at } 95\% \text{ confidence Level}$$
  
$$q = 100 - p$$
  
$$d = 5\%$$
  
$$\text{Sample size} = \frac{196^2 \times 50 \times 50}{5 \times 5}$$
  
$$= 384.2$$

To nearest sample size = 400

**3.9 Data Collection Tools**

Data collection was done through an administered structured interview schedule using both open and closed ended questions. The interview schedule was appropriate for it allowed us elicit

information on the impact of user fees on quality health services for women in Solwezi District. This instrument also allowed women who were not able to read and write to participate in the study thereby reducing biasness. The instrument was translated into Kaonde during interview sessions. The instrument was divided into two sections. Section A sourced information on socio-demographic characteristics of respondents; Section B elicited information on user fees. In addition, Focus Group discussions were conducted to elicit additional information on the topic and validate quantitative data. Two Focus Group discussions were held each consisting of ten eligible women. One discussion was held at Solwezi General Hospital and the other one was a combined discussion for women from the two health centres.

### **3.9.1 Validity**

In order to determine content validity, the experts criticized the tool so that they could give expert advice and input in the way the questions were supposed to be formatted.

### **3.9.2 Reliability**

As part of the instrument was investigator developed, a pilot study was conducted with the aim of improving the questionnaire by modifying the areas where the subjects failed to elicit responses.

### **3.10 Data Collection Techniques**

Data was collected using an interview schedule and focus group discussion guide. Informed consent was collected from respondents after explaining the purpose of the study. To ensure confidentiality, the interview sessions were done away from other respondents.

### **3.11 Pre Test of Research Tools**

A pilot study was done at college health center. This center was not included in the study. Ten percent of the study population was interviewed. This was important for it assisted the researcher to evaluate and refine the methodology. It also helped in determining the length of time it would take to administer the entire instrument. This also helped the investigator to test the instrument for completeness, clarity and accuracy.

### **3.12 Data Management**

#### **3.12.1 Data Processing**

Raw data was checked for completeness and accuracy and then entered manually into the computer.

#### **3.12.2 Data Analysis**

All data was coded. It was processed and analyzed using Epi-info. Descriptive statistics and application of chi-square ( $\chi^2$ ) test was used to determine the significant associations in the research.

### **3.14 Ethical Consideration**

Ethical approval was obtained from the Research Ethics Committee as required by the Graduate Studies Committee of the University of Zambia, School of Medicine. An informed consent was obtained from each respondent before administering questionnaire. Names and addresses of respondents were not included in the interview schedule. Permission to conduct the study in Solwezi was obtained from the Executive Director, Solwezi General Hospital and the District



Director of Health, Solwezi District Health Management Team. This was meant to recognize all the concerned authorities and to gain their cooperation.

## CHAPTER FOUR

### PRESENTATION OF FINDINGS

Data was collected from 428 women seeking health services for curative or preventive care at Kimasala clinic, urban clinic and Solwezi General Hospital OPD. All the women were aged between 15 and 55 years old. The data was collected using structured questionnaire and focus group discussions. The findings from the structured interview schedule are presented in section A and section B contains results from focus group discussions.

#### 4.1. Section A: Quantitative Data

Table 3 shows the socio- demographic characteristics of the 428 respondents.

- i) **Age:** 38.79% of the women interviewed were in the age range 15-24 years and 38.32% in 25-34 years range. The age range from 15-34 hence had a total of 77.11%. This means that the majority of the women attending the three health facilities were in this age group. The age range from 35 onwards had very few women (22.69%)
- ii) **Marital Status:** 67.99% of the respondents were married and 21.96% single. Very few of them were divorced or widowed at 5.37% and 4.67% respectively.
- iii) **Education Level:** The majority of the women had education up to secondary (48.83%) and primary (38.08%). Very few respondents reported as never been to school (6.07%). College education was also very low amongst the women (7.01%).
- iv) **Employment Status:** Most of the respondents were unemployed (44.39%). Very few were employed (8.41%). Some of the women were engaged in farming (21.73%) and 7.01% of them were self employed.

**Table 3: Socio-demographic characteristics of the respondents**

S/N	Characteristics	Frequency	Percentage
<b>1</b>	<b>Age</b>		
	15-24	166	38.79
	25-34	164	38.32
	35-44	72	16.82
	Above 45	26	6.07
<b>2</b>	<b>Marital Status</b>		
	Married	291	67.99
	Single	94	21.96
	Divorced	23	5.37
	Widowed	20	4.67
<b>3</b>	<b>Education Level</b>		
	Never been to school	26	6.07
	Primary	163	38.08
	Secondary	209	48.83
	College	30	7.01
<b>4</b>	<b>Employment Status</b>		
	Unemployed	190	44.39
	Employed	36	8.41
	Farmer	93	21.73
	Self employed	30	7.01
<b>5</b>	<b>Employment status of spouse</b>		
	Unemployed	33	11.34
	Employed	153	52.58
	Farmer	58	19.93
	Self Employed	47	16.15

- v) **Employment Status of Spouse:** Unlike the women, table 3 shows that most of the women's spouses were employed (52.56%) and only 11.34% were unemployed. The rest were engaged in farming (19.93%) and self employment (16.15%).

Table 4: User Fees

S/N	Characteristics	Frequency	Percentage
1	<b>Pay for health services</b>  Yes No	  427 1	  99.77 0.23
2	<b>Amount paid</b>  Less than K5,000 Between K5,000 and K10,000 Between K10,000 and K20,000 Between K20,000 and K50,000 Above K50,000	  290 41 68 19 9	  67.92 9.60 15.93 4.45 2.11
3	<b>Reason for paying</b>  To see doctor To get drugs Laboratory services Others	  184 187 77 59	  42.99 43.69 17.99 13.79
4	<b>General view on user fees</b>  Good to pay Bad system Good if accompanied by quality Bad, not accompanied by quality Do not know	  96 278 36 16 2	  22.43 64.95 8.41 3.74 0.47
5	<b>Knowledge on exemption criteria</b>  Breastfeeding mothers Women in labour Pregnant women Under fives Elderly above 65 Chronically ill Others	  8 35 26 255 300 149 58	  1.87 8.18 6.07 59.58 70.09 34.81 13.55

Table 4 shows characteristics in relation to user fees. Almost all the respondents interviewed agreed to be paying user fees when attending the three health facilities (99.77%). Only one respondent did not agree to the paying of user fees. The majority of them (67.92%) were paying amounts less than K5, 000. The rest were paying amounts above K5, 000. The main reasons mentioned by the women for paying user fees were to see the doctor (42.99%) and to get drugs (43.69%). The other main reason was to pay for laboratory services (17.99%). Charging patients for health care may encourage poor people to treat themselves with traditional medicine or with drugs bought from a peddler instead of attending a clinic. This often causes courses of treatment not to be completed (Lucy Gilson and Di McIntyre, 2005).

The respondents were also asked on how they felt about user fees. Table 4 illustrates that the majority of the women felt that paying for user fees was a bad system (64.95%). The other women were generally divided on how they felt about user fees. 22.43% of them felt that it was good to pay. 8.41% felt that it was good to pay provided they saw quality improvements in the health care delivery. The others (3.74%) felt it was a bad system because no quality improvements were evident.

Table 4 also illustrates that knowledge on exemption criteria in Zambia was fairly good amongst the women. In Zambia, people eligible for exemption are under fives, elderly above 65, people with chronic illness, emergencies and antenatal services. Most women knew that elderly above 65 (70.09%), under fives (59.58%) and chronically ill patients (34.81%) were exempted from paying user fees. A few of them felt that exemption criteria also include women in labour (8.18%) and pregnant women (6.07%).

**Table 5: User Fee Affordability**

S/N	Characteristics	Frequency	Percentage
<b>1</b>	<b>If cannot afford user fees</b>		
	Sent away	263	61.45
	Payment in kind	1	0.23
	Nothing happens	125	29.21
	Others	39	9.11
<b>2</b>	<b>Turned away for non affordability</b>		
	Yes	261	60.98
	No	167	39.02
<b>3</b>	<b>Alternatives utilized</b>		
	Private clinic/ hospital	49	11.45
	Missionary Hospital	8	1.87
	Local dispensary	177	41.36
	Traditional healer	41	9.58
	Prayers and church	57	13.32
	Just stay at home	89	20.79
	Others	7	1.64
<b>4</b>	<b>Affects access the most</b>		
	User fees	119	28.20
	Distance	34	8.06
	Transport costs	3	0.71
	Waiting time	233	55.21
	Attitude of health workers	33	7.82

Table 5 shows the affordability of user fees amongst the women interviewed. A high number of them (61.45%) reported to have been sent away at one time for non affordability of user fees. Others reported that nothing happens (29.21%) as they are still attended to. Only one respondent said to have paid in kind. Most of the women turned away reported to be utilizing local dispensaries for cheap drugs (41.36%), Prayers and church (13.32%) and private clinics and hospitals. Only 20.79% of the women said they just stayed at home when sick.

When asked about what affected their access to quality care the most, Table 5 shows that most women complained about waiting time (55.21%). This is because a lot of time is spent waiting to be attended to by the health workers. User fees were reported to be the second most frequent hindrance (28.20%). Distance (8.06%) and attitude of health workers (7.82%) were third and fourth respectively. Transport cost was the least at 0.71%.

**Table 6: Household Decisions**

S/N	Characteristics	Frequency	Percentage
1	<b>Decision maker over finances</b>		
	Self	100	23.36
	Husband alone	23	5.37
	Both but husband has final say	183	42.76
	Both but self has final say	72	16.82
	All family members	19	4.44
	Others	31	7.24
2	<b>Sold household goods</b>		
	Yes	136	31.78
	No	292	68.22
3	<b>Borrowed money</b>		
	Yes	252	58.88
	No	176	41.12
4	<b>Money borrowed from</b>		
	Family	33	7.71
	Friends	224	52.34
	Money lenders	1	0.23
	Others	170	39.72
5	<b>Who assist when cannot afford</b>		
	Employer	43	10.05
	Social worker	5	1.17
	Government	71	16.59
	Insurance	1	0.23
	Family	277	64.72
	Others	31	7.24

Table 6 above shows how household decisions were made regarding finances and household goods. It was clearly demonstrated that decision making over finances were mostly made by both husband and wife but husband had final say (42.76%). Only 16.82% of the women reported to be making decisions as self with final say. The women who made decisions alone over finances were 23.36%. Only 5.37% of husbands made decisions alone.

The selling of household goods in order to raise money for user fees was not very common among the interviewed women. Only 31.78% agreed to have sold household goods at one time to raise money for user fees. Borrowing money for user fees was common amongst the women (58.88%). Most of these borrowings were from friends (52.34%).

**Table 7: Association between affordability of User Fees and other variables**

	Decision maker	Cost of health service	Spouse's occupation	Occupation Of respondents	Education Level	Marital Status
<b>Affordability of user fees</b>	$\chi^2=35.44$ P=0.002	$\chi^2=76.54$ P<0.001	$\chi^2=12.34$ P=0.195	$\chi^2=18.76$ P=0.027	$\chi^2=13.22$ P=0.153	$\chi^2=8.91$ P=0.445

Table 7 illustrates the associations between the affordability of user fees and other variables as indicated. Affordability of user fees had a close relationship with person making intra-household decisions on finances ( $\chi^2 = 35.44$ , P = 0.002) and how much was paid for user fees ( $\chi^2 = 76.54$ , P < 0.001). They was also an association between affordability and respondents occupation ( $\chi^2 = 18.76$ , P = 0.027). There was, however, no association statistically between affordability of user fees and occupation, spouse's occupation, education level, marital status and age.



**Table 8: Association between being turned away and other variables**

	Cost of health service	Sold Household goods	Borrowed money	Just stay at home	Decision maker	Occupation	Education Level
Turned Away	$\chi^2=27.12$ P<0.001	$\chi^2 = 24.10$ P<0.001	$\chi^2 = 22.07$ P<0.001	$\chi^2=8.20$ P=0.004	$\chi^2=20.30$ P=0.001	$\chi^2 = 4.46$ P=0.22	$\chi^2 = 4.27$ P=0.23

Table 8 shows the association between the women turned away and other variables as shown. They was a close association between being turned away and the amount they were asked to pay for user fees ( $\chi^2 =27.12$ , P < 0.001). The selling of household goods was also closely associated with the women turned away for non affordability of user fees ( $\chi^2 = 24.10$ , P< 0.001). They was also an association between being turned away and borrowing of money ( $\chi^2 =22.07$ , P < 0.001) and the person responsible for intra-household decision on the finances ( $\chi^2 = 20.30$ , P = 0.001). The women who reported to have been turned away were also more likely to just at home ( $\chi^2 = 8.20$ , P = 0.004). There was, however, no correlation between being turned away and occupation ( $\chi^2 = 4.46$ , P= 0.22) or between being turned away and education level ( $\chi^2 = 4.27$ , P = 0.23).

**4.2. Section B: Qualitative Data**

Two focus group discussions were held each comprising ten women eligible for the study. The discussions were held at Solwezi General Hospital and Urban Clinic. The study population comprised women 15 to 55 years old attending the health facilities for preventive or curative services. The total number of participants in the FGD was twenty.

**Table 9: Focus Group Discussion: Women’s Responses to User Fees**

FGD Question	Solwezi General Hospital Responses from Women (15-55 years old)	Health Centre Responses from Women (15-55 years old)
Are you charged anything when you go to seek health care?	-All agreed that they are charged for whatever visit to any health facility including visits for labour.	-All agreed to be charged all the time they went to the clinic.
How much are you charged?	-Charged K1, 500 for registration and K16, 500 for admission.	-Charged K1,500 for registration
Are you able to pay?	-Only able to pay sometimes though no receipts are given.  -No proper care for nonpayment of user fees. No medicines will be given.	-Only pay when able to.  -If you do not have money to pay for user fees, just go back home.

Table 9 shows the women’s responses on user fees during the focus group discussions at Solwezi General Hospital and the two health centres. All the women generally agreed that they were charged user fees every time they visited a health facility. Some women complained that they were charged even for labour and antenatal visits to the hospital. The charges usually range from K1, 500 to K16, 500. The charges for K1, 500 are usually for registration and the exercise books

used for recording patients details. Higher fees of K16, 500 were said to be charged at the hospital mostly for admissions and laboratory investigations.

Though user fees charges were asked for at every visit to a health facility, the women said they were only able to afford sometimes. They complained that the few times that they manage to pay user fees, no receipts are given to them. No proper attention is given when user fees are not paid. This includes the giving of prescriptions only to go and buy drugs at the drug stores. At the Urban Clinic, women said they just stay at home when not able to afford fees.

Table 10 below shows the discussions concerning reasons why user fees are charged. Most women during the focus group discussion expressed ignorance as to why user fees were being charged. They felt that health care services were supposed to be free especially that the government had abolished user fees. The women also felt that they were no corresponding quality improvement in health institutions despite people paying for user fees. They thought that health workers were misusing the money. Because of this, generally all the women did not like the idea of paying user fees because. This was aggravated by the fact that user fees were paid at time when someone was sick and not everyone could afford to pay. The few that manage to pay were still told to go and buy medicines from commercial drug stores.

**Table 10: Focus Group Discussion: Reasons for Charging User Fees**

FGD Question	Solwezi General Hospital Responses from women (15-55 years old)	Health Centres Responses from women (15-55 years old)
Why do the Hospitals and Clinics charge user fees?	<p>-Do not know why user fees are charged because the government abolished user fees.</p> <p>-Health workers steal the money paid for user fees.</p>	<p>-Had no idea why user fees were charged.</p> <p>-Health services were supposed to be free.</p>
Do you think it's good to charge user fees?	<p>-Do not like user fees because not clear what the money paid was used for.</p> <p>-Its not good to charge user fees because not everyone has the money to pay for user fees when sick.</p>	<p>-The women felt it was not good to pay because they do not know where the money went to.</p> <p>-Complained that even those that manage to pay, were still told to go and buy medicines from commercial drug stores.</p>
Do the fees affect your ability to access health services?	<p>-It was obvious because if one did not have money, they just stayed at home.</p>	<p>-If do not have money they just stay at home to die. This forces people to struggle and look for money.</p>

Table 11 below shows the effect of user fees on household income as expressed by the women during the focus group discussions. Almost all the women accepted that user fees had an effect on their household income. Since they fail to raise money for user fees, women are forced to borrow money and sell off some household goods in order to avoid being sent away. When sent away, women opted to just stay at home and pray to God. It was evident from the discussions that no proper treatment is received if one did not pay user fees. They complained that better services are offered at high cost clinic for people who are rich and able to pay more money. Husbands do not assist in these situations because majority of them are poor and unemployed. Women are just advised by their husbands to stay home or go to traditional healers.

**Table 11: Focus Group Discussion: Effect of User Fees on Household Income**

FGD Question	Solwezi General Hospital Responses from women (15-55 years old)	Health Centres Responses from women (15-55 years)
Do paying user fees at the Hospital/ Clinic affect your household income? If so how?	-Forced to sell items at home in order to raise money for user fees.  - Difficulty paying school fees and hospital user fees.  One of these will suffer.	-Forced to raise money to pay for user fees by selling off household goods and by borrowing.  -Better to sell household goods and get better than to die.
If you are unable to pay the fees, what do you do?	-You are sent away unless you pay. Alternative is just stay at home and pray to God.	-Forced to seek cheaper alternatives like drug stores and witch doctors.  -Otherwise, just stay at home.
Do you get the same service whether you pay the fees or not?	-No proper treatment without paying  -The rich are better looked after because they have money to pay.	-The service is not the same.  If you do not pay, you are sent away.  -Even if one pays, they are just given prescriptions.
How do husbands react when asked for money?	-The husbands ask wives to just stay at home.	- Most husbands are unemployed.

## **CHAPTER FIVE**

### **DISCUSSION OF THE FINDINGS**

This chapter presents the discussion of the main findings from the study. The study identified some factors that might influence the impact of user fees on the women of Solwezi District.

The information obtained included socio-demographic data of the women attending the health facilities for curative or preventive visits and the impact of user fees. This data was collected through a structured interview schedule. Supplementary information was obtained through focus group discussions. Two focus group discussions were organized separately at the hospital and clinic.

#### **5.1. Socio-demographic Profile of Respondents**

It is very important to know the socio-demographic characteristic of the respondents because it helps to assess the representativeness of the sample. This may have a bearing on how the study participants responded to issues pertaining to user fees.

The study revealed that the majority of the respondents fell in the age range 15-24 and 25-34 years. The least representative age group was the respondents in the age range above 45 years.

The majority of the women visiting health facilities were married (67.99%). Looking at the age range of the majority of the women, it shows some element of early marriage at the expense of education. This is because in Zambia, by age 24, someone was supposed to be doing college education. This element of early marriage clearly promotes male dominance. The majority of the respondents had attained primary (38.08%) and secondary education (48.83%) respectively. Very few women had been to college (7.01%). This low college attendance may explain why

almost half of the interviewed women were unemployed and more than half were already married. In contrast, more than half of their spouses were employed (52.58%). In the ZDHS of 2001-2002 it was also noted that overall, 12% of the women aged 15-49 had low education levels and were generally less educated than men.

**5.2. Affordability of User Fees**

There is a strong association between affordability of user fees and how much was being paid for user fees. Most of the respondents reported to be paying less than K5, 000 for user fees at the clinics and up to K20, 000 at the hospital. During focus group discussion all the women agreed that they were charged user fees for every visit made to a health facility. They were only able to afford paying user fees occasionally. They complained against user fee payments because some have to travel long distances to access health care. The long distances meant more money to be paid for transport in addition to the user fees. At the clinic focus group discussion, some women brought up the issue of long waiting time and the bad attitude of the health workers. This was also supported by respondents who said that waiting time was the most significant barrier that affected their access to health care (55.21%) followed by user fees (28.20%). Long waiting time meant that more money was spent on upkeeps like food whilst waiting to be attended to.

User fees have several important implications for the Millennium Development Goals (MDGs)

- i) Their effect on both health and economic status could mean that they act as a barrier to poor individuals remaining healthy becoming more educated or eating- especially where ill health leads to increased cost and hence preventing the human development MDGs from being achieved.



- ii) Ill people have lower productivity and so generate less income and are more likely to stay poor especially that user fees are paid at a time when one was sick..
- iii) Treatment may be delayed or not happen at all
- iv) Payment for drugs will mean that correct prescriptions and dosages are not consumed especially for more expensive drugs.

During focus group discussions, both groups of women stated that it was obvious that user fees negatively affected their access to health services. This made most of them to just stay at home. Alternatively, if unable to afford user fees, women utilised drug stores, witch doctors and prayers. The majority of the respondents (60.98%) reported to have been sent away at one time or another due to nonpayment of user fees. This was also supported by women during focus group discussion. There is hence a clear demonstration that user fees negatively impacted on access to health care for those unable to pay. Though promoted by the World Bank and the IMF as means of generating revenue for the health sector, the evidence shows that user fees have actually succeeded in driving the poor away from health care services

User fees generally tend to deter poorer people from seeking health care to a large extent than they deterred the rich people (Gertler and Van der Gaag, 1990). During the focus group discussion at Solwezi General Hospital, the women brought out the issue of segregation. They complained that the rich who were able to pay more had better health services than the majority of the people. At Solwezi General Hospital, those able to pay more usually get attended to in the high cost clinic and admitted in the high cost ward. The high cost facilities have better services than the low cost in terms of cleanliness, availability of drugs and personnel to attend to patients.

**5.3. Intra-household Decision on Finances**

Affordability of user fees is related to person responsible for making intra household decisions on finances. Most of the respondents reported that final decisions on finances were made by their husbands (42.76%). Among those who made own decisions as ‘self’ showed 23.36% while those with joint decision but empowered to make final decision were few (16. 82%). Lack of access to intra household resources and decision making means that women face problems when trying to meet costs for user fees and transport cost (Priya Nanda, 2002).

During focus group discussion women generally stated that husbands usually suggest to them to just stay at home because of lack of money. The women attributed this to large families, lack of education and the unemployment status of their husbands. The women also said that husbands sometimes ask their wives to just stay at home even when very sick because of laziness. They complained that husbands in Zambia do not like assisting in household chores like cooking, washing and drawing water for home use. Men usually just indulge in excessive beer drinking and extra marital relationship depriving their families of the money needed for health and education. This makes it difficult for women to cope when sick and make them trade off some household items to raise money for user fees. 31.78% of the women reported to have sold household items to raise money for user fees and 58.88% of them reported to have borrowed money to pay for user fees. This may explain why 64.95% of the women said that user fees are bad. This was supported during the focus group discussion where women stated that user fees were bad because it was difficult to raise money during periods of sickness. One woman said she would appreciate if health care can be accessed on credit and pay later when well.

#### 5.4. Knowledge on User Fees and Exemption Criteria

During the focus group discussion, most women did not know why user fees were charged. According to them, user fees were scrapped off by the government and hence health services were supposed to be free. The Government of Zambia in 2006 abolished user fees for people living in the rural areas. The women were not aware that this scrapping off of user fees did not affect municipalities like Solwezi District. The women further argued that they did not know where the money paid for user fees went. They expected to see improvement in the quality of health care delivered. Instead, they are just given prescriptions to go and buy medicines from drug stores because of shortages of medicines in hospitals and clinics. The women felt that this was theft as evidenced by the lifestyles of some health workers. User fees, generally, are not accompanied by improvement in quality of health care or availability of surgical and medical supplies (Priya Nanda, 2002). The net revenue raised is insufficient to address the existing quality and weakness in coverage of the health system as a whole. Some of the reasons why this is not so include corruption, bureaucracy, lack of planning for the raised money, insufficient money and inefficient spending.

In 1992, the Government of Zambia produced a National Health Policy Document that outlined health sector reforms. The vision of the Health Reforms was to provide equity of access to cost-effective quality health services as close to the family as possible. There were fears, however, that these charges though low could hurt the poor and vulnerable groups. Therefore, in 1994, the government introduced demographic base exemptions. Individuals aged five years and younger, those 65 years and older, and those suffering from chronic diseases were exempted from payment of fees. Others exempted were those suffering from diseases of public health

importance and women attending Antenatal Care. The introduction of user fee exemption for the poor is often ineffective because it relies on health providers to target the relevant population, a task that they are often not qualified or interested to do effectively (Wim Hardeman, 2004).

Knowledge on the people eligible for exemption from user fees was fairly good among the respondents. 59.58% of them knew that under five children were exempted from paying user fees. 70.09% knew that the elderly above 65 are exempted and 34.84% knew that chronically ill are exempted too. During the focus group discussion, the women mentioned that these schemes intended to benefit the poor from paying user fees were not effective. Some mentioned incidences when they have been turned away with sick babies strapped on their backs for nonpayment user fees. The arrogant and the non caring attitude of health providers made even those eligible for exemption fear to seek health care when sick. A study by UNICEF claims that poor people are generally unaware of such exemptions, and that there are often complex administrative barriers involved. The report concluded that the implementation of exemption schemes is infrequent and is applied in adhoc ways.

**5.5. Implication of the Study**

The study findings have shown that there are socio-economic factors that affect the impact of user fees on women in Solwezi District.

Some cultural factors have also been identified as influencing the impact of user fees in Solwezi District. These cultural factors include intra household decision on finances and early marriage at the expense of education.

It was encouraging to note that most women had good knowledge about exemption criteria in Zambia. The women also clearly came out in condemning the user fees as a bad system and strongly advocated for the total removal of user fees. These user fees, certainly, may affect our dreams of realizing the MDGs. It is, however, encouraging that user fees are now being removed in a growing number of African countries (Lucy Gilson and Di McIntyer, 2005).

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATION**

#### **6.1. Conclusion**

The Government of Zambia in April, 2006 introduced free health care for people living in rural areas, scrapping off user fees which for years had made health care inaccessible for millions. The Government took this position in view of the overwhelming poverty levels in the country, the high cost of accessing health care services and the desire to ensure a base for improving health outcomes through the formation of fundamental elements for attaining universal access (Ministry of Health, 2006). This move was made possible using money from debt cancellation and aid increases agreed at the G8 summit in Gleneagles when Zambia received \$4 billion of debt relief; the money which was now invested in health and education. This move represented a growing recognition by aid agencies and policy makers that health should be considered productive collective investment rather than a commodity subject to short term cost recovery through user fees. Young girls and women in rural areas were the main victims of the user fees policy as their families were rarely willing or able to pay for their treatment (Africa Focus Bulletin, 2006).

According to the current study, factors such as cost, decision maker on finances, employment and cultural beliefs have been identified as some of the factors that might determine the impact of user fees on the access to quality health services.

However, the study had limitations. Sample selected was from women already seeking health care services. It could have been better to select from all women in Solwezi District preferably through a household- based survey. Sample size and sampling areas were also limited. A larger

sample size which should possibly include rural areas as control sites, would add an important dimension to the quality of any future research in this area. Despite these limitations, the study findings do point out the impact user fees have on the access to quality health care for women in Solwezi District.

Improving access to basic health care can help accelerate progress towards the MDGs. Cost is usually the major obstacle preventing the poor from accessing basic health care. Improving the affordability of essential health care services requires measures aimed at reducing all costs-whether they are official fees, informal out of pocket payments or indirect costs such as transport.

In Zambia, better health care services are provided by high cost facilities at public institutions. These provide better services in comparison to the services provided by the private sector at market prices. Although the poor utilize low cost public facilities, they are more likely to also utilize the high cost facilities and private sector. This comes at a cost that drives many into more poverty. This shows why most women were for the idea that healthcare services should be the same regardless of one's ability to pay more. According to the Department for International Development, (DFID), 2004, public funding for health is generally low in most African countries. This may partly explain the fact that the better off have much better access to quality services and enjoy better health outcomes than the poor. Beyond the issue of affordability, private sector health care is inappropriate in responding to people's particular health needs. When infectious diseases constitute the greatest challenge to vulnerable people, free public health care is essential. Private or high cost facilities cannot make the necessary interventions at

the community level. These facilities are less able to cope with epidemic situations. Successfully and fully responding to the spread of HIV and AIDS and other diseases in our communities requires free and strong public health care services.

**6.2. Recommendations**

Based on the findings of this study, the following recommendations are made:-

- i) This study shows that women are not able to afford user fees in Solwezi. The Zambian Government abolished user fees in all rural areas except urban and municipality areas like Solwezi. The abolition of user fees should, therefore, be extended to all areas.
- ii) The study has further revealed that the person responsible for intra household decisions on finances has a bearing on women’s access to quality health services. According to the study, most decisions are made by both husband and wife but husband had final say. Therefore, there is need to educate men on the importance of equal rights and fight for more women’s rights through the government and Non Governmental Organisations (NGOs).
- iii) Employment status of the women was also shown in the study to be a contributing factor to the non affordability of user fees. The low educational attainment by the women could explain the small number of women in employment. There is, therefore, the need for the government to continue fighting for the education of the girl child and offer equal opportunities in employment for both males and females.
- iv) The study also revealed that women pay user fees mostly for drugs. However, most women complained that these drugs are not usually available despite paying. This



forces them to utilise commercial drug stores. The removal of user fees being advocated here could lead to increased usage of health services leading to even more drug shortages. Funding, therefore, has to be increased by the government to a level which only compensates for the loss of fees from existing users, but also allows the system to cope with an influx of new users.

- v) Another recommendation that could be made is that future studies on this topic should employ a larger set of districts and sites to make the results more generalised.

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## APPENDIX A

### INTERVIEW SCHEDULE

Questionnaire to assess the impact of User fees on the quality of health care services for the women of Solwezi

SERIAL NUMBER:

--	--	--

#### RESPONDENTS IDENTIFICATION

AGE:

--	--

RESIDENTIAL ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PARITY: NUMBER OF LIVING CHILDREN: \_\_\_\_\_

NUMBER OF DEAD CHILDREN: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

#### B. INTERVIEWERS IDENTIFICATION

NAME OF INTERVIEWER : \_\_\_\_\_

DATE OF INTERVIEW \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

QUESTIONNAIRE COMPLETION: ☐ COMPLETED

TICK

☐ NOT COMPLETED

REASON FOR NON COMPLETION : \_\_\_\_\_  
\_\_\_\_\_

# **SECTION A** **DEMOGRAPHIC CHARACTERISTICS**

1. In what month and year were you born?

Month .....

--	--

Year.....

--	--	--	--

2. Are you married?  
(Tick)

1. Yes

2. No

3. If not married, what is your marital status?

1. Single.....

--

2. Divorced.....

--

3. Widowed.....

4. What is your education level

--

1. Never been to school.....

--

2. Primary.....

--

3. Secondary.....

--

4. College.....

--

5. University.....

--

5. What do you do for a living?

1. Employed..... ☐

2. Just a housewife..... ☐

3. Farming..... ☐

4. Business ..... ☐

5. Other, specify..... ☐

6. If married, what does your spouse do for a living?

i. 1. Unemployed..... ☐

ii. 2. Employed..... ☐

iii. 3. Farming..... ☐

iv. 4. Business..... ☐

v. 5. Other, specify..... ☐



**SECTION B**

**USER FEES**

1. Do you pay for health services at your nearest health facility?

(TICK)

1. YES

☐

2. NO

☐

2. If your answer is yes, how much do you pay?

1. Less than K5, 000.....

☐

2. Between K5, 000 and K10, 000.....

☐

3. Between K10, 000 and K20, 000.....

☐

4. Between K20, 000 and K50, 000.....

☐

5. Above K50, 000.....

☐

3. Why do you pay fees?

1. To see the doctor .....

☐

2. To get drugs.....

☐

3. For laboratory investigation.....

☐

4. Other Specify.....

☐

4. What happens if you cannot afford the fees?
1. You are sent away..... ☐
  2. You pay –in-kind..... ☐
  3. Nothing..... ☐
  4. Other, specify..... ☐
5. Have you ever been turned away because you could not afford the fees?
1. YES ☐
  2. NO ☐
6. If you cannot afford to pay the fees, who else comes in to assist you?
1. My employer..... ☐
  2. Social welfare..... ☐
  3. Government exemption criteria..... ☐
  4. Insurance..... ☐
  5. Other specify..... ☐
7. Have you ever sold household assets to raise cash for user fees?
1. YES ☐
  2. NO ☐

8. Have you ever borrowed money in order to pay for your user fees?

1. YES ☐

2. NO ☐

9. If your answer is yes, from where did you borrow money?

1. Family..... ☐

2. Friend ..... ☐

3. Money Lenders..... ☐

4. Other specify..... ☐

10. What alternatives do you utilize when you cannot afford the user fees?

1. Private Clinic / hospital ..... ☐

2. Missionary Hospital ..... ☐

3. Local dispensary..... ☐

4. Traditional healer..... ☐

5. Other, specify..... ☐

11. Who makes the decision in your home on how money will be spent?

1. Yourself alone..... ☐

2. Husband alone..... ☐

3. Both of you but husband has final say ..... ☐

4. Both of you but yourself has final say..... ☐

5. All family members ..... ☐

6. Other specify..... ☐

12. Do you know the people who are eligible for exemption from user fees in Zambia?  
(May tick more than once)

- 1. Breastfeeding mothers..... ☐
- 2. Women in Labour..... ☐
- 3. Pregnant women ..... ☐
- 4. Under 5 year olds..... ☐
- 5. Elderly above 65..... ☐
- 6. Chronic illness..... ☐
- 7. Other, specify..... ☐

13. Do you think it's good to charge user fees in health centres or hospitals?

- 1. Yes, good to pay ..... ☐
- 2. It is a bad system..... ☐
- 3. Good to pay if accompanied by quality improvement..... ☐
- 4. Bad to pay because no quality improvement..... ☐

14. How do you feel about paying user fees? ☐

.....

.....

.....

.....

15. Of the following, which one do you think affects your access to quality health care the most?

1. User fees
2. Distance
3. Transport costs
4. Attitude of Health Workers
5. Waiting time.

## **APPENDIX B**

### **FOCUS GROUP DISCUSSION GUIDE**

**TITLE:-IMPACT OF USER FEES ON THE OUALITY OF HEALTH SERVICES FOR THE WOMEN OF SOLWEZI DISTRICT.**

My name is Dr Simon Kunda. I'm a student at the University of Zambia. I would like to discuss with you a few issues concerning my research.

1. Are you charged anything when you go to the hospital/ clinic?
2. How much are you charged?
3. Are you able to pay?
4. Why does the clinic/hospital charge user fees?
5. Do you think it is good to charge these fees?
6. Do the fees affect your ability to access health services?
7. How do your husbands react when you ask for money for user fees?
8. Do paying user fees at the hospital/clinic affect your household income? If so how?
9. If you are unable to pay the fees, what do you do?
10. Do you get the same service whether you pay the fees or not?

## **APPENDIX C**

### **INFORMED CONSENT**

**TITLE:-IMPACT OF USER FEES ON THE QUALITY OF HEALTH SERVICES FOR THE WOMEN OF SOLWEZI DISTRICT.**

#### **Introduction**

You are hereby requested to take part in this research study because every woman is expected to receive quality health services when they visit any health facility. Before you decide whether or not to take part in this study we would like to explain to you the purpose of this study and what is expected of you .If you agree to take part, you will be asked to sign or make a mark on this consent form in front of someone. Your participation in this study is entirely voluntary. You are under no obligation to participate.

#### **Purpose of the Study**

The study will assist to get information on the impact of user fees on quality of health services for women in Solwezi. It will also assist us to plan for health services in the district.

#### **Confidentiality**

All the information that you shall provide will be kept strictly confidential. You will be identified by code and no personal information will be released without your written permission

#### **Please Note:-**

Your participation is entirely voluntary.

You may decide to take part or withdraw from study at any time.

Consent to Join the Study

Name.....

Having been fully informed of what this study is all about does hereby agree to participate willingly.

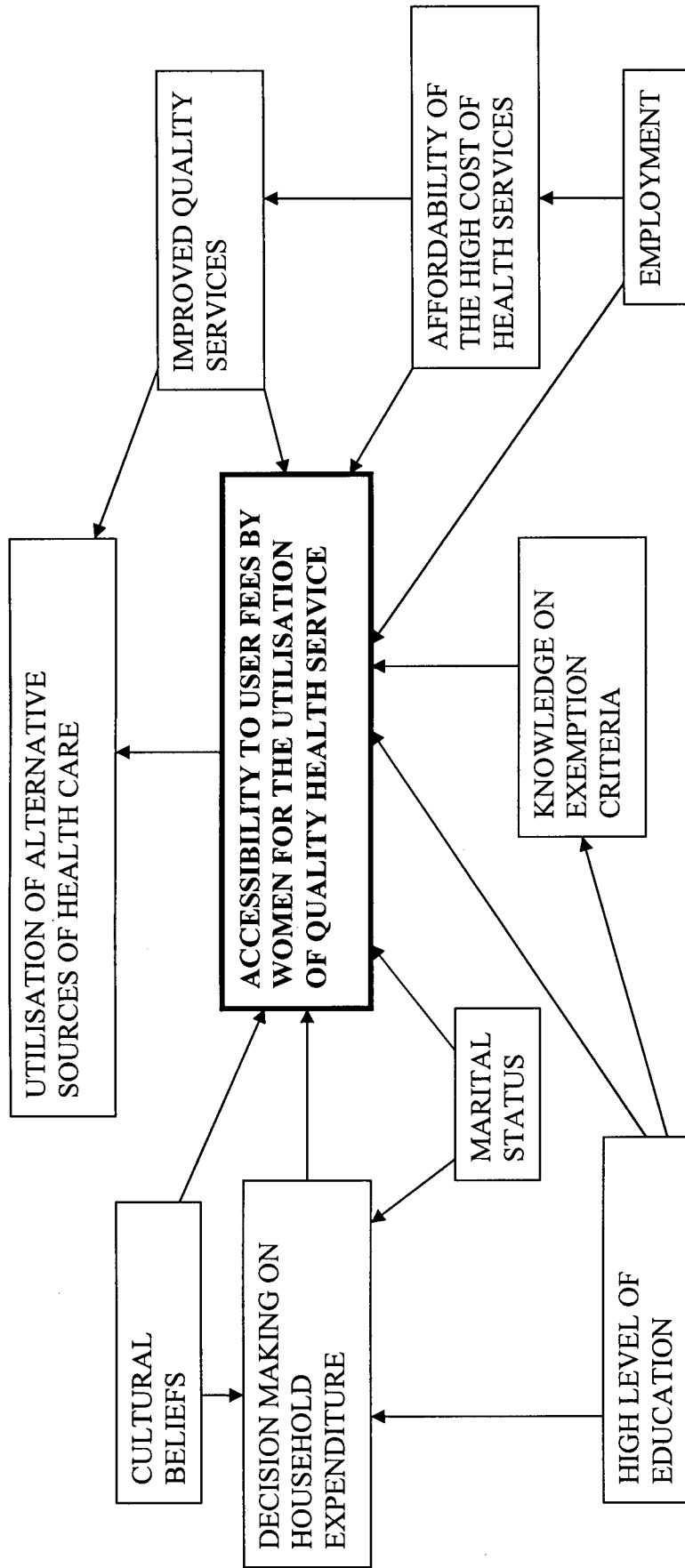
Signed.....Date.....

Witness[Name].....Sign.....





FIGURE 2: CONCEPTUAL FRAMEWORK DIAGRAM





**THE UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE**

Telephone: 097-849302

Assistant Dean's (PG) Office  
P.O. Box 50110  
LUSAKA

10<sup>th</sup> July, 2006

Dr. Simon Kunda  
Dept. of Community Medicine  
LUSAKA

Dear Dr. Kunda

**Re: GRADUATE PROPOSAL PRESENTATION FORUM**


Following the Graduate proposal presentation Forum (GPPF) which was held on Thursday, 29<sup>th</sup> June, 2006 in the Main Lecture Theatre (UTH) at 14:00 hours, we have the pleasure to inform you that your research proposal titled: **"User fees as access barriers to quality health services for women in Solwezi District"**, has been approved by the Board of Graduate Studies of the School of Medicine. The assessors gave you a mark of 84%.

The overall comments were that;

1. It is a good study.
2. It needs better literature review.
3. Needs to justify why women are the target group; it removes bias by comparing the people who use and those who do not.
4. The statement of the problem needs to be made clearer. Issue of usage and quality of care as well as income needs to be addressed.
5. The methodology and data analysis are not made clear enough.

The proposal is judged as passed subject to the above adjustments.

Congratulations and good luck in your research.

  
Mr. Kasonde Bowa, MSc (Glasgow) M.Med (UNZA), FRCS (Glasgow)  
ASSISTANT DEAN, POSTGRADUATE

CC: Director, Graduate studies  
Dean, School of Medicine  
Head, Community Medicine



**THE UNIVERSITY OF ZAMBIA**

**RESEARCH ETHICS COMMITTEE**

Telephone: 260-1-256067  
Telegrams: UNZA, LUSAKA  
Telex: UNZALU ZA 44370  
Fax: + 260-1-250753  
E-mail: unzarec@zamtel.zm

Ridgeway Campus  
P.O. Box 50110  
Lusaka, Zambia

**Assurance No. FWA00000338**  
**IRB00001131 of IORG0000774**

11 May, 2007  
Ref: 006-08-06

Dr Simon Kunda  
Solwezi General Hospital  
P.O. Box 110009  
SOLWEZI

Dear Dr Kunda,

**RE: RESEARCH PROPOSAL ENTITLED: "IMPACT OF USER FEES ON THE QUALITY OF HEALTH SERVICES FOR WOMEN IN SOLWEZI DISTRICT"**

The above-mentioned research proposal was presented to the Research Ethics Committee meeting held on 27 September, 2006 where changes were recommended. We would like to acknowledge receipt of the corrected version with clarifications. The proposal has now been approved. Congratulations!

**CONDITIONS:**

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.

Yours sincerely,

for Prof. J. T. Karashani, MB, ChB, PhD  
**CHAIRMAN**

**Date of approval:** 11 May, 2007

**Date of expiry:** 10 May, 2008