HEALTH REFORMS AND HEALTH CARE DELIVERY IN LUSAKA URBAN DISTRICT

By

Charles Tennard Banda

A dissertation submitted to the University of Zambia in partial fulfillment of the requirements for the award of the degree of Master of Public Administration (MPA).

The University of Zambia.

April, 2009

DECLARATION

This dissertation represents my work, and has not previously been submitted for a degree, diploma or any other qualification at this or another University.

Name:.....

Signature:.....

NOTICE OF COPYRIGHT

CERTIFICATE OF APPROVAL FORM

This dissertation of Charles Tennard Banda is approved as partially fulfilling the requirements for the award of the degree of Master of Public Administration by the University of Zambia.

Examiners	**Date**	**Signature**
Internal Examiner	.....	.....
Internal Examiner	.....	.....
Supervisor	.....	.....

ABSTRACT

Health care delivery policy and strategies in Zambia could be said to have evolved through four significant phases. First, the pre-independence era whose health policies and strategies were based on the racial segregation ideology. Secondly, the immediate post-independence era whose health care policies and strategies were aimed at abolishing the imbalances introduced during the colonial era. The third phase was the adoption of the Primary Health Care (PHC) in the provision of health care in the 1980s and fourthly, because of the failures of the Primary Health Care concept in the 1980s when the Movement for Multiparty Democracy (MMD) government took office in 1991, they embarked on Health Reforms whose main thrust was the establishment of District Health Boards as basic management units in the delivery of health care.

The aim of this study was to establish the failures of health reforms in ensuring effective health care delivery in Lusaka Urban District which is run by Lusaka Urban District Health Management Board. In realizing the aim of the study, this dissertation takes a comparative study of health care services offered by different health care facilities in Lusaka urban district so as to make a balanced assessment of the performance of the health facilities under the health reforms in ensuring effective health care delivery.

This study was conducted in Lusaka district. A total of 193 Health Care Providers, 382 Clients and 503 Community members were interviewed from 22 Health Centers. In arriving at the sample the researcher considered the number of health facilities under study, their staffing levels, and the feasibility of attaining the intended sample size with regard to available resources such as time, manpower and finances. A list of health centers in Lusaka Urban was obtained. Included in this list were University Teaching Hospital (UTH), Chainama Hills Hospital and Maina Soko Military hospital. Under the list of health centers, five (5) health centers that offer baby delivery services and five (5) that do not offer baby delivery services were randomly chosen. All health care providers who were found on duty (averaging 15-20) on the days of the survey were interviewed. Likewise,

all the Health Care Providers on duty in the Out-patient and Specialist clinics were also interviewed. Social Science (SPSS Version11.0) was used to analyze the data. The study established that although the health reforms has contribute in the introduction of District Health Boards with a view of bringing health care service delivery as close to the family as possible, a number of issues still remain unresolved.

The study established that although there are clear indications that there is some movement towards availing health care providers in sufficient numbers to all the health care facilities in the district, there is need also to balance gender of the staff distributed to these facilities. However, the lack of feed back on referred patients and the charging of user fees were some of the issues cited for the dissatisfaction amongst users of health care facilities in Lusaka Urban District.

Critical questions pertaining to equity of access and quality of delivery of health care system were highlighted. All these questions reflected concern and indeed this study, clearly demonstrated these concerns: Implementing user fees with persistent drug shortages, efforts to decentralize power to the districts without resolving de-linkage and staff motivation and equity of access to health care, setting of quality standards without involving stakeholders are some of the issues requiring immediate attention.

ACKNOWLEDGEMENTS

There are many people that I need to thank for this effort. Firstly, I'm particularly grateful to Dr.M.C.Bwalya who is my Supervisor who provided the necessary academic support and guidance in writing this dissertation. Secondly, I wish to thank all members of the Political and Administrative Studies department at the University of Zambia and indeed all my friends for the support rendered in one way or the other. Thirdly, I extend my thanks to the Director General of the Central Board of Health and all the Ministry of Health officials who made this study possible through facilitation of data collection. Fourthly, I'm grateful to all the respondents who despite being busy found time to be interviewed. Lastly, I'm grateful to my family (Rebecca, Terry, Kambe, Wanga and Chimbiri) for their understanding.

Table of Contents

LIST OF TABLES

ABBREVIATIONS

BP	Blood Pressure
CCJP	Catholic Commission for Justice and Peace
IMF	International Monetary Fund
SAP	Structural Adjustment Programme
SIDA	Swedish International Development Agency
C.S.O	Central Statistical Office
W.H.O	World Health Organization
MMD	Movement for Multiparty Democracy
WB	World Bank
GRZ	Government of the Republic of Zambia
DHMTs	District Health Management Teams
PHO	Provincial Health Office
CBOH	Central Board of Health
MTR	Mid –Term Review
NHSP	National Health Strategic Plan
LUDHMT	Lusaka Urban District Health management Team
CDES	Classified Daily Employees
UNICEF	United National Children's Fund
AIDS	Acquired Immune Deficiency Syndrome.

T.B	Tuberculosis
NGOs	Non Governmental Organization
PHC	Primary Health Care
NEDL	National Essential Drug Lists
SPSS	Statistical package for Social Sciences
NHC	Neighborhood Health Committees
PWD	Public Works Department
LWSC	Lusaka Water and Sewerage Company
ZESCO	Zambia Electricity Supply Cooperation
ZMK	Zambian Kwacha
f	Frequency
%	Percent
NERP	New Economic Reform Programme
HERA	Health Empowerment Rights and Accountability

CHAPTER ONE

INTRODUCTION

Introduction

At independence, Zambia inherited a medical system formed during the colonial era which had a strong bias towards urban and the copper mining areas. During the first years after independence, Zambia had a strong economy reliant on a vibrant copper mining sector. In the 1980's, however, the country faced economic decline in both its external and domestic sectors, due primarily to falling copper prices and the sudden rise in oil prices. Relatively scarce foreign exchange that was available at the disposal of government for provision of various services including health care delivery was used to purchase oil for mining activities. While the cost of copper production escalated, output still remained below production targets in the 1980s. This in turn affected the earnings from the sale of copper putting a strain on government's ability to offer quality health care that is free and accessible to every citizen. Although health care services that were provided through the government were free, the bias towards urban-based tertiary health care pushed most services out of reach for a large population.

Lake and Musumali (1999) observed that in the 1980s, as a result of the poor economic performance, government expenditure in the social sectors including health begun to decline. The decline in the health sector investments resulted in the deterioration of the physical infrastructure, acute shortage of drugs and medical supplies leading to a deterioration of services. In addition, Foltz (1997) noted that health workers became demoralized through working with inadequate resources and an overly centralized management structure unresponsive to local needs and conditions.

Indeed, according to Kalumba (1997), one third of senior medical personnel left their jobs to go and work abroad leaving their positions resulting in a shortfall in the much needed qualified manpower to provide health care. Kalumba further added that during

this period, mortality figures rose considerably and specifically cited infant mortality rates which increased from 90 to 109 per 1000 births between 1988 and 1991. The 1980s also saw the re-emergence of malaria which was thought to have been contained with the use of Chroloquine and Quinine and a new threat of HIV/AIDS, all of which served to increase the demands on an already under funded health sector.

In response to this challenge of declining health care delivery system, the government turned to the World Bank (WB) and International Monetary Fund (IMF) for assistance. This led to the adoption and implementation of health sector reforms which were seen as the only way health service delivery could be improved. By 1991 Health Sector Reforms in Zambia were officially launched. GRZ (2003:16), identified the main goal of health sector reforms as "to provide Zambians with equity of access to cost effective, quality health care as close to the family as possible", with the districts as the main focus for service delivery and primary health care as the vehicle for achieving this.

Statement of the Problem

In a reformed health sector whose goal is to provide equity of access to cost effective, quality health care as close to the family as possible, it is expected that there would be improved health care delivery. However, in Zambia and Lusaka Urban in particular, despite the introduction of health reforms, the perception of health care delivery is still low MOH (1992). According to WHO (2002), under the reformed health sector, Lusaka's health care provision was organized around 22 Urban Health Centers, the University Teaching Hospital, Maina Soko Military Hospital, Chainama Hills Hospital, 12 private hospitals, 1 parastatal hospital, over 200 private physician clinics, 4000 Traditional Healers, 15 trained Traditional Birth Attendants and 24 Community Health Workers. This is against 93 residential areas in Lusaka Urban of which 30% of these being shanty compounds.

Although there seems to be a concentration of health facilities in Lusaka Urban as a result of the introduction of health sector reforms a decade ago, Kalumba (1997) observed that mortality rates from treatable diseases had continued to rise while health service delivery

continued to decline (specifically infant mortality rates increased from 90 to 109 per 1000 births between 1988 and 1991, the challenge brought by malaria which was thought to have been contained with the use of Chroloquine and Quinine and a new threat of HIV/AIDS, all of which served to increase the demands on an already under funded health sector.

The failure to resolve the health care crisis raised a lot of questions, including the following: Are Health Care Providers adequate in Lusaka Urban? Do Health Care Providers co-ordinate their services? What ranges of Health Care services is provided? Is the Health Care Delivery system efficient and effective? Are the Health Care services accessible? A void therefore, does exist, and there is need of establishing the underlying factors for the failure by the government to successfully implement a Health Care delivery system in Zambia and Lusaka Urban District in particular.

Objectives of the Study

General Objective

To establish the impact of health reforms on service delivery in Lusaka Urban District

Specific Objectives

Objective 1:

To examine health care services provided by the Lusaka Urban District.

Objective 2:

To identify factors affecting accessibility to health care services.

Objective 3:

To assess the effects of each factor on health care delivery.

Objective 4: To suggest ways of improving health care delivery in Lusaka Urban District

Significance of the Study

The results of this study were expected to provide an insight in to the factors that inhibit or make it difficult to successfully deliver health care in Lusaka Urban District under the health reforms. The findings of the study not only tried to contribute to the body of knowledge on health care delivery, but could also be used to adjust the current health reform strategies in order to enhance performance of the health sector.

Conceptual Framework

This dissertation centers around the relationship between government policies, programmes and strategies on one hand and the health care delivery system on the other. The policies and strategies formulated by government should be able to resolve the health care delivery problems in the country. Social science researchers see health reforms as a process through which health care delivery could be improved.

The health reform strategy that the Zambian government adopted in 1991, emphasized providing Zambians with equity of access to cost effective, quality health care as close to the family as possible. In this study, health reform has been conceptualized within the context and demarcations established by Berman (1995) who viewed health sector reforms as a sustained, purposeful change to improve access, efficiency, and effectiveness of the health sector.

This perception of health reforms by Berman is preferred and adopted in this study because it has the benefit of linking up the strategy with the elements emphasized in the Zambian health reform process. Further, it has the benefit of defining the elements for acceptable health care delivery and provides a means for assessing the desired goals.

It can be concluded therefore that health sector reforms are concerned with the interrelated processes of the health care delivery system such as availability of

qualified health care providers at health institutions, range of services available for access, coordination among health care providers, accessibility to health facilities and the effectiveness and efficiency of the health care delivery system which should be present and well galvanized to achieve the desired service delivery levels. The factors mentioned above, enable an institution or country such as Zambia to develop a health care strategy that will lead to the development of a health care delivery system that would have the greatest potential to the Zambians.

However, decisions must be made about which new or additional features will fit in with the existing service delivery ranges, how the available services currently could be altered to keep pace with the ever changing demands on health care delivery and how change and renewal of the service delivery could be implemented. The aspect of continually assessing the service delivery levels in this respect becomes very relevant.

In this dissertation, factors referred to the elements necessary to drive the health reform process in order to achieve improved health care delivery. It included comparing the goals of the health sector reforms with what has been achieved so far in meeting those goals.

Health Care Providers referred to those people employed in the health sector to provide health care and these were analyzed according to their categories such as Doctors, Nurses, and Laboratory Technologists.

Coordination of services provided refers to the ability by health care providers to coordinate their service delivery activities in order to avoid duplication of the offered services. Feed back for instance should be provided on patients that are referred to other levels of care in order to maintain correct statistics among other benefits.

Types of health care services referred to the range of health care services that were provided by the institutions in the health sector and the frequency at which these services were provided.

Outreach programmes are those programmes that involve home visiting, school health and Mother to Child activities conducted by health care providers.

Management of health services on the other hand is the process with which superior officers in Lusaka Urban District are able to supervise the operations of health care providers in the various locations in Lusaka. The frequency of interaction between these structures.

Efficiency and effectiveness of health care delivery services referred to the availability of drugs and whether they were adequate and regular, whether clients were satisfied with the services that were being offered and whether clients were visiting health care facilities for treatment.

Accessibility to health services referred to clients being able to access health care facilities either through outreach programmes or by visiting health facilities either through ambulance referral or self referral by using public transport to the nearest facility. Additionally, assessing the effects of user fees on attendance to health care facilities.

Clients and Communities referred to those people or patients that may visit the health facility and those that may reside within that locality or catchment area respectively.

Literature Review

Literature on the different aspects of Zambia's health policy is quite substantial even though that which deals specifically with access to health services and facilities cannot be said to be as much.

A number of studies on Zambia's health reforms have been undertaken. For example, a survey by Limbambala and Choongo conducted in 1994 entitled "Asessment of Current Government Health Care Delivery Services in Lusaka Urban District" whose main aim was to examine health care services provided by Lusaka Urban District concluded that health care services provided by Lusaka Urban District Health were inadequate. The conclusions by Limbambala and Choongo (1994) are relevant for our study for the reason that they analyzed health care services that are provided in the district. However, in determining health care delivery in Lusaka District, our study looked at the services provided by Lusaka Urban District Health Board of management in a broader perspective encompassing other areas such as those relating to access to available services. This is the gap that our study was able to fill in the contribution of knowledge.

A study by Shaw and Griffin done in 1995 entitled," Financing Health Care in sub-Saharan Africa" published by the World Bank covered some aspects that are used as determinants of access to health services in our study. The study looked at aspects of cost –sharing, community participation, decentralization, quality of health care, and utilization of health services. Although this study looked at some aspects of health reforms and health care delivery which are of relevance to our dissertation, the study was conducted at the time when health reforms were in their "infancy", for example the National Health services Act which provides for the structure of the health reforms was introduced in the year, 1995, when this study commenced. The conclusions that were made then might not be the same now about ten years after the introduction of the health reforms. This is the gap that our study aimed to fill as it provided conclusions that are current.

MOH (1996) in a study, tilted "Review of the Zambian Health Reforms", conducted an evaluative study of the health reforms. The evaluation carried out in September, 1996, analyzed in general and documented the process of implementing the health policies and strategies. Therefore, this study assessed in general terms the status of the effort that was being made in implementing the health reforms at the time that is in 1996.The study by MOH (1996) emphasized the lessons that had been learnt during the implementation of the health reforms by identifying areas that were on schedule and those that required reworking.

This report is relevant to our study in that it provided general insights to the implementation of the health policies and strategies. However, a gap was identified in this report in that it placed emphasis on the lessons that had been learnt during the implementation of the health reforms in 1996 while our study specifically aimed at assessing health reforms and the delivery of health care in Lusaka Urban District.

Paton (1997) was more apt about achieving equity of access to cost effective and quality health care as close to the family as possible being one of the cornerstones of the health reforms. Based on his study in the Netherlands in 1997 entitled "Intended Uses of Funds in Utilization Focused Evaluations", published by Sage Publications in Delhi, he concluded that introducing medical insurance as part of the health reform process based on risk equalization through a risk equalization pool improved access to medical services. The conclusion by Paton (1997) was arrived at after studying the effects of insurance on access to health care.

In this way, a compulsory insurance package would be made available to all citizens at affordable cost without the need for the insured to be assessed for risk by the insurance company. Paton (1997) added that indeed health insurers had become more willing to take on high risk individuals because they received compensation for the higher risks. Paton provides a broader perspective of the health reform process that is relevant for the study for the reason that the strategy introduced by the Dutch government encompasses the introduction of compulsory insurance in order to increase access to health facilities.

Although, these contributions by Paton (1997) are relevant to our study because they bring out the issue of increasing access to health services through introduction of compulsory insurance, this study was conducted in the Netherlands. The willingness in our opinion amongst the people of the Netherlands to accept forced insurance might not be the same as in Zambia. Our study looked at health reforms and service delivery in Lusaka Urban District and how access to health care delivery could be improved. The gap in knowledge left by the study by Paton (1997) was therefore filled by our dissertation.

Another view on the reforming of the health sector was brought out by Strandberg-Larsen *et al* (2007) in their report entitled "Health Systems in a Transitional Denmark". They noted that the mainly *tax based* Danish health care system had traditionally been very decentralized politically, financially and operationally with public, regional and local authorities being responsible for the provision and delivery of health care services. The Danish health care system has been characterized by strict expenditure control resulting in high patient satisfaction as expenditure is restricted only to those activities that enhance service delivery. However, Strandberg-Larsen *et al* concludes that as a consequence of decentralization access to health care in different parts of the country has been somewhat unequally distributed as health care delivery was dependant on the taxes collected in the areas.

These observations by Strandberg-Larsen *et al* (2007) are also relevant to this study in that they brought out the issue of decentralization in an effort to achieve equity of access to cost effective health care as close to the family as possible. The Zambian health reforms embrace decentralization through the creation of Health Boards which are in turn charged with the responsibility of health care delivery. Equity of access would be a fallacy if all health facilities are going to be concentrated in one location. Equity of access to health services could be improved in a decentralized set up as adopted by the Danish government. However, despite the findings by Strandberg-Larsen *et al*, a gap still exists in that their study was conducted on the Danish health care system while our study

concentrates on health reforms in Zambia and service delivery in Lusaka Urban District. Secondly, the study conclusions by Strandberg-Larsen *et al* were more based on a tax based health care delivery system while the health sector in Zambia is financed through grants and not taxes collected in a local area.

Lengwe (1985) in his PhD Thesis entitled "An approach towards an equitable and affordable health care delivery system in a developing country": The case of Zambia" discussed the imbalances that exist between rural and urban areas in accessing health services and facilities. He argues that health facilities are more accessible in urban areas than in rural areas. He says there are more hospitals and clinics in urban areas than in rural areas such that patients in rural have to walk for long distances to access the nearest health centre. Further, he concludes that trained health personnel have a tendency of working in urban health centers where conditions of life are relatively attractive (Ibid).

Lengwe's work is very relevant to our analysis of the impact of health reforms on access to health facilities and services as it gives us a detailed analysis of the distribution of health services and facilities in urban and rural areas. However, Lengwe's work places emphasis, on the equitable distribution of health services and facilities, while our study focuses on the impact of health reforms on health services in Lusaka Urban District. In addition, Lengwe's study was done before the introduction of health reforms in Zambia. When Lengwe's study was conducted, most hospitals, clinics and rural health centers were still managed by the government except for a few which were run by the churches. Today the management of health institutions is under district health boards and that's the reason for conducting a study that would specifically analyze the service delivery of the Lusaka Urban District Health Board.

Booth *et al* (1995) discussed aspects of access to health services, particularly the impact of user fees. This is in a report entitled," Coping with Cost Recovery", published by Stockholm University. In this study, Booth *et al* analyzed the uses of user fees by health care providers. They concluded that the additional revenues earned from user charges had contributed towards improvements in the quality of care at some clinics and hospitals.

They noted that there had been improvements in the physical environments, availability of cleaning materials and linen. They further observed that staff morale as a result of the introduction of bonuses, provision of tea during tea breaks and the introduction of new uniforms (trousers for female nurses) had improved. In addition drug availability problems had ceased at some hospitals especially those entitled to purchase drugs from private suppliers (Zambia/UN, 1996). However, Zambia/UN report indicates that the emphasis on efficiency had in some instances outweighed efforts to improve equity and access to health services.

In concluding their study, Booth *et al* lamented that the levels of charges had prevented a large proportion of poor people from gaining access to health services, especially women and children who need health services most. According to (Zambia/UN, 1996), there had been a decline in patient flows of 60 to 80 percent at urban health centers following the introduction of user charges.

It has been found out that other African countries have introduced user fees in health institutions as a way of mobilizing resources for health services. WHO (1994) found that all francophone sub-Saharan countries and almost all Anglophone and Lusophone had some form of user fee system in place. Raising of additional revenue, improving efficiency and improving of quality health care have been identified as the main objectives for charging user fees.

Evidence on the impact of user fees on access to health services is mixed. In the Zambian case as mentioned above, it can be concluded that user fees have prevented a large promotion of poor people from gaining access to health care facilities. In Mozambique fees income in 1992 only accounted for an insignificant less than 1% of the total government recurrent health spending (Ministry of Health Nigeria, 1993). However, in Cameron, a pilot study which made a comparison between two health centers which increased fees and used the extra revenue to purchase drugs thus improving the quality of health care, and other two control health centers where no charges were made showed

that utilization rates improved amongst the group of health centers with fees Rohde's (1984).

These studies by Booth *et al* (1995), (Zambia/UN, 1996) and (Rohde's (1984) provided us with an insight into the effects of user fees on attendance and quality of health care delivery. Although the studies are relevant to our dissertation, limitations have been identified in these studies in that they were not only conducted outside Zambia, but also did not comprehensively address the issue of the impact of health reforms and health care delivery in Lusaka Urban District.

A study by Shaw and Griffin conducted in 1995 entitled," Financing Health Care in Sub Saharan Africa", which was published by the World Bank at Washington D.C, discussed new insights which had resulted from their survey on cost sharing/user fees in African countries. (Shaw and Griffin, 1995) concluded that utilization of health facilities after the introduction of user fees reduces. They however outline eight pre-conditions for successful policies on user fees to be implemented. These were identified as:

- Community participation in local health facility governance;
- The formulation of an explicit policy on user fees;
- Emphasis of efficient management of facilities;
- A re-think of targeting subsidies;
- Permission for lower level care providers to retain a portion of their fees collection;
- Improved procurement practices, especially for drugs;
- Promotion of the development of private sector health care providers; and
- The building of an information base for future policy evaluation. (Ibid:3-4)

In the same manner Reddy and Vandermoortel in their report entitled" User Financing of Basic Services: A review of theoretical arguments and empirical evidence", published in 1996 by UNICEF categorized what they termed principles of best practice of user

financing of the basic social services. They concluded that some of the issues listed below were very important to user financing of the basic social services:

- To rely heavily on community participation in the design and management of user financing so as to instill a sense of ownership commitment from the community.
- To initiate a major programme of community training and social mobilization to build capacity for meaningful co-management.
- To ensure that users perceive an improvement in the quality of services in the early stage of user financing, e.g., by directing revenue to the procurement of quality enhancing inputs such as essential drugs. By so doing, the user's commitment to paying user fees can increase.
- Ensure that selected services offered are exempt such as immunization and specific target groups that are more easily identified than the poor.
- Gradual introduction of user financing so as to allow for adequate modification to take account of many cultural, regional and seasonal factors that may inhibit success
- Provide adequate information and incentives to the providers of the services. This does not only aid capacity building but also improves the morale of health workers.
- To retain the bulk of the revenue and authority to spend it at the local level to ensure that financing does not substitute for existing budgetary allocations. This enhances autonomy of local authorities and can promote re- investment of locally generated financial resources thereby supporting identified future needs.

The categorizations of the principles or key elements of the best practice of user financing helped the researcher greatly in the assessment of the effects that user fees have had an access to health services and facilities in Zambia. Through such lists, we were able to determine some of the elements which could have been left out by the policy makers at the design stage of health reforms in Zambia

However, although both studies by (Shaw and Griffin, 1995) and (Reddy and Vandermoortel, 1996) were relevant to our study, we noticed some limitations in their analysis and conclusions in that Shaw and Griffin's work had a broader area of analysis which covered all sub-Saharan countries. Our scope of the study specifically looked at Zambia and Lusaka Urban district in particular. On the other hand the conclusions by Reddy and Vandermoortel, 1996) although relevant to our study, categorized what they termed principles of best practice of user financing of the basic social services. This study and subsequent conclusion was more focused on user financing of basic social services in general. We found these conclusions to be very broad as our focus is to assess health care delivery in Lusaka Urban District. This is what therefore motivated us to fill the gap in knowledge.

On the other hand, Government of the Republic of Zambia in a study conducted in 1994 which was entitled," A Guide to Zambian Health Reforms", published by the Ministry of Health discussed the issue of access to health services by looking at the issue of availability of health facilities and the personnel to man them. According to this report, by 1990, the population in Sub-Saharan Africa with access to health services was estimated at 75%. This meant that about 25% had no access at all to health services and facilities. Coupled with this problem was the low capacity in some categories of health personnel such as doctors, nurses and clinical officers in many health centers. By 1994, there were 10,000 people to one doctor creating a lot of pressure on the doctors.

Reports such as the study discussed above were relevant to the study as they provided us with general information regarding the levels of attendance to health facilities in sub-Saharan Africa and also the categories of staff in health care facilities. However, our study concentrated on the attendance levels and availability of health care services in Lusaka Urban District. This is where a gap in knowledge existed.

Papua New Guienea was a case that served as a basis for analyzing the benefits of autonomy of district health boards Paton (1997). Autonomy is emphasized by the Zambian health reforms. Bell's work on the organization and administration of health

services in Papua New Guinea states that the Chairman of the District Health Committees is the District Health Officer, and members of staff in charge of programmes at district level are included in the District Health Committees. Church representatives sit on the committees, as do representatives of other key departments such as district administration and education. Additionally, the officer in charge of each major health centre in the district also sits on the committee Paton (1997). What was of significant importance to us were the successes of these autonomous committees which are out lined by Bell as follows:

- They have formally brought together government and church health workers together.
- Problems through out the district are presented and solutions may be possible before a representative returns to his/her own centre.
- Central policy can be passed on to district staff and discussed in free and open form.
- District administration, education and other departments relate very well and realistically to health matters and programme targets and achievements in the preventative health field can be set and reviewed by discussions and negotiations (Ibid: 422).

Such successes as these were used as yardsticks in this study when assessing health care delivery in Lusaka Urban District.

In writing on the success story of China's primary health care and its concept of 'barefoot' doctors (village level health workers) Rohde in a publication by the Oxford University Press, published in 1984 and entitled," Health for All in China: Principles and Relevance for Other Countries", also gave a number of factors which we had to bear in mind as we undertook our study. He writes that the success story in China was as a result of six main factors. First is that, political and health systems are inextricably linked. That is from the highest political levels through to revolutionary committees and production brigades; China's health care system is deeply embedded in political institutions and processes which emphasize self-reliance and the equitable distribution of resources.

services in Papua New Guinea states that the Chairman of the District Health Committees is the District Health Officer, and members of staff in charge of programmes at district level are included in the District Health Committees. Church representatives sit on the committees, as do representatives of other key departments such as district administration and education. Additionally, the officer in charge of each major health centre in the district also sits on the committee Paton (1997). What was of significant importance to us were the successes of these autonomous committees which are out lined by Bell as follows:

- They have formally brought together government and church health workers together.
- Problems through out the district are presented and solutions may be possible before a representative returns to his/her own centre.
- Central policy can be passed on to district staff and discussed in free and open form.
- District administration, education and other departments relate very well and realistically to health matters and programme targets and achievements in the preventative health field can be set and reviewed by discussions and negotiations (Ibid: 422).

Such successes as these were used as yardsticks in this study when assessing health care delivery in Lusaka Urban District.

In writing on the success story of China's primary health care and its concept of 'barefoot' doctors (village level health workers) Rohde in a publication by the Oxford University Press, published in 1984 and entitled," Health for All in China: Principles and Relevance for Other Countries", also gave a number of factors which we had to bear in mind as we undertook our study. He writes that the success story in China was as a result of six main factors. First is that, political and health systems are inextricably linked. That is from the highest political levels through to revolutionary committees and production brigades; China's health care system is deeply embedded in political institutions and processes which emphasize self-reliance and the equitable distribution of resources.

Secondly, health in China is an integral part of national development. This means that China has managed to integrate health with other sectors of national life such as education, housing, sanitation, food production and distribution, communications, employment and industry. The third factor is self reliance fostered by total participation of the community in the health systems. Forth is that health workers are selected, maintained and controlled by their own communities. That is rather than being accountable to an individual on a higher level of the hierarchy of the institution, China's barefoot doctors are accountable to communities which originally selected them, continue to maintain them and of which they are equal members. The fifth factor is that universal access to all the levels of health care services is assured through a cadre of Para-professional health workers backed by a network of reliable communications and well staffed and equipped health facilities at secondary and tertiary levels. Finally, in China, the use of traditional medicine has helped to make primary health care more affordable and acceptable to Chinese people (Ibid,).

Since the Chinese concept of implementing the concept of primary health care is generally accepted as a success story, then the question we had to ask ourselves was what aspects of the Chinese success story were left out. This is the gap that our study analyzed and tried to fill by contributing to the existing body of knowledge.

There are a lot more works from which we learnt and compared our strategy of provision of health care services with. Works such as; Kalyalya (1995) "User Fees in the Health Sector: Policy Practice and Perception". Gibson (1995) "Management and Health Care Reform in Sub-Saharan Africa". Marley *et al* (1883) "Health care in Cuba: A Model Service or a Means of Social Control- or both" Mkhpadhyay, "Human Development through Primary Health Care: Case Studies from India" in Morley *et al* (eds) Practicing Health for all, Oxford, Oxford University Press, (1983). Gary and Warren "Theoretical and Practical Underpinnings of Primary Health Care" in Gary *et al* (eds) Primary Health Care in the Kingdom of Lesotho: The Nurses Perspective, Kellogg Foundation Battle Greek, Michigan (1991). All these works by different researchers and organizations focus on the different aspects of the concept of health care delivery as it is being applied in

different contexts. In general, the different authors tried to bring out the benefits and difficulties associated with the implementation of health reforms.

Summary of Literature Review

In conclusion, the literature review shows that work done on the different aspects of Zambia's health policy is substantial. A number of research projects on Zambia's health reforms have been undertaken by varying study groups such as; research institutes, government departments, and United Nations (UN) organizations. These research projects cover a wide range of aspects that are indicators of how accessible health services and facilities are in Zambia. For example, Seshamani and others in their book published in 2002 entitled, "Zambia's Health Reforms: Selected papers 1995-2000", covers a wide range of aspects of health reforms. Also there are a number of reports published by the WHO, the World Bank, and the UN that discuss aspects to health services, particularly the impact of user fees. However, research findings on the impact of user fees on access to health services are conflicting. In some cases, such as in Zambia, user fees have been seen as barrier to accessing health services, while in some other cases, for example in Cameron, user fees have improved utilization levels of health services and facilities. This therefore justifies the carrying out of further research that includes an analysis of the impact of user fees on access to health services and facilities.

In addition there are a lot of scholars who have written on health systems in other parts of the world from which we can learn as we take an analysis of the impact of health reforms on access to health services and facilities in Zambia. These include Paul and Griffin's (1995) discussion on cost sharing/user fees in African countries; Reddy and Vandemoortele's (1996) outline of the principles of the best practice of user financing of basic social services; Paton's (1997) work on the organization and administration of the health services in Papua New Guinea; Rohde's (1984) presentation of the success story of China's primary heath care and its concept of barefoot' doctors.

However, the existing literature does not specifically focus on establishing factors for the failure of health reforms in ensuring effective health care delivery in Zambia and Lusaka Urban District in Particular. This is the gap which our research attempts to fill.

Methodology

Type of Study

This was an evaluative study which used a combination of research methods to establish the impact of health reforms and health care delivery in Lusaka Urban District Urban.

Sample Size

A total of 193 Health Care Providers, 382 Clients and 503 Community members were interviewed from 10 Health Centers and 3 Hospitals. In arriving at the sample the researcher considered the number of health facilities under study, their staffing levels, the feasibility of attaining the intended sample size with regard to available resources such as time, manpower and finances.

Sampling Methods

The stratified random sampling method was chosen for the study. This was meant to divide the population under study into different classifications or groups that are called stratum and ensure that each element of the population belongs only to one stratum to avoid duplicated counting.

A list of health centers in Lusaka Urban was obtained. Included in this list were University Teaching Hospital (UTH), Chainama Hills Hospital and Maina Soko Military hospital.

Under the list of health centers, five (5) health centers that offer baby delivery services and five (5) that do not offer baby delivery services were randomly chosen.

All health care providers who were found on duty (averaging 15-20) on the days of the survey were interviewed. Likewise, all the Health Care Providers on duty in the Out-patient and Specialist clinics were also interviewed.

Clients

Every client who visited the health facility at the time of the survey was interviewed. Considering that clients who visit health centers are from different strata, there was therefore no need to randomly sample the clients. However, to ensure that every client had a chance to be selected to participate in the survey, the first client who came out of the exit side of the health facility after being provided with the required services was interviewed. Thereafter, it was any client who came through the exit after interviewing the previous client. Considering that the daily attendance for a health centre at the time of the survey was between 200-500 patients, 10% of the total number of the clients was considered representative enough a sample. Therefore 20 clients were interviewed in each health centre.

However, for the three hospitals, the sample sizes were as follows:

- University Teaching Hospital (200) i.e. ten times that of health centre
- Chainama Hills hospital (100) i.e. five times that of a health centre
- Maina Soko Military Hospital (50) i.e. two and half times that of health centre.

Community Members

Multi-stage sampling method of research was used to sample the households to be selected in each catchment area of the health facilities. A list of sections and house numbers in the community was collected. The researcher used a systematic sampling method using randomized numbers to select the stating point. Once the house hold was selected, the head of the household was preferred for the interview, and where the head of the household was not present, the next adult present would be selected for the interview. The target for this sample was 60 houses per health centre catchment area. However, no community members were to be interviewed for the three hospitals as clients who utilized the three hospitals were said to come mainly from the communities in Lusaka urban and beyond and not necessarily one catchment area.

Focus Group Discussions

Additional information was collected through Focus Group Discussions in the health centers in order to obtain more information on the effects of health reforms on the quality of heath care delivery in medical institutions in Zambia in general and Lusaka urban in particular. This complimented information obtained from interviews with Health Care Providers, clients and the community members

Data Collection Techniques & Instruments

Pre-structured questionnaires were used to gather information from Health Care Providers, clients and the communities. Participant observation methodology was also used by virtue of the researcher being a member of the Ministry of Health/Central Board of Health. Observation areas were attitude of staff towards clients, levels of cleanliness at a facility, client –staff interaction and flow of clients.
Focus Group discussions were also conducted and results documented and analyzed.

Data Analysis

The statistical package for the social sciences (SPSS Version 11.0) a software package for analyzing data of a primary nature in Social Sciences was used to interpret data. The researcher on the other hand manually analyzed and interpreted secondary data collected.

REFERENCES

Booth, D, Milimo J, Bond, G, (1995) "Coping With Cost Recovery". Stockholm University.

Bell, C, (1993) "Organization and Administration of Health Services" : The Diseases and Health Services of Papua New Guinea. Port Moresby.

Limbambala, M. E and Choongo, D.E, (1994), "Assessment of Current Government Health Care Delivery Services in Lusaka Urban".

Lengwe, Mwansa, K.J (1985)" An approach Toward an Equitable and affordable health care delivery System in a developing Country: The Case of Zambia. PhD Thesis. Brandeis University

MOH, (1996) "National Policies and Strategies": Health Reforms, Lusaka. Zambia.

MOH, (2003)" National Policies and Strategies": Health Reforms, Lusaka, Zambia

Paton, M, Q, (1997), "Intended Uses of Funds in Utilization Focused Evaluations". Delhi: Sage Publications.

Reddy, S and Vandemoortele, J, (1996)" User Financing of Basic Services": a Review of Theoretical arguments and Empirical Evidence.UNICEF

Rohde, J, (1984),"Health for all in China" Principles and Relevance for Other Countries: Practicing Health for all. Oxford University Press. New York.

Seshamani, V and Mwikisa N.C (Eds) (2002) "Zambia's Health Reforms. Selected Papers".K.F.S. AB.Sweden.

Shaw, P.R and Griffin C.C, (1995),"Financing Health Care in Sub Saharan Africa". Directions in Development Series. The World Bank at Washington D.C

Strandberg-Larsen M, Nielsen MB, Vallgarda S, Krasnnik A, Vrangaek K, (2007) "Health Systems in Transition-Denmark. The European Observatory on Health Care Systems": London.Mossialos E, (E).Unpublished.

WHO, (1994) "Primary Health Care". Geneva. Switzerland.

Zambian, Government of the Republic of / United Nations Development Programme (1996) "Prospects for Sustainable Human Development in Zambia-More Choices for our People". GRZ/UNDP.Lusaka.

CHAPTER TWO

THE CONTEXT OF HEALTH SERVICE DELIVERY IN LUSAKA URBAN DISTRICT

Introduction

The dynamics of the global environment have been attributed to a number of changes that have occurred. The Zambia's health policy for example, as the case is with health policies of the rest of the world, has not been static. It has been forever changing. However, much as the changes in Zambia's public health policy have been mainly influenced by global trends, they have also been influenced, to a certain extent, by changes that have taken place in the structure of the Zambian economy from the colonial period to up to modern times. It is recognized that the structure of the economy, together with the prevailing ideology and philosophy, to a certain extent, tend to define and condition the living circumstances as well Lengwe (1985). This entails that the provision of, and access to, health services and facilities in Zambia cannot be divorced from its economic developmental efforts. It is in fact often urged that health and economic development are extricable interrelated, each serving as both ends and means with regards to the other Zambia (1992).

This chapter therefore outlines the changes that have taken place in the Zambian health sector as regards the delivery of health care from the colonial period to the time of the study. The chapter is divided into three sections. The first section is a brief discussion of the nature of the public health system that existed under the colonial administration, during the immediate post independence period from 1964 to about 1980, and the period after the adoption of the primary health care concept from 1980 up to 1991 and subsequently the introduction of health reforms. The second section discusses the policy objectives underlying the reforming of the healthy sector and the structural changes that have been made in the public health system in order to achieve these policy objectives. The third section analyses available facilities at health centers which were transformed as a result of the introduction of health reforms health reforms.

Historical Background

A review of the practices and policies in the provision of health care delivery services during the colonial era shows that these were part of the colour- segregation ideology that existed at that time. Colour was a factor when it can to distribution of health services. The distribution of services closely followed the formally instituted categories of Europeans, Asians, coloureds and Africans respectively. In addition, because the economic situation at that time demanded that Africans had to provide cheap labour to the mines, the colonial administration provided the Africans with social amenities such as education and health in order to have a literate and health labour force. Mining was done along the line of rail and as such health and education services were provided first and foremost to the urban Africans rather the rural African population who were in the majority (Lengwe, 1985 and Zambia, 1965).

At independence, in 1964, the new government inherited a system whose health policy was very much oriented along racial lines and which had imbalances between rural and urban areas in terms of service provision. The challenge therefore that government was faced with was to create a public health system which could eliminate these imbalances in the provision of, and access to, health care services and facilities. The government's major thrust in health care delivery was equity of access to health services-ensuring that even the poor and vulnerable people had some access to health care.

In order to achieve this, the government adopted a health management system which was pyramidal. At the apex of this pyramid were central hospitals where the specialist medical personnel were. At the second stage lower than the apex were the main general and regional hospitals to cater for all cases other than those requiring specialist treatment or attention. The third stage were the district hospitals which dealt with all normal diseases and surgical requirements. The levels at the bottom of the pyramid where clinics and rural health centers are found are considered to be the most important as they play the "gate-keeper role". The aim of government at the time was to achieve equity of access to

health facilities through construction of as many clinics and health centers in the rural areas as possible. As stated in the outline of the Transitional Development Plan, in general, government policy learned towards strengthening of facilities and services so as to make normal medical treatment geographically and even locally accessible to all Zambians (Zambia, 1965). In fact United National Independence Party (UNIP) in 1972 brought out the scheme of health for-all and the Zambian government abolished user fees and private hospitals (First National Development Plan 1966-1968).

After attaining independence, considerable progress was made by the new government in providing health facilities and services. Between 1964 and 1974 the following improvements were recorded: central government expenditure on health services increased four fold while the number of hospitals and hospital beds increased by nearly two-thirds to reach the level of one of the most favorable in Africa. The ratio of the beds and cost in the hospitals to the Zambian population was 3.9 beds and costs per 1000 people. In addition, the number of health centers and clinics doubled (International Labour Organization, 1970 and Zambia, 1992).

The improvements were how ever short-lived. The health services and facilities in Zambia started deteriorating in the late 1970s. There are two major sets of reasons attributed to this. The first reason is the economic decline which the Zambian economy started to experience in 1975 as copper prices fell due to the economic recession experienced by Western economies. For example the Quarterly Financial Statistical Review of Bank of Zambia, June, 1982 indicates that the unit value of copper (K/tone) declined from K 1,245.20 in 1974 to K 947.90 in 1978. Not only did copper prices fall, but there was also a decrease in the production of copper from 825,000 tones in 1969 to 252,000 tones in 1973 Cederlof (1996).

The decline in both copper production and copper prices led to a reduction in copper export earnings. In view of the fact that export copper earnings constituted the most significant component of the country's Gross Domestic Product (GDP), there was consequently a decline in GDP in real terms. Bank of Zambia Report and Statement of

accounts for the year ended December, 31 1987 shows that there was an overall decline in the GDP between 1982 and 1987. There was a decline of -2.8% from 1981 to 1982, -1.9% from 1982 to 1983 and from 1986 to 1987 a decline by -0.2%. This therefore led to the decline of the economic and social advances achieved in the post independence decade.

Compounding the situation further were the increased oil prices on the world market, terms of trade also deteriorated, trade routes through what was then called Southern Rhodesia (Now Zimbabwe) were closed through the Unilateral Declaration of Independence (UDI) by the Ian Smith regime. As if this was not enough, the external debt grew as the government turned to the International Monetary fund (IMF) for balance of payment support Kelly (1991). The second reason was the adoption of a system of medical care originally developed in the industrialized countries. The system places more emphasis on the curative aspect of health care delivery than prevention of diseases. Increasingly, such a system relies on complex high technology methods which require highly trained personnel to carry out. It is also highly expensive such that it reaches a level that no country especially developing countries can afford to offer all its citizens a standard of health care to match the potential that exists (Zambia, 1980).

In trying to redness the unfavorable health care provision situation that the country was experiencing during the 1970s, the Zambian government adopted the Primary Health Care (PHC) concept in 1980 as a major element in the improvement of health facilities and services in the country. The Primary Health Care (PHC) concept was an Initiative of the Alma Ata conference in the then Soviet Union which declared Primary health Care as a strategy for the attainment of health for all by the year 2000. Primary Health Care was defined at the conference as follows: Primary Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation on and at a cost that the community and country can effort. It forms an integrated part both of the country's health system of which it is a nucleus, and of the overall social and economic development of the country (WHO/UNICEF, 1998).

The objectives of the Primary Health Care approach of achieving health for all by the year 2000 was to be attained through emphasis three key aspects. Community participation is the first element. This is a realization that in order to achieve the declared aim of making health care accessible to all the people, the nation must make effective use of all its resources. Since the most important resource is the population itself, the people must become actively involved in all aspects of primary health care. The second aspect was sectoral support. Sectors are interdependent and support from other sectors is very cardinal in ensuring success. This is in recognition of the fact that no section involved in community development can work effectively in isolation because activities in one sector have an impact on the goals of another. And the third aspect emphasized is the health system support. This in essence means primary health care cannot function without back-up and guidance from more skilled health workers. By adopting the primary health care approach, The Zambian government aimed at paying special attention to the rural areas where health needs of the people were greatest.

In spite of all the effort made by the government, there were no indications of improvements on the health status of the Zambian people. The country experienced an erosion of the health infrastructure, the quality of access to health care services declined. The deterioration was further manifested in the increasing cases of malnutrition; inadequate drug supply, high infant and child mortality rates and poor staff morale due to unfavorable working conditions (see Zambia 1992, UNDP 1992, and Zambia 1994).

Consequently, when the Movement for Multi Party Democracy (MMD) government came in to power in 1991, it took office against a background of unfavorable conditions in the health care delivery system as discussed above. As such it was realized that the health of the people could only be improved if the health system in the country underwent a radical reform. As a result , the health reform programme that involved a radical restructuring of the health system whose goal is to orient health care away from the urban, curative bias that characterized it during both the colonial and post independence periods (WHO, UNICEF, WORLD BANK) was introduced in 1992.

When the MMD government introduced reforms, it initially had to rely on existing legislation to provide a legal framework for its restructuring of the health system. A team of researchers which was commissioned by the Ministry of Health/ Health System Research (HSR) Unit /Health Reforms Implementation Team (Limbambala and Choongo, 1994) noted that the existing legislation at the time was the Public Health Act of 1930 and the Medical Services Act of 1985.

According to MOH (2003), the Medical Services Act empowers hospital Boards to raise revenue through charging of user fees under regulatory procedures defined by the Minister of Health. The provisions of this Act covered the reforms that had been introduced at the clinic and hospital level by the National Health Policies and Strategies, the original document on health reforms. This document proposed the establishment of the National Health Council in the organization structure of the health system. This council, which was to have multi sectoral representation, would have been answerable to the President of the Republic. The main role of this council was to give advice on policy directions of the health systems at national level. However, it was later realized that by changing the name of the National Health Council to the Central Board of Health, the proposal would fall within the provisions of the Public Health Act which states that the President may constitute the Central Board of Health and appoint its Secretariat. The Public Health Act and the Medical Services Act however do not cover the establishment of the District Health Boards and Hospital Boards that are provided for in the National Health Policies and Strategies.

This therefore rendered the existing legislation at the time unhelpful as the 1981 Local Government Act, which gave District Councils the power to run clinics and hospitals had not yet been repealed. It was against this background that in 1995, the government passed the National Health services Act. This is the Act which provides legislative framework on which public health care delivery system in Zambia is provided.

Structures of the Health Reforms

The section will briefly look at the features that characterize the health reforms, the structures of the reformed health system and the functions that they perform. The health reforms are primarily centered around three key elements as set out by the policy. These elements are; Leadership, Accountability and Partnership. These elements are highlighted and explained in the Handbook for District Health Board members. In this handbook, Leadership entails guiding health service managers and to provide a good example to all Zambians on how to protect and promote good health. This leadership role is to be provided by the Ministry of Health.

The Ministry of Health is mandated to provide leadership at district, province and central hospital levels in the implementation of health reforms. Accountability on the other hand entails meeting the needs and expectations of Zambians and to ensure that resources are used responsibility and efficiently. Lastly Partnership. In this context, Partnership is perceived in two ways. First, it is perceived in terms of users contributing towards the cost of care mainly through paying of user fees. Secondly, partnership is perceived in terms of government working in partnership with donors and agencies in the private and voluntary sector and other sectoral ministries in the implementation of health reforms. This initiative entails that all stake holders such as churches, communities, patients, health workers and indeed everyone affected by health matters should work together with government to produce better health.

In order to be able to achieve the above highlighted policy objectives and in line with decentralization aspect of the public service reform programme, the structure of the health sector had to be changed. District Health Management Systems had to be put in place. Autonomous District Health Management Boards were created. The Boards had the power to administer and manage public health systems in their respective districts. They facilitated the active involvement of providers of health services at peripheral health facilities and users of health services in decision making and planning for health care providers. The district therefore, becomes the basic unit of public health management where bottom up planning and implementation initiatives meet the trust of national

policies (see Zambia, 1992, Kamwanga and others, 1999, and Choongo and Milimo, 1995).

The structure of the of the district health system is made up of four key organs. First is the District Health Board (Zambia, 1992). The second organ is the District Health Management Team (DTMT) while the third and major organ of the district health management system is the Neighborhood Health Committee (NHC) and lastly the fourth major organ of the district health management system is the Health Centre Committee. (HCC).

Although District Health Boards have been given the power to manage public health activities in their respective districts, in situations where a particular district has a general hospital, the hospital would operate independent of the District Health Board. General Hospitals are managed under Hospital Management Boards (HMB). The general hospital acts as referral hospitals for district services. Worth noting is that even though these hospitals are not under the leadership of District Health Boards, Hospital Management Teams are responsible to the District Health Management Teams. This therefore is an indication that general hospitals are not completely divorced form the district health management system.

At the provincial level, the public health system has no autonomous organs. According to the handbook for District Board Members, the Provincial Health Office (PHO) is considered as an extension of the Central Board of Health (CBOH).

The Central Board of Health and the Ministry of Health are the two organs involved in managing public health in Zambia. The Central Board of Health supervises all the other health Boards in the country and can take over responsibilities of failing boards and provides technical advice, guidance, regulatory services and facilitates the network of technical expertise in the provision of health services. The Board also assists the Ministry of Health in the formulation of health policy by providing the necessary technical advice. The Ministry of health on the other hand is mandated under the policy of the health

management system to provide leadership. The Ministry is expected to be responsible for policy development, setting national goals and targets and performance review. The Ministry's leadership role is further exercised at the level of control and financial audit, quality assurance and statutory compliance and opening up of partnerships with various agencies and sectors in support of district health programming as outlined in the national health policy.

Available Facilities at Health Centers

One of the elements of the health reforms was to upgrade health centers to a mini-hospital level and be able to mange a number of less complicated cases within these upgraded clinics. Amongst the upgraded clinics in Lusaka Urban District are Kanyama, Kalingalinga, Chilenje, and George health centers. Other clinics such as Chainda and a few others were however not upgraded. For patients whose first point of contact with health care providers is with an ordinary health centre such as Chainda, the first referral centre will either be Chelston, Chilenje or Kalingalinga clinic as indicated in our study.
The study also assessed the available facilities in these health centers in relation to the catchments population as follows:

Kanyama Health Centre

Kanyama Health Centre is located in Kanyama compound. This is a high-density area in Lusaka Urban District. It is located about 1km off Los Angel's road, on the western side of Soweto market. The health facility is situated in an area which has a catchment population of 187,538 people and its catchment areas include Soweto, Chibolya, New Kanyama, John Laing, Chinika, part of Makeni and some farms in Lusaka West.

Kanyama Health Centre has the following facilities; maternity ward, children's ward, female ward, male ward and a mortuary. It also provides laboratory services to its catchment population.
However, Kanyama Health Centre does not have x-ray facilities and as such does not provide x-ray services. All cases requiring diagnosis by x-ray will have to be referred to other institutions.

The absence of x-ray at Kanyama Health Centre is a major set back in the provision of quality health care because x-ray equipment is necessary to conducting correct diagnosis.

Chelstone Health Centre

Chelstone Health Centre is located in the Chelstone residential area. This is a medium density area in Lusaka. It lies on the eastern part of Lusaka Urban District and covers part of the area between Airport road and Great East road. It has a catchment population of 53,147 people and the area covers Chelstone, Avondale, Kasisi, Public Works Department compound, Zambia Airways compound, Chainama Township and part of Kaunda Square.

The mini-hospital has facilities such as maternity ward, female ward, male ward and mortuary services.

Although Chelstone Health Centre has a laboratory which assists with the diagnosis of cases, it does not have x-ray facilities. It is necessary that besides having a laboratory, x-ray services should also be available in order to provide complete and quality health care services.

Chilenje Health Centre

Chilenje Health Centre is situated in the Chilenje residential area which is a medium density township in Lusaka Urban District. It has a catchment population of 79,650 people and the catchment areas include Chilenje, Chilenje South, Woodlands, Nyumbayanga and Libala. The health centre has the following infrastructure and facilities; maternity ward, children's ward, female ward and mortuary facilities. It also provides laboratory services but does not also have x-ray facilities.

George Health Centre

George Health Centre is located in George Township which is a high density area. The township is unplanned with a high incidence rate of diseases. It has a catchment population of approximately 142,994 people and its catchment area includes George, Lilanda, part of Matero, Zingalume, parts of Chunga, Ballastone Park, Desai and the surrounding farming areas. The mini-hospital has maternity ward, children ward, female

ward, male ward and mortuary services. The mini-hospital also provides x-ray and laboratory services to the catchment population.

In concluding this Chapter, it is however important to state that of the different organs of the organizational structure of the health management system outlined in the review, the study focused at district level. This is because as earlier mentioned, the core of the health reforms as introduced by the Movement for Multiparty Democracy government is the creation of autonomous District Health Boards. This study was therefore done with the view that in order to establish factors for the failure of health reforms in ensuring effective health care delivery can be better assessed at that level.

REFERENCES

Cederlof, C. (1996), "An Essential Basic Health Care Package for Zambia". Ministry of Health. Lusaka, Zambia.

International Labor Organization (1970) "Narrowing the Gap –Planning for Basic Needs and Productivity Employment in Zambia: Jobs and Skills Programme for Africa". International Labor Office.

Lengwe, Mwansa, K.J, (1985)" An approach Toward an Equitable and affordable health care delivery System in a developing Country: The Case of Zambia. PhD Thesis. Brandeis University

Limbambala, M. E and Choongo, D.E, (1994), "Assessment of Current Government Health Care Delivery Services in Lusaka Urban".

MOH, (2003)" National Policies and Strategies": Health Reforms, Lusaka, Zambia

WHO/UNICEF, (1998) "Alma-Ata-1998, Primary Health Care". WHO. Geneva. Switzerland.

Zambia, Government of the Republic of (1965), "An Outline of the Transional Development Plan". Ministry of Finance. Zambia

Zambian, Government of the Republic of, (1992) "National Health Strategies and Policies (Health reforms)".GRZ.Ministry of Health.

CHAPTER THREE

HEALTH CARE SERVICES PROVIDED BY LUSAKA URBAN DISTRICT

Introduction

One of the main thrusts of reforming the health sector is the decentralization of the health care provision system to ensure that beneficiaries are involved. This as was seen in the earlier chapters entails the creation of autonomous District Health Boards that are charged with the responsibility for the provision of public health facilities and services in their respective districts.

The District Health Boards as tools of health care delivery in a decentralized system are responsible for the provision of adequate health centers, all aspects of staffing, equipment and drug supplies, preparation of annual work plans and budgets for their respective districts. The district therefore becomes the basic unit of public health management where bottom up planning and implementation initiatives meet the thrust of national policies.

This chapter, therefore attempts to establish the extent to which Lusaka Urban District Health Board has handled its mandate of managing Lusaka Urban District in as far as the provision of health care is concerned as provided for by the National Health Services Act Number 22 of 1995 and Statutory Instrument number 76 of 1977.

The main focus for this chapter is to assess the available health care providers in Lusaka urban district, services that they are able to provide and the frequency of providing these services. This will be done because of one the main goals for establishing District Health Board under the health reforms is to provide access to health care as close to the family as possible.

In looking at the services provided by Lusaka Urban District Health Board, we shall focus on the available categories of staff. Related to this factor is the assessment of health

services that are provided by these categories of staff. The importance of assessing health services that are offered is a major step in determining the health service delivery to the people as it is one of the central provisions of reforming the health sector.

The study will also look at the frequency at which the services are offered to the patients. In this regard we will also look at the feed back process of patients that are referred to other levels of treatment especially within Lusaka Urban District. Lastly we will assess the availability of Outreach programmes in as far as taking health facilities to the people is concerned.

These factors have been used as the key indicators to establishing health care services provided by the Lusaka Urban District Health Board in Lusaka District. In discussing these, factors we will be making an analysis of their implications based on the responses from the respondents, both negative and positive on availability of health care services in Lusaka Urban District.

Categories of Health Care Providers

The availability of Health Care Providers at health facilities is very critical to health care delivery. Health Care Providers are Medical and non medical staffs that were found at health care delivery facilities. These were either trained or untrained staff from various categories. Table 3.1 below shows the categories of health care providers and how many of these staff were found during the study.

The study further did a profile of the Health Care Providers and established that out of the (193) Health Care Providers 29 were males representing (15.1 %) and 163 females representing (84.9%). These were from different positions in the overall health care delivery system.

Table 3.1 Distribution of Health Care Providers by Category

Health Care Provider Category	*N*	*%*
Doctor	*8*	*4.1*
R/N,R/M,FH/N,Z/EPN	*40*	*20.7*
E/N,E/M	*90*	*46.6*
Clinical Officers	*21*	*10.9*
Para Medicals	*5*	*2.6*
Daily Classified Employees	*29*	*15*
Total	*193*	*100*

KEY
R/N Registered Nurse, R/M Registered Midwifery, FH/N Family Health Nurse, Z/EPN Zambia Enrolled Public Health Nurse, E/N Enrolled Nurse, E/M Enrolled Midwifery.

The study revealed that there were more female (84.9%) Health Care Providers in the institutions that were under study than males (15.1%). see Table 3.1. This situation could present a challenge in the delivery of health care as some male patients may prefer to be attended to by Health Care Providers of the same gender orientation who are less. The impact of this gender imbalance is that those clients that do not get the preferred Health Care Providers in terms of gender will perceive service delivery as being inadequate.

Where else do people go when they are sick

Table 3.2 below discusses where else the patients go to seek medical services when they are sick other than going to the government health centers. To this effect, Health Care Providers were asked about the responses they received when they interviewed clients/patients on where else people go when they are taken ill other than their health center.

Table 3.2 Distribution of Health Care Provider's responses on where else people go when they are ill.

Facility	*N*	*%*
Private Clinics	*199*	*42*
University Teaching Hospital(Self referral)	*28*	*34*
Traditional Healers	*62*	*24*
Total	*382*	*100*

In looking at this aspect, the study did take cognizance of the fact that the health reforms did recognize that in order to cater for the needs of fast growing populations and to solve the problem of limited access to health facilities, the government needed to encourage public –private partnerships in the delivering of health care. The government encourages private sector for profit providers to collaborate with the public sector through non-monetary and monetary incentives inherent in the collaboration. Several countries have documented experiences with the provision of supplies such as vaccines, condoms and other contraceptives through private practitioners to the public in order to encourage them offer preventive services. The health reforms also recognized traditional healers as part of the health care delivery system in Zambia and Lusaka Urban district.

Range of Health Care Services that are provided

One of the indicators of effective health care delivery is the range of health care services that people are able to access and the frequency at which these services are offered. Health Care Providers were therefore asked to indicate which services they were providing in their health facilities. In responding, they stated that they regularly provided the following services; Curative (treatment of the patients who come to health facilities with various illnesses), Mother and Child Health(health care services that are provided to both mother and child), Diagnostic Services (Laboratory and other testing done to determine the cause of illness or response to treatment), Nutrition Demonstrations and Health Education (teaching people on preparation and handling of foods for good health and also general information on how to stay healthy).

To this effect, the Health Care Providers were requested to further clarify whether these services were provided on a daily basis. Of those interviewed, (57.2%) responded that the services listed above were provided on a daily basis while (42.8%) indicated that the services were provided only on scheduled days. See Table 3.3.

Table 3.3 Distribution of Health Cares Provider's responses on whether health care services were provided on a daily basis

Response	*N*	*%*
Yes	*111*	*57.2*
No	*82*	*42.8*
Total	*193*	*100*

The results from Table 3.3, above have demonstrated that there are mixed perceptions on the frequency of service delivery in Lusaka Urban District. However, of significance is the fact that the study established through responses from Health Care Providers that amongst the services that were not delivered on a daily basis were Mother and Child Health (MCH), Nutrition demonstrations and outreach activities. This means that at the time the researcher was collecting data, patients/clients did not have access to a complete range of services needed on a daily basis. The Health Care Providers interviewed attributed this situation of non – delivery of services on a daily basis to lack of transport to support mobility, shortage of manpower to conduct the services and inadequate equipment and supplies. In response to the question on whether there was need for additional services to be given to clients and members of the community, the providers felt the following should be made available in all the centers:

- Maternity services to be introduced in non-maternity health centers.
- Home care for the terminally ill whose numbers have been on the increase with the advent of HIV/AIDS.
- Diagnostic facilities- in many health centers that do not have laboratory and X-ray facilities.

- In- patient and minor surgery in smaller heath centers that have not been upgraded yet.

MOH (1996) in a study, titled " Review of the Zambian Health Reforms", conducted an evaluation of the health reforms and noted that due to the non availability of certain health care services at some health centers, almost all the centers have to refer patients to another health centre or to the University Teaching Hospital. The Health Care Providers identified commonly referred cases as acute illnesses, complications of otherwise treatable cases, surgical cases and those requiring specialist care. Some cases are referred for diagnostic purposes due non availability of such facilities in some of the centers.

Referral of medical cases to other institutions

Another aspect of importance in the delivery of health care is the coordination of health care delivery facilities. Patients can be referred from one institution to another either at the same level or higher level for continued care. There are a number of factors that necessitate referrals amongst which would be lack of equipment, lack of expertise or lack of supplies. For the purposes of offering a complete package of health care, all the services necessary at a specific level must be available and in working condition with adequate supplies to support the operations of that level.

However, the study revealed that more than one third (35.5%) see Table 3.4 of Health Care Providers who referred patients for continued care to higher levels such as University Teaching Hospital, Chainama and Maina Soko Military Hospitals never received any feed back on the patients they referred. This makes it difficult for the providers to make follow ups or indeed to report correctly on cases. As shown in Table 3.4, (24.7%) of the Health Care Providers reported getting feedback each time they referred a patient to higher levels of care. This represents only one quarter of the Providers that were interviewed.

Table 3.4 Distribution of Health Care Provider's responses on whether they received feedback after referring patients

Response	*N*	*%*
Never	*69*	*35.5*
Sometimes	*76*	*39.8*
All the Time	*48*	*24.7*
Total	*193*	*100*

However, when respondents were asked if they provided feedback on patients that were referred to them (see Table below), the study revealed that similarly most Health Care Providers in health centers do not give feed back about patients referred to them. Table 3.5 below shows that only (21.6%) of the respondents always gave feed back on patients referred to them. Table 3.4 above shows that (51%) of those interviewed responded that they never provide feedback while (27%) responded that they sometimes did.

Table 3.5 Distribution of Health Care Provider's response to whether they provided feedback on referred patients

Response	*N*	*%*
Never	*99*	*51.4*
Sometimes	*52*	*27.0*
All the Time	*42*	*21.6*
Total	*193*	*100*

Effective communication is a two way process which involves a communicator and the one who is being communicated to. Each party to the communication process is supposed to play a part in order to make communication complete. Those that are being communicated to must be able to provide a feedback on the subject matter. Those interviewed attributed poor communication infrastructure in health facilities and

ignorance about the need to give feedback as reasons for either not receiving or giving feedback about referred patients.

Table 3.5 shows that (51.4%) of the respondents never gave feedback on referred patients and attributed this failure to poor communication and indeed ignorance on the need to provide feedback as stated above. Lack of feed back on referred patients within Lusaka Urban District is viewed as a constraint to ensuring effective health care delivery. Quality of health care can only be enhanced if communication structures are well defined both between institutions in the health care delivery system and also between providers and clients.

Provision of Outreach Programmes.

The health reforms embrace primary health care as a vehicle to be used to achieve the objectives of the Alma Ata declaration *of attainment of health for all by the year 2000.* One of the strategies adopted to achieve health for all by year 2000 is through provision of health care services as close to the family as possible through outreach programmes.
Table 3.6 shows responses when Health Care Providers were asked whether they provided outreach programmes to their communities. (67.2%) of the Providers stated that they provided outreach activities. Although only (32.8%) denied that there were outreach activities, this percentage is worth investigating further. Outreach programmes when properly conducted tend not only to decongest health facilities, but also improve quality of life for the communities. The outreach activities reported to have been carried out were mainly home visitations, school health and Mother and Child activities.

Table 3.6 Distribution of responses from Health Care Providers on whether they provided Outreach programmes.

Response	*N*	*%*
Yes	*130*	*67.2*
No	*63*	*32.8*
Total	*193*	*100*

Lack of transport was repeatedly voiced as a major constraint to effective service delivery by health providers in all the health institutions. Two categories of transport service were particularly emphasized, ambulance and utility vehicles. In cases were there was a vehicle, sometimes a vehicle would have restrictions from the donor who donated that vehicle to the health facility. Donors usually would support specific activities and as such these vehicles may not be allowed to be used for any other activities. For example, an ambulance donated by the Irish Aid Project for Maternity cases can not be used for Malaria Control Outreach programmes. However, almost all the services they provided could be improved further. Those interviewed suggested the following areas as requiring immediate improvement; Transport (For Outreach and ferrying patients), equipment (For diagnosis) and drug availability (For treatment).

In discussing the various aspects of a health care delivery system brought out in this chapter, we note that one of the elements of the health reforms was to make available health facilities as close to the family as possible. This means that health facilities should first and foremost be available which should be manned by adequate and qualified staff. This study has given an overview of some of the crucial issues in the current government health care delivery services system in Lusaka Urban District. The sample that was picked comprised a total of 193 Health Care Providers, 382 Clients and 503 Community members. Those who were interviewed were from 10 Health Centers and the three government hospitals under Lusaka Urban District. The sample for health care providers comprised 193 respondents. It was constituted by 29 males representing (15.1%) and 163 females representing (84.9%).see Table 3.1. These were all from different positions in the overall health care delivery system. When interviewed about where else people go when they fell ill apart from attending their health centers, the following responses were received from Clients i.e. private clinics 159 (42%), University Teaching Hospital (self referral) 130 (34%) and traditional healers 93(24%). See Table 3.2.

From the findings, the study established that at least people in Lusaka Urban District seek medical attention of one form or the other when they fall sick. They will either go to see a

traditional healer, go to a private clinic or refer themselves to the University Teaching Hospital.

The Zambian health care delivery system which was designed under the health reforms was meant to operate in a pyramid fashion. All hospitals were supposed to have doctors. The doctors at district level would be generalists while those at provincial level or general hospitals would in addition have a limited range of expertise in various medical departments such as general surgery, obstetrics and gynecology, medical physicians and pediatricians. These form a base for the provincial referral facility. Central hospitals such as University Teaching Hospital, which are also national referral centers, have a higher level of specialists. In addition to these facilities, the health reforms ushered in partnerships in the provision of health care by collaboration with the private sector.

Barker, (1996) noted that in order to cater for the needs of fast growing populations and to solve the discriminately tendency that is brought about by the private bed system in hospitals, most governments are now entering into public –private partnerships in the delivering of health care. They can encourage private sector for profit providers to collaborate with the public sector through non- monetary and monetary incentives inherent in the collaboration (Ibid).

According to (Banger, 2000), the health reforms also brought in cooperation with Non governmental Agencies in the provision of health care. The advantage of Non-Governmental Organizations (NGOs) is that they have a better capacity which is (Ibid) attainable at low costs as they can easily mobilize volunteers who could easily adapt to any local situation and as a result of these perceived advantages, the promotion of NGOs in Africa has taken centre stage.

Partnership between the church and governments exist in a number of countries in Africa and this has brought about competition in the delivery of services, hence may lead to improved access to health care.

Health Care Providers in Lusaka Urban district are distributed among the 22 government Health Centers, 3 Hospitals (University Teaching Hospital, Chainama and Maina Soko Military hospitals). Additionally, the private sector, parastatals and traditional healers also contribute to the delivery of health care in the district. The health sector reforms do recognize these stakeholders as collaborators in the delivery of health care. Of great importance however, the study revealed that these Health Care Providers formed a base on which comprehensive Primary Health Care (PHC) would be mobilized.

Primary Health Care (PHC) being the central approach of the health reform process to achieve the goals of the Alma Atal declaration is provided at Health Centers and Clinics. Lusaka Urban has 22 Health Centers run by the government. Most of the health centers (i.e. 66 %) country wide are operated by government but quite a number (i.e.: 34 %) are also operated by industrial and service companies, missions and individuals. For example, the health care system in Lusaka in addition to the 3 hospitals, 22 health centers owned by government has 144 private for- profit clinics that provide primary health care and over 1000 Traditional Healers (TH) and Traditional Birth Attendants (TBAs). The density of health centers also seems to be fairly evenly distributed through out the country, but again the effects of poor staffing on health services are quite a threat.

In analyzing the availability of health care providers in Lusaka Urban, the study revealed that Health Care Providers can be sub-divided into four main groups as follows:

- Medical group (medical doctors)
- Nursing group (registered Nurses, Midwives, Public Health Nurses, Enrolled Nurses, Midwives and Family Health Nurses)
- Paramedics group (Clinical Offices, Laboratory Technicians and Technologists, Environmental Health Specialist)
- Untrained Group (Support staff who are often not recognized as care providers).

These staff categories were enumerated in table 3.1. The Medical Officers in the Health Centers are either general duty Medical Officers or Dental Surgeons. The nurses in the nursing group differ in the length of their training and the requirements for entry to the

colleges that provide them with the training. Registered Nurses at the basic level train one year longer than their (Enrolled Nurses) counterparts. Paramedical programmes usually take as long as those of Registered Nurses.

It is quite clear from the above finding that in terms of skills mix, most health centers have teams which would be expected to deliver quality health care service to their clients. Members of the communities interviewed in the study appeared to be happy with staffing levels in as far as nursing and paramedical staff were concerned. However, the respondents were not happy with the numbers of Doctors available in the Health Centers. Table 3.1 shows that out of 193 Health Care Provides interviewed; only (4.1%) were Doctors. A sound Doctor-Patient ratio is very important to the delivery of Health Care. If a Doctor has more patients to see than the recommended Doctor – Patient ratio, it simply means that some patients might either wait for longer times to see a Doctor or might not see a Doctor at all.

Meanwhile, Health Provider's responses to whether outreach programmes were conducted were different from that of the clients. (67.2%) of the Health Care Providers stated that they provide outreach services. See Table 3.6. Outreach services are meant to follow Communities to their localities and thereby increase access to Health Care even by those that may not have the means to go to the nearest Health Center. However, this did not augur well with (8.5%) responses from the clients who indicated having Health Care Providers outreach visits. This finding confirms (Roeddes *et al,* 1992) recognition that the present Primary Health Care model which is the backbone for Health Care delivery is oriented to rural areas and that a model for Urban Primary Health Care needs to be developed with appropriate policy support and organizational structures. In the absence of documentation on outreach activities by Health Care Providers in all the studied Health Centers, it was difficult to verify and support that outreach activities were undertaken. This is in agreement with the assertion by Medina, (1993) that routine analysis of information collected is not done and used at the Health Center level. It was noted that Health Care Providers in the study tended to list services that some of the consumers were not fully aware of as being available at their Health Centers.

Although most consumers (clients at the centers and in the communities) usually visited Health Centers for curative services, immunizations and family planning most of them were unaware of services such as nutrition demonstrations, outreach activities as also being services available at the health centers. The fact that the Health Care Providers in the study tended to list services that some of the consumers were not fully aware of is an indication of the tendency by Health Care Providers to concentrate their services at static units. This agrees totally with (Medina, 1993) in her Aide-Memoir on Urban Primary Health Care in which she stated that the Health Centers have little interaction with the communities and the personnel is concentrated in the facility to wait for people to come.

Health Care Providers themselves felt that in addition to existing services, the following should be made available in all health centers; maternity (in non-maternity health centers), home care, diagnostic facilities and an in patient facility for curative cases and some capacity to do some minor surgery. This would then amplify the status of health centers as institutions for promoting primary health care. This is in agreement with Starfield, (1992) assertion that a higher primary health care orientation of a health system was more likely to produce better population health outcomes at the lowest cost and with greater user satisfaction.

The other aspect to consider in the delivery of health care is the range of services that are available to clients and how these services compliment one another. In the Zambian context, the first government health care facility level of contact in the community is the health center. It provides the gate-keeping function for access to the subsequent levels of health care. This was evident from the findings of the study as (82%) of those who answered the questions on distance from their home to the nearest Health Center reported that they were within walking distance.

Ministry of Health, (1996) outlines the levels of care and functions of various units in the country and that the functions of the Urban Health Centers were said to be providing maternal and child health, preventive medical services including diagnosis and treatment

of serious conditions. However, this has proved not to be the case as none of the health centers had functioning laboratory meant at the time of the study to conduct simple laboratory tests. Of the clients interviewed, (42.8%) responded that the services were not available on a daily basis while (57.2%) indicated that services were available on a daily basis. See Table 3.3.

On the other hand, (51.4%) of the Health Care Providers indicated that they never give feedback about referred patients and the reasons cited for not providing feedback on referred patients were poor communication facilities available at health centers (i.e. non – functioning phones and radios) and ignorance about the need to produce feedback. See Table 3.5. This finding of lack of communication and ignorance among Health Providers perhaps confirms the findings in a study conducted by (Blass and Musowe, 1997) which concluded that access to information was very poor and that there were some excellent examples of local initiatives showing that, even under difficult financial and infrastructural circumstances, it was feasible to improve Health workers access to information using low technology information access initiatives. Of paramount importance however, is the formulation of an information policy that will guarantee the provision of health information to Zambian Health Workers.

This study finding perhaps further confirms the reason why the health services in Lusaka Urban are poorly co-coordinated and divorced from involving themselves with the communities they serve.

Conclusion

From the study of Lusaka Urban District regarding the extent of health care services that are provided by the Ministry of Health, the following conclusions can be made. First, the health reforms recognize the existence of other health care providers such as private clinics, non-governmental organizations and traditional healers. The efforts of these institutions complement one another in the provision of health care thereby bringing health care as close to the family as possible.

A number of government clinics have also been upgraded to mini hospitals. These have increased service ranges including X-ray and laboratory services which have improved on the ability to deal with cases. The services are also offered frequently to the clients. Health care providers of different categories are available in health institutions and these are from both genders although the study revealed that there were more female health workers than males (29% males against 84.9% females).Respondents also noted the need to have additional services in order to improve quality of care such as maternity in non maternity centers such as Chainda clinic, in-patient services and home based care.

The second conclusion is that health care providers are able to refer cases to other health institutions when need arises. They are however not providing feed back on referred patients due to poor communication infrastructure existing at their centers while others indicated that they did not know that they needed to provide feed back on referred patients. The Health Care Providers have also not been actively able to provide outreach programmes due to lack of transport and sometimes man power.

REFERENCES

Barker, R (1996), "Characteristics of Practices, general practitioners and patient related to levels of patient's satisfaction with consultation priorities in Europe". British Journal of general practice 46:606-60

Bangser, M. (2000), "Reframing Policies for Gender Equity: Women's Agency, participation and Public Accountability": Harvard Centre.

Blass and Musowe, V, (1997) "A Great Leap forward for Health Reforms in Health Reform news": A Quarterly Bulletin of the Health Reforms of the Central Board of Health. Ministry of Health. Lusaka.

Starfield B, (1994) "Is Primary Care Essential?" Lancet344:1129-1133

MOH, (1996) "National Policies and Strategies": Health Reforms, Lusaka. Zambia.

CHAPTER FOUR

ACCESSIBILITY OF HEALTH SERVICES

Introduction

The primary health care approach to the provision of health care services that has been embraced by the health reforms puts a lot of emphasis on effective coordination of effort among various stakeholders and the effectiveness and efficiency of health care delivery at district level. This chapter analyses the various factors affecting accessibility to health care services which will include assessment of the supervision provided at health centre level. The chapter will also examine the availability and adequacy of drugs at various centers and determine the levels of satisfaction among facility users. In addition, the chapter will assess the effects of user fees on access to health care services and facilities in Lusaka Urban District.

Management of Health Services in Lusaka Urban

In order to appreciate the health structures in Lusaka District, a brief background is necessary. This section therefore focuses on cataloging the number of health care delivery facilities in Lusaka Urban District and how these are spread in terms of geographical location. The section will examine the effects of management of health care facilities on the delivery of health care by looking at whether health centers were visited by management and the frequency of these visits. The section will also determine whether the health care providers were satisfied with management in Lusaka Urban District.

The study established that there are a number of health facilities in Lusaka Urban District. The facilities are managed by various institutions that own them. Private clinics and hospitals are managed by the private sector while an institution such as Maina Soko Military Hospital is run by the Defense Medical Services. The University Teaching Hospital and Chainama Hospitals are statutory bodies which are managed by Hospital Management Boards.

The 22 Health Centers in Lusaka Urban are run by the Lusaka Urban District Health

Management Team while the clinic located at Chainama Hospital is run by the Chainama Hospital Board. These Boards are eventually all answerable to the Provincial Health Director for Lusaka Province. The Provincial Health Director is part of the central structure at the Central Board of Health. The Central Board of Health is answerable to the Ministry of Health through its Director General and Board of Directors.

Regarding Management, Health Care Providers were requested to indicate the frequency at which they are visited by their supervisors. The study revealed that (see Table 4.1) more than half of the responding Health Care Providers were either never visited by their professional supervisors or were only visited at irregular intervals. 27.1% indicated that supervisor visits were irregular while (24.1%) responded that they were never visited by their supervisors.

Table 4.1 Distribution of responses on supervisor's visits to health institutions

Response	*N*	*%*
Regular	*94*	*48.8*
Irregular	*52*	*27.1*
Never	*47*	*24.1*
Total	*193*	*100*

On the other hand, Table 4.1 above however, shows that (48.8%) of the Health Care Providers interviewed stated that the visitations from their supervisors were done regularly.

Meanwhile, levels of satisfaction with management in Lusaka Urban District are high. (59.3%) of the respondents indicated that they were happy with the management of their institutions (See Table 4.2 below).This was attributed to the visits that were made by supervisors to explain what management was doing at any given time. The high levels of accepting management of health facilities in the District was as a result of management in Lusaka Urban District adopting participatory methodologies in terms of decision making

where every body at least those at senior levels are invited to workshops where major decisions affecting health institutions in Lusaka are made.

However, (40.7%) of those interviewed responded that they were dissatisfied with management. Those Health Care Providers who were dissatisfied with Management cited a number of reasons for their dissatisfaction amongst which were:

- Political interference
- Unresponsive Management

As regards political interference, Health Care Providers lamented at the lack of freedom to exercise their professionalism in their catchment areas. They reported that when politicians come to health centres, they do not want to follow the laid down procedures but to be given preferential treatment. The Health Care Providers indicated that in some cases, politicians would even influence management to take some actions that are unwarranted on the basis of a complaint from a politician. On the other hand, the study revealed that some Health Care Providers felt that in most cases management was unresponsive to their needs. They stated that some of the limitation in the provision of certain health care services were caused by the insensitivity of management. Management was accused of not responding to their requests for additional vehicles and personnel in order to be able to provide outreach programmes.

Table 4.2 Distribution of responses on whether Health Care Provider were satisfied with management.

Response	*N*	*%*
Yes	*114*	*59.3*
No	*79*	*40.7*
Total	*193*	*100*

Although only (40.7%) of the providers responded that they were dissatisfied with management, the causes of the dissatisfaction need to be addressed. Health Care

Providers work with human life and as such they need to be highly motivated by their management in order to be able to offer quality health care. Satisfaction with management is closely linked to motivation and service delivery ultimately. Management of an institution is regarded as institutional support. Institutional support has been defined as the environment within which an employee performs his or her tasks (Holden *et al*, 1998) has a significant effect on the performance of an individual employee in that ,even a highly competent employee will find it difficult to perform effectively in an environment that is not supportive. In fact, it can be argued that an environment that does not offer adequate support to its highly qualified and competent staff will end up frustrating that employee, thereby lowering his or her work morale and health care delivery standards.

Drug Supply and Other Factors Related to Health Care Delivery.

In this section the focus is on assessing the factors that may inhibit access to health services by firstly interviewing clients and the members of the community within which the facility located. This is an analysis of the effectiveness and efficiency of Lusaka Urban District's capacity in performing the responsibility of providing public health in the district. In order to assess the effectiveness and capacity of Lusaka Urban District, we will use the following variables. Firstly, we will look at the availability of drugs in health centers and obtain responses from clients. We will establish whether drugs are adequate and regular in supply. Lastly the clients will be requested to indicate whether they were satisfied with services offered by the health facilities.

Secondly, the community will also be interviewed to determine levels of utilization of health facilites, availability of transport to health centers, effect of user fees on access to health care services and the consequences of failure to pay user fees.

Clients

The researcher interviewed a total of 382 clients from thirteen (13) health institutions in Lusaka Urban district to ascertain whether drug supplies were adequate in the health facilities. This is an important aspect of institutional effectiveness in terms of service delivery in the district.

In responding to the question regarding drug supply adequacy in health facilities (49.7%) of the respondents reported that drug supplies were adequate in the health facilities (Table 4.3 below) while (44%) of the clients said they were not adequate. (6.2%) did not know what the drug situation was in the health facilities. (6.2%) of the client's interviewed had a different perception on the adequacy of drugs and when probed further stated that they did not know the drug situation at the health centre because each time they were given a prescription to buy the medicines, they did not ask to find out whether prescriptions to buy medicines were being given because drugs were not adequate or that it was part of the health reforms to share the cost of buying drugs. The inability to supply adequate drugs is particularly important because what emerged during the study is that the client's measure of a quality medical service is mostly the availability /or non availability of appropriate drugs in health facilities.

Table 4.3 Distribution of client's responses on whether drugs were adequate.

Response	*N*	*%*
Yes	*190*	*49.7*
No	*168*	*44.0*
Don't Know	*24*	*6.2*
Total	*382*	*100*

However, in responding to the question whether drug supplies were regularly given to clients in health facilities, Table 4.4 below shows that (51.7%) of the respondents indicated that drug supplies were regularly given while (48.3) said they were not regularly given.

Table 4.4 Distribution of Client's responses on whether drugs were regularly given

Response	*N*	*%*
Yes	*197*	*51.7*
No	*185*	*48.3*
Total	*382*	*100*

A variety of reasons were advanced to explain why clients are not regularly given the drugs that have been prescribed for them. (51.7%) of the (48.3%) of the clients said that the health providers say either there is no medicine or the medicine has run out of stock. The other reasons given had major implications on how health care providers use the drugs at their respective health centers. For example one set of reasons implied that health care providers actually take drugs from the health centers to, either their own drug stores or to their friends, drug stores were they sell them to supposedly beneficiaries of these drugs. Clients who gave such answers justified these responses by adding that they were convince that this is what happens because when a client is given a prescription to go and buy the medicines, the health care provider will even recommend which drug store to go and buy from. And that through investigations they have found out that the owners of those drug stores are the health workers themselves of their spouses and friends. Another factor that is used to determine the level of health care delivery is the types of services that are available for access by the clients and communities. In ascertaining the responses to this factor, respondents were asked to state whether they were satisfied with the services offered in Lusaka Urban district. Clients from different age groups were interviewed and also from different health centers within the district. Table 4.5 shows respondents representing almost (60%) were generally satisfied with the services that were being provided by health facilities. These were generally from all the age groups that were interviewed.

However, the other proportions of respondents accounting for (43.1%) as presented in Table 4.5 were dissatisfied with the services. In fact the age group between 51-60 years recorded the highest number of dissatisfaction. They believed that poor staff attitudes towards clients, the need for prompt service and inadequate drug supplies were the causes of dissatisfaction. Table 4.5 further illustrates that those below 40 years of age appear to have been more likely to show dissatisfaction than those below 20 years of age. The clients who were dissatisfied indicated that there was need to have ambulance service, reduced and stabilized user fees, improved supply of drugs and medical supplies, as the most important improvements they would want to see in the health centers.

Table 4.5 Distribution of client's responses to whether they were satisfied with services offered (by Age Group).

Age	*Yes*	*No*	*Total*	*%*
Below 20 years	*32*	*17*	*49*	*(13.0)*
21-30	*99*	*82*	*181*	*(47.6)*
31-40	*59*	*44*	*103*	*(27)*
41-50	*17*	*15*	*32*	*(8.5)*
51-60	*7*	*6*	*13*	*(93.1)*
61 and above	*3*	*1*	*4*	*(8)*
Total	*217(56.9%)*	*165(43.1%)*	*382*	*100.0*

Clients from different health centers within Lusaka Urban were also interviewed to determine their views. As the case was with age groups, (57.3 %) of the respondents felt that they were satisfied with the services that are offered in the district while (42.7%) were of the view that the service was not satisfying.

Of significance to note was the number of respondents who were not satisfied with services offered at the University Teaching Hospital (UTH). University Teaching Hospital is a tertiary level institution that is used as a national referral hospital with supposedly all the services in place. All complicated cases that could not be treated at Provincial Hospital level are supposed to be referred to the University Teaching Hospital. Client's who do not have confidence in other levels of health care that are available also refer themselves directly to UTH.

Table 4.6 Distribution of Client's responses to whether they were satisfied with services offered (by Health Centre).

Name of Community	*Yes*	*No*	*Total*
Bauleni	*13*	*4*	*17*
Chilenje	*13*	*8*	*21*
UTH	*52*	*39*	*91*
Kanyama	*8*	*13*	*21*
Matero	*12*	*13*	*25*
Mandevu	*10*	*7*	*17*
Chainama	*24*	*16*	*40*
Chelstone	*14*	*6*	*20*
Kalingalinga	*9*	*11*	*20*
Kaunda Square	*12*	*8*	*20*
George	*8*	*12*	*20*
Kamwala	*8*	*11*	*19*
Maina Soko	*30*	*11*	*41*
Total	*219(57.3)*	*163(42.7)*	*382(100%)*

Table 4.6 shows that the level of Clients satisfaction of the health care service delivery ranged from (30%) to (76.5%) amongst the Bauleni Health Centre Community. Kanyama, George, Kamwala, and Kalingalinga health centers had the lowest percentage of Clients who were satisfied with the services.

Community

In the study, members of the community within the catchment's area of the health centre were also interviewed. This was necessary to try and enlist their responses as regards their utilization of the nearest health centre in their locality. As earlier indicated in the methodology, from the total sample of respondents, 503 community members were interviewed from (10) residential compounds. (54%) of the respondents from the community members were in the age group of 30 years and below. Additionally, more than (80%) of the interviewed community members were females.

Table 4.7 Distribution of community member's responses on utilization of the nearest health centre.

Response	*N*	*%*
Yes	*412*	*82*
No	*91*	*18*
Total	*503*	*100.0*

The study revealed that the commonest reason for visiting health facilities (centers) was primarily for treatment of ailments followed by seeking immunization and family planning services respectively. Of those interviewed as shown in table 4.7 above, 82% utilized the nearest health centre when they fell ill. This against 18% of the members of the community who said they did not. This finding shows that the majority of people do have access to health care facilities. In terms of satisfaction with services being provided by health centers about two thirds of the respondents reported dissatisfaction while about one third said they were satisfied. They both (men and women) cited reasons for the dissatisfaction as shortage of staff, bad staff altitudes, corrupt staff, uncommitted staff and shortage of equipment. Most consumers interviewed reported that they would want to see an increase in the number of doctors in the health centers, improved staff altitudes, introduction of ambulance service and improved supply of drugs and equipment.

Institutional Capacity to Provide Health Care Facilities that can Easily be Accessed.

The capacity to provide health care services that can be easily accessed by the entire population under study in Lusaka Urban District Urban was measured in the study using two main varuables; these are distance and cost involved in accessing the services and facilities provided by the health facilities in the district. Distance is one of the key variables in determining the extent to which users can easily access health facilities, because the further the health facility is from the clients, the more difficult it is to access

health services due to logistical problems such as availability of transport and or transport money, and long period it takes to reach the health centers.

Costs involved in accessing health care services are equally important in that high costs tend to exclude a large part of the catchments population who are not capable of meeting the variable costs. Such costs include: actual user fees, costs of using specialist services and equipment and transport costs.

Clients

Table 4.8 Distribution of client's responses on availability of transport to Health Centers

Response	*N*	%
Yes	*271*	*70.9*
No	*111*	*29.1*
Total	*382*	*100.0*

Table 4.8 shows that (70.9%) of the clients interviewed responded that there was availability of transport to health care facilities while (29.1%) said there wasn't. The availability of transport is very necessary in facilitating access to health centers. The respondents indicated the commonest reasons for attending a health center in their order of importance as treatment, immunization and family planning.

In Lusaka Urban District, one would be tempted to say that each user of health care services leaves within walking distance to at least one health care facility. What this means is that almost every one (apart from those who might be critically ill) can go to a health facility without using some form of transportation and as such the issue of transportation and its attendant cost may not come in to inhibit access to health care facilities.

However, for clinics such as Kanyama with a catchment population of 187, 538 people and George clinic with a catchment population of 142, 994 and also catering for the

surrounding farms, the situation is totally different. Although it is true to say that the situation is better now than before the health reforms were introduced, distance is still a major hindrance to accessing health care services. In Kasisi, for example, people have to walk the whole day to get to Chelston clinic a distance of more than 25 kilometers.
The implication of the long distances that people have to cover to get to the nearest health facility is that sometimes parents may not take their children to under five clinics, especially in the rain season when people are busy working in their fields. Also they tend to resort to traditional medicines to cure illnesses as these can be easily accessed at shortest possible times and without having to walk many kilometers.

Effects of user fees on access to health care services

The costs involved in accessing health care facilities provided by health centers was in the study divided into three categories; These are the standard user fees that have to be paid irrespective of the diagnosis to be carried out on a client and treatment process, the extra payments made for certain services such as x-ray and laboratory costs, and transport costs were applicable to go to the health centre.

The introduction of user fees as a condition to accessing health care facilities to some degree prevents users of these services from accessing these facilities. Firstly, because of the high poverty levels in the country; most users do not have the capacity to pay these fees. Measurement of the poverty levels in Zambia has been based on the 'food basket' approach that, as is defined in Chapter V, focuses on the adequacy of a household's income in so far the ability to purchase the basic food stuffs required for its existence is concerned (see Nsemukila, 2001).The cost of the food basket at the time the research was being conducted was estimated at K700, 000 by the Catholics Commission for Justice and Peace (2006:6). According to the Living Conditions Monitoring Survey of 1998, (72.9%) of the Zambians are poor, while urban poverty is estimated at 56%.Although Lusaka Urban District is supposedly in the urban area, part of the areas are in rural settings with high poverty levels.

While Lusaka residents of Chelstone, Chilenje and parts of Matero are able to pay the demanded user fees, the majority of people in Chainda, Chibolya and George compound can not afford to pay the fees.

Table 4.9 shows the Health Care Provider's responses on whether the user fees had an effect on attendance to their health care facility.

Table 4.9 Distribution of Health Care Provider's responses on whether the payment of user fees had an effect on attendance to their health centre.

Response	*N*	*%*
No effect	*89*	*23.4*
Reduced	*216*	*56.5*
Stabilized later	*50*	*13.0*
Increased	*27*	*7.1*
Total	*382*	*100.0*

The majority of the Health Care Providers interviewed felt the payment of user fees had reduced their patient's attendance to health centers. This category of respondents accounted for almost (56%) However, (13%) of the respondents reported a reduction immediately when the user fees were introduced but that with the passage of time, attendance stabilized. Only (7.1%) were of the view that there was an increase in attendance despite the introduction of user fees.

Table 4.10 Distribution of client responses on whether user fees were affordable

Response	*N*	*%*
Yes	*36*	*9.4*
No	*346*	*90.6*
Total	*382*	*100.0*

Table 4.10 shows that payment for services rendered was applicable to all commonly provided services at health centers, such as treatment of ailments, immunization and family planning. In the study, (90.6%) of the respondents felts that the fees that were

currently being charged were too high. However, (40.6%) felt that the charges were just right (see Table 3.11). 6.3% on the other hand were of the view that actually the fees were just too low (see Table 4.4).

Table 4.11Distribution of clients responses on how they felt about user fees.

Response	*N*	*%*
Too high	*202*	*53.1*
Just right	*156*	*40.6*
Too low	*24*	*6.3*
Total	*382*	*100.0*

With regard to what would happen if a member of the community failed to pay user fees at a health centre, Table 4.12 shows that just overt half of all respondents (i.e. 51.1%) said that they would be sent away from a health center should they fail to pay the prescribed user fees and (9.0%) stated they would be treated free of charge while on the other hand (4.6%) reported that they would be treated and allowed to pay later. However, (5.2%) were of the view that they would stay home even if they fell sick instead of going to the health care facility and get humiliated for failing to pay user fees. The feeling that fees were too high was expressed by clients from all residential areas included in the sample (see Table 4.11). Meanwhile, (50.0%) of the responding Clients had either experienced a referral or had a relative who was referred. Lack of transport and inability to pay user fees at the next referral level were the most commonly reported problems associated with the referral process.

Table 4.12 Distribution of clients responses on what happens when they are unable to pay user fees.

Response	*N*	*%*
Don't know	129	28.5
Treated free	34	9.0
Sent away	195	51.1
Treated and pay later	8	4.6
Refer to Social Welfare	6	1.6
Stay home	10	5.2
Total	382	100.0

Community

In the study, members of the community within the catchment's area of the health centers were also interviewed. This was necessary to try and enlist their responses as regards the effects of user fees on their utilization of the nearest health centre in their locality. They were further requested to indicate whether services that were offered were adequate both in terms of quality as well as the range of services.

Community members were also requested to indicate what happens if they failed to pay the user fees. As earlier indicated in the methodology, from the total sample of respondents, 503 community members were interviewed from (10) residential compounds. This was to get their views besides the views that were already provided from the clients.

Table 4.13 below shows responses from members of the community when they were asked how they felt about paying user fees at health facilities each time they wanted to access health care services.

Table 4.13 Distribution of community's responses on how they feel about user fees.

Response	*N*	*%*
Too high	*356*	*71*
Just right	*116*	*23*
Too low	*30*	*6*
Total	*502*	*100.0*

Responding to a question on what happens when community members were unable to pay the user fees (72.4%) (See Table 4.14) below reported that they would be sent away without being treated. (12.7%) did not know what would happen to them if they failed to pay the fees while only (1%) said they would be referred to a Social Worker. A further (6.0%) percent reported that they would rather just stay at home if they fell ill and were unable to pay the user fees (see Table4.13) below.

Table 4.14 Distribution of community's responses on what happens if they are unable to pay user fees

Response	*N*	*%*
Don't know	*63*	*12.7*
Treated free	*15*	*3.0*
Sent away	*364*	*72.4*
Treated and pay later	*24*	*4.8*
Refer to Social Worker	*5*	*1.0*
Stay away	*30*	*6.0*
Total	*503*	*100.0*

Arising from the findings from the sections above, the study established that both the clients and the communities had similar views on the issues of user fees and its impact on accessibility to health care services. Besides identifying user fees as an inhibitor to accessing health care services because of the high poverty levels prevailing in the

country, the study also revealed that people were just reluctant to pay user fess because of what they see as poor health services provided compared to the money they are required to pay and the quality of service that they receive after paying that money.

A number of people who do not go or rarely go to health centers in Lusaka urban district alluded to the fact that because prescribed drugs are rarely given at the clinics, it is better to pay the money that someone intended to pay at the clinic as user fee, to buy drugs from the chemist than to pay at the clinic and only get a prescription.

Logically, most clients and communities argue that there is no point in paying user fees when one is almost certain that instead of being given the medicine for whatever illness one ends up getting a prescription for that medicine. The end result of this thinking process is that the majority of users of health services perceive going to the clinic as a waste of time and money in that they have to pay user fees and at the same time be given prescriptions to go to buy medicines.

In addition to the regular fee that is charged at the health centre, there are extra payments that have to be made for laboratory tests and x-ray services. These payments are in fact much more than the regular fees. Therefore given the above situation where we have many users both in the urban and rural areas that fail to pay user fees, it becomes even more difficult to get access to these important services. In addition to the fact that these services are expensive, they are also not available in most health centers. In Lusaka Urban District for instance, out of 22 health centres, only 5 centers have laboratory and x-ray services.

Availability of adequate health care services that can be accessed

Community

This section primarily looks at the available health care services in the health care centers of Lusaka Urban District. The factors discussed below are very important in determining the effectiveness of the health care delivery system. To start with we will look at the

availability of services such as outreach programmes into residential areas, availability of x-ray and laboratory services, and availability of drugs.

As a starting point, members of the community were requested to indicate whether the health services that were offered by Lusaka Urban District Health Board were adequate. The responses are provided in the table below:

Table 4.15 Distribution of community's responses on adequacy of health services.

Response	*N*	*%*
Yes	*10*	*2*
No	*492*	*98.0*
Total	*502*	*100.0*

Table 4.15 shows that (98%) of the respondents reported non- availability of either a mobile health service or center staff that are providing various outreach services into residential areas. This view was shared equally between males and female.

This entails that those clients and communities who get their services from smaller clinics have to be referred to the bigger centers where these services are available. To get to these referral centres, referred patients often have to meet extra transport costs. This has two implications in as far as ease of access to health facilities is concerned. First, the user has to have transport money to go to the centers were these services are provided and back to his/her clinic. This adds more costs to the already expensive services, thereby lessening the chances of utilizing such services. Secondly, the process of being referred from one health centre to another is time consuming, particularly to patients in a desperate situation who want to access immediate help from health centres.To such patients, referrals may actually not mean delayed assistance to the patient but no assistance at all.

The problem of laboratory tests and x-ray facilities was much bigger at the time of the study in Lusaka Urban District. For example, Kanyama Health Centre which is located in Kanyama compound, a high-density area in Lusaka Urban District, a health facility

situated in an area which has a catchment population of 187,538 people and its catchment areas include Soweto, Chibolya, New Kanyama, John Laing, Chinika, part of Makeni and some farms in Lusaka West has no x-ray facilities. All cases requiring diagnosis by x-ray will have to be referred to other institutions.

On the other hand, George Health Centre is located in George Township which is a high density area. The township is unplanned with a high incidence rate of diseases. It has a catchment population of approximately 142,994 people and its catchment area includes George, Lilanda, part of Matero, Zingalume, parts of Chunga, Ballastone Park, Desai and the surrounding farming areas. The mini-hospital has maternity ward, children ward, female ward, male ward and mortuary services. The mini-hospital also provides x-ray and laboratory services to the catchment population.

Closely related to the factors earlier alluded to in the chapter is the capacity by Lusaka Urban District Health Board to provide health centers that can easily be accessed by the entire Lusaka district population, is the question of the extent to which the health centers found in the district are actually able to provide basic facilities such as general admission ward, labor wards, and ambulance services. While we have stated above that Lusaka Urban District has adequate health centers in terms of numbers, such that nearly every one can walk to a health centre, we need to look at what kind of services are provided and which ones are not provided. In Lusaka Urban district, of the 22 health centers available, only 7 have capacity to admit patients while the rest have 1 or 2 observation beds that a patient can use temporarily during the time when health workers are deciding what to do next. Once a decision to refer has been reached, except in very few circumstances, a patient has to wait for anything from 3-6 hours before an ambulance to transport him/her to a referral centre can be made available.

Of all the health centers that were converted to mini hospitals visited during the study, all of them had admission facilities. In other words, they all had admission facilities. However, although these mini hospitals boost of admission wards, the number of health workers available to man these wards was inadequate. The nurses on duty had to attend to

mothers in labor ward, attend to patients in the general admission wards and at the same time attend to out patients. The implication of the situation found at some of these mini hospitals during the study is that even though the physical facilities, such as wards, are there, the quality of services offered is still low due to lack of adequate and qualified manpower capable of operating such facilities to acceptable standards.

As alluded to earlier, most of the health centers do not have adequate supplies of drugs. This is an important aspect of health service delivery and client's access to health care services. The inability to provide adequate drugs is particularly very important in that what emerged from the study was that clients' measure of quality health care delivery is mostly the availability and/or non-availability of appropriate drugs in health centers.

A variety of reasons were given to explain why users of health services were not always given drugs that are prescribed for them. The commonest reason being that drugs were out of stock. The other set of reasons indicated suggested that health workers discriminated when giving drugs to the users. Claims of discrimination were mostly mentioned in Chilenje and George clinics. The clients interviewed said the relatives/friends of health workers are most of the time given drugs which are prescribed by health personnel, and it is only those that are not known by health workers at respective clinics that are told to go and buy the medicines. Most of the clients who gave such answers were even swearing that they had seen incidences where on the same day one person would be told to go and buy a particular medicine while the other person who is known to the health worker would be given that same drug.

The other aspect regarding accessibility to health care services and an important indicator of the effectiveness of the health reforms is the availability of medical equipment that is in working order. The general feeling among all the 193 Health Care Providers, except the general workers was that even though they could not say that they have all the equipment needed, they have reasonably 'good condition' basic equipment needed for the day to day operations of the clinic. However 10% of the Health Care Providers interviewed raised concerns regarding sterilizers, incubators, BP machines, diagnostic

sets etc, most of these concerns were based on the fact that the Lusaka Urban District Health Board was not replacing these pieces of equipment as frequently as they should. Besides these pieces of equipment wear out very fast due to their intensive use, in some cases Health Care Providers are forced to use equipment that can not attain the required reliability.

Motivational Levels of Staff and Provision of Health care Services

This section discusses the levels of motivation among Health Care Providers in Lusaka Urban District Health Boards. Determinants of motivation that are commonly used by various employers will be used. Initially, we will look at the effects of monetary rewards such as salaries and allowances that are payable to health workers and their effect on the morale of the workers in the district. Monetary rewards as has been postulated by one of the most famous behavioral scientists Abraham Maslow Kutzin (1994) are a basic determinant of any employee's behavior towards work because they fulfill the physiological needs of an employee such as hunger, shelter, clothing and other human requirements. For most employees, it is the monetary reward that results from their respective jobs that will enable them to buy food, pay rentals for accommodation and buy some clothing and blankets.

Secondly, we will look at training and development opportunities that are available to health care providers in the disrict.Training and development opportunities determine an individual's behavior towards his or her work in a number of ways. For example, training and development increases the capacity of individual employees to perform their tasks and instills feeling of recognition, growth and achievement in the individual employees.

The third factor that the study tried to consider is the kind of institutional support that health workers at the clinics that were sampled receive from their respective boards. Institutional support that has been defined as the environment in which the individual employee performs his or her tasks (Holden *et al,* 1998) has a significant effect on perform effectively in an environment that is not supportive. In fact, it can be argued that an environment that does not offer adequate support to a highly competent employees ends up frustrating that employee, thereby, lowering his or her work morale. After

establishing the levels of motivation using the three factors mentioned above, we are going to discuss the manifestation of this motivation as perceived by the health facility users.

Remuneration and other conditions of service.

This section endeavors to establish whether the level of remuneration given to health workers in terms of salaries/wages, leave benefits, accommodation allowance, transport allowance, bonuses, loan facilities and other monetary rewards, is at the level that can instill high levels of motivation in the health providers. The indicators of motivation levels among health workers that we analyzed in relation to these inducements focused on ways through which employee dissatisfaction manifests itself in places of work. The variables we focused on in this respect were complaints and grievances, labour turnover, absenteeism, moonlighting, reporting late for work, and health workers attitude towards the patients. In addition, in the process of analyzing these measures of motivation, we tried to demonstrate that, aspects of remuneration such as salaries/wages, bonuses, allowances, loan facilities and other conditions of employment account, to a very large extent, to the dissatisfaction being experienced among health workers in Lusaka Urban District.

The study reviewed that in general remuneration and other conditions of service that health care providers in Lusaka district experience are so bad that most of them found it very difficult to identify any aspects of their conditions that they found to be attractive. Most of the respondents stated that the only attractive aspect they found in their jobs was the satisfaction that they derive from providing treatment, and care to the users of health services. They stated that job security that is experienced in most of the civil service and only free medication for the family as the benefit of working in the health sector.

Remuneration as mentioned earlier is one of the most important factors in determining the level of motivation for employees as it accounts for the quality of an individual's life. At the time when most of the interviews with health care providers were conducted, all the health care providers in Lusaka clinics including the in-charges were getting salaries of between K500, 000 and K 1,000,000 per month. This was despite the fact the cost of

the "food basket", a list of basic food-stuffs that a family of about 5-7 people must purchase and consume to lead a normal life, as indicated by the CCJP reports of 2003, was well above K 700,000 at that time. A small number of health care providers that were interviewed after the June, 2003 salary increments expressed dissatisfaction with their salaries. Most of them were in passing describing their salaries as slave wages, "peanuts and mockery of the noble profession" when they were asked to indicate the amount of their monthly incomes.

Table 4.16 Distribution on how Health Care Providers feel about their conditions of service

Response	*N*	*%*
Dissatisfied	*130*	*67.2*
Satisfied	*63*	*32.8*
Total	*193*	*100.0*

Infact, 130 out of 193 0r 67.2% of all the health care providers interviewed in Lusaka Urban district identified poor conditions of service, particularly the salary, as one of the most unattractive aspects of their work. Health care providers also expressed dissatisfaction on erratic and inability of provision of allowances that they are entitled to.

On transport allowance, the major complaint was that the allowance was being paid very late, at times three months later than normal. Other allowances that the employees consider to be cardinal for them to operate effectively with a good peace of mind, such as housing and education allowance were nonexistent. For the health providers in the rural parts of Lusaka Urban who are supposed to get hardship allowance, their major concern was that the amount of money were getting was very little compared to the magnitude of hardships that they have to endure.

Other remuneration – related factors that employees expressed dissatisfaction about are leave benefits, such as passages allowance and communication leave days for cash. There was a general concern that even though one goes on long leave passages is never paid to

them. In addition people who wish to commute their days are never given a chance, as management always says that things are clearly stated in their conditions of service. They feel that, they are being denied what, according to the conditions of service, rightly belongs to them.

Other conditions of service that health workers expressed unhappiness about are loan facilities. The health workers said that, it is highly disappointed and stressing to have beautiful conditions of service on paper that are never implemented. According to the health workers interviewed, the conditions of service provide for house, car and furniture loans, but it is impossible to get such loans even if one applied for them. The health care providers, who were not directly employed by government at the time of the interview, indicated that they were given contract employment by the District Health Boards, and these had different kinds of complaints regarding conditions of service. First, they complained that their contracts of three months each were too short and unrealistic considering that they have to ensure that their contracts get renewed. Secondly, they complained that the District Health Boards have no written conditions of service which they can be able to refer to whenever need arises. They argued that it is very difficult to operate in a situation where almost all your rights are implied because such a situation can be easily manipulated by management. The gave an example of salary increases that were awarded to all health care providers under the civil service conditions of employment and not to those under the contract arrangement of the District Health Boards despite having the same competences and working in the same health centers.

The factors discussed above results into low motivation generally among health workers. Out of a total number of 193 health care providers interviewed in both Lusaka Urban district only 63 representing 32.8%, described that they were satisfied with their conditions of service and as such their levels of motivation were high. The major reason that most of the health care providers, who described their motivation levels as being high, gave to account for this level of motivation was that, since the introduction of the District Health Boards, there have been a lot of workshops and seminars that have been

conducted such that on average each health care provider attends a workshop or seminar every year.

Those who described their motivation as being low cited bad conditions of employment as the major reason for their low levels of motivation. Other reasons given for low motivation were the risks associated with the job, very few training opportunities, and insensitive managers. Some of the respondents said their jobs pose a high risk to their lives given today's environment where there are a lot of infectious and deadly diseases, such as Aids and T.B. They also claimed that management is doing very little to put security measures in place. As regards training opportunities, those interviewed cited management insensitivity towards problems of workers, particularly those in rural health centers.

To back his claim, one of the respondents gave an example of how management conducted support visits to the respective health centers. He claimed that instead of trying to get the problems that health workers experience in their respective health centers, the support visits were turned into what was referred to as "min-courts" where health workers were interrogated by management on a number of issues.

Training and Development Opportunities

In this section the focus is on impact that activities aimed at improving the competency levels of health workers have on motivation levels of these workers, and consequently on the way health workers are going to perform their tasks. To do this we tried to analyze the impact that further training has on the work behaviour of health workers. The impact of short-term training in the form of workshops and seminars was also analyzed. In addition, we tried to evaluate the impact that promotion related aspects such as chances, and the criteria used to identify people for promotion have on the morale of health care providers in Lusaka district.

Table 4.17 Distribution of Health Care Providers who have gone for further training

Response	*N*	%
Number who have gone	*150*	*77.7*
Number who have never gone	*43*	*22.3*
Total	*193*	*100.0*

In Lusaka Urban District, of all the 193 health care providers interviewed 150 or 77.7% had gone for further training since they started working in the Ministry of Health and subsequently the District Health Boards. However 43 0r 22.3% had never gone for further training since they started working.

However, 75% of all the health care providers interviewed expressed concern over the inability of Lusaka Urban District Health Board to send its employees for further training because, those who want to go for further training have to identify and seek admission to a training institution. They also claim that one has to find own sponsors or pay for training. Emphasizing the inability of Lusaka Urban District Health Board to send its employees for further training, one health worker had this to say "we have now come to consider going for further training as an individual thing because we have to identify our training needs as individuals and identify the training institution, and even pay for ourselves." Another health provider in Lusaka Urban District argued that District Health Boards are not concerned about sending people for further training. She justified her claim by giving an example of the time when she had got a place at Evelyn Hone College, but could not go because the board could not pay for her training. There is a general feeling among the health providers in both districts that, it was easier to go for further training before than after the establishment of the District Health Boards.

However, those who have gone for further training before and after the establishment of District Health Boards said that the training which they have undergone has helped them tremendously in performing their duties. All health providers, including those that have never gone for further training argue that further training benefits a health care provider in a number of ways. 150 out of 193 health care providers interviewed in Lusaka district, said further training increases the knowledge and self-confidence of a health provider. 30 out of 193 feel that further training is cardinal in today's rapidly changing environment. With the changes in technology and patterns of diseases, and the emergence of new types of diseases, these health providers feel that further training should be encouraged now than ever before. The respondents stated that training increases employees' responsibility towards their work, and additionally attributed the importance of further training, particularly in the Zambian situation where there are perpetual shortages of health workers, to multi-skilling. According to these health care providers, further training does not only improve on one's area of specialization. For example, one environmental technologist, who had gone for a six-month training course for clinical related issues, claimed that after the course she was able to perform most of the duties of a clinical officer in addition to her usual duties.

Table 4.18 Distribution of Health Care Providers who have attended workshops and seminars in the last three years

Response	*N*	*%*
Number who have attended	*190*	*98.4*
Number who have never attended	*3*	*1.6*
Total	*193*	*100.0*

In terms of short –term training, Lusaka Urban District Health Board seems to be doing very well. In Lusaka district, of all the 193 health care providers interviewed 190 that is about 98.4% had gone for at least one workshop or seminar in the last three years. The remaining 3 respondents, who indicated that they had never gone for a workshop or seminar comprises of general workers, like cleaners and security guards. This means that,

if we have to consider only the health care providers per se, we can safely say that, all the health care providers interviewed in Lusaka Urban District have gone for at least one workshop or seminar in the period between January 2003 and September 2008. The majority have attended more than one workshop or seminar.

According to the point of view of the health care providers interviewed in Lusaka Urban district, workshops and seminars are quite useful in the performance of one's duties. Their benefits are almost the same as those of further training in that, they can also instill confidence in the way the worker performs his /her duties, and can enable one to adapt to the changes that take place in the environment however, compared to further training, health providers interviewed identified two major disadvantages of seminars and workshops. First, they argued that seminars and workshops have a tendency of reinforcing one's area of specialization, therefore, not useful in multi-skilling the worker. Secondly, though attendance certificates are given at seminars and workshops, these attendance certificates do not constitute formal qualifications. This is made worse by the fact that the influence that attendance certificates have on the position that one can hold, duties that one can perform, and the chances of being promoted one has is very minimal. In fact one of the health care providers in Lusaka Urban District who indicated that they have attended more than five workshops during the period under review had this to say in relation to the usefulness of workshops and /or seminars, I cannot say that they are useful because while we get the knowledge but when we come back to our jobs we still perform the same duties, we are still in the same positions, and we still get the same salaries.

The general view of all health care providers interviewed in Lusaka Urban district is that the establishment District Health Boards when fully operational will enhance the chances of being promoted for health staff in each district. Since the District Health Boards are independent and autonomous, management will be inclined to fill senior positions by promoting people from within the district rather than bringing people from outside the district, and by so doing increasing the chances of being promoted for health workers in the district. However the health providers in Lusaka expressed apprehension that the possibility of people not being promoted on merit exists. Some people felt that friends

might get promoted rather than those who actually qualify to be promoted while others felt relatives to district management will have higher chances of being promoted than anybody else.

Institutional support.

This section attempts to evaluate the extent to which the support that the health centers in Lusaka district receive, from Lusaka Urban District Health Board, affects the levels of motivation of the workers and how in turn this affects the work behaviour of the health care providers. The indicators of institutional support that are examined are the provision of favorable physical working environment, transport, sufficient drugs, effective leadership and supervision, and general institutional policy.

In Lusaka Urban District of all the health centers visited, four (Chilenje, Chelstone, Kalingalinga and Matero) seem to operate in favourable physical working conditions. However, health care providers at Kaunda Square and Bauleni health centers complained about their physical working conditions. The workers from both clinics had a similar complaint of the size of premises that they are operating from. They said their premises are so small and the buildings are that they are operating from were not designed for the purposes of a clinics. Kaunda –Square clinic is housed in a building that was originally a residential house while Bauleni clinic operates from a structure not suitable for a health centre. The health workers at both clinics complained that because their premises were originally not meant to be clinics it is difficult to appropriately fit all the different departments of the clinic. An example that was given by one of the nurses at the Kaunda Square health centre is the non-availability of a family planning room private enough to enable them administer any method of family planning including those that should be done in privacy like inserting a loop". The health care providers from both clinics also complained that their premises can not allow any form of expansion in the future. At Kaunda Square clinic there was also a complaint about the location of the clinic. The Health care providers complained that the premises are not only small but that the clinic is also badly located, right into the middle of residencies and that it is too near a very

noise bus stop making it very difficult for health care providers to concentrate in their work.

Lack of transport was repeatedly voiced as a major constraint to effective service delivery, by health care providers in all the clinics that were chosen as sample clinics in the district. Two categories of transport services were particularly emphasized ambulances and utility vehicles. At the time of the study the health care providers interviewed in Lusaka district claimed that there were only two ambulances in the district to transport all the refereed cases to referral centers and/or to University Teaching Hospital (UTH). The respondents interviewed in Lusaka, particularly the in charges of the health centers studied, complained that once a patient has been referred either from a small clinic like Chainda to a referral centre like Chelstone to UTH, it can take as long as six hours before an ambulance can be made available to transport the patient to the referral centre to the UTH. In fact the health providers interviewed said that it very common for patients to die while waiting for the ambulance to transport them to the referral centre or to UTH.

Lack of utility vehicles in health centers in Lusaka district is also viewed as a major constraint against effective delivery of health services among the health care providers. Two major reasons were advanced for the necessity of utility vehicles. The first reason is that each health center is supposed to conduct out –reach programmes where there are go out in the community once in a week to carry out health education related services. The respondents said it very difficult to conduct these programs effectively without transport as health workers have to literally walk from one point to the other. The second reason came from the Environment Health Technologists (EHTs) of the Lusaka health centers studied complained that most of the tasks of theirs involve going into the communities and this cannot be effectively done without transport.

The general feeling among the health care providers interviewed in Lusaka district is that District Health Boards are trying their level best in trying to ensure that all the health centres have sufficient supply of drugs all the time. The, however, say that a situation

where almost all types of drugs are always available in all health centres is yet to be reached. This is in agreement with the views expressed by Clients earlier on who feel that the supply of drugs in health centres was adequate. Table 4.3 shows 51.7% of the clients indicating that drug supplies were regularly given in health centres while 48.3% said they were not regularly given.

One feasible explanation for the discrepancy in the views on the availability of drugs between the users of health services is that there is always a tendency to exaggerate situations among the users of health services.

They were only isolated complaints from health care providers interviewed in Lusaka district regarding the nature of leadership and supervision. One clinic in Lusaka Urban District complained about the way support visits from the District Health Management Team were being conducted. He argued that there was too much interrogation in the whole process making it difficult for the providers who host these visits to freely express themselves and tell management all the problems they face in their operations. At two clinics in Lusaka they were issues raised concerning supervision of the health centres for more than two years. She argued that this makes those employees who are employed under the District health Board conditions of employment feel insecure in their jobs.

Concern was also expressed on the fact that District Health Boards seem to have failed to come up with a clear policy position on the implications of the health reforms on the terminal benefits of the health workers who had served for a number of years in the Ministry of health before the introduction of the District Health Boards. Health workers claim that the current situation where management of health centres is totally under District Health Boards but salaries for most employees are still being paid by the government is very confusing to employees as it makes them doubt the ability of District Health Boards to effectively control the behaviour of health workers in the districts. One respondent said that one logical conclusion that can be made about the whole situation is that District Health Boards have failed to be financially autonomous.

Users' perceptions of Health Care Providers' attitudes.

The low levels of motivations that health workers are experiencing manifest themselves in a variety of ways, most of which have a negative impact on the performance of workers. The first manifestation of low motivation levels by health workers has been the development of "work as you earn principle", that turn has a negative influence on the health care providers work altitudes and which the facility users found unacceptable. The community members interviewed in Lusaka district complained that the low levels of motivation among health workers make them adopt poor working habits. Respondents from both categories (clients and community members) identified a number of such poor working habits. One such poor working habit was the negative attitude of the health care providers towards the clients and community members.

From the interviews of the health facility users in Lusaka it emerged that the level of human relations to patients is very.

Some of the frequent reasons given for this poor rating include, the nurses being rude, waiting for a very long before being attended due to the fact that most nurses report late for work and sometimes they leave people waiting in the line and go to chat or drink tea, they are fond of shouting at the patients especially at under five and anti-natal clinic, the health care providers particularly nurses are not friendly and do not even greet the patients.

Another work attitude that was a manifestation of the low motivation was the initiatives taken by health care providers to mitigate low incomes. This is rampant, particularly among the health care providers in urban areas. This is something that came out of the views of clients, providers and some officials. The result of moonlighting is having employees who actually work about 16hrs in a day because they will nock off from their normal duties and go and start another shift at a private clinic. The end result of this is a worker who is very tired and stressed almost all the time.

Reporting late for work and absenteeism are other manifestations of low motivation. The explanation health care providers give for this kind of behavoiur is usually two-fold. First they say that because they earn very little money from the jobs, they spend the first two

hours of the morning trying to get money in whatever way to enable them provide for their families with basic necessities such as food. Secondly they say that management does not seem to value their work going by the kind of conditions of service under which they serve, particularly salaries that they get. They make a logical comparison between their contributions and the inducements that they get from their jobs. And the way they try to make the otherwise inequitable situation fair is by practicing the "work as you earn" principle, the principle that has come to be accepted as the norm of the workers in the Zambian civil service. Related to absenteeism and late reporting is the habit of knocking off before time.

Other bad working habits that have identified because of low motivation levels of health care providers is having very long tea breaks, and being very rough and unwelcoming to patients. They also complained that emergencies were not attended to promptly.

Conclusion

From the findings of the study regarding factors affecting access to health care services and facilities in Lusaka Urban District, the following conclusions could be made. Lusaka Urban District Health Board has been able to provide supervisory visits to all the health care facilities under the district and these visits were classified as regular by (48.8%) of the Health Care Providers interviewed. These visits are necessary as they would determine the quality of health care and be able to deal with issues of access to services by clients. The study showed that (59.3 %) of the Health Care Providers also indicated satisfaction with the management. The situation was not different on the adequacy and the regularity of drug availability in the health centers were (49.7%) and (51.7%) responded that drugs were adequate and available regularly respectively.

Similarly, there was satisfaction with the services offered by the Lusaka Urban District and this was expressed by respondents from various age groups at (56.9%). Responses were also obtained from a cross section of health centers under Lusaka Urban District where (57.3%) of the clients interviewed expressed satisfaction with services offered.

hours of the morning trying to get money in whatever way to enable them provide for their families with basic necessities such as food. Secondly they say that management does not seem to value their work going by the kind of conditions of service under which they serve, particularly salaries that they get. They make a logical comparison between their contributions and the inducements that they get from their jobs. And the way they try to make the otherwise inequitable situation fair is by practicing the "work as you earn" principle, the principle that has come to be accepted as the norm of the workers in the Zambian civil service. Related to absenteeism and late reporting is the habit of knocking off before time.

Other bad working habits that have identified because of low motivation levels of health care providers is having very long tea breaks, and being very rough and unwelcoming to patients. They also complained that emergencies were not attended to promptly.

Conclusion

From the findings of the study regarding factors affecting access to health care services and facilities in Lusaka Urban District, the following conclusions could be made. Lusaka Urban District Health Board has been able to provide supervisory visits to all the health care facilities under the district and these visits were classified as regular by (48.8%) of the Health Care Providers interviewed. These visits are necessary as they would determine the quality of health care and be able to deal with issues of access to services by clients. The study showed that (59.3 %) of the Health Care Providers also indicated satisfaction with the management. The situation was not different on the adequacy and the regularity of drug availability in the health centers were (49.7%) and (51.7%) responded that drugs were adequate and available regularly respectively.

Similarly, there was satisfaction with the services offered by the Lusaka Urban District and this was expressed by respondents from various age groups at (56.9%). Responses were also obtained from a cross section of health centers under Lusaka Urban District where (57.3%) of the clients interviewed expressed satisfaction with services offered.

In addition, (82%) of the 503 community members within the catchments area of the health centers did respond that they utilized the nearest health centre when they fell ill.

The study has further established that there is availability of public transport to health centres and that most health care facilities in Lusaka Urban District are within walking distance. Secondly, it was established that the payment of user fees had an effect on attendance. 56.5% of health care providers indicated that user fees had an effect on attendance to their health centers. Clients interviewed stated that user fees that health centres charged were not affordable because they were generally too high. Both clients and members of the community interviewed, indicated that health care providers sent away those that were not able to pay user fees.

Thirdly, it was established that health care services in Lusaka Urban district are not adequate as certain facilities such as x-ray, admission and laboratory services are not available in some centres. The supply of drugs was also established to be erratic and some equipment such as BP machines and diagnostic sets needed replacement due to wear.

Fourthly, the study also revealed that health care providers were not motivated due to poor remuneration and conditions of service. However, it was established that the majority of health care providers had gone for further training and also attended workshops and seminars. As regards institutional support, there was general agreement that this was provided although some health care providers had some misgivings on the approach of providing supervising visits which they felt had been turned into "Kangaroo Courts". The study further revealed that there was low morale among health care providers in Lusaka. The low morale experienced by the majority of health care providers in Lusaka district manifested itself in many ways which in turn have a negative effect on the clients and community members. Workers have also adopted their own working norms such as "work as you earn principle" that makes health care providers develop a negative altitude towards the users of health care facilities and services. Other

manifestations of low motivation include moon lighting, reporting late for work and absenteeism and prolonged tea breaks.

REFERENCES

Holden, N, Cooper, C. and Car, J. (1998), "Dealing With the New Russia: Management of Cultures in Collusion". London, Wiley.

Kutzin, J, (1994), "Experiences with Organization and Financing Reform of the Health Sector". W. H.O. Geneva, Switzerland.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

Introduction

In concluding our study on health reforms and health care delivery in Lusaka Urban District, the chapter will focus on two major aspects. Firstly, it will provide the key conclusions arising from the study findings. Secondly, it outlines the recommendations to policy makers in the Ministry of Health and key players in the implementations of health reforms on some areas of the health reforms implementation process that might require re-visiting and /or where possible changes in the method of implementation may be needed in order to improve performance of District Health Boards in general and Lusaka Urban District Health Board in particular. These aspects are very critical to the success of any project or programme that government undertakes.

The study was guided by the basic principle that the provision of effective health care delivery that can be easily accessed by all the citizens of a particular country is the essence of any public health policy and its subsequent revisions that may follow. The focus of our study was on health reforms and health care delivery in Lusaka Urban. With the introduction of health reforms, the policy makers envisaged that access to quality and cost effective health care as close to the family as possible would be achieved.

Our study therefore tried to analyze the idea that through the introduction of health reforms, and the creation of District Health Boards, health facilities would be brought closer to the communities and as such health facilities would be easier to access. In undertaking this analysis, the study focused on a number of aspects. The first one was to examine the health care services that are provided by the Ministry of Health in the Lusaka Urban District and how these have been able to improve access to health care services. The second aspect was to identify factors affecting accessibility of health services in the district while the third was to assess the effects of each factor on service delivery.

Conclusion

In general terms, our study established that the goals of the health reforms as visualized by the policy makers have not yet been fully realized. This is despite the fact that health reforms have been under implementation for about 10 years. While success can be identified in certain aspects of the health reforms, there are still some areas where the policy objectives of the health reforms have not fully been realized, thereby limiting the extent to which health service delivery would be effective.

Regarding the first aspect of the study which analyzed the health care services provided by the Lusaka Urban District, the study reviewed categories of health care providers that are available in Lusaka Urban District. The study established that although there was a broad category of health care providers in the district as provided for in the health reform policy documents, the issue of gender balancing needed to be looked at critically. Out of the total number of 193 health care providers, in the institutions under study, 84.9% were females. The impact of this gender imbalance of health care providers is that clients who prefer to be treated by health care providers of their gender might consider health care service delivery as inadequate if their preferences are not met. Another area that would raise questions on the categories of health care providers in Lusaka urban district are the numbers of available staff in each category especially doctors who are only accounting for 4.1% of the total number of health care providers. The fact that only 8 doctors were found during the study in the 22 health centers could potentially reduce access by clients to a doctor thereby affecting effectiveness of health care delivery.

On the issue of access to alternative health care facilities in Lusaka Urban other than those services that are provided by the Ministry of Health through the Lusaka Urban District Health Board, health care providers were requested to find out where else the clients went when they fell ill. In analyzing this element, the study recognized the fact that in order to cater for the medical needs of the ever increasing population in Zambia and Lusaka Urban District in particular, there was need to encourage Public – Private Partnership in the provision of health care services. The study established from responses that clients would either go to private clinics, University Teaching Hospital (self referral)

and Traditional Healers. The effect of this is that people have wider choices in the accessibility of health care services which is in line with health reform policy.

As regards provision of health care services it was revealed that health care services such as mother to child Health, nutrition demonstrations and out reach services were not provided on a daily basis. There was therefore need to improve delivery of these services and indeed introduce others.

In terms of referral cases to other institutions either at the same level of health care or to a higher level of health care the study revealed that health care providers (35.5%) never received any feed back on referred patients. When equally asked to whether they provided feedback on patients they referred to other health facilities (51.4%) responded that they never did. The effect on this lack of feed back on the effectiveness of health care delivery is that it may create dissatisfaction of the services by both clients and communities. It is also probable that duplication in records or statistics may occur.

In as far as provision of outreach programmes is concerned; the study established that Health Care Providers were able to provide outreach programmes in their areas. Those that had agreed to having provided outreach programmes accounted for (67.2%). However, (32.8%) did not agree to providing out reach programmes. This was attributed to the fact that there are certain programmes which were supported by donors that provided outreach such as immunization while other programmes much as the health providers needed to offer the service, resources could not permit.

Regarding the second aspect of the study which aimed at identifying factors affecting accessibility of health services in Lusaka Urban District, management of health services in the district was analyzed. The majority of health care providers interviewed indicated that they were visited by their supervisors and that they were satisfied with the manner in which Lusaka Urban District Health Board was managing the affairs of the district. However, a small component of Health Care Providers was dissatisfied with the management of affairs in the district. A dissatisfied employee may have low motivation

to work. Low levels of motivation manifest themselves through negative altitude workers develop towards the performance of their tasks. This could make clients reluctant to go to a health centre to seek help when they get sick, thereby having a negative impact on access to health care service. In as far as the adequacy of drug supply and how regular the supply was, the majority of clients and community members stated that drugs were adequate and regular in supply. Additionally, both clients and members of the community were satisfied with services that health care facilities under Lusaka Urban district were offering. The majority also indicated that they utilized the nearest health facility when they fell ill. Although some clients and members of the community were dissatisfied with services offered by Lusaka Urban District Health Board the majority were satisfied. This factor is consistent with the vision of the health reforms in as far as provision of quality health care services which is as close to the family as possible is concerned. The effect of this aspect is that people are able to access quality health care services without having to walk long distances.

Regarding the third aspect of the study which assessed the factors affecting accessibility of health care services, from the findings of this study, District Health Boards particularly Lusaka Urban District Health Board has been able to provide health care facilities that the people of Lusaka district can easily get to whenever need arises.

However, the quality of services provided has not met the satisfaction of the clients and community members because of the following factors. First, there is a reduced attendance to health care centers because of the introduction of user fees. These user fees are said to be unaffordable for the majority of the people in Lusaka urban. The majority of respondents felt that the fees that are charged are too high and that they would be sent away from the health care facility if they failed to pay these fees. The belief that they will be sent away from health facilities shows the level of understanding among users of health care services. Most respondents did not know the assistance that would be rendered by health care facilities to those that are not able to pay user fees. The core of health reforms is to increase access to health facilities, this could indicate a high

ignorance among the users of health services under the health reforms, resulting into very little or no appreciation among the users of different aspects of the reforms.

Secondly, there is a limitation in terms of health care services that can be accessed. Health care services offered by institutions in Lusaka Urban District are inadequate. Health facilities do not offer uniform services. Even the health centers that were converted into mini-hospitals such as Chelstone, George, Kalingalinga clinics do not have the same facilities. At the time of the study, it was established that some institutions did not have laboratory services while others did not have x-ray services. There also has been a continuous shortage of drugs particularly in the health services that are in the urban areas. Ambulance service services are rarely available. Hence a large number of users who were interviewed in the study in Lusaka Urban did not provide a positive view of the services offered by Lusaka Urban District Health Board.

In addition, the effectiveness of these health care providers has been adversely affected by shortage of qualified personnel so much that a number of clinics are running below their establishments. The majority of these health care providers are de-motivated. To account for their position, the health care providers interviewed advanced a number of reasons. The first and most cited of the reasons advanced is the poor conditions of service, particularly the low salaries. Some employees interviewed described their salaries as "slave wages". Non-implementation of other fringe benefits such as allowances and loan facilities that exist in their written conditions of service was identified as a major cause of de-motivation. The second reason given for the low motivation was the inability by Lusaka Urban District Health Board to send employees for further training. Those interviewed felt that it is more difficult to go for further training under the decentralized system of District Health Boards than it was before the introduction of health reforms. The third reason given for low motivation is the lack some elements of institutional support from Lusaka District Health Management Team. Smaller Health facilities such as Chainda expressed concern on the lack of services such as x-rays, laboratory and dental services while the bigger health centers with the status of mini-hospitals or referral centres such as Chelstone, felt that provision of a mini-theatre

was necessary for the clinic of its size to operate effectively. Low motivation affects service delivery in that workers tend to develop their own working norms such as "work as you earn principle" that makes health care providers develop a negative altitude towards the clients.

Recommendations

In view of the conclusions of the study that have been made above, on health reforms and health care delivery in Lusaka Urban district, the following recommendations can be made to the designers of the reforms and all other stakeholders involved in the implementation process of health these reforms.

First, there is need to ensure that there is gender balancing amongst various categories of health care providers available in the district. Deliberate steps must also be taken to ensure that categories of health care providers are increased especially doctors.
Public-Private Partnership in the delivery of health care should be encouraged in order to increase access to health facilities.
The range of services provided to users also needs to be expanded to include maternity and laboratory services in those clinics that do not have such facilities.

Second, there is need to provide feedback on referred cases. There must be a system of monitoring all referred cases to ensure correct records and service to the clients. Measures should also be taken to provide outreach programmes to the catchments areas. This would create a follow up system of cases that are on home based care and indeed provision of other outreach programmes.

There is further need for direct players in the provision of public health that is the health care providers and supervisors to sit together and resolve issues pertaining to management of health services in the district. This would increase levels of satisfaction among health care providers and possibly increase accessibility through improved worker altitudes towards clients.

Third, the issue of drug supply needs to be addressed particularly drug availability in health care centres and regularity. Drugs need to be regularly available in adequate qualities in order to meet the needs of the users.

Further availability of health facilities as close to the family as possible is of prime importance. Therefore is need to construct additional health care facilities to reduce distances to health care. The scenario that is there in Lusaka Urban district now, where only those that are able to walk to health centres access health care while the critically ill can not access health care due to absence of ambulances brings about dissatisfaction regarding the performance of health reforms.

Fourth, there is need to improve the quality of services provided by Lusaka Urban district. The current arrangement where clients have to be charged user fees to access services has reduced attendance to health facilities. The users of health care facilities consider the fees to be too high and as such the majorities have stopped seeking health care services. The core of the health reforms is to increase access to health care which is of high quality and the user fees although they may contribute towards improved health care delivery by use of the fees for buying cleaning materials and some basic necessities, have been observed to be barriers to access. Users of health services who pay for various health services and facilities must see a clear relationship between the fees paid and the quality of service received.

There is need to involve the clients/communities at the level of deciding the activities on which the money collected through payment of user fees should be spent. This will not only improve the degree of community participation in public health provision, but will also make the users appreciate and understand the significance of funds collected through user fees in providing quality health care services and facilities. The findings of the study are such that currently, the users expect high quality public health services from the little money that they pay as user fees.

There would be need to strengthen information sharing with communities on exemptions. Clients and members of the community should be made aware of the

exemptions that exist on the payment of user fees. "Senior Citizens" and under fives are exempt from paying user fees. Social Workers could play a major role in this area.
Fifth, low levels of motivation and its effect on the performance of health care providers need to be seriously addressed. Key determinants, (capacity, willingness and institutional support) of an individuals behavior in the performance of his/her duties need to be attended to.

There is also need to enhance employee's capacity to perform their tasks effectively by deliberately providing them with opportunities to go for long term training in their various specializations.

Health Care Provider's salaries and/or their monetary rewards need to be improved. Even with the salary increment that was awarded to health workers in mid 2003, most of the salaries of health workers are still below a living level. This as indicated earlier has a negative effect on the willingness of the workers to perform their different tasks effectively and efficiently.

There is need to improve the environment in which the health care providers perform their tasks. This would entail enhancing institutional support from Lusaka District Health Board of Management and or Teams to various health centres in the district, for example, support visits to health centres in Lusaka district particularly in the rural catchments areas, need to be carried out in a true "supportive manner" and not in an interrogative atmosphere, as was alleged by some health care providers during the study.
There is need to provide relevant and adequate tools and equipment to Health Care Providers.

There is also need to supply health centres with appropriate drugs to administer to clients at all times.

It is therefore the Researcher's view that if government implemented the above recommendations, the vision of the health reforms would be realized.

BIBLIOGRAPHY

Bangser, M, (2000), "Reframing Policies for Gender Equity: Women's Agency, Participation and Public Accountability": Harvard Centre.

Bashe, B.I. and L.J. Jongman, (2005) "Lessons of Experience in the Design and Implementation of the Public Service Reforms: The Case of Botswana Public Service". A paper presented at the 3rd Eastern and Southern African Consultative Workshop on Public Service Reforms held between 2nd – 4th June, 2005 in Arusha, Tanzania.

Berman, P (1995) "Health Sector Reform: Making Health Development Sustainable In Health Sector Reform in Developing Countries". Boston: Harvard University Press.

Bhat, G.J, (1987), "Childhood Morbidity and Mortality at the University Teaching Hospital". Lusaka. Zambia.

Bjorkman, J.W, (1997)" Health Policy Reform, National Variations and Globalization". New York St. Martins Press

Berry, F.S., B. Wechsler, (1995) "State Agencies' Experience with Strategic Planning: Findings from a National Survey". Public Administration Review, Vol. 55, No.2.

Blass and Musowe, V, (1997) "A Great Leap Forward for Health Reforms in Health Reform News": A Quarterly Bulletin of the Health Reforms of the Central Board of Health. Ministry of Health. Lusaka.

Booth, D, Milimo J, Bond, G, (1995) "Coping With Cost Recovery". Stockholm University.

Byarugaba, F, (2005), "Public Service Reforms in Uganda". A Paper Presented at the 3rd Eastern and Southern African Consultative Workshop on Public Service Reforms held between 2nd – 4th June, 2005 in Arusha, Tanzania.

Bwalya, M.C, (2005) "Lessons of Experience in the Design and Implementation of the Public Sector Reforms: A Brief Review of the Recent Zambian Experience". A paper presented at the 3rd Eastern and Southern African Consultative Workshop on Public Service Reforms held between 2nd – 4th June, 2005 in Arusha, Tanzania.

Carroll, S.J. and H.L. Tosi, (1973) "Management by Objectives: Application and Research", Macmillan, New York, NY.

Cassel, A, (1997)" A Guide to Sector Wide Approaches for Reproduction Health and Rights". Takoma Park, MD

Catholic Commission for Justice and Peace, (1992)" Zambia Episcopal Conference.1992.Lusaka.Zambia.

CBOH, (1996)" Hand Book for District Health Board Members," Lusaka: Central Board of Health.

Cederlof, C, (1996) "An Essential Basic Health Care Package for Zambia". Lusaka, Ministry of Health.

C S O, (2000)" Census Report 2000". Ministry of Finance, Lusaka, Zambia.

Dada, J.O, (2002) "Performance Management in Nigeria's Public Enterprises: Issues and Prospects". Paper presented at the 24th AAPAM Annual Round Table Conference in Lesotho.

Dunlop, W.D., Eilene B.O, Chung, Kim B, (1982) "Korea Health Demonstration Project: Aid Impact", Evaluation report No36 agency for International Development.

Fitzpatrick, S., (2003) "Performance Management in the Public Sector: What Can We Learn from the Past? An Insiders View", European Institute of Public Administration (EIPA).

Foltz, AM, (1997)"Policy Analysis. In Comprehensive Review of the Zambian Health Reforms". Vol.II, Technical Reports.WHO.Geneva.

Forster, M, (1993)" Lessons from Sector Wide Approaches in Health". W.H.O.Lusaka.Zambia.

Gibson, L, (1995) "Management and Health Care Reform in Sub-Sahara Africa" Social Science and Medicine Journal.

GRZ, (1993)" Public Service Reform Programme", Cabinet Office, Lusaka.

GRZ, (2002) "Draft Strategic Plan for the Ministry of Finance and National Planning "(2003-2007), MDD, Lusaka.

G.R.Z, (2003) "National Health Strategic Plan 2001-2005 Mid Term Review

Report". Ministry of Health. Lusaka.

HERA, (1999)" Issue Briefs, Disseminated at the ICPD + 5 Preparatory Committee". New York.

Holden, N, Cooper, C. and Car, J, (1998)"Dealing With the New Russia: Management Cultures in Collusion. London Wiley.

James, A, (1897/1958)"A Pluralistic Universe". New York, Longman, Green.

International Labor Organization, (1970) "Narrowing the Gap –Planning for Basic Needs and Productivity Employment in Zambia: Jobs and Skills Programme for Africa". International Labor Office.

Kalumba, K, (1997) "Towards an Equity Oriented Policy of Decentralization in Heath System under Conditions of Turbulence": The Case of Zambia. Geneva. W.H.O

Kalyalya, D.H, (1995) "User fees In the Health Sector: Policy, Practice and Perception": Lusaka. Department of Economics, University of Zambia.

Kelly, M, (1991) "Education and Declining Economy: The Case of Zambia 1979-1985".World Bank. Washington

Kutzin, J (1994)" Experiences with Organization and Financing Reform of the Health Sector". Geneva. W. H.O.

Lake, S. and Musumali, C., (1999) "Zambia: The Role of Aid Management in Sustaining Visionary Reform." Health Policy and Planning.

Leighton, C. (1999) "The Implication of Health Sector Reforms for Reproductive Health and Rights". Takoma Park, MD

Lengwe, Mwansa, K.J (1985)" An approach Toward an Equitable and affordable health care delivery System in a developing Country: The Case of Zambia". PhD Thesis. Brandeis University

Limbambala, M. E and Choongo, D.E, (1994), "Assessment of Current Government Health Care Delivery Services in Lusaka Urban". Ministry of Health, Lusaka.

Lugalla, J. (1995)"Economic Reforms and Health Conditions of the Urban Poor In Tanzania" Presented at Anthropological Association Conference". Washington D.C

Martinez, J., (2001) "Assessing Quality, Outcome and Performance Management", Geneva: World Health Organization.

Mataka, R., (1998) "Civil Service Reforms in Zambia", Workshop Presentation at the Regional Consultative Workshop on Civil Service Reforms in Eastern and Southern Africa, Arusha, Tanzania.

Morrow, R.H, (1984),"A Primary Health Strategy for Ghana in David Morley, John Rohde and Glen Williams (Eds) Practicing Health for All. Oxford University Press.Oxford.University Press.

Mc Pake, B (1993)"A Model of the Equity Implications of Hospital Reforms in Zambia". London School of Hygiene and Tropical Medicine.

MOH, (1996)" National Policies and Strategies: Health Reforms", Lusaka. Zambia.

MOH, (2003) "National Policies and Strategies: Health Reforms", Lusaka, Zambia

Mkopadlyyay, M (1984)"Human Development Trough Primary Healthcare: Case Studies from India. In David Morley, John Rohde and Glen Williams (Eds) Practicing Health for All". Oxford University Press.Oxford.University Press.

Nachmias, C.F, and Nachmias, D (1994)" Research Methods in Social Sciences", UK. St. Martinis Press Inc.

Nanchengwa, M.V, (1984) "Peoples Beliefs and Causation of Diseases and Implications for Choice of Health Care in Zambia". A Thesis presented to the University of Zambia.

Nsemukila, B (2001), "Poverty and Food Security indicators in Zambia: Analysis of Household Survey data, Paper presented at a workshop on strengthening food and agricultural statistics in Africa in support of food security and poverty reduction policies and programmes": Pretoria, South Africa.

Public Service Reform Programme (PSRP) (2000) "Civil Service Reform in the Context of Structural Adjustment Programme", SERVICE: A PSRP Bulletin, Volume 3, Issue 1, Lusaka.

Paton, M, Q, (1997)" Intended Uses of Funds in Utilization Focused Evaluation". Delhi: Sage Publications.

Phiri, E (1999)," Maternal Mortality at the University Teaching Hospital". M.Med Thesis Presented to the University of Zambia.

Reddy, S and Vandemoortele, J (1996)" User Financing of Basic Services": a Review of Theoretical arguments and Empirical Evidence.UNICEF

Riley, M, Wood, R.C, Clark, M.A Wilkie, E and Szivar, E (2000) "Researching and Writing Dissertation in Business and Management" .Thompson learning.

Rohde, J, (1984),"Health for all in China" Principles and Relevance for Other Countries: Practicing Health for all. Oxford University Press. New York.

Sakinge, K.B (1995)"The Health Staff's Knowledge, Attitudes and Practices of the Health Reforms: A comparative Study". A Thesis submitted to the University of Zambia.

Seshamani, V and Mwikisa N.C (Eds) (2002) "Zambia's Health Reforms. Selected Papers".K.F.S. AB.Sweden.

Shaw, P.R and Griffin C.C, (1995),"Financing Health Care in sub Saharan Africa". Directions in Development Series. The World Bank at Washington D.C

SIDA, (1989), "The Current Economic Crisis in Zambia, Health Sector, Development and Prospects". SIDA Evaluation.

Strandberg-Larsen M, Nielsen MB, Vallgarda S, Krasnnik A, Vrangaek K, (2007) "Health Systems in Transition-Denmark. The European Observatory on Health Care Systems": London.Mossialos E, (E).Unpublished.

Starfield B, (1994) "Is Primary Care Essential?" Lancet344:1129-1133

United Nations Development Programme (1992), "Development Cooperation Report of the United Nations Development Programme (UNDP)".Lusaka. Zambia.

United Nations Children Fund (1995). "The Bamako Initiative: Rebuilding Health Systems". New York: UNICEF.

World Bank (1995) "World Development Report 1993: Investing in Health". New York, Oxford University Press for the World Bank.

WHO/UNICEF, (1998)" Alma-Ata-1998, Primary Health Care". Geneva. WHO.

WHO, (1994) "Primary Health Care". Geneva. Switzerland.

Zambia, Government of the Republic of (1965), "An Outline of the Transional Development Plan".

Zambia, Government of the Republic of (1982)" Quarterly Financial and Statistical Review of Zambia", 1982.Bank of Zambia.

Zambia, Government of the Republic of (1995)" The National Health Services Act. Chapter 535 of the Laws of Zambia". Health Reforms Implementation Team Secretariate.Lusaka.

Zambia, Government of the Republic of (1994)" A Guide to Zambians Health Reforms". Ministry of Health.

Zambian, Government of the Republic of / United Nations Development Programme (1996) "Prospects for Sustainable Human Development in Zambia- More Choices for our People. GRZ/UNDP.Lusaka.

Zambian, Government of the Republic of, (1992) "National Health Strategies and Policies (Health reforms)".GRZ.Ministry of Health.

QUESTIONAIRES USED IN STUDY **SERIAL NO.....**

TO ESTABLISH FACTORS FOR THE FAILURE OF HEALTH REFORMS IN ENSURING EFFECTIVE HEALTH CARE DELIVERY IN LUSAKA URBAN DISTRICT

MASTERS DEGREE QUESTIONAIRE

QUESTIONAIRE 01 - HEALTH CARE PROVIDERS

Please Fill in or Tick correct answers

Name of Institution:.....

Name of Interviewer:.....

Date of Interview:.....

Time Interview started:.....

Time Interview end:.....

1. Level of Facility
   - [ ] Central
   - [ ] General
   - [ ] Specialist
   - [ ] District
   - [ ] Health Centre

   Other.....

2. Sex: Male [ ] Female [ ]

3. Position:.....

4. What type of health care services do you provide at this health facility?

   (a) .....
   (b) .....
   (c) .....
   (d) .....
   (d) .....

5. Are all these services you mentioned above provided on Daily basis?

Yes [ ]
No [ ]

6. If No which services are not provided on daily basis?

a. .....
b. .....
c. .....
d. .....
e. .....

7. Are there other services you would want to be provided at this health facility which are not presently provided?

Yes [ ] No [ ]

8. If yes specify:

a. .....
b. .....
c. .....
d. .....
e. .....

9. Give reasons why these desired services are not provided?

(a) .....
(b) .....
(c) .....
(d) .....

10. Is the supply of essential drugs adequate or not adequate?

a. Yes [ ]
No [ ]

11. Is the supply of essential drugs regular or irregular.

Yes [ ]

No [ ]

12. If No What are the reasons:-

a. .....
b. .....
c. .....
d. .....
e. .....

13. What has been the effect of paying for service on patient attendance at this health facility?

(a) No effect on attendance [ ]
(b) Reduced attendance [ ]
(c) Attendance reduced for a while and then stabilized [ ]
(d) Increased attendance [ ]
(e) Other specify .....

14. Do you refer patients to other Health Institutions?

Yes [ ]
No [ ]

15. What are the common conditions for which you refer patients?

a. .....
b. .....
c. .....
d. .....

16. Do you get feedback on your referred patients

a. Never [ ]
b. Sometimes [ ]
c. All the time [ ]
d. Other.....

17. If you do not get feedback why not?

a. .....
b. .....
c. .....
d. .....

18. Do you get patients referred to you from other Health Institutions?

Yes [ ]
No [ ]

19. Do you get patients referred to you?

a. Never [ ]
b. Sometimes [ ]
c. All the time [ ]
d. Other.....

20. If never above why not?

a. .....
b. .....
c. .....

21. Do you provide outreach activities? (Does this health facility carryout some health activities in the community)

Yes [ ]
No [ ]

22. If "yes" which activities? (See records at the end of the interview)

a. .....
b. .....
c. .....

23. If no why not?

a. .....
b. .....
c. .....
d. .....

24. Do you have a running vehicle attached to this health facility?

Yes [ ]
No [ ]

25. If yes,is it accessible to all patients?

Yes [ ]
No [ ]

26. If No specify why?

a. .....
b. .....
c. .....
d. .....
e. .....

27. Do you think the type of services that you provide at this health facility could be improved?

Yes [ ]
No [ ]

28. If yes what improvements would you want to see?

a. .....
b. .....
c. .....
d. .....
e. .....

29. How often are you visited by your professional supervisors from District or Provincial Office?

.....
.....
.....
.....
.....

30. If visited are you satisfied with supervision provided?

Yes [ ]
No [ ]

31. If never visited how has this affected you?

a. .....
b. .....
c. .....
d. .....
e. .....

32. Are you satisfied with the management of this institution?

Yes [ ]
No [ ]

33. If No, specify why?

a. .....
b. .....
c. .....
d. .....
e. .....

34. Is there anything you would like to ask me about the things we have been talking.

.....
.....
.....
.....
.....

Thank the respondent and check the questionnaire for completeness

TO ESTABLISH FACTORS FOR THE FAILURE OF HEALTH REFORMS IN ENSURING EFFECTIVE HEALTH CARE DELIVERY IN LUSAKA URBAN DISTRICT

MASTERS DEGREE QUESTIONAIRE

QUESTIONAIRE/02 - COMMUNITY MEMBERS

Serial Number.....

Name of Community.....

Name of Interviewer.....

Date of Interviewer.....

Time Interview started.....

Time Interview ended.....

Please fill or tick correct answers to the under written questions.

1. What was your age on you last birthday?

2. Sex..... Male ..... [ ] Female.....[ ]

3. What is your Religion denomination.....

4. Which is your nearest Health Centre?

.....

5. How far is this Health Centre from your home?

.....

.....

6. Is there a regular Public Transport Service going to and from this health centre?

Yes [ ]
No [ ]

7. Do you at all go to your nearest Health Centre

Yes [ ]
No [ ]

8. For what purposes do you go for your health centre and how often?

(a) Treatment of Ailments [ ]

(b) Immunization [ ]

(c) Family Planning [ ]

(d) Prevention of malaria [ ]

(e) Chlorination of Water /wells [ ]

(f) Other specify

.....

.....

9. Do you pay for the health services rendered?

Yes [ ]
No [ ]

10. What do you pay for?

a. Treatment of ailments [ ]

b. Immunization [ ]

c. Family Planning [ ]

d. Prevention of Malaria [ ]

e. Chlorination of water/wells [ ]

(f) Other specify.....
.....
.....
.....

11. How do you feel about the fees would you say they are too high or too low or just right?

(a) Fees too high [ ]

(b) Fees just right [ ]

(c) Fee too low [ ]

12. What happens if you are unable to pay for the health services?

a. Don't know
b. Treated free
c. Sent away
d. Treated and pay later
e. Referred to social welfare services

f. Other specify .....
.....

13. Have you or any member of your family ever been referred from your local health centre to other institution?

Yes [ ]
No [ ]

14. If 'yes' what problems did you encounter?

.....
.....
.....
.....

.....
.....
.....

15. A part from the Health centre where else do people go when they are sick?

.....
.....
.....
.....
.....
.....
.....

16. Do you use any of the facilities you mentioned above?

Yes [ ]
No [ ]

17. If yes, which ones.....

18. a. Do you have a mobile health service operating in your area

Yes [ ]
No [ ]

19. b. If 'yes' who runs it?

Government [ ]
NGO [ ]
Private [ ]

20. Do staff from your nearest Health centre visit your home? (if no, skip to question19).

Yes [ ]
No [ ]

21. a. Are you satisfied or not satisfied with the services of your health centre?

Yes [ ]

No [ ]

22. b. Please give comments for your answer

.....
.....
.....
.....
.....
.....

23. What suggestions for improvement would you recommend?

.....
.....
.....
.....
.....
.....

24. Is there anything you would like to ask me about the things we have been talking?

.....
.....
.....
.....
.....
.....

Thank the respondent and check the questionnaire for completeness