IMPACT AND PUBLIC PERCEPTION OF HEALTH SERVICE USER FEES: THE CASE OF HIGH DENSITY RESIDENTIAL CHAWAMA COMPOUND.

by

Musole Siachisa

A dissertation submitted to the University of Zambia in partial fulfillment of the Requirements for the degree of Master of Public Administration

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DECLARATION

I hereby declare that the work presented in this dissertation for the degree of Master of Public Administration (MPA) represents my own work and it has not previously been submitted for a degree, diploma, or any other qualification at this or another University.

Signed: .....

This dissertation of Musole Siachisa is approved as the fulfilling part of the requirements for the award of the degree of the Master of Public Administration by the University of Zambia.

Prof. J. C. Momba.....		28/7/2009
Supervisor	Signature	Date
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Internal Examiner:		29/07/2009
	Signature	Date

ABSTRACT

Zambia's health policy and strategies can be said to have evolved through four significant phases. First, was the pre-independence period whose health policies were influenced by the colour-segregation ideology. Secondly, immediately after independence health policies and strategies were formulated that aimed at eliminating the imbalances in the provision of public health. The third phase was the adoption of the Primary Health Care (PHC) approach to the provision of public health services in 1980. The PHC approach, however, did not perform as expected so much that when the MMD government took office in 1991, they embarked on health reforms whose core focus was the establishment of the District Health Boards as the basic management units. These Boards were in operation till 2007 when the Central Board of Health was abolished as the mother body.

The overall purpose of this study was to investigate the impact of user fees on accessibility to health services and facilities in high density residential areas.

The dissertation takes a case study of a high density residential area so as to investigate the impact of user fees on accessibility to health services and facilities.

This case study was conducted in Chawama Compound of Lusaka District. In Chawama catchment area, four zones were covered which represent the diversity of the residential area where these respondents were picked. Within Chawama catchment area, there are Chawama and Lilayi clinics where part of the research was carried out. The total number of respondents in the catchment area was 332; 50 opinion leaders, 20 health providers, 10 traditional healers and 252 facility users.

It was established that initially, people had accepted the idea of cost sharing where provision of public health services and facilities was concerned. Surprisingly enough, after the introduction of user fees, the majority of the people developed a negative attitude towards user fees. But people's reluctance in paying user fees is influenced by a number of factors. These include income, occupation, education, availability of quality services and sensitization. Income was not a major factor in determining people's attitudes towards user fees. But the most negatively affected are those who earn low incomes. Occupation and education also played a marginal role in influencing people's attitudes towards user fees. It was also found that the majority of people were reluctant to pay user fees because of inadequate or non availability of quality health services and facilities as well as lack of sensitization. Due to the factors indicated above, people resort to alternative sources of health. Alternative sources of health services include traditional healers, spiritual healers, private local drug stores, chemists and private clinics. The majority of people feel that user fees should be abolished.

This dissertation is dedicated to my loving parents, the late Mr. Andrew Namuswa Siachisa and Mrs. Martha Benkele Siachisa, for fondly and carefully socializing me through life. These two very special and important people to me are a big determinant of the kind of person I am today.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBD	Community Based Distributor
CCF	Christian Children's Fund
CBoH	Central Board of Health
CCR	Coping with Cost Recovery
CHW	Community Health Worker
DHMT	District Health Management Team
GDP	Gross Domestic Product
GRZ	Government Republic of Zambia
HCC	Health Centre Committee
HIV	Human Immuno-deficiency Virus
HRDS	Human Resources Development Survey
IMF	International Monetary Fund
MMD	Movement for Multi-party Democracy
MoH	Ministry of Health
NHC	Neighbourhood Health Committee
NHPS	National Health Policy and Strategy
NGO	Non Governmental Organization
PHC	Primary Health Care
SPSS	Statistical Package of the Social Sciences
STI	Sexually Transmitted Infection
UN	United Nations
UNICEF	United Nations International Children's Fund
UNZA	University of Zambia
UTH	University Teaching Hospital
WHO	World Health Organization
ZIHP	Zambia Integrated Health Programme

CHAPTER 1

INTRODUCTION

Introduction

Health has been conventionally defined in terms of the prevalence of disease or its absence. Therefore, health is not simply the absence of disease; it is something positive. Therefore, the World Health Organization (WHO) (1947:2) defines health as the status of complete physical and social well-being and not merely the absence of disease or infirmity. It is one of the indicators of the standard of living and quality of life of any population and can be described as poor, good, very good and so on.

In Zambia, progress has been made since independence in developing health facilities and improving their physical accessibility to the majority of the population. Since 1964 and until the change of government towards the end of 1991, Zambia provided free universal health care, a system that was not only costly but even difficult to sustain. With time, Zambia started experiencing economic difficulty and the universal health care system could not be sustained. Consequently, acute drug shortages, deterioration of health facilities, exodus of trained national medical personnel and long distances to health facilities became common place. In order to keep the system afloat, the government turned to donors for funding and, as expected donor funding increased, although this raised concerns about the sustainability of the system (Kalyalya, 1995:12).

Recognizing the difficulties of maintaining free universal health services, and taking into account the on-going economy-wide Structural Adjustment Programme (SAP), the government of the Movement for Multi-party Democracy (MMD), articulated radical health policy reforms. According to the Ministry of Health (MOH, 1993:15), these reforms were characterized by a move from a strongly centralized health system in which the structures provided support and guidance to the peripheral structures.

Three major elements make up the Public Service Reform Programme.These are the restructuring of the Public Service that entails downsizing and rightsizing of the government departments, human resource improvement and decentralization. It is thus, within the spirit of the civil service reform programme that the health reforms were introduced. (Zambia, 1992:3-5).

Thus health reform programme highlights the following aspects:

1. Restructuring of Ministry of Health with a district focus (Primary Health Care) approach that emphasizes community participation.
2. Renewed emphasis on human resource development and retention.
3. Cost sharing in the delivery of health services.
4. Establishing of mechanisms to ensure financial and management accountability.

To achieve the above policy objectives, the MMD government, through the enactment of the Public Health Act No.22 of 1995, changed the structure of the Public Health Management System in Zambia. The Act established two types of autonomous boards that were charged with the responsibility of managing the Public Health System at two different levels. At national level was established the Central Board of Health that extended to the Provincial level through the Provincial Health Office. At District level, autonomous District Health Boards with their District Health Management Teams were established. These were given the power to manage all public health facilities and services in their respective districts, except general hospitals.

An important component of these health reforms is the restructured Primary Health Care (PHC) programme. However, major changes in the health service provision included the introduction of cost sharing and the establishment of new institutions of community participation in health care. The introduction of cost sharing provided a guiding principle or strategy that every able-bodied person in Zambia and earning an income should contribute towards the maintenance of his/her health. The adoption of this strategy was based on two major considerations: the need to raise extra resources to meet the cost of a basic package of cost-effective services to be guaranteed to all Zambians; and the desire to foster the spirit of partnership in health, an essential component of the Health Reforms. The implementation of the above principle or policy has been through user charges or fees. Lake (1990:19) points out that the potential objective of user fees include raising revenue, promoting efficiency, fostering equity, enhancing decentralization and sustaining and promoting private sector participation.

In spite of the written guidelines on the introduction and purpose of user fees and strategy, and the existence of the policy framework, actual practice has however varied widely around the country (NHPS, 1991:11 and MOH, 1993:51). Available information from the Ministry of Health indicates that there has been a marked decline in attendances at health

institutions following the introduction of user fees (MOH, 1993:45). Important factors to consider include the ability to pay for these services among most Zambians bearing in mind the general economic decline in the country; non availability of drugs at health centres; inadequate or no doctors; negative attitudes by health providers and long distances to health centres.

Statement of the Problem

The question of people paying fees for health care is perhaps the most debated element of the health reforms among interested people. This is because "there are diverse opinions about health service user fees" (World Bank, 1996: v).

The main approach in the implementation of cost sharing has been to decentralize responsibilities for essential service functions to the district level, in order to make services responsive to local needs and accountable to users. This has generally been accepted by people as a positive impact yielding essential results in terms of making better use of resources, stocking of essential drugs and raising staff morale. These positive impacts are regarded as emerging directly from people's monetary contributions (Milimo et al, 2000:6).

Despite this positive effect, the emphasis on efficiency has in some instances outweighed impact of user fees to improve equity and access. Cost sharing was initially introduced without sufficient regard for the level of user charges that the poor could afford. With the introduction of user fees, the government wanted to raise revenue, improve on service delivery in terms of supplying drugs, improve infrastructure and retention of medical personnel and also to improve on people's accessibility to quality health services and facilities.

Despite the introduction of user fees as part of the health reforms to improve accessibility to health services, it seems accessibility to health services has not improved in high density residential areas.

The objectives of the study

General Objective

To establish the impact of user fees on people's access to health services and public perception in view of unimproved provision of health services.

Specific Objectives

1. To assess the extent to which income, occupation and level of education affect level of access to health services and people's attitudes towards user fees.
2. To establish the extent to which the quality of health services determine the level of access to health services and people's views towards user fees.
3. To establish the views of opinion leaders on the introduction of user fees and the role they play in either the public rejection or acceptance of the user fees.
4. To assess the impact of income levels and occupation on people's accessibility to health services and facilities.

Rationale

The following reasons account for the significance of this study;

1. Investigative studies such as this one would assist policy makers monitor and control their progression towards the achievement of the intended objectives of the health reforms, and undertake corrective actions where necessary.
2. The study contributed towards people's participation on policy issues by airing their views on health matters.
3. The study is one of the requirements for meeting the Master of Public Administration qualification.

The Conceptual Framework

In life, the major yardstick used to measure the well being of a person is health. Health in this case, according to World Health Organisation (WHO) (1947), is defined as the status of complete physical and social well-being and not merely the absence of life of any population. Central to our study is the aspect of access to health facilities and services. Access entails the right to using, reaching or obtaining something. In this regard, Momba (2006) outlines a number of factors that influence citizen's access to health services and facilities. These factors include the cost of medical care in terms of user fees, availability of health providers and availability of drugs and medical equipment. Health services are provided by health providers.

In this study, a health provider refers to a person who is skilled and qualified in providing health services. Health providers in this case would include doctors, clinical

officers, nurses, environmental health technologists, dentists, pharmacists and other paramedics. These are the main clinic or hospital cadres who provide services needed for the health of their clients, though there could be other support staff. In this study, people's access to health services and facilities is upon payment of health user fees at the clinic.

According to Litvak (2001), user fees are charges for health care at the point of use. User fees were introduced in order for people to contribute towards the provision of quality health services and facilities. User fees are in different forms. In the study, the common type of user fees is a medical scheme. A medical scheme is an insurance which allows a person to seek medical attention from a clinic or hospital when ever he or she is sick and is subject to renewal every month. Medical schemes are a cheaper way of paying for health services on the part of facility users. People who do not want to be on medical schemes are allowed to pay directly an amount slightly higher than that paid for a medical scheme. For facility users who want to be on medical schemes for the first time, schemes have to mature after 24 hours before they are in use. In the study, a person who wants to be on a medical scheme is supposed to pay an amount of K2, 500 and renewal of the medical scheme is done monthly at the cost of K1, 000. For those who are not on the medical scheme, they are supposed to pay K5, 500 each time they need medical attention. In all cases, consultations and treatment are supposed to be given once payments are done. Apart from the medical scheme, there are other user fees paid for specialist treatment by facility users. These include dental services which range between K25, 000 and K30, 000; x-ray services which are at K30, 000; and lab services which also vary from K5, 000 to K10, 000 per contact.

Facility users are people who visit the clinic or hospital in order to receive health services offered by health providers. In this study, facility users refer mainly to Chawama residents. The services provided include consultations, treatment, counseling and referrals. In the study, poverty could be one factor affecting people's accessibility to health services.

According to the Collins New School Dictionary, poverty is the state of being very poor. Measurement of poverty in Zambia has been based on the 'food basket' approach that focuses on the adequacy of a household's income in so far the ability to purchase the basic food-stuffs required for its existent is concerned (Nsemukila, 2001:4). The cost of the food basket at the time of the research was estimated at K1, 600,000 by the Jesuit Centre for Theological Reflection in 2008.

Review of Literature

Literature on the different aspects of Zambia's health policy is quite substantial. A number of studies on Zambia's health reforms have been undertaken by University teams, research institutes, government departments, and students from different fields of study.

Moderate Momba (2006) in her Masters Thesis analysed the impact of health reforms on access to health services and facilities: A comparative case study of Lusaka and Kafue District Health Boards. Though this study tried to examine user fees, its focus was on the impact of the decentralized public health provision system on access to health facilities and services by users in urban and rural areas. The study tried to assess the level of autonomy of health boards, though they are abolished. The study indicates that the introduction of user fees is one of the factors which affect the willingness of users to participate in public health provision. However, the study does not discuss factors which could have influenced people's attitudes towards user fees and the impact of user fees on people's access to health services. The study does not look at occupation, education and opinion leaders' role in influencing people's attitudes towards user fees and their accessibility to health services. The study attempts to close up that gap.

Several studies have been undertaken on user fees in Zambia. Among those who undertook such studies are Foster, Malama et al, van Der Geest et al, Dinar, Limbambala, Pearson, Mubiana, Yates, Masiye, Deininger, Mpoga, Chuma, Litvak and Daka. Some studies have looked at the introduction of user fees from a positive point of view. The studies indicate that user fees have brought about improvements in the quality of health services and facilities.

There are reports from The World Bank, World Health Organisation and United Nations on the impact of user fees. A joint report of the government of the Republic of Zambia and United Nations system in Zambia (1996:13), for instance, refers to a study done by Booth et al, in 1995, on the impact of health reforms, particularly user charges. According to the findings of the report, additional revenues earned from user charges have contributed towards improvements in the quality of care at some clinics and hospitals. There have been improvements in the physical environments, cleaning materials and linen, staff morale as a result of the introduction of bonuses and provision of tea breaks and new uniforms. In addition, drug availability problems have eased at some hospitals, especially those entitled to purchase drugs from private suppliers (Government Republic of Zambia/United Nations

Development Programme, 1996:66). Even if the study indicates that there have been some improvements after the introduction of user fees, it does not examine the negative impact of user fees, especially whether many people access the services. It does not also discuss factors which prevent people from accessing quality health services.

However, other studies indicate the negative effects which are as a result of the introduction of user fees. The studies indicate that the introduction of user fees have marginalized majority of people when it comes to accessing health services especially the vulnerable groups.

In his paper, Foster (1993:3) examines the negative impact of user fees, and states that the level of charges has prevented a large population of poor people from gaining access to health services, especially women and children who need health services most. There has been a decline in patient flows of 60 to 80% at urban health centres following the introduction of user charges (Zambia/UN, 1996:67). The study helps us in the sense that it looks at reduction of patient flows after the introduction of user fees in urban centres in general. The study tries to give us some insights on the negative effects of user fees, more so on accessibility to health services. However, even if there is an observation on the decline in patient flows, the findings do not specifically analyze prevailing situations in high-density residential areas. The study overlooks other factors other than the inability to pay. There is lack of attention on other factors which influence people's attitudes towards user fees and their accessibility to health services. Hence the need for this study to close up the gaps.

The Jesuit Centre for Theological Reflection tries to look at some factors which could make people not access health services and the solution to that. In the publication entitled "Abolish health service user fees?" the Jesuit Centre for Theological Reflection (2008:4) examines the proposal by the former Minister of Health, Sylvia Masebo that user fees for health services should be abolished. The article noted that good health care in the country depends on two things: *availability* of quality services and *affordability* of these services to the majority of the population. The article points out that whether the poor can afford the available services is a matter of dealing with some realities that should not be ignored. It further indicated that the former minister spoke forthrightly about user fees, however small they might appear, being a hindrance to thousands of poor in Zambia, many of whom die because of lack of medical attention. The article shows that The World Health Organisation also sees the removal of user fees as a first step, a necessary but insufficient step, towards

better health care in the country. In its attempts to analyze some challenging facts, the article points out that in the current scenario, a person approaching a government health clinic fits into one of three categories: (1) Carries an up-to date scheme card, having regularly paid K1, 500 per month; the Central Statistics Office estimates that only 4% of the population are under such an arrangement. (2) Carries an expired scheme card and so pays K5, 000 to see the doctor the same day. (3) Carries no scheme card, so either buys one on the spot at K2, 500 to be admitted only the next day, or pays a K8, 000 "emergency fee" to see the doctor the same day. The article further indicates that what is increasingly occurring in the country is that a sick member of most low-income families (the majority "poor"- around 70% of the total population) will not have a scheme card, and if too sick to wait for a day, will be required to pay the emergency fee. But the question to ask is: is that poor person willing to pay K8, 000 just to be admitted to the clinic, with no guarantee of seeing a doctor, and no guarantee of receiving free medicine. The article shows that even though government policy states that there should be no charge for such care, this points to another problem that has to be faced: the public perception of government health services. It points out that certainly government has made efforts, many commendable efforts, to improve services. But by and large there is a perception of long waits in queues, non-availability of doctors or nurses, inadequate testings, lack of free drugs. Whether or not these perceptions are accurate and fair, there is need to undertake detailed study which looks at experiences in high density residential areas.

Other scholars have assessed the quality of health services after the introduction of user fees. For instance, in their article entitled "User fees and drugs: what did the health reforms in Zambia achieve?" Sjaak van Der Geest et al (2000: 59-65) report on exploratory research into the effects and prospects of health reforms in Zambia. The research, which was qualitative, was carried out in two rural and two urban health centres and their surrounding catchment populations. The authors focus on four principles of health reforms: community involvement (including cost sharing), prevention, equity and quality of care. One of their main conclusions is that many people criticize the introduction of cost sharing because it does not improve the quality of care, by which they first of all mean the availability of drugs. The authors plead for a humane implementation of user fees in public health care that is directly linked to a more efficient provision of essential medicines. The report, however, does not touch on other parameters which may contribute to the improvement of quality of

services provided. It does not assess the need for institutional support for health centres to improve on the health delivery system. It also overlooks the importance of public sensitization on the value of user fees.

Unlike van Der Geest et al article, Felix Masiye et al (2008:2) aim to assess the impact of the removal of user fees at primary health care level in rural areas of Zambia. The study was based on data collected from a sample of 23 districts in Zambia. The findings of the study will be of help to this study because the authors have indicated that following fifteen years of implementing user fees, great concerns have been raised about the role of user fees in a health setting in which widespread poverty and dismal key health indicators are pervasive. According to the study, abolishing user fees was a major policy issue in the health sector in which proponents for and against user fees had rallied in debate in the period leading up to the acceptance of the policy measure. The study further indicates that what needed to be done was to begin to evaluate emerging evidence relating to the changes as a consequence of scrapping user fees. It also points out that evaluation had to be undertaken as debate still continued on whether the removal of user fees, which initially was restricted to only rural districts, should be extended to urban districts as well. However, the gap identified with this study is that it was only concerned with the impact of user fees in rural areas. The study, just like other preceding studies, did not analyze the impact of user fees in urban areas, more especially in high density residential areas.

In the Journal of Tropical Pediatrics, Malama et al (2002:371-372) in their article entitled "User Fees Impact Access to Healthcare for female children in rural Zambia" argued that user fees offer revenue and may decrease inappropriate care. They further state that user fees may, however; deter needed care especially in vulnerable populations. Efficiency in the provision of health services may be improved by user fees if the fee schedule is structured in such a way as to encourage patients to use health services and facilities in an efficient manner (for example, going to the local health centre first rather than going directly to the referral centre) and for providers to give an efficient service. Quality health care may result from two different factors. First, revenue collected from user charges may be used to improve health care and secondly, the providers may become more responsive to their patients' needs because of fee payments. However, the authors were only concerned with the advantages of user fees without examining the negative effects of user fees on people's access to services

and factors which may influence public perception of user fees. This study is an attempt to fill up that gap.

In his paper entitled "User-payment, Decentralization and Health Service Utilization in Zambia" Limbambala (2001:19) indicates that the general attendance of people to health institutions has been greatly reduced by the introduction of user fees. This is evidenced by a study that was undertaken to assess the impact of health sector reform from 1993 to 1997 in respect of health service utilization and the shift of caseload from hospitals to health centre. The study covered 4.5 million people out of the total population of 9.7 million in 1997, and the result shows a dramatic decrease of about one-third in general attendance over a two year period, followed by a period with continued but slower decrease. Just like the other literature which has been reviewed before, the studies have shown that with the introduction of user fees, there has been a reduction in the number of people seeking medical attention from clinics and hospitals. But the study does not have a deeper analytical view of trying to find out on other factors which could have caused the reduction in the number of people visiting clinics. This study will close that gap by trying to examine factors which could have determined people's attitudes towards user fees and their accessibility to health services.

In the Africa Focus Bulletin, Dinar (2006:1) in his paper entitled "Africa: User Fees", notes that the case for removing official user fees for primary health services is strong but cautions that this measure should not be regarded as a panacea or divert the attention from the broader need for adequate investment in health. The paper shows that the most immediate ways to help the poor are common- sense remedies: stop making them pay for essential services and give them cash. According to Dinar, user fees were introduced in Zambia under IMF and World Bank pressure in the early 1990s. He argues that young girls in rural areas were the main victims of the policy as their families were rarely willing or able to pay for their treatment. He further says that in April 2006, the government of Zambia introduced free health care for people living in rural areas, scrapping fees which for years had made health care inaccessible for millions. In his paper entitled "The case for abolition of user fees for primary health services", Pearson (2004:1) also argues that cost is usually the major obstacle preventing the poor from accessing basic health care. He indicates that improving the affordability of essential health care services requires measures aimed at reducing all costs- whether they are official fees, informal out of pocket payments or indirect costs such as transport. These studies provide an insight that poverty could be one of the factors which

made people unable to access health services and facilities, especially in rural areas before the abolition of user fees. However, the studies were only focusing on scrapping user fees in rural areas because they marginalized a lot of people, especially the vulnerable groups. The studies did not assess the situation in urban areas and people's accessibility to quality health services, especially in high-density residential areas.

In his paper entitled "No, it is not April fool's: Free health care in Zambia" Daka (2006:2) comments on Zambia's policy of scrapping user fees. He noted that the new health policy is misguided in that it assumes that everyone in the rural area can not afford the user fees and that everyone in the urban area can afford. He argues that if the government's aim is to help the poor, then it needs to define them based on local consideration and put a mechanism that will effectively and efficiently identify them wherever they are. If implemented as it is, what stops a wealthy man from traveling a few kilometers to access free services? Similarly, a poor man from the rural area who comes to the urban area for whatever reason can not access the free services if they fall ill. According to Daka, Zambia had a similar policy in the 80's and it proved to be unsustainable, the current policy will fail for the same reason. He argues that the only way out is to create wealth. He proposes that instead of channeling the savings gained from the HIPC initiative, the government should consider establishing a revolving fund that should be invested in local productive ventures such as rice cultivation and processing. This would in turn raise the capacity of the locals to finance their own health. He concludes by saying that free health facilities should be maintained for the vulnerable where ever they are located. Daka's study adds substance to this study in that he gives us an insight that the vulnerable are affected by user fees in terms of accessing health services. But just like the other scholars discussed earlier, he does not analyse other factors which could affect people's access to health services and their perceptions towards user fees; thus this study is a remedy to that.

The preceding literature on Zambia will be of help in that it has provided us with some insights on the impact of the introduction of user fees on people's accessibility to health services especially the vulnerable groups like women and children who need the services most. However, the introduction of user fees has not only affected the vulnerable groups but also even those who are able to pay. The preceding literature has not provided a detailed analysis of factors which make people have a negative attitude towards user fees;

hence unable to access quality health services. Thus, the need for this study to fill up that gap.

Having seen what has been written about user fees in Zambia, and in the process having identified the value of those works and the gaps that the literature has left, the following literature examines experiences in other countries concerning the impact of user fees on people's access to user fees.

Rob Yate (2007:1) in his paper entitled "The Impact of Abolishing User Fees in Africa- Recent Developments in Six African Countries" analyses health management information data from Zambia, Burundi, Uganda, DRC Congo, Niger and Rwanda in the period pre and post the policy change to abolish patient fees. He noted that the issue of whether Governments should charge user fees for health services has risen, once again, to the top of the health sector development agenda in Africa. He further argues that since South Africa (in 1994) and Uganda (in 2001) scrapped user fees, other Governments have shown growing interest in adopting this policy to increase the consumption of essential services, especially among the poor. The author points out the medium term data presented from Uganda which indicated that the large increase in health care is a similar trajectory in utilization of health services being observed in Burundi and Zambia, shows consumption following the abolition of fees being a temporal phenomenon. He says that other countries could also benefit from a sudden and sustained use of health services where they have to remove patients' fees. The study concludes with a reflection on the political significance of these recent reforms. The author emphasizes that in each case, the decision to remove user fees was taken by the Head of State and that this appears to have been the cornerstone of the success of these policies which have benefited both the population (in terms of increased use of health services) and the Presidents concerned (in terms of increased popularity). The paper helps in trying to analyze situations in other countries which prompted respective governments to adopt the policy of abolishing user fees. But Yate does examine other factors like those which will be discussed in this paper which may affect people's access to health services.

According to Klaus Deininger and Paul Mpuga (2005:51-91) in their paper entitled "Economic and Welfare Impact of the Abolition of Health User Fees: Evidence from Uganda" state that household level data for Uganda for 1999/2000 and 2002/2003, before and after the abolition of user fees for public health services, are used to explore the impact

of this policy on different groups' ability to access health services and morbidity outcomes. The authors found that the policy change improved access and reduced the probability of sickness in a way that was particularly beneficial to the poor. The paper points out that although the challenge of maintaining service quality remains, aggregate benefits are estimated to be significantly larger than the estimated shortfalls from the abolition of user fees. Just like other scholars, the authors concentrate on the poor as being the only ones affected by user fees, without considering the fact that even other groups are affected in away by user fees due to a number of factors which are discussed in this study.

Yate (2006:1-3) in his paper entitled "International Experiences in Removing User Fees for Health Services-Implications for Mozambique" states that user fees were introduced in Africa at a time of widespread downward pressure on public expenditure and dwindling aid flows during the late 1980s. The study asserts that realizing that health services were woefully under funded, it suited both donors and Governments to shift some responsibility for health care financing to population through "cost sharing". The literature indicates that the rationale for charging user fees was set out in The World Bank document in 1987, which argued that user fees would: raise substantial additional revenue for the health sector which could be used to improve efficiency and equity; improve targeting of resources by reducing frivolous demand; and improve efficiency by encouraging people to use low cost primary health care services, instead of more expensive hospital services. The author indicated that initially, in the 1990s, some research literature appeared to support this theory, in demonstrating that introducing fees and improving management systems could increase the consumption of services. The study shows that fees have raised very little additional revenue; fee levels have been sufficiently high to suppress demand from poor people and exemption schemes have been ineffective. Yate argues that recent international experiences in removing user fees show that in addition to the obvious and powerful equity arguments (increasing access for the poor), there are strong efficiency grounds to abolish patient fees and that this is because user fees raise very little revenue and when administration costs are taken into account, their overall impact is often negligible.

Yate (2006:1) points out that as a means to improve access to health services and build national unity, one of the first actions of the African National Congress Government in South Africa, in 1994, was to remove health care user fees for: all children under six and pregnant and lactating women and that because of the policy change, outpatient attendance

increased by 77%, especially on curative services which had not yet been free. He states that based on these findings the Government realized that the health sector was coping with these additional demands and that it could and should expand access for all population groups. Literature tells us in 1997, the Government introduced a policy of free primary health care services and this triggered a substantial and sustained increase in out-patient attendance which continued into 1998. The study shows this pattern of increasing use over a sustained period was later repeated in Uganda. We are also told that considering that increased demand for services would have created an additional workload for health units, it is interesting to note in a British Medical Journal paper, in which Wilkinson et al (1997:6) conclude that the introduction of free services was popular with communities and health workers. But Yate observes that it would also appear that many saw these reforms as being "hurried and unplanned" This suggests that the implementation of the policy could have been more successful had there been better planning and management before fees were scrapped.

There are also lessons we can learn from literature on Madagascar.Yate (2006:3) states that following a disputed Presidential election, there was a blockade of part of the island of Madagascar, which resulted in a suspension of supplies to health facilities. Using output statistics (out-patient attendance) the author concludes that the health system was surprisingly resilient against these shocks. Indeed, he concludes that the 26% reduction in the numbers of patients visiting health centres was not so much due to problems of the supply of services but mostly due to increased levels of poverty, meaning that patients could no longer afford services. To emphasize the importance of demand side factors, the paper looked at the period after the blockade was lifted and the new Government temporarily abolished user fees. Once services became free, there was a significant increase in the consumption of services to the extent that "monthly visits post-crisis almost doubled compared to the previous year". In addition to the obvious lesson about the importance of removing user fees, other lessons can be learnt from Madagascar. One lesson we can learn is that this policy was successful even when it was suddenly introduced in an unstable environment where presumably there had been little pre-planning. Obviously this is not a recommended strategy but it does indicate the robustness of the policy.

In the International Journal for Equity in Health, Jane Chuma et al (2008:2) in their paper entitled "Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice?" look at the extent to which primary health care facilities in Kenya

continue to adhere to the 'new' charging policy three years after its implementation. The authors state that Kenya is one of the countries that have implemented a user fees reduction policy. The paper indicates that like in many other settings, the new policy was evaluated less than one year after implementation, the period when expected positive impacts are likely to be highest. This early evaluation showed that the policy was widely implemented, the level of utilization increased and that it was popular among patients. The literature shows that whether or not the positive impacts of user fees removal policies are sustained has hardly been explored. The authors conclude that reduction of user fees in primary health care in Kenya is a policy on paper that is yet to be implemented fully. The findings demonstrate that removing or reducing user fees, though well intended can have negative implications for service delivery. They join other authors who have called for careful planning before user fees are removed. They recommend that caution be taken when deciding on how to reduce or abolish user fees and that potential consequences are considered. The paper indicates that measures to ensure effective implementation of fees reduction or abolition should be put in place through: (1) ensuring that policy guidelines are clearly defined; (2) engaging health workers in the policy design process; (3) providing timely information to health workers, District Health Management Teams; (4) promoting awareness of the policy to the community members; (5) providing alternative funds to compensate facilities for lost revenue and to cope with utilization increases; and (6) monitoring adherence to the policy through, for example, community interviews. The authors give us an insight of recommendations on the adoption of the policy, though they just give a general view of the experiences in other countries without assessing specific situations like in high density residential areas in respective countries.

In the paper entitled "User fees as a form of cost sharing in developing world", Ilya Litvak (2001:4) examines the effect of user charges on medical care. According to Litvak, the 1990's were marked by massive introduction of user fees health care plans as a means of improving efficiency by moderating demand, containing cost, and mobilizing more funds for health care than existing sources provided. He added that the introduction of user fees raised a lot of controversy with common claims that their implementation reinforced the poverty trap in the developing world, which has considerable health and livelihood impacts. He pointed out that opponents of user fees argue that their introduction decreases service utilization, does not improve the quality of care and causes medical services to be priced

higher than those charged by private healthcare providers. Proponents of user fees relate, inter alia, to cost recovery, improved equity and greater efficiency. The view is supported by several studies. For instance, Shaw and Griffin (1995:17) in "Financing health care in sub-Saharan Africa through user fees and insurance", argue that hospital facilities that retain revenues generally performed better than facilities that sent all their revenues to the treasury. The claim advocates that user fees avoid the provision of subsidies to those who can afford to pay all or a portion of costs of services for those less capable of paying. Litvak indicated that the dominant perspective behind user fees is that charging attaches value to a service, increasing demand by increasing perception of quality and deterring inadequate use of health care services. According to this view, free services reduce utilization because of inefficiencies leading to quality, and because of low value attached to free service. In conclusion, Litvak says that user fees are not a perfect solution to the inadequate funding for the health care sector and that user charges have proven to be ineffective as a stand-alone policy. He also noted that the countries that experienced a raise in revenue flow from user charges have at the same time experienced drastic reduction in care utilization and no improvement in the quality of care. The author further said that countries that still maintain the user charge programs have slowly substituted additional health initiatives to help poor people who can not afford to pay.

In her dissertation of 2006, Momba quotes Jon Rohde who wrote on the success story of China's Primary Health Care and its concept of 'barefoot' doctors (Village-level health workers) and also gives a number of factors which we needed in mind as we undertook our study of user fees as part of health reforms in Zambia.

Quoting Rohde, Momba says that the success story in China is as a result of a number of factors. First is that, politics and the health system are inextrinsicably 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. The findings on China highlight the importance of the health issues to developing countries and suggest that future interventions in this area must involve political leaders at all levels.

The lesson learned from other countries is that user fees are widespread around the developing world, despite mounting opposition to them. Many studies have found them to be

among the barriers to the use of health services, and have shown that they affect poor people more than others. Yet there are reasons to be cautious about abolishing user fees. They are rarely the most important barrier to using health services, and abolishing them would remove a relatively small, but often important source of funding for primary health facilities. Unless this funding is replaced from other sources, there could be adverse consequences for the quality of service. The other lesson derived from the studies above is that whilst promoting a clear message that user fees should be scrapped, the policy should be complemented by other health sector reforms. To maximize the long- term effects of removing fees, there must be actions that increase overall national resources for public sector health services and that deal with international conditions and policies that undermine this.

In conclusion, our literature review shows that work done on the different aspects of Zambia's health policy especially on user fees is quite substantial. The views or conclusions of various authors in the literature reviewed added credence and value to this study. However, the inability by the preceding studies to comprehensively analyze issues on the impact of user fees in Zambia, most particularly in high density residential areas indicated the need to undertake this study on the impact of user fees on people's accessibility to health services and facilities in high density residential areas: Case of Chawama compound.

The Research Methodology

Data Collection

The research sought both primary and secondary data as follows:

Secondary data were obtained from the University of Zambia (UNZA) main library, from the Medical library, annual reports of health institution and from other organizations where data related to the study topic could be obtained.

The data were obtained through structured and unstructured interviews from the three categories of respondents as shown in the sampling technique and sampling size below. Structured interviews were used for most of the respondents. However, in certain cases, especially to the Chairperson of the Neighbourhood Health Committee (NHC) and to the in-charges of the health centres, unstructured interviews were used.

Study Design

The general focus of the study is to investigate the impact and people's perception of user fees, including people's accessibility to health services and facilities in high density residential house holds. The approach adopted in the study is that of focusing on both direct measures and facilitative influences on access to health services and facilities. Direct measures of access are those factors which negatively affect the actual utilization of health services and facilities. Facilitative influences are, in the study, viewed as variables that create an environment that ensures easy access to health services and facilities.

The impact of direct measures of access to health services and facilities have been looked at by assessing the extent to which the user fees are able to effectively improve the availability of health services and facilities that can be accessed by the users. These direct measures include basic services and facilities such as admission wards and ambulances, sufficient drugs and equipment; special services such as X-ray; and adequate and well qualified health providers.

The facilitative influences on access to health services and facilities that the study evaluates are motivational levels of health providers, community participation and integration. The general measures of motivation levels that have been used in the study are the impacts that remuneration, training and development, and institutional support have on the motivation levels of health providers.

Sampling Technique and Sample size

The initial total sample size planned before carrying out the actual research was 420 respondents. However, the actual number of respondents interviewed was 332. These were broken as follows:

(i) The first category is that of health workers from both Chawama and Lilayi health centres, both of which are in Chawama catchment area and since health workers at Lilayi clinic offer services to Chawama residents. The total number of health workers interviewed was 20 and these included the In-charges, clinic officers and nurses. 10 respondents were picked from each health centre.

(ii) The second category is that of opinion leaders and these included leaders from local political parties, churches, Non-Governmental Organizations and the Neighbourhood Health Committee. The initial number planned for interviews was

90. However, only 50 opinion leaders were interviewed from the catchment area of the five (5) zones covered due to logistical problems and other community leaders were not available at the times when they were needed to be interviewed.

(iii) The researcher had planned to interview a total number of 300 service and facility users. However, 252 users were interviewed altogether. These were evenly distributed by interviewing at least 50 respondents from each of the five (5) zones which make up Chawama catchment area.

Data Analysis

Most of the data collected were analyzed and interpreted using the Statistical Package of the Social Sciences (SPSS). It is from the use of the SPSS programme that the data presented in the form of numbers, percentages, and tables were derived. Data collected from the health providers and Neighbourhood Health Committee representatives were interpreted manually as the respondents in these categories were not only few but, were also considered to be key sources of information.

The structure of the dissertation

The dissertation is divided into five chapters. The first chapter is the introduction, which provides the context of the issues that are raised in the dissertation. The second chapter provides the nature and historical context of the cost sharing policy in Zambia. It focuses on the changes that have taken place in the health system from the colonial period up to the time of the new system. The third chapter examines the impact of income, occupation and education on people's attitude towards user fees. The fourth chapter focuses on availability of quality health services and facilities. Chapter five looks at opinion leaders and people's attitudes towards user fees. The last chapter is the conclusion about the findings of the study.

REFERENCES

Abel, S.B. and Rawal, J. (2003), "Tanzania – Opposing User Fees", *in African Policy E-joournal.* Royal Tropical Institute; Amsterdam.

Arhin, D. (1992). *Health Financing in Zambia: Approach to Cost Sharing.* Consultancy Report, London School of Hygiene and Tropical Medicine. London.

Bell, Clive (1973), "Organization and Administration of the Health Services", in Clive Bell (ed.), *The Diseases and Health Services of Papua New Guinea*, Port Moresby.

Booth, D; Milimo, J. T; Shilito, T; and Brock, K. (1995). *Coping with Cost Recovery*, Department of Social Anthropology, Stockholm University: Stockholm.

Chuma et al (2008), "Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice" in *International Journal for Equity in Health.* London School of Hygiene and Tropical Medicine.

Daka, H. (2006), "No, It's Not April Fool's: Free Health Care...in Zambia" *in the American Journal of Bioethics.* Taylor and Francis Health Sciences: Toronto.

Deininger,K. and Mpuga, P.(2005), "Economic and Welfare Impact of the Abolition of Health User Fees: Evidence from Uganda". *Journal of African Economics*, Vol. 14. Social Science Electronic Publishing Inc: Washington D.C.

Dinar, A. (2006), *Africa: User Fees*, African Studies Centre- University of Pennsylvania: Pennsylvania.

Foster, S. (1993). *"Cost and Burden of Aids on the Zambian Health Care System: Policies to mitigate the impact on health services"*. United States Agency for International Development (USAID): Lusaka.

Government of the Republic of Zambia (1994), *A Guide to Zambia Health's Reforms.* Ministry of Health: Lusaka.

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

International Labour Organization (1970), "Narrowing the Gap – Planning for Basic Needs and Productivity Employment in Zambia: Jobs and Skills Programme for Actions". *Study commissioned by MOH with financial support from the study Fund.*

Jesuit Centre for Theological Reflection (2002) *Abolish Health Service User Fees*, Home Publishers: Lusaka.

Kalyalya, D.H. (1995), *User Fees in the Health Sector: Policy, Practice and Perception*, Oxford University Press: London.

Lake, S. (1990) "Annex B", in "Cost Sharing in the Health Sector: Principles and Practice". *Report of the Ministry of Health meeting held at Fairview Hostel on 16th August, 1990.*

Limbambala, B.E.M. (2001) "User- payment, Decentralization and Health Service Utilization in Zambia", *in Pubmed, Health Policy Plan.*http://www.ncbi.nih/gov.

Litvak,I (2001), *User Fees as a Form of Cost Sharing in Development World*, Oxford University Press: London.

Macwan'gi, M. et al (2000), "User Fees and Drugs: what did the health reforms in Zambia achieve?" in *Health Policy and Planning.* Oxford University Press: London.

Malama,C. et al (2002), " User Fees Impact Access to Healthcare for Female Children in Rural Zambia" *in Journal of Tropical Pediatrics.*

Masiye, F. et al (2008) "Removal of user fees at Primary Health Care facilities in Zambia: A study of the effects on utilization and quality of care" *in the EQUINET discussion paper.* Department of Economics, University of Zambia: Lusaka.

Milimo, J.T. and Choongo, (1994) "People's Perceptions and Experiences with Feelings on User Fees", in *Cost Sharing in the Health Sector: Principles and Practice*. Report of the MOH meeting held at Fairview Hotel on 16th August: Lusaka.

Ministry of Health (1993), *Health Financing in Zambia: Insurance through prepayment* (draft). Lusaka: Ministry of Health.

Momba, Moderate (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards"*MPA Dissertation Submitted to the University of Zambia: Lusaka.*

National Health Policy and Strategies (Planning Unit) (1991*), Health Reforms*. Lusaka: MOH.

Pearson, M. (2004) "The case for abolition of user fees for primary health services", *Africa Focus Bulletin. African Studies Centre-* University of Pennsylvania: Pennsylvania.

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

Rhode, Jon (1984), "Health for all in China: Principles and Relevance for other countries" in David Morley, Jon Rhode, and Glen Williams (eds.), *Practicing Health for all.* Oxford University Press, New York.

Sakinge, K.Beatrice (1995), "The Health Staff's Knowledge, Attitudes and Practices of the Health Reforms: A Comparative Study", *MSc Thesis Submitted to the University of Zambia, Lusaka.*

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

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

van der Geest, S. et al (2000), "User fees and drugs: what did the health reforms in Zambia achieve?" *Health Policy and Planning.* Oxford University Press: London.

Yate, R. (2007*), The Impact of Abolishing User Fees in Africa- Recent Developments in Six African Countries.* UK Department for International Development-Human Development. United Kingdom.

Wilkinson et al (1997), "Health user fees in Sub saharan Africa", in *a British Medical Journal,* London: London School of Hygiene and Tropical Medicine.

World Bank (1994), *Better health in Africa: Experience and lessons learned.* Washington: World Bank.

Zambia, Government of the Republic of (1992), *National Health Policies and Strategies* (Health Reforms). GRZ/ MOH: Lusaka.

Zambia, Government of the Republic of/United Nations (1996), *Prospects for Sustainable Human Development in Zambia: more choices for our people.* Lusaka: GRZ and United Nations systems.

CHAPTER II

THE HISTORICAL CONTEXT AND NATURE OF USER FEES

Introduction

The chapter outlines the changes that have taken place in Zambia's health system from the colonial period to date. The chapter is a discussion of the nature of the public health system under colonial administration, during the period immediately after independence from 1964 to about 1980, and the period after the adoption of the Primary Health Care concept from 1980 up to the time when the MMD government took office in 1991 and subsequently introduced user fees under the health reforms. The chapter also examines the nature and structure of health reforms, modalities of applying user fees, cost sharing and its objectives as part of the health reforms introduced by the MMD government when it took office in 1991 and subsequently introduced cost sharing under health reforms.

Historical Context

A brief view of the health provision practices and policies of the colonial administration shows that these were part of the colour-segregation ideology that existed at that time. The distribution of health services closely followed the formally instituted categories of Europeans, Asians (who came into the country as traders and shop owners), coloureds (off springs of black and white unions), and Africans, in that order of importance.

In addition, because the economic situation at that time demanded that the African had to provide cheap labour for the mines, the colonial administration provided Africans with social services such as health and education in order to have a healthy, literate labour force. Since mining was done in the urban areas, the health and educational services provided were first and foremost to the urban Africans rather than to the rural African population who were in the majority (Lengwe, 1985:26-30, and Zambia, 1965:59).

When Zambia gained independence in 1964, the new government inherited a régime whose health policy was very much oriented along racial lines and which had imbalances between rural and urban areas. Government was, therefore, confronted with the problem of how to create a public health system which could eliminate these imbalances in the provision of, and access to, health services and facilities. The government's major concern in health

service delivery was equity access to health services, ensuring that even the poor and vulnerable had some access to health care. To achieve this, the Zambian government adopted a health management system, which formed some kind of a pyramid. At the apex of this pyramid were central hospitals where the specialist medical personnel of the country were. One stage lower down the specialist scale were the main general and regional hospitals to cater for all cases other than those requiring specialist attention.

At the third stage down were the district hospitals, which dealt with all normal diseases and surgical requirements. The level at the bottom of the pyramid (clinics and rural health centres) was considered to be the most important. The aim of the government health policy at the time was to improve the quality of the health services in the rural areas by constructing as many clinics and health centres as possible. As stated in the outline of the Transitional Development Plan, in general, government policy leaned towards strengthening of facilities and services so as to make 'normal' medical treatment geographically and even locally accessible to all (Zambia, 1965:59-63). Infact the UNIP government in 1972 brought about the theme of "Health-for-all" and the Zambian government abolished user fees and private hospitals (First National Development Plan 1966-1968).

Considerable progress in providing health facilities and services was made after independence. 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 one of the most favourable in Africa. In addition, the number of health centres and clinics doubled (International Labour Organization, 1970:108, and Zambia, 1992:3). These improvements, however, were not very long-lived. The health services and facilities in Zambia started to deteriorate in the late 1970s. There are two major sets of decline. The Zambian economy started to decline in 1975 as the 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/tonne) declined from K1, 245.20 in 1974 to K947.90 in 1978. Not only did the copper prices fall, but there was also a decline in copper production. Momba (2006:23) states that copper production declined from 825, 000 tonnes in 1969 to 252, 000 tonnes in 2003. The reduction in both copper prices and copper production led to a decline 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. The 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,-0.4% from 1983 to 1984. It gained slightly in the next three years by 1.6% and 0.5% respectively and then declined again from 1986 to 1987 by-0.2%. This, therefore, led to the decline of the economic and social advances achieved in the post-independence decade.

In addition, the oil prices rose, terms of trade deteriorated, trade routes through what was then Southern Rhodesia (now Zimbabwe) were closed. As if this was not enough, the external debt grew as the government turned to the International Monetary Fund (IMF) for the balance of payments support (Kelly, 1991:16-20). The second reason is the adoption of a system of medical care which was mainly curative in nature and originally developed in the industrial countries.

The system places emphasis on curative medicine rather than on prevention of disease. Increasingly such a system relies on complex high technology methods, which require highly trained personnel to carryout. It is also highly expensive, such that it reaches a level that no country, particularly, developing countries, can afford to offer all its citizens a standard of care to match the potential which exists (Zambia, 1980:1).

In an effort to redress the unfavourable public health provision situation that the country was experiencing during the 1970s, the Zambian government in 1980 adopted the Primary Health Care (PHC) concept as a major element in the improvement of health facilities and services in the country. This concept came as a product of a conference jointly sponsored by the World Health Organization (WHO) and the United Nations International Children's Fund (UNICEF) in Alma Ata in the Soviet Union. Primary Health Care was declared a strategy for the attainment of health for all by the year 2000.The concept of PHC 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 afford. It forms an integral 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, 1978:2).

The primary health care approach was supposed to achieve its objectives of health for all by the year 2000 by emphasizing three key aspects. The first one is community participation. *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; from planning and development through implementation to the day to day management of primary health care activities. The second aspect was support from other sections. This is a recognition that no section involved in community development can work effectively in isolation because interdependence is such that activities in one section have an impact on the goals of another. And the third aspect emphasized the health system support. That is, primary health care can not function without backup 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 the health needs of the people were greatest.

In spite of the efforts made by the government, there were no indications of improvements on the health status of the Zambian people. This gave rise to a situation whereby instead of moving towards the achievement of the objectives of health for all, there was a downward trend in health services delivery. The country experienced an erosion of the health infrastructure, the quality of access to health services declined. The deterioration was further manifested in the increasing cases of malnutrition as well as inadequate supply of drugs, high infant and child mortality rates, poor staff morale due to unfavourable working conditions (see Zambia 1992; UNDP 1992; Zambia 1994).

The failure of the Primary Health Care to achieve its objectives could be attributed not only to the declining Zambian economy as alluded to earlier, but also to some management issues which were not successfully tackled during the implementation of the concept.

These include:

(i) Health planning or planning for health. Health planning is a general condition of planning method for somebody in mind, especially in terms of presence of illness, injuries or impairment. The problem in this area is associated with a lot of enthusiasm and haste in implementing the programme that went far ahead of coordinated planning and management.

(ii) Integration, vertical or horizontal programmes. Integration is the process of opening a group, community, place or organization to all regardless of race, ethnicity, religion, gender or social class. Horizontal and vertical collaboration between the health institutions and other stake holders remained very weak. Hence opportunities for consultation and coordination could not be utilized.

(iii) Institutional funding or programme budgeting. This is the process of providing the money required for health activities or programmes. The economic recession at the time of trying to implement the Primary Health Care concept widened the gaps in levels of development and income thereby making it difficult to adequately finance the programme.

(iv) Centralized control. This is the removal of political or administrative power from local or subordinate levels and concentrate it in central authority. There was very little beneficiary involvement and as such very little commitment to the programme. (Ministry of Health, 1994:1).

When the Movement for Multi-party Democracy (MMD) came into power in 1991, it took office against the unfavourable situation discussed above. As such it was realised that the health of people could only be improved if the health system in the country underwent a radical reform. Consequently, the health reform programme that involved a radical restructuring of the health system whose goal is to reorient health care away from the urban, curative bias that characterized it during both the colonial and post independence periods (WORLD BANK, 1996:5) was introduced in 1992. Part of the health reforms was the introduction of user fees; the UN Report of June 2008 through IRIN indicates that, "user fees were introduced in Zambia as part of a financial reform package by the International Monetary Fund and World Bank in the early 1990s".

Initially, when the MMD government introduced the health reforms, it had to rely on the existing legislation to provide a legal framework for its restructuring of the health system. Momba (2006:36) indicates that according to a team of researchers, that was commissioned by the Ministry of Health/Health Systems Research (HSR) Unit/Health Reforms Implementation Team the existing legislation at the time was the Public Health Act of 1930 and the Medical Services Act empowers hospital boards to raise revenue through user fees and prescription charges 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 health reform document. This document also proposed the establishment of the National Health Council in the organizational structure of the health system.

This council, which was to have multi-sectoral representation, would have been accountable to the President. The main duty of this council was supposed to be; to give advice on policy directions of the health system at national level. However, it was later realised that by changing the name of the National Health Council to the Central Board of Health, the proposal would fall within the existing 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 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 yet to be repealed. It was against this back ground that in August 1995, the government passed the National Health Services Act, the Act that gives legal backing to the current organizational structure of the public health system.

The Nature and Structure of Health Reforms.

This section looks at features that characterize the health reforms to which user fees were part, the structures of the reformed health system and their respective functions.

The National Health Policies and Strategies, a document that sets out the policy objectives of the health reforms states that the reforms are centred around three key themes of Leadership, Accountability, and Partnership. These themes have been simplified in the Handbook for District Health Board Members as follows: Leadership entails guiding health service managers and to provide a good example for all Zambians on how to protect and promote good health. This leadership role, as will be seen later when discussing the various organs or levels of the health system and their functions, is supposed to be provided by the Ministry of Health. The Ministry of Health is supposed to provide leadership at district, province, and central hospital levels in the implementation of the health reforms. Accountability entails meeting the needs and expectations of Zambians to ensure that resources are used responsibly and well. The reforms aim to make the providers of health care more accountable to those that use the services and accountable in whatever they do, for

example in the way they use the resources and having resources in place, that promotes accountability. Partnership is perceived in two ways. First, it is perceived in terms of users contributing towards the cost of health care, mainly through user fees. A user fee is a charge that a patient pays for the use of health services and facilities. 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 means that patients, health workers, traditional healers, community leaders, churches, NGOs, the private sector, and any other stakeholders should work together with the government to produce better health (Momba:2006:27).

To achieve the above policy objectives, and in line with the decentralization aspect of the public service reform programme, the structure of the health system was radically changed. At the core of the changes made is the creation of a district health management system. District Health Boards, autonomous in their methods of operation, were created.

Power to administer and manage the public health system in each respective district was delegated to District Health Boards with the view of facilitating active involvement of providers of health services at peripheral health facilities and users of health services in decision making and planning for health provision. The district, therefore, becomes the basic unit of public health management where bottom up planning and implementation initiatives meet the thrust of national policies (see Zambia, 1992; Kamwanga and others, 1999). The district health system was made up of four key organs before the abolition of the District Health Boards. First was the District Health Board that was endowed with planning for improvement of the health status of the population in the district, ensuring that targets can be achieved (Zambia, 1992). Specific functions of District Health Boards as outlined in the District Guidelines of 1995 include the following: approval of all health development plans in the district, including those of non-government and private health providers; approval of all district annual plans and budgets; approval of quarterly progress reports and revisions to the District Health Plans and budgets; approval of all initiatives for local mobilization of financial and other resources, including user fees; monitoring and evaluation of all health related activities and reporting to the Ministry of Health ; ensuring quarterly internal and external audit of all asserts, equipment, financial resources and human resources with the district; providing mechanisms to create conducive working environments, which motivate and retain qualified and well performing staff; ensuring intersectoral cooperation in the

district with relevant government departments and private organisations; initiating mechanisms for sustainability of community based volunteer health workers such as Traditional Birth Attendant (TBAs), Community Health Workers (CHWs), Community Based Distributor (CBDs) e.t.c.

The Composition of this organ of the district health management system, as stipulated by the National Health Services Act Number 22 of 1995, is not less than five (5) members and not more than fifteen (15). The act also specifies that, the members shall include a representative from the Ministry of Community Development and Social Welfare and a representative from the area health boards.

According to Momba (2006:28) the second organ is the District Health Management Team (DHMT) which is the District Health Office. The DHMT was the executive body of the District Health Board and is responsible for delivering quality based, cost effective district health services, which provide equity of access to health care as close to the family as possible. The DHMT actively cooperated with the District Health Board in the formulation of the district health policies and implemented their policies. This executive body of the district health system was supposed to provide the District Health Board with relevant and up to date information on national policies and was responsible to the District Health Board for the performance of the District Health System. Its specific functions, therefore, include preparing district health plan and the budget; Managing the implementation of health services in the district; Initiating and promoting of partnership with health providers in the district, with other sectors, and with the Community; Managing Personnel; and Monitoring and evaluation of the health provision process in the district.

To ensure effective performance of the responsibilities and functions outlined above, the DHMT is supposed to have five (5) mandatory committees. The finance committee approves all expenditure according to approved budget and assesses the ongoing expenditure in relation to the approved action plan, budget, and ceilings as given by the Ministry of Health. The tender committee scrutinizes applications for procurement from the DHMT, ensures that procurements are according to plans and budgets, selects suppliers and awards tenders for procurements and draws up contracts for supply of goods and services in accordance with MOH requirements. The technical committee, among other functions, reviews and advises on the effectiveness of all promotive, preventive and curative matters at all levels of the district health management system. The human resource committee reviews

disciplinary cases and recommends to DHMT, recommends appointments and promotions to DHMT, adopts national Human Resource Strategies according to district functions and recommends to DHMT, carries out training needs assessment and recommends to DHMT, and reviews recruitment and appointment needs. The administrative committee is responsible for transport and daily duties of the district health system (Ministry of Health, 1994:17)

The third major organ of the district health management system is the Neighbourhood Health Committee (NHC) whose mission statement, as stated in the District Guidelines of 1995, is "to promote and contribute an increased sense of ownership and responsibility by the community for the health services and care in the neighbourhood to improve their own health status". The NHC was supposed to be established by the District Health Board and is responsible to the community and the Health Centre Committee (HCC). The essence of this committee is to be a linkage between the community and the health centre staff. Other functions of the NHC include, identifying community needs and integrating these into Health Centre Action Plans, initiating and participating actively in health related activities of household and community level, developing mechanisms for sustainability for community based health care workers, initiating and strengthening all local development initiatives with other sectors such as within education, agriculture, housing, social welfare etc, collect relevant community based data, and mobilization and accountability of local resources. The NHC is supposed to comprise not less than five (5) and not more than fifteen (15) members, half of which should be women. There are also ex-official members from other local sectors of government departments such as education, local government, social welfare, etc.

The fourth major organ of the district health management system is the Health Centre Committee (HCC) that was responsible to the District Health Board by then. This is basically a committee that aims at synchronizing the activities of the health centre with those of NHC and is composed of two representatives from each NHC of a particular catchment area and one or more representatives from the Health Centre. The particular functions of the Health Centre Committee include consolidating and/or prioritizing community needs, initiating and participating actively in health related activities at household and community level, supporting community based health care volunteers, supporting all local developments, mobilizing and accounting for resources, consolidating, analyzing, using and disseminating

data, contributing to preventive maintenance and security of the clinic, and to monitor and evaluate the progress of health provision (Ministry of Health, 1992:14)

Though District Health Boards had been given the power to manage public health activities in their respective districts, in situations where a particular district had a general hospital, such a hospital operated separately from the District Health Board. General hospitals had their own Hospital Management Boards, and their own budgets. These are large hospitals normally with more than 200 beds and capable of providing specialized care services that are often not provided by the district hospitals. The general hospitals, therefore, act as level II and III referral hospitals for district services. They act as level II referral hospitals for patients whose first point of contact with the health .providers is at the first referral centres such as Chelston and Chilenje. In such a case the general hospital will be the second referral centre after the district hospital. For patients whose first point of contact with the health providers is at an ordinary health centre such as Chainda, general hospitals act as level III referral hospitals, as such a patient will have been referred three times by the time he/she gets to the general hospital. It is, however, worth noting that even though these hospitals were not under the leadership of the District Health Board, Hospital Management Teams are responsible to the District Health Management Team. This is an indication that general hospitals are not completely divorced from the district health management system (Momba, 2006:30).

At provincial level, the public health system has no autonomous organs. However, there are Provincial Health Offices that used to be extensions of the Central Board of Health before it was abolished. Provincial Health Offices, according to the Handbook of District Board Members, provide assistance and support to districts and hospitals in each province. The Handbook for District Board Members goes on to state that " the provincial health offices provide technical advice, mediation, enforcement of health related laws and statutory instruments and facilitate the network of technical expertise to District Health Management Teams, District Health Boards, Hospital Management Teams and Hospital Management Boards"(Ibid)

At the national level, the organ involved in managing public health is the Ministry of Health. The role of the Ministry of Health under the current structure of the health management system is that of providing leadership. The Ministry is expected to be

responsible for policy development, setting national goals and targets, and reviewing of performance.

The Ministry's leadership role is further exercised at the level of control and financial audit, quality assurance and statutory compliance, and opening up partnership with various agencies and sectors in support of district health programming. The specific responsibilities of the Ministry of Health outlined in the National Health Policies and Strategies are as follows:

(i) To develop visions and operational policy settings within the sector.

(ii) To develop National guidelines and standards.

(iii) To manage the budget process within the health sector.

(iv) To ensure public accountability.

(v) To ensure that effective health promotion programmes are carried out, and

(vi) To coordinate donor contributions within the health sector (Ministry of Health, 1994:12).

It is, however, important to state from the out set that, of the different organs of the organizational structure of the health management system outlined above, the study focused on the district level. This is because, as earlier mentioned, the core of the radical health reforms introduced by the MMD government is the creation of autonomous District Health Boards, though now these boards have been abolished. It was at the district level where the policy of cost sharing was to be initially implemented.

The introduction of cost sharing provided a guiding principle or strategy that every able-bodied person in Zambian and earning an income should contribute towards the maintenance of his/her health. The adoption of this strategy was based on two major considerations: the need to raise extra resources to meet the cost of the basic package of cost-effective services to be guaranteed to all Zambians; and the desire to foster the spirit of partnership in health, an essential component of the Health Reforms. The implementation of the above principle or policy has been through user charges or fees.

The following are the objectives behind the introduction of user fees:

(i) Raising revenue

(ii) Promoting efficiency

(iii) Fostering equity

(iv) Enhancing decentralization and

(v) Sustaining and promoting private sector participation.

The Nature and Modalities of applying user fees.

According to Central Board of Health/Zambia Integrated Health Programme (2002:7), cost sharing in the health sector refers to the contributions that are made by the population towards the expense of the Basic Health Care Package (BHCP). The BHCP represents cost effective interventions that different levels in the health care system will implement to address the priority disease burden; malaria, Tuberculosis (TB), HIV/AIDS, Child health and Sanitation.

In addition, the policy provides that two committees, the Health Centre Committee (HCC) and Neighbourhood Health Committee (NHC) should decide on the level of local community contributions. Both committees set the charges, which by then needed to be approved by the District Health Board (which had received responsibility from MoH). Health Centres put their contributions into a fund at the District Health Office, and all these funds are accessible to the community through a formal request signed by the Chairperson of the HCC suffices.

The communities are expected to cost share through medical schemes and other special user fees for x-rays, dental services and other laboratory services. A medical scheme is a health insurance which is paid for and is subject to renewal every month. As long as a person is on a medical scheme, he or she is entitled to consultation and treatment at any time. There is also an exemption strategy meant for special cases such as children under five years, people over 65 years of age and the vulnerable with evidence of social welfare or other organizations, ante-natal services, family planning and treatment of chronic illnesses like Tuberculosis and HIV/AIDS.

In the current scenario the amount paid for a person to be on a medical scheme is K2, 500 and the scheme is renewed every month at the cost of K1, 000. For those who do not have medical schemes the amount paid is K5, 500 during each and every contact. Once payments are made, people are entitled to services like consultations and treatment. However, there are other services which have to be paid for in addition to the K2, 500 whenever people need such services. Such services include X-ray, dental, some laboratory tests and other specialist treatments. For instance, the amount paid for X-ray is K30, 000 and the amount paid for some dental services is K25, 000. Medical schemes were introduced with

the intention of helping the clients to receive medical treatment as long as they keep on reviewing their schemes monthly. In this respect, the schemes were seen as a cheaper way of paying for health services on the part of the client (GRZ, 1996:13). Essentially, therefore, it is the medical scheme and the additional payment for specialist services that constitute the core of user fees.

According to CBoH/ZIHP, (2002), cost sharing exemption strategy is an attempt by government to avoid the negative impact of cost sharing on accessibility, to enhance an equitable and appropriate delivery of health services to all Zambians. It removes any financial barriers created by the strategy of cost sharing. The exemptions are based on four factors: age, type of intervention, socio-economic status and disease burden (shown in the table below).

Table 2.1

Cost Sharing Exemption Strategy

Free Medical Services	Persons to be treated Free
• Treatment of chronic illnesses like TB, HIV/AIDS; • Treatment of Sexually Transmitted Diseases (STDs) • Ante-natal service delivery and Post-natal services; • Treatment of epidemics such as Cholera; • Family Planning and Emergency cases like accidents	• Children under five years of age; • People over 65 years of age ; • The vulnerable with evidence of social welfare or other organizations; and • Anyone who is unable to pay

Source: CBoH/ZIHP (2002) Cost Sharing Brief

Efforts have been made to disseminate the exemption policy widely but continuous efforts are required to increase knowledge further (MoH/CBoH: 2002). This applies to the public but also to the service providers themselves. The exemption policy calls for a formal role of the Ministry of Social Welfare and Community Development, which should help to identify the most vulnerable in the community.

REFERENCES

Central Board of Health/Zambia Integrated Health Programme (2002) *Cost sharing Brief*, MOH: Lusaka.

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

International Labour Organisation (1970*), Narrowing the Gap-Planning for Basic Needs and and Productivity Empowerment in Zambia: Jobs and skill Programme for Africa.* International Labour Office, Addis Ababa.

Kamwanga,J. et al, (1999), *Revitalisation of Primary Health Care in Zambia: Exploratory phase.* Unpublished report, Institute for African Studies: Lusaka.

Kelly, Michael (1991), *Education and Declining Economy*: *The case of Zambia, 1975 to 1985.* World Bank, Washington DC.

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.*

Ministry of Health/Central Board of Health (2002) *Basic Health Care Package from Community to Third Level.* Lusaka: MOH/CBOH.

Momba, M. (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards" *MPA Dissertation Submitted to the University of Zambia.*

United Nations Development Programme (1992), *Investing in Health.* Washington D.C. UNDP

World Bank (1996), *Health Sector Reform Review*. Lusaka: WHO/UNICEF

World Health Organization/United Nations Children's Fund (1978), *Primary Health Care*, A Joint Report by The Director- General of the World Health Organization and The Executive Director of the United Nations Children's Fund, WHO, Geneva.

Zambia, Government of the Republic of (1965) An *Outline of the Transitional Development Plan.* GRZ. Lusaka.),

Zambia, Government of the Republic of (1992*), National Health Policies and Strategies (Health Reforms*). GRZ, Ministry of Health, Lusaka.

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

CHAPTER III

IMPACT OF INCOME, OCCUPATION AND EDUCATION ON PEOPLE'S ATTITUDES TOWARDS USER FEES

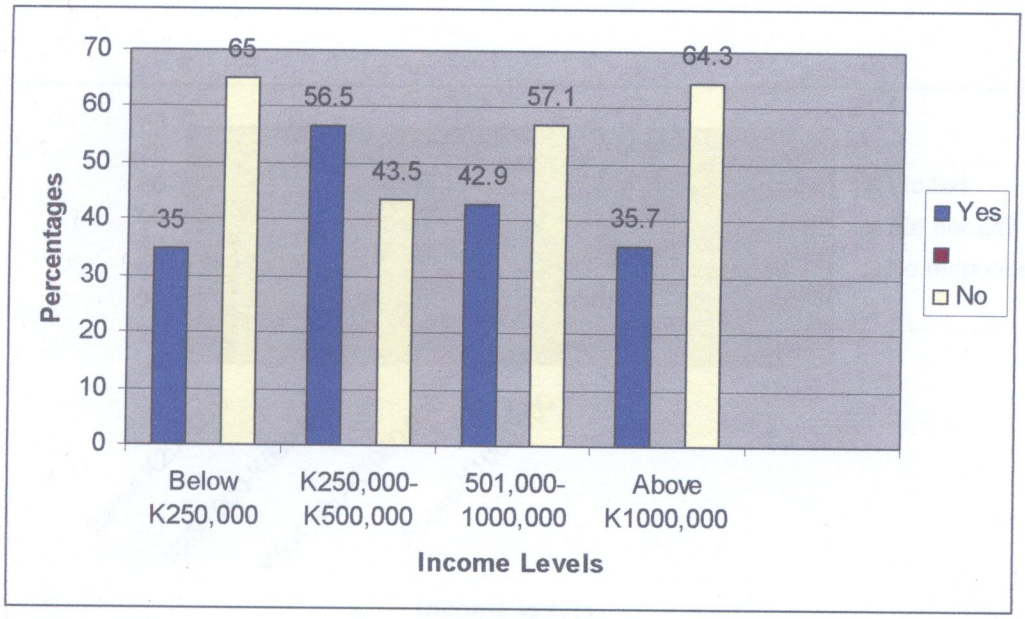
Introduction

This chapter examines public reaction to the introduction of user fees with specific focus on the factors. In this regard, this chapter is an assessment of the extent to which income, occupation and education influence people's attitudes towards user fees. This chapter has four sections. The first section is the introduction. The second section is about income and attitudes towards user fees. The third section is a discussion on occupation and people's attitudes towards user fees and the fourth section is a discussion on education and people's attitudes towards user fees.

Impact of Income and Attitudes towards User Fees.

This section is an attempt to analyze the impact of income and the extent to which it has influenced people's attitudes towards user fees. The significance of looking at income is the fact that one of the reasons why people may have negative attitude towards user fees is poverty considering the present measurement of poverty in Zambia. Measurement of poverty in Zambia has been based on the 'food basket' approach that focuses on the adequacy of a household's income in so far the ability to purchase the basic food-stuffs required for its existent is concerned (Nsemukila, 2001:4). The cost of the food basket at the time of the research was estimated at K1, 600,000 by the Jesuit Centre for Theological Reflection in 2008. According to the Living Conditions Monitoring Surveys of 1998, 72.9% of all Zambians are poor, while urban poverty is estimated to be at 56%. The medical scheme was introduced so that people could not only make contributions towards the provision of health but to have access to quality health services and facilities at a lower cost.

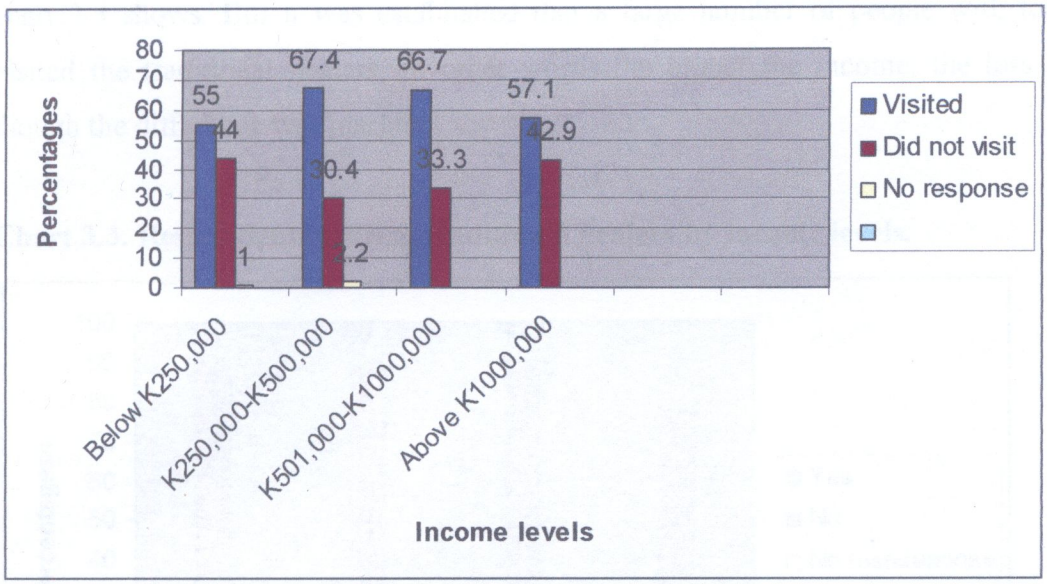
Chart 3.1 Distribution of respondents with medical schemes by their income levels



On the overall, although a very marginal higher number of people earning less than K250,000 indicated that they were not on the medical scheme, what was established in the research findings is that the majority of the people sampled are not on the medical scheme as shown in chart 3.1, only a total number of 100 or 36.7% out of 252 were on the scheme.

As indicated earlier, there were other aspects of the user fees that people were expected to pay when getting specialist services. If a person has a scheme, he or she is entitled to consultation and treatment. However, one has to pay for specialist services like x-ray and dental services which seem to be much higher than the scheme fee. This further could have affected people's visitation to the clinic. Respondents were asked whether they, themselves, or any member of their family visited the clinic for medical attention in the last six months. Out of the 252 respondents, 58.7% visited the clinic and 39.3% did not visit and 2% did not respond. The largest number of people who visited the clinic was those who earned incomes between K250, 000 and K1000, 000.

Chart 3.2. Distribution of visits to clinic by income levels.

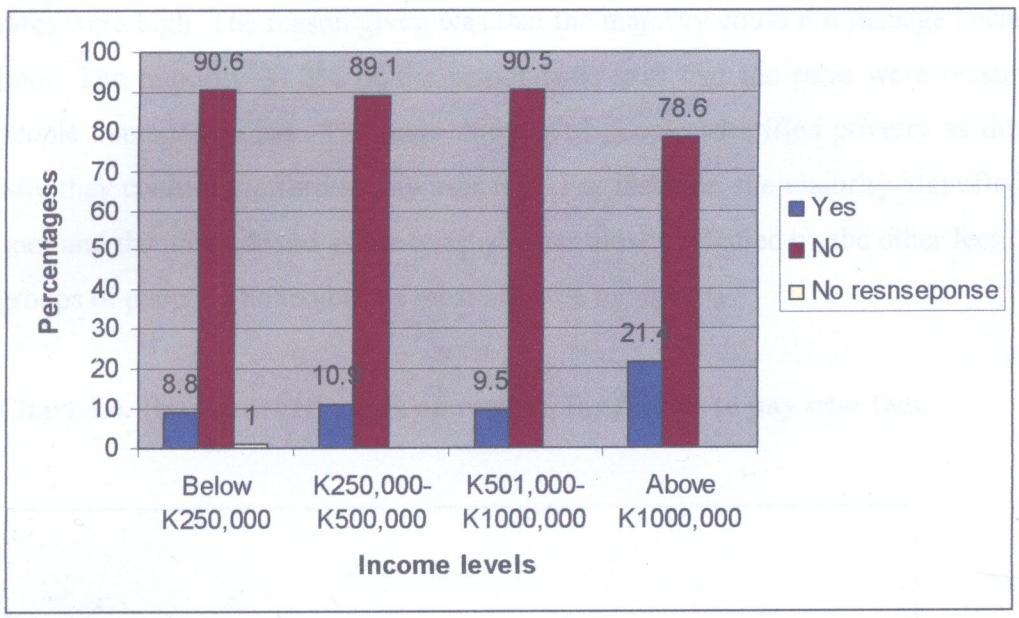


Deducing from the chart above, most of the people who visit the clinic earn incomes between K250, 000 and K1000, 000 and this is the income category that has also the largest number of people with medical schemes as chart 3.2 shows. Most of the people who earn incomes below K250, 000 and above K1000, 000 do not visit the clinic, and as shown in chart 3.1, most of these people do not also have medical schemes. The possible explanation for people who earn incomes above K1000, 000 for not visiting the clinics could be that they go to alternative sources of medical care like private clinics. For instance, M. Bupe who is a sales managers and who happened to earn an income of above K1000, 000, pointed out during the interview on 17th July, 2008, that she only went to private clinics because she could afford. Even though the lowest number of people who visited the clinic is in the K250, 000 and below income category, the difference between in attendance with this category and those in the K250, 000-K1000, 000 is not that very significant. It can be said that as in the case of people with medical schemes, income differences were not a very important determining factor on whether people visited the clinic or not.

Despite the fact that most people complained about the provision of health services at government clinics, not many sampled respondents indicated that they opted for traditional healing, in spite of the fact that traditional medicine was cheap. The majority of them said that they never visited traditional healers because they felt that services were not as good as

those provided in public clinics. Only 10.3% of 252 sampled said that they visited traditional healers and 89.3% never visited traditional healers. This was across all income groups as chart 3.3 shows. But it was established that a large number of people with low incomes visited the traditional healers; in other words the higher the income, the less visitations, though the difference was marginal.

Chart 3.3. Respondents visiting traditional healers by income levels.

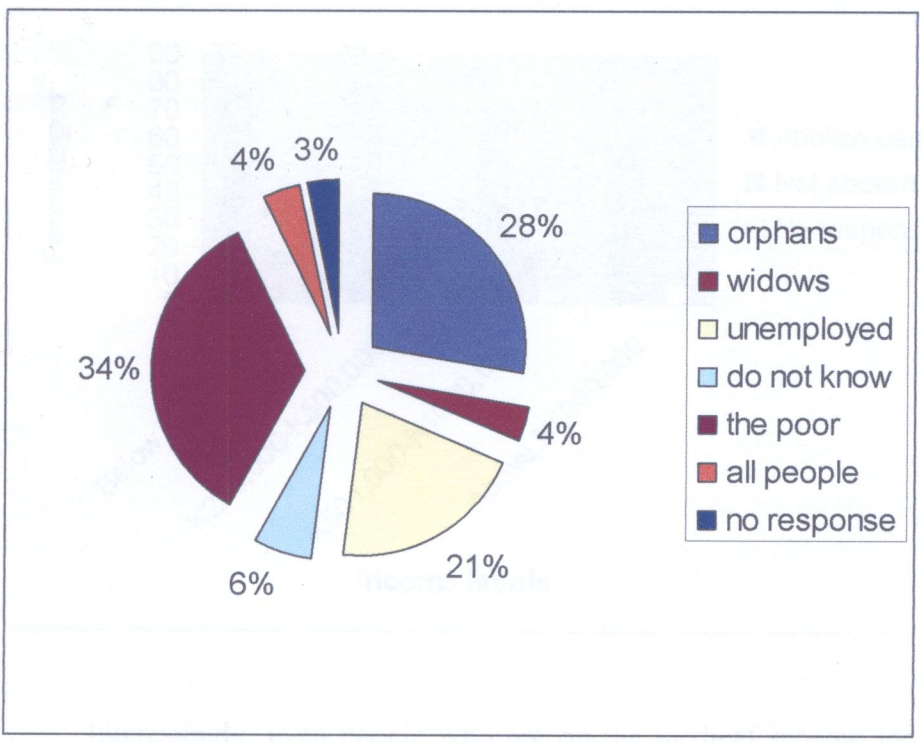


However, a number of facility users also indicated that they preferred to go to local drug stores as alternative sources of medical attention. Local drug stores are outlets in Chawama compound owned by private individuals where common medicines are sold. Most of the medicines prescribed in clinics are sold from those drug stores. Medicines which are commonly sold include panadols, aspirin, cafenal and some antibiotics. The majority of people, especially those who earn below K250, 000, like visiting those drug stores. There is evidence that common drugs prescribed at the clinic are considered cheaper compared to those sold from chemists in town. For example, common drugs like panadol and aspirin were bought at cheaper prices such as K500 per course. The second reason is that most essential medicines were either inadequate or usually not available at the clinic and as a result patients were just given prescriptions. However, most of those drug stores were not licensed and at times expired drugs were sold to unsuspecting clients. Many facility users, however, claimed that those drug stores have proved to be better alternative sources of medical attention to the

majority of people who can not afford to pay user fees because drugs were cheaper (Momba, 2006:90).

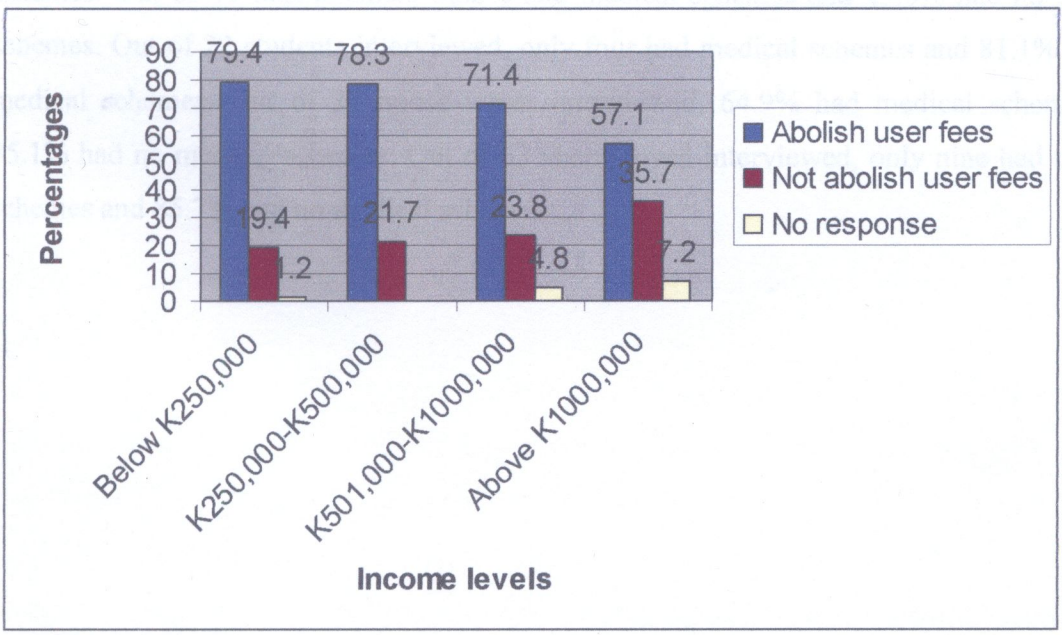
One issue that seems to have come out prominently in the research findings is that most respondents, irrespective of income, were not supportive of the user fees because of the view that a large number of poor people, orphans and other vulnerable groups cannot afford user fees. Thus, respondents were asked whether the rates of payments for user fees were reasonable enough for the people to afford to pay. 61.5% of respondents indicated that the rates were high. The reason given was that the majority could not manage because they were poor. The minority 31.3% of the respondents said that the rates were reasonable because people managed to pay. The large number of people identified poverty as the main reason why they could not afford to pay user fees. For instance, the majority identified orphans, the poor and the unemployed as the ones who are mostly affected by the other fees. These are the groups of people who tend to be most affected by poverty.

Chart 3.4. Respondents' views on reasons for failure to pay user fees



As a result of inability of a number of poor people to access health services, the majority, irrespective of income levels, said that user fees should be abolished, although a slightly large number of people in above K501, 000 income bracket indicated otherwise. Out of 252 respondents who were interviewed, 77% said that user fees should be abolished. 21% of them said that user fees should not be abolished. Of the respondents who earned below K250, 000, 79.4% said that user fees should be abolished, whereas 19.4% said that user fees should not be abolished. Respondents who earned income of K250, 000-K500, 000, 78.3% said that user fees should be abolished and 21.7% said that user fees should not be abolished. For those who earned incomes of K501, 000-K1000, 000, 71.4% said that user fees should be abolished compared to 23.8% who said that user fees should not be abolished and 4.8% did not know. Respondents who earned above K1000, 000, 57.1% said that user fees should be abolished compared to 35.7% who said that user fees should not be abolished and 7.2% did not know.

Chart 3.5. Respondents' views on the continuity and abolishment of user fees by income levels



Interestingly, even people who are on the medical scheme indicated that user fees should be abolished. For instance, income categories of below K250,000 and K501,000-

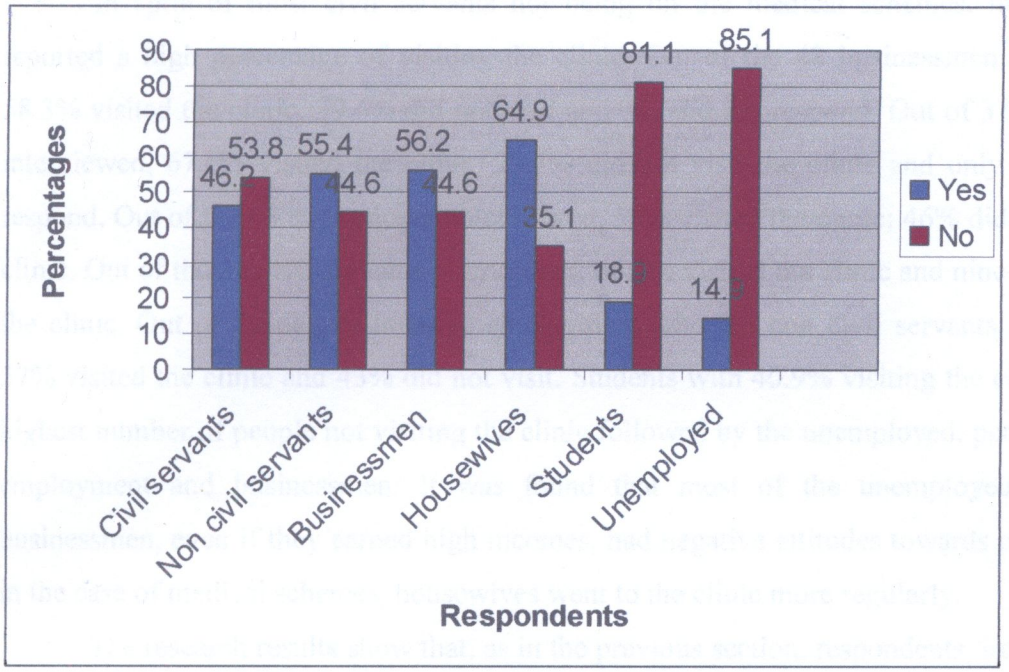
K1000,000 recorded large numbers of respondents on medical schemes as chart 3.1 shows, but many people in these categories want user fees to be abolished.

Occupation and people's attitudes towards user fees.

In the previous section it has been found that although recognition of the general poverty among the people played an important role in the respondents' rejection of the introduction of user fees, income played a marginal role in determining people's attitudes towards user fees. This could mean that other factors might have influenced their attitudes towards user fees. Therefore, this section is a discussion on the role that occupation could play in determining people's attitudes towards user fees.

According to the findings, out of the 252 respondents, 42.5% had medical schemes and 57.5% had no medical schemes. Out of the 26 civil servants interviewed, 46.2% had medical schemes and 53.8% had no medical schemes. Out of 56 people in other forms of wage employment interviewed, 55.4% had medical schemes and 44.6% had no medical schemes. Out of 48 businessmen, 56.2% had medical schemes and 43.8% had no medical schemes. Out of 22 students interviewed, only four had medical schemes and 81.1% had no medical schemes. Out of 37 house wives interviewed, 64.9% had medical schemes and 35.1% had no medical schemes. Out of 63 unemployed interviewed, only nine had medical schemes and 85.7% had no medical schemes.

Chart 3.6. Distribution of respondents by medical schemes



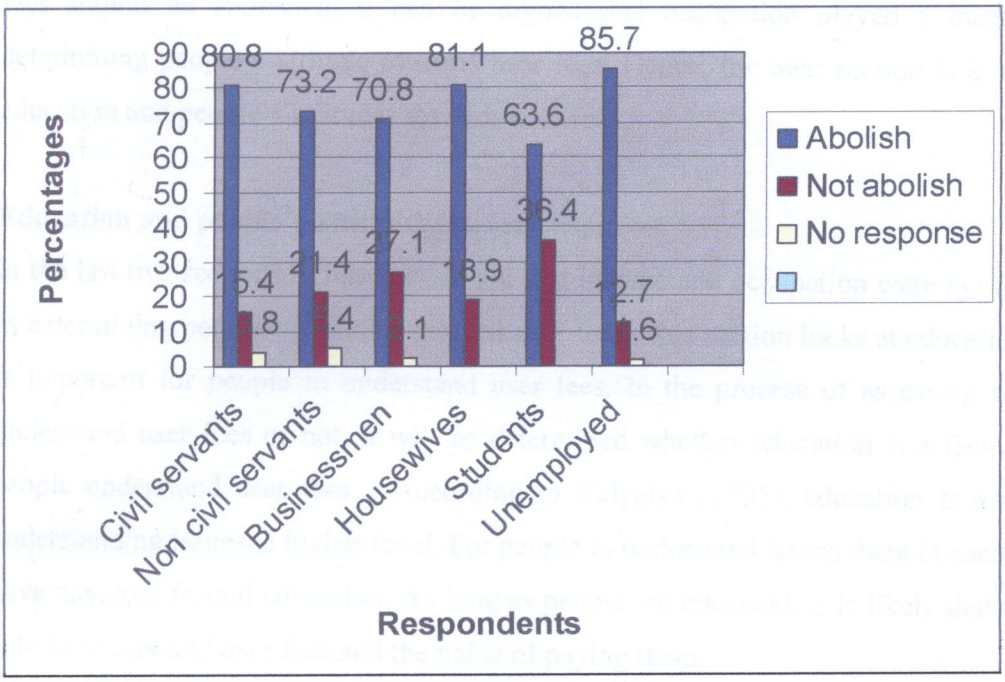
As indicated earlier, the overall picture is that most of the respondents had no medical schemes. According to the occupation variable however, it was established that most of the people with medical schemes are house wives, businessmen and people in wage employment other than civil servants. It was also found that most of the housewives have medical schemes and visit the clinic. A Mrs.B. Mubiana, who is married and a housewife, mentioned during the interview on 20th July, 2008, that as mothers, they are very much concerned with the welfare of children and maternal matters, especially that most such services are exempted. The highest percentage of those who had no medical schemes was recorded amongst the unemployed and students. These are the same people who rarely visited the clinic. Most businessmen had no medical schemes regardless of whether they earned more money or not. The study indicated that most of civil servants had no medical schemes. One teacher said that he preferred paying directly (express) than having a medical scheme. Others preferred to go to private clinics where they thought services were better than those provided at public clinics. Some civil servants were part of the 24% of the sampled respondents who were being sponsored by their employers. For housewives, most of the services they needed were exempted from paying medical schemes; hence they were expected to have medical schemes.

In spite of most civil servants not being on the medical schemes, most of them reported a high percentage of visiting the clinic. Out of the 48 businessmen interviewed, 58.3% visited the clinic, 39.6% did not visit and one did not respond. Out of 37 housewives interviewed, 67.6% visited the clinic, 29.7% did not visit the clinic and only one did not respond. Out of the 63 unemployed interviewed, 54% visited the clinic; 46% did not visit the clinic. Out of the 26 civil servants interviewed, 66.7% visited the clinic and nine did not visit the clinic. Out of 56 people in wage employment who are non civil servants interviewed, 57% visited the clinic and 43% did not visit. Students with 40.9% visiting the clinic had the highest number of people not visiting the clinic followed by the unemployed, people in wage employment and businessmen. It was found that most of the unemployed and some businessmen, even if they earned high incomes, had negative attitudes towards user fees. As in the case of medical schemes, housewives went to the clinic more regularly.

The research results show that, as in the previous section, respondents, irrespective of occupation, were reluctant to pay user fees. One business man who did not want give his name said that he was not willing to pay user fees for himself or other family members because of poverty. How ever, he further mentioned that the problem comes in when it required paying other fees for certain services like x-ray and laboratory tests. During the study, it was established that people's reluctance to participate in paying user fees was at times caused by the way they were treated by health providers, depending on the occupation one was engaged in. For example, during the interview on 17th July, 2008, G. Mubanga who happened to be a minibus driver indicated that teachers, managers and pastors received good attention from health providers compared to the unemployed, minibus drivers and barmen. This also influenced the attitude of people towards user fees, especially that they were able to share the same idea and beliefs as they interacted since they had almost same experiences. It can thus be safely said that occupation could determine people's attitudes towards user fees.

It was established that irrespective of the occupation category, the majority of respondents said that user fees should be abolished.

Chart 3.7. Respondents' views on continuity and abolishment of user fees by occupation



It was found that in all categories of occupation, respondents said that user fees should be abolished. However, the larger percentages of those who wanted user fees to be abolished were recorded amongst the unemployed, housewives and civil servants. For the unemployed and students, the reason why they want user fees to be abolished could be because they earn low incomes, hence they can not afford to pay user fees. Surprising enough, even housewives, most of whose services are exempted from paying user fees, are against user fees. Civil servants who are public servants are supposed to promote the cost sharing policy. However on the overall, most of them were against user fees, even in the case of other categories, more respondents as chart 3.7 shows were not in favour of the user fees. The main reason which was put across was that majority of the people were poor to the extent where others died in their homes because they could not afford to pay user fees. For instance, Mrs. J. Lungu, who is a widow and unemployed, said during the interview on 28th July, 2008, that her twelve year old child died in her home because she could not afford to pay for the medicals services. In the case of the businessmen and people in wage employment, most of them have medical schemes but the majority of them want user fees to be abolished. The fact that on the overall many people regardless of occupation said that user

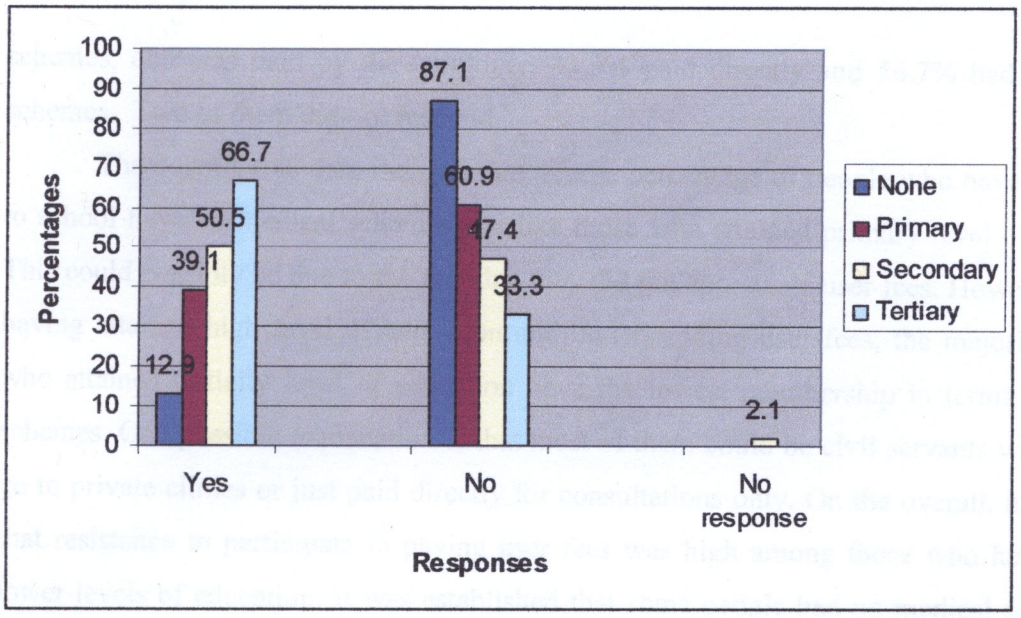
fees should be abolished, it can be argued that occupation played a marginal role in determining people's attitude towards user fees. Hence, the next section is a discussion on education and people's attitudes towards user fees.

Education and people's attitudes towards user fees

In the last two sections, it has been found that income and occupation were not major factors in determining people's attitudes towards user fees. This section looks at education because it is important for people to understand user fees. In the process of assessing whether they understand user fees or not, it will be determined whether education is a factor in making people understand user fees. . According to Kalyalya (1995), education is a vital tool in understanding issues at higher level. For people to understand issues there is need for them to have acquired formal education. As long as people are educated, it is likely that they will be able to understand user fees and the value of paying them.

In trying to establish whether education could determine people's attitudes towards user fees, the sampled respondents were asked if they understood user fees or not. Out of 252 respondents, 43.7% understood user fees; 55.6% did not understand user fees and two did not respond. Out of 31 respondents who never went to school, 12.9% understood user fees and 87.1% did not understand. Out of 92 respondents who went up to primary level, 39.1% understood user fees and 60.9% did not understand user fees. Out of 97 respondents who attained secondary level, 50.5% understood user fees; 47.4% did not understand user fees and two did not respond. Out of 30 respondents who reached tertiary levels, 66.7% understood user fees and 33.3% did not understand user fees. There were no responses from two of them.

Chart 3.8.Respondents' knowledge about user fees by education levels



It was established that a large number of people who attained secondary and tertially education indicated that they understood user fees but a large number of those who have never been to school did not understand user fee. For people who attained primary level of education, a large number did not understand user fees compared to those who understood. People who attained secondary level, most of them understood user fees compared to those who did not have similar level of education. In other words the higher the level of education the higher the knowledge about user fees.

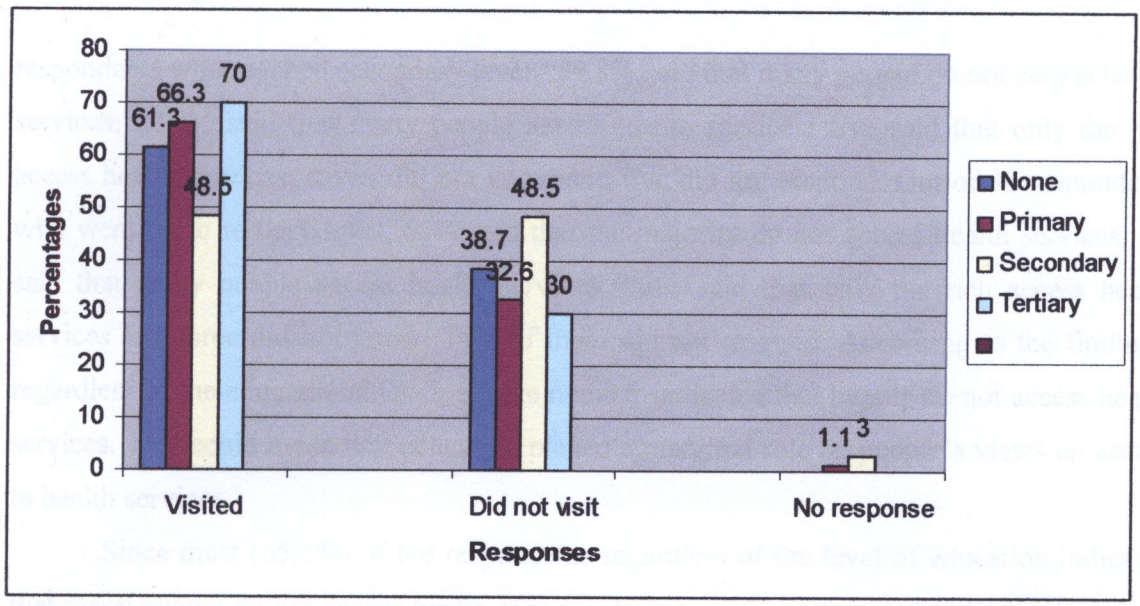
In view of the findings in chart 3.8, we need to find out if those who have knowledge about user fees have medical schemes. Many people had no medical schemes, especially those people who attained lower levels of education and those who have never been to school. However, even among those who went up to tertiary level of education, most of them had no medical schemes. According to the findings, out of 252 respondents, 16.3% had medical schemes, 58.3% had no medical schemes, 24.2% paid directly because they had no medical schemes and three were paid for by employers. Out of 31 respondents who never went to school, 93.5% had no medical schemes and 6.5% paid directly. Out of 92 respondents who went up to primary level, 50% had no medical schemes, 21.7% had medical schemes and 28.3% paid directly. Out of 97 respondents who reached secondary level, 19.6% had medical schemes, two were paid by employers, 23.7% paid directly and 54.6% had no medical schemes. Out of 30 respondents who went up to tertiary level, only two had medical

schemes, one was paid by the employer, 33.3% paid directly and 56.7% had no medical schemes. Two of them did not respond.

The quantitative data indicate that a large percentage of people who have never been to school have no medical schemes just like those who attained primary level of education. This could possibly be due to the fact that they did not appreciate user fees. However, despite having attained high level of education and understanding user fees, the majority of those who attained tertially level of education have the lowest membership in terms of medical schemes. One possible explanation is that most of them could be civil servants who opted to go to private clinics or just paid directly for consultations only. On the overall, it was found that resistance to participate in paying user fees was high among those who have attained lower levels of education. It was established that some people had no medical schemes not because they were not able to pay, but just because they did not appreciate the importance of participating in paying user fees as result of their level of education. For instance, a Mrs. Moonga who indicated during the interview on 16th July, 2008, that she went up to grade six said that she could not waste her time to go to the clinic and have a medical scheme when she knew where to buy drugs.

However, having a medical scheme may not mean that one visited the clinic regularly. Therefore, respondents were asked if they visited the clinic in the past six months. It was found that regardless of the level of education, a large percentage in each category visited the clinic. Out of 252 respondents, 58.7% visited the clinic, 39.3% did not visit the clinic and two of them did not respond. Out of 31 respondents who never went to school, 61.3% visited the clinic, 38.7% did not visit the clinic. Out of 92 who attained primary level, 66.3% visited the clinic, 32.6% did not visit the clinic and one did not respond. Out of 97 who went up to secondary level, 48.5% visited the clinic, 48.5% did not visit and three did not respond. Out of 30 who attained tertiary level of education, 70% visited the clinic and 30% did not visit the clinic. There were no responses from two interviewees.

Chart 3.9. Distribution of visits to clinic in the last six months by educational levels.



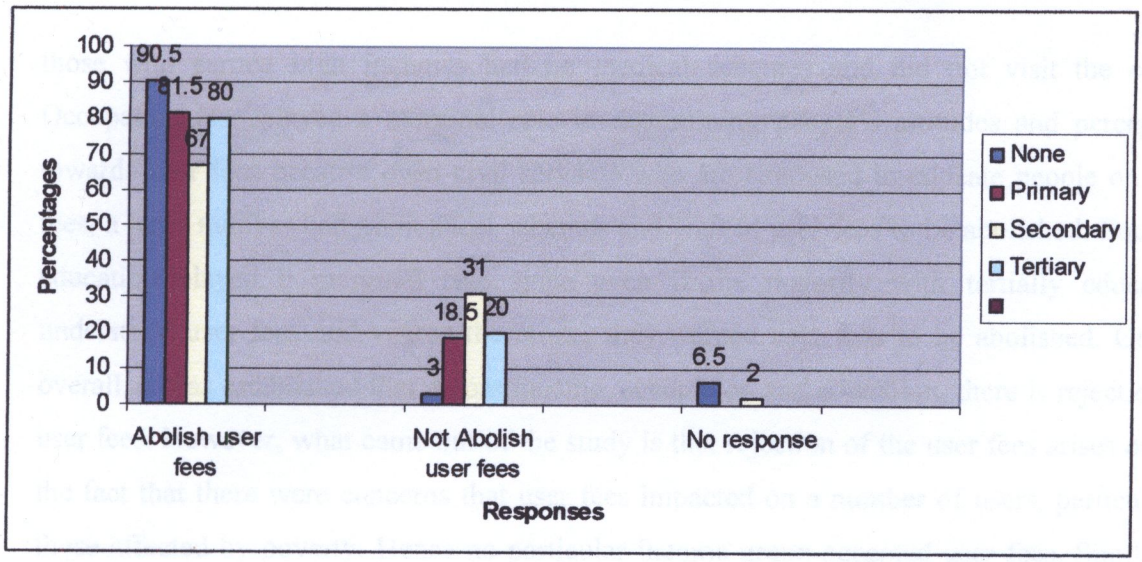
According to chart 3.9, a large number (70%) of people with tertially education visit the clinic. Even those who have never been to school and those who attained primary level, most of them (61.3% and 66.3% respectively) visit the clinics compared to those who do not visit. But for those who attained secondary level of education, a large percentage do not visit the clinic compared to those who visit, though the difference is small. On the overall, it was established that more people with tertially education visited the clinics compared to those with lower levels of education. This could be because they understood and appreciated user fees. Thus, education influences people's visitation to the clinics.

In view of the fact that most people (70%) with tertially education visited the clinics more than those who attained lower levels of education, respondents were asked to give their views about people's access to health services with the introduction of user fees. Out of the 252 respondents, 65.1% said that many people do not access quality health services. 15.1% said that many people access quality health services. 5.6% said that only the rich access quality health services and six did not respond. Out of 31 respondents who never went to school, 61.3% said that many people do not access health services; one said that many people access the services; two said that only the rich access health services and nine did not know. Out of 92 respondents who went up to primary level, 72% said that the majority do not access health services; nine said that many people access health services; four said that only the rich access health services; 12% did not know and one did not respond. Out of 97

respondents who reached secondary level, 59.8% said that many people do not access health services; 22.7% said that many people access health services; five said that only the rich access health services; seven did not know and five did not respond. Out of 30 respondents who went up to tertiary level, 60% said that the majority do not access health services; six said that many people access health services; three said that only the rich access health services and three did not know. Two of them did not respond. According to the findings, regardless of the educational level, a large number indicated that people do not access health services. This could mean that education played a marginal role on people's views on access to health services.

Since most (65.1%) of the respondents regardless of the level of education indicated that many people do not access health services, the researcher attempted to find out whether user fees should be abolished or not. It was found that many of those respondents who never went to school and those who attained primary, secondary and tertiary levels of education said that user fees should be abolished but reasons for abolishment differed. According to the findings, out of 31 respondents who never went to school, 90.4% said that user fees should be abolished; only one said that user fees should not be abolished and two did not know. Out of 92 who attained primary level of education, 81.5% said that user fees should be abolished; 18.5% said that user fees should not be abolished. Out of 97 respondents who went up to secondary level, 67% said that user fees should be abolished; 31% said that user fees should not be abolished and two did not respond. Out of 30 respondents who attained tertiary level of education, 80% said that user fees should be abolished and six said that user fees should not be abolished. Two of them did not respond. Following the statistics, in all educational levels, a large percentage of respondents said that user fees should be abolished. However, the larger percentages were recorded from those who have never been to school and those who attained primary and tertially levels of education. For those respondents who attained high levels of education and said that user fees should be abolished, many of them felt that user fees should be abolished for the poor and others said that user fees should not be abolished but to improve services. Those who never went to school and those who attained lower levels of education felt that user fees should totally be abolished because many people were poor.

Chart 3.2.0. Respondents' views on abolishing user fees by education levels.



It was established that the majority of people in all categories felt that the government should abolish user fees and the main reasons given out from all categories of education levels were that, people should have equal accessibility to quality health services for all and many people were poor. The highest percentage was recorded from those who have never been to school and those who attained lower levels of education. Surprisingly, a large number of sampled respondents who attained tertially level of education indicated that user fees should be abolished because services were poor. This is the same education level category which understood user fees the most and visited the clinic regularly. The fact that even those who attained high levels of education wanted user fees to be abolished; it was an indication that they were not willing to participate in paying user fees. Thus, it can be argued that education played a marginal role in determining people's attitudes towards user fees. However, others complained about the quality of health services and facilities provided. In the next chapter, we are going to look at availability of quality services and facilities because it could be a determining factor.

Conclusion

During the study, it was established that people's attitudes towards user fees could be determined by a number of factors. These factors include income, occupation and education. According to the study, income played a marginal role in determining people's attitudes towards user fee. This is because the majority of both people who earned low incomes and

those who earned high incomes had no medical schemes and did not visit the clinic. Occupation also played a marginal role in determining people's attitudes and perception towards user fees because even civil servants who are supposed to educate people on user fees, a large number had no medical schemes and wanted user fees to be abolished. Equally, education played a marginal role since even if the majority with tertially education understood user fees and visited the clinic; they wanted user fees to be abolished. On the overall, it was established that across income, occupation and education, there is rejection of user fees. However, what came out of the study is that rejection of the user fees arises out of the fact that there were concerns that user fees impacted on a number of users, particularly those affected by poverty. Hence no particular income group accepted user fees. Similarly, there was no particular occupation category or education group which accepted user fees. It can, therefore, be concluded that the perception that the user fees have impacted negatively on the people's access to health services particularly those affected by poverty is justified.

REFERENCES

B. Mubiana (20, July, 2008), Chawama resident: Lusaka

Central Statistical Office (2002-2003) *Living Conditions Monitoring Survey*, GRZ: Lusaka

D. Kalyalya (1995), *User Fees in the Health Sector: Policy, Practice and Perceptions.* MOH: Lusaka

F. Moonga (16 July, 2008) Chawama resident: Lusaka.

G. Mubanga (17 July, 2008), Chawama resident: Lusaka.

J. Lungu (28 July, 2008), Chawama resident: Lusaka.

M. Bupe (17 July, 2008), Chawama resident: Lusaka.

Moderate M. Momba (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards" *MPA Dissertation Submitted to the University of Zambia.*

Zambia, 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 IV

AVAILABILITY OF QUALITY HEALTH SERVICES AND FACILITIES

Introduction

In chapter three it was found that income, occupation and education did not play a significant role in determining people's attitudes towards user fees. However the critical point was that many people were not on medical schemes. This chapter assesses the quality of health services and facilities and people's views about it because one possible explanation why people are not keen to pay user fees may be the quality of health services and facilities they are offered.

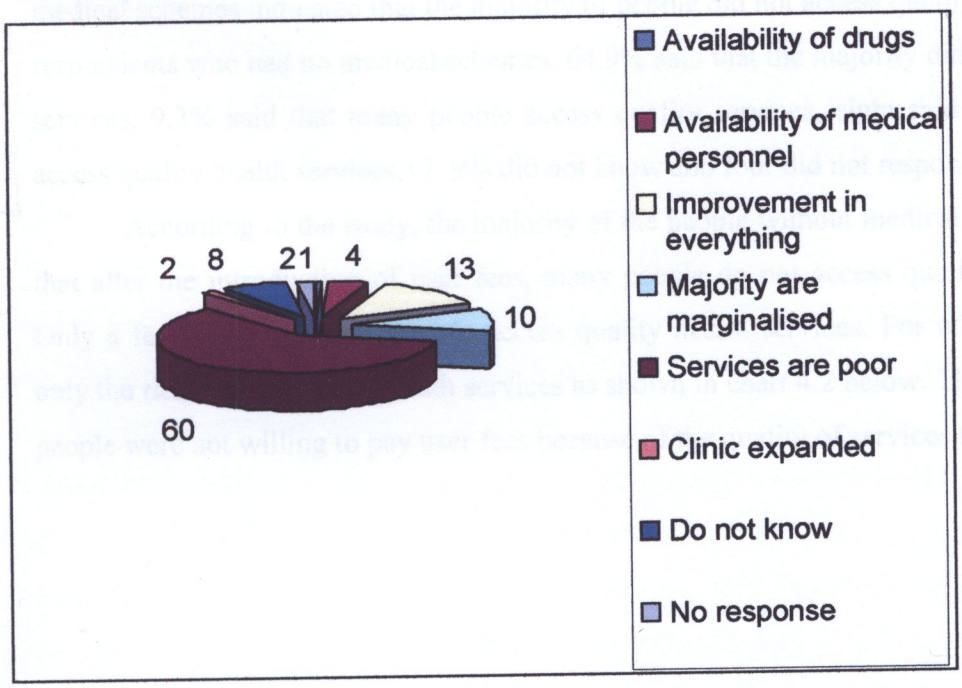
Provision of quality health services and facilities

After the introduction of user fees, people expected health services and facilities to be adequate and of good quality especially that they paid user fees. One police officer who operates from Chawama police station and whose name was not disclosed pointed out during the interview on 15th September, 2008 that after the introduction of user fees, facility users expected the health delivery system to be more efficient and effective in terms of provision of quality health services and facilities. He further said that people expected to see a situation where there was also equal access to quality health services and facilities. One point which was raised by a Baptist church pastor on 8th September, 2008 from one of the Baptist churches in Chawama and declined to mention his name, is that as long as facility users pay user fees, they deserve to be availed with good quality health services and facilities. During the interviews on the same date, some people were unwilling to participate in paying user fees because they were not happy with the quality of health services and facilities they were provided. For instance, two businesswomen who are charcoal sellers, and refused to give their names, complained that even if they paid user fees, they were not given drugs but just prescriptions for them to go and buy medicines. During the interview on 11th September, 2008, others like Mr.C. Daka who is a businessman (drugstore owner) cited inadequate or non availability of specialist treatment, inadequate medical personnel and lack of medical facilities. The research established that most sampled members of the public indicated that there have been no improvements of health services and facilities after the introduction of

user fees. Out of 252 respondents, 60.7 % said that there was no improvement and the services were still poor. 13.5% said that there was improvement in everything. 9.5% mentioned that there was no improvement because the majority was marginalized. 7.5% did not know. 4% said that there was an improvement in medical personnel. Four said that improvement was seen in the expansion of the clinic and seven did not respond. A number of shortcomings in the quality of services provided were identified as shown in chart 4.1.

As per chart 4.1. it was established that the majority of the people were not happy with the quality of services which they were being offered. 60% of the sampled respondents indicated that services were poor. Only 13% of the respondents said that there was improvement in everything. A few, cited improvements in isolated areas like availability of drugs, expansion of the clinic and availability of medical personnel. 10% indicated that majority of the people were marginalized. Following the statistics above, it can be argued that health services offered to people have not improved even after the introduction of user fees because majority of the sampled respondents said so. This could have made them be reluctant to pay user fees.

Chart 4.1. Respondents' views on improvements in terms of services and facilities out of 100 percent.

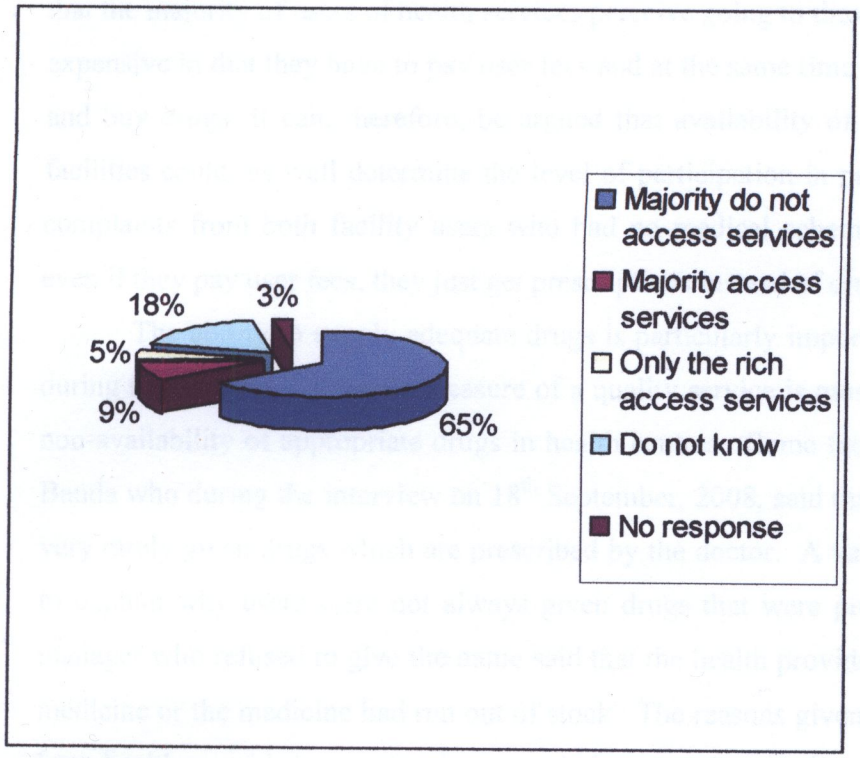


In view of the fact that the quality of services was questionable, some of the facility users, both those who had medical schemes and those who had no medical schemes, pointed out that they preferred going to private clinics where they felt services and facilities were better than those provided by public clinics. One school teacher at Lilayi during the interview on 5th August, 2008, argued that even if the user fees paid at private clinics were high, the services and facilities were good. Since there is no availability of quality services and facilities, it could mean that people are disappointed and that brings reluctance in paying user fees. A Mr. L. Ngulube who is a contractor indicated during the interview on 10th August, 2008, that there were improvements in certain areas but these were very few. The argument is that people were not willing to pay user fees because of lack of quality health services and facilities at the clinic. A number of the respondents also pointed out that because of the prevailing situation at the clinic, many people do not access quality health services and facilities, especially low income earners, can not afford to pay for services in private clinics where there are quality services and facilities. Therefore, it is likely that non participation in paying user fees could be determined by non availability of quality health services and facilities.

The research study established that a large number (65%) of respondents without medical schemes indicated that the majority of people did not access quality services. Of 151 respondents who had no medical schemes, 64.9% said that the majority did not access quality services, 9.3% said that many people access quality services, eight said that only the rich access quality health services,17 .9% did not know and four did not respond.

According to the study, the majority of the people without medical schemes indicated that after the introduction of user fees, many people do not access quality health services. Only a few said that many people access quality health services. For others, they felt that only the rich access quality health services as shown in chart 4.2 below. This could mean that people were not willing to pay user fees because of the quality of services they were offered.

Chart 4.2. Respondents who had no medical schemes and their views on accessibility to quality health services and facilities.



A number of respondents, who were not on medical schemes, said that the majority of the people in Chawama do not access quality health services. Some respondents mentioned that non availability of quality health services and facilities discouraged them to have medical schemes; hence they were reluctant to pay user fees. For example, one police officer, who operates from Chawama police station and was not on a medical scheme, alluded to the fact that because prescribed drugs are rarely given at the clinics, it was better for him to take his children to a private clinic than going to the clinic where only a prescription is given. During the interviews on 10th September, 2008 a number of facility users argued 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. For instance, one teacher at Chawama basic school was not hesitant to say that he went to private clinics when ever he needed medical attention because services and facilities at Chawama clinic were not good. During the interview on 9th August, 2008 a Mr. S. Jere who is a bus driver said that when he got sick, he went to local drug stores to buy medicines since at the clinic they just

give prescriptions because of inadequate or non availability of drugs. The end result of this is that the majority of users of health services perceive going to the clinic as a waste of time and expensive in that they have to pay user fees and at the same time be given prescriptions to go and buy drugs. It can, therefore, be argued that availability of quality health services and facilities could, as well determine the level of participation in paying user fees. There were complaints from both facility users who had no medical schemes and those who had that even if they pay user fees, they just get prescriptions instead of drugs.

The ability to supply adequate drugs is particularly important because what emerged during the study is that user's measure of a quality service is mostly the availability and / or non-availability of appropriate drugs in health centres. Some facility users like a Pastor M. Banda who during the interview on 18th September, 2008, said that they were either never or very rarely given drugs which are prescribed by the doctor. A variety of reasons were given to explain why users were not always given drugs that were prescribed for them. A sales manager who refused to give the name said that the health providers said either there was no medicine or the medicine had run out of stock. The reasons given had major implications on how health providers use the drugs at their respective clinics. For example, one set of reasons implied that health providers actually take the drugs from the health centres to either their own drug stores or to their friends' drug stores where they later sell them to the same supposedly beneficiaries of these drugs. Users who gave such answers justified their answers by adding that they were convinced that, that is what happened, because when prescriptions to go and buy drugs were given, they were also told the specific drug stores where the drugs indicated on the prescription could actually be found. And through investigations they had come to find out that the owners of those drug stores were the health workers themselves or their spouses and friends. The police officer at Chawama police station who could not give out his name during the interview on 15th September, 2008, was quick to say that because of their experiences, people were not willing to pay user fees because they new that some of the essential drugs were swindled from the clinic.

In addition to non-availability of essential drugs, facility users also mentioned about inadequate or no specialist services at the health centre. This is because of either lack of equipment or non-availability of qualified personnel. For instance, a Mr. C. Namachila who is a businessman (restaurant owner) pointed out during the interview on 10th September, 2008 that x-ray facilities which are provided at Chawama clinic are not government owned

but for a private individual. Because of that, most cases requiring specialist treatment are referred usually to U.T.H. Unfortunately, even ambulance services are inadequate due to the few vehicles available at the clinics. Mr. C. Namachila further mentioned that mostly facility users have to look for their own transport in case of any referral case. One nurse from Chawama clinic who did not give her name said that some people who require specialist treatment have to be referred to bigger centres or hospitals where such services are available.

In addition to non-availability of essential drugs and specialist treatment, some respondents complained of the health providers' attitudes towards user fees. During the interview on 2nd September, 2008 a Mr. P. Nyambe, who is an SDA church elder, said that the negative attitude towards patients and work by health providers was a manifestation of low motivation of health workers due to poor working conditions. He further mentioned that because of the poor working conditions, some health workers have a tendency of moonlighting with a view of supplementing the monthly income. The result of moonlighting is that employees have to work about 16 hours in a day because they will knock off from their normal duties and go and start another shift at a private clinic. The end result of that is a worker who is very tired and stressed almost all the time. Such health workers are not expected to offer quality services to patients since all the time they are tired. Therefore, as long as facility users do not receive quality services and facilities they are not expected to pay user fees.

In addition to the above complaint about health workers, some users complained that health workers discriminate when giving drugs to the users. Claims for discrimination were mentioned by users and some community leaders. For instance, it was claimed by one police woman from Lilayi that the relatives and / or friends of health workers were most of the time given medicine which was prescribed by the health personnel and that it was only those that were not known by the workers at respective clinics who were told to go and buy the prescribed drugs. Some of the users who could not give their names were even swearing that they had seen incidences where on the same day one person could be told to go and buy a particular drug while the other person who was known by the health personnel would be given that same drug. Some facility users said that it was only those that were well to do and not the poor who were given drugs at the clinics. For example, a group of bus drivers argued that those people from rich families were given VIP treatment at the clinic and as such there were always drugs reserved for them. They further claimed that there are certain drugs,

especially those that are administered through injections, which run out very fast due to high demand.

Even health providers seem to have given credence to the public views. Out of 20 health providers interviewed 13 of them said that clinics do not adequately provide health services while only seven said that clinics adequately provide health services after the introduction of user fees. However, various reasons were given for the answers. For those who said that clinics adequately provide, they said that there has been improvement in terms of availability of drugs, modern equipment and qualified personnel. They further argued that services seem inadequate because of the sudden increase in population in Chawama compound and the surrounding squatter compounds. The majority gave the following reasons: inadequate or non availability of essential drugs and medical facilities, low staffing levels, inadequate resources, poor working conditions of service and inadequate institutional support. The majority of health providers mentioned that many people in Chawama were reluctant to be on schemes because of what they called deteriorating health delivery system. They further said that most of their clients just visited the clinic for consultations because they preferred to seek medical attention from private clinics where there are better health services and facilities. Since it has been found that people complained about poor services and facilities at the clinics, the next section evaluates the extent to which institutional support affects the provision of health services. This is because institutional support may determine the quality of services offered, hence it could affect people's attitude towards user fees.

Institutional support

In the previous section, it has been found that the public perception that they are not accessing quality health services and facilities even after the introduction of user fees is a major factor in the low acceptance of the user fees. It has also been established that infact the services and facilities are not that good. In addition to what has been indicated on the quality of health services and facilities, the problem is there on institutional support. In this section, therefore, it will be highlighted that poor institutional support may determine the quality of services and facilities provided.

During the study, the researcher visited Chawama and Lilayi clinics which are in Chawama catchment area. Both clinics seemed to operate from favourably clean environments. However, health workers from both clinics complained about their physical

working conditions. The workers complained about the size of premises that they were operating from. They said that their premises and buildings they were operating from were small, especially Chawama clinic, considering the increased population. An example that was given by one of the nurses at Chawama clinic is the non- availability of an admitting ward at Lilayi clinic. Consequently, all cases needed for admission are referred to Chawama clinic, worsening the problem of congestion in admission wards. One expectant mother complained that even when they pay user fees for urine tests, they did not know the use of such fees instead of using the money to expand the maternity ward. She further said that because of the inadequate space in the admission wards at the clinic, most of the patients were not willing to pay user charges and those who manage opt to go to private clinics for treatment. During interviews on 29th September, 2008 most of the nurses from Chawama clinic, without giving their names, complained that their premises can not allow any form of expansion in the future. They also complained about the location of the clinic. The health providers complained that the premises were not only small but that the clinic is also badly located, right near very noisy bus stop, making it very difficult for health providers to concentrate on their work. As a result this affects the morale of health workers, consequently their performance in the delivery of services.

It was also established that health centres like Chawama clinic were characterized by the low staffing levels. According to the article entitled "Zambia uses G8 debt cancellation to make health care free for the poor" by Oxfam International (2006:1), Zambia's next challenge will be its chronic shortage of health workers. The article further indicates that there is currently only one doctor per 14,000 people in Zambia (compared to one doctor per 600 people in the United Kingdom) and the numbers of nurses in the country need to be double. A dentist at Chawama clinic mentioned that the number of medical personnel is inadequate looking at the increased number of those seeking medical services. During the interview with one clinical officer on 15th September, 2008, he said that inadequate number of health providers is as a result of the brain drain in the Ministry of Health. A number of doctors and nurses have left the country to other countries like U.S.A, United Kingdom and Australia for greener pastures. The brain drain is mainly due to poor working conditions and work environment in Third World countries like Zambia(Banda:1990). Evidence is there that the number of patients to one medical personnel has increased such that health providers are stressed. As a result the time a doctor is supposed to spend with each patient is reduced in

trying to attend to each and every patient. A situation which could affect the quality of service offered. According to the Sister In –charge of Chawama, while being interviewed on 29th September, 2008, the clinic was supposed to have at least three doctors but during the time of study, the clinic had only one visiting doctor. During the interview on the 28th September, 2008, one of the nurses who did not want to mention the name and operated from the maternity ward, said that the maternity ward was supposed to have at least eight nurses, but during the study, it was found that there were only three nurses, the situation which made them to be over worked. The nurse further pointed out that the situation forces some mothers to give birth from their homes because they know that the clinic is unable to provide quality services they need. A number of facility users indicated that they were unwilling to pay user fees because of the inadequate or non availability of services which was as a result of inadequate medical personnel.

In view of the fact that there is brain drain in Zambia, the majority of the health providers described the level of motivation as being low due to mainly the poor conditions of service, particularly the low salaries. Some health workers interviewed described their salaries as "slave wages". For instance, night duty allowance for nurses is as low as K30, 000 per night. For uniform allowance, they are given K50, 000. Non-implementation of other fringe benefits such as allowances and loan facilities that exist in their written conditions of service was also identified as a major demotivating factor.

The next indicator of institutional support is the ability of the Ministry to provide adequate equipment and transport in order to enable health providers to perform their work effectively. Inadequate medical equipment and facilities have affected the health delivery system. Due to inadequate equipment and transport, health providers are unable to perform their duties accordingly. One clinical officer, who was interviewed on 14th September, 2008 said that as health providers they have the basic equipment such as BP machines, thermometers and forceps required for the day to day operation of the clinics. The only complaint regarding such basic pieces of equipment was that at times it takes long for them to be replaced once they get old and cannot operate effectively any more. They argued that the usage rate for such kinds of equipment is very high such that they wear out very fast and need to be replaced every so often.

Accessibility to quality health services for people becomes a problem when it comes to relatively bigger pieces of equipment such as laboratory, X-ray, dental and mortuary

equipment. Even if the equipment is available, the quantity of the equipment found at the clinic does not much the demand. While being interviewed on 28th September, 2008 a Mrs.D. Kanyanta who is a nurse argued that such a situation is stressful because many times they feel inadequate to patients due to their inability to assist them. She further said that as a result, patients keep on being referred to other health centres where such services could be available. She also complained that users of health services referred to health centres where the required services could be available do not take their test results to their respective clinics; mainly because of the costs involved and especially that the majority of facility users have low incomes as discussed earlier. This makes it very difficult to complete the diagnosis process on such patients and have full records of both their illness and treatment measures affected on that illness. Mrs. D. Kanyanta indicated that this is very frustrating to the providers of health services and makes them lose confidence in themselves and in the public health system as a whole. During the study a number of respondents said that Chawama clinic lacks a lot of medical equipment and as a result services were poor. They went on to say that they did not want to spend money when there were no facilities needed for them to be treated. (Momba, 2006:79)

Lack of transport was repeatedly voiced by all health providers as a major constraint to effective service delivery. Two categories of transport services were particularly emphasized, that is ambulances and utility vehicles. At the time of the study the health providers interviewed claimed that ambulance services were inadequate to transport all the referred cases to referral centres like U.T.H. For instance, they indicated that the whole Lusaka district had only two ambulances to be utilized by all clinics. They said that this is very frustrating to them such that at times they are forced to donate money to enable them book a taxi or any other form of transport that can take the referred patient to the referral centre or to U.T.H. Coupled with that is the long time it takes for a patient to be taken to referral centres like U.T.H due to traffic congestion in the City of Lusaka. Infact the health providers interviewed said that it is very common for patients to die while waiting for the ambulance to transport them while on their way to the referral centre or to U.T.H.

Lack of utility vehicles in health centres is also viewed as a major constraint against effective delivery of health services among the health providers (Ibid). Two major reasons were advanced for the necessity of utility vehicles. The first is that each health centre is supposed to conduct out-reach programmes where there are supposed to go out in the

community once in a week to carry out health education and under five clinic services. The respondents said it is very difficult to conduct these programmes effectively without transport or workers have to literally walk from one point to the other. Some of the tasks of medical personnel like Environmental Health Technologists (EHT) involve going into the communities and this can not be effectively be done without transport. Lack of sufficient utility vehicles has affected the health service delivery system negatively.

Regarding general institutional policy, the major complaint was the fact that the Ministry has not yet put in place good policies on training. For example one Zambia enrolled nurse complained that money is allocated which is meant for capacity building but only a few members of staff, especially those in management benefit. She further argued that training was necessary for health providers to improve on their medical skills. As a result, those employees who wish to go for further training have to identify a training institution and sponsor themselves.

Conclusion

It was established that most of the people were not happy with the quality of services and facilities provided at clinics. Facility users said that most of the time the clinics had inadequate or no essential drugs; there was inadequate medical equipment and as a result some specialist treatment was not provided; and inadequate were medical staff, yet people are required to pay. A number of people attributed their reluctance to join the medical schemes on account of poor health services. Otherwise, they opted to go to private clinics where they said services and facilities were of good quality. It was further established that non availability of quality services and facilities was as result of lack of institutional support and even health providers indicated that lack of institutional support made people not access health services. On the overall, it can be said that availability of quality health services and facilities is also a factor in determining people's attitudes towards user fees. However, some people showed ignorance about user fees, hence they were against user fees because they claimed that they did not know anything about the cost sharing policy. It could be that after the introduction of user fees, people were not sensitized. Hence, chapter five is a discussion on opinion leaders and people's attitudes towards user fees since leaders' attitudes towards user fees could as well determine the public's attitude towards user fees.

REFERENCES

Basic school teacher, (5 August, 2008), Liliya: Lusaka.

Baptist church pastor, (8 September, 2008), Chawama resident: Lusaka.

Central Statistical Office (2002-2003) Living Conditions Survey, GRZ: Lusaka.

Clinical Officer, (15 September, 2008), Chawama clinic: Lusaka.

C. Daka (11 September, 2008) Chawama resident: Lusaka.

C. Namachila, (10 September, 2008), Chawama resident: Lusaka.

D. Kanyata, (28 September, 2008), Chawama resident: Lusaka.

L. Ngulube (5 August, 2008), Chawama resident: Lusaka.

Moderate Momba (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards"*MPA Dissertation Submitted to the University of Zambia.*

Pastor M. Banda, (18 September, 2008), Chawama resident: Lusaka

P. Nyambe, (2 September, 2008), Chawama resident: Lusaka.

S. Jere (9th August, 2008), Chawama resident: Lusaka.

Sister In-charge, (29th September, 2008), Chawama clinic: Lusaka.

Wimble, N. (2006) *Zambia uses G8 debt cancellation to make health care free for poor*, Oxfam International, Press Release: Lusaka.

W. W. Banda (1990), "Constraints Affecting the Administration of Mental Health Services in Zambia: With Reference with manpower Training and Utilisation", *MPA Thesis Presented to the University of Zambia,* Lusaka.

CHAPTER V

OPINION LEADERS AND PEOPLE'S ATTITUDES TOWARDS USER FEES

Introduction

In the third chapter it was found that people were not in support of the introduction of user fees partly because they thought it impacted negatively on those who can not afford to pay. In chapter four it was found that even facility users who were able to pay user fees were not very much in support of the idea of cost sharing due to the poor quality of health services and facilities which were being provided at the clinic. Given the critical role that opinion leaders play in shaping people's attitudes, this chapter, devotes our discussion to the attitude of the opinion leaders towards the user fees and the role that they played in either assisting in the general acceptance of those fees or in the public rejection. Among these opinion leaders are members of the Neighbourhood Health Committee, local leaders of major political parties, church leaders and representatives of Non-Governmental Organizations.

This chapter is divided into three sections, the first being the introduction. The second section is a discussion on opinion leaders and the introduction of user fees, specifically to examine what has been the reaction of opinion leaders towards user fees. The third section is an assessment of the role which opinion leaders played in influencing people's attitudes towards user fees and the factors that may have accounted for their behaviour towards the introduction of user fees.

Opinion leaders and introduction of user fees.

This section, discusses factors which influenced leaders' attitudes towards user fees. It analyses whether leaders understood the concept of user fees and whether user fees have brought about positive changes in the quality of services and facilities. The section examines the extent to which opinion leaders utilized the health facilities and the extent to which they support the medical scheme and reasons for their support.

During the study, the researcher interviewed about 50 opinion leaders from various organizations which operated in Chawama compound. Interviews were carried out on opinion leaders from the organizations identified in the introduction, that is, from the Neighbourhood Health Committee, local leaders of major political parties, church leaders

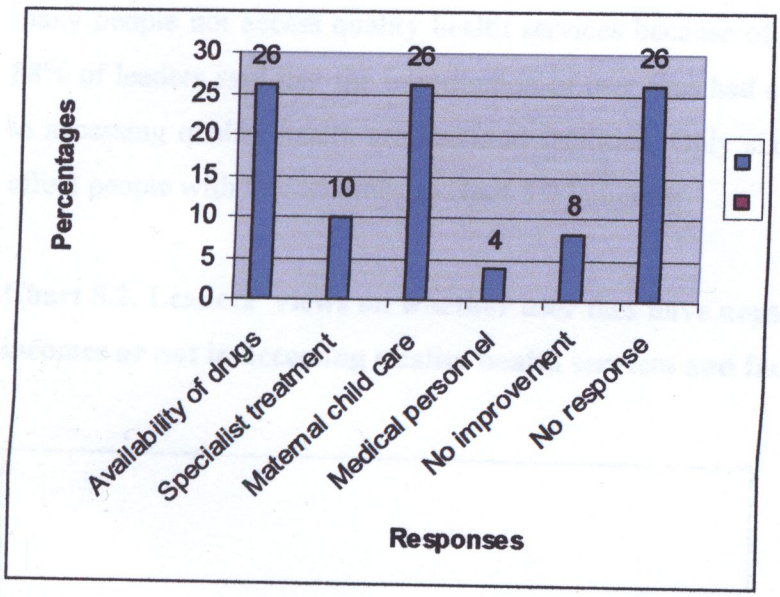
and representatives of Non-Governmental Organizations (NGOs). It was found out that almost all the leaders understood user fees and why they were introduced as part of the health reforms. All but one of the 50 opinion leaders interviewed indicated that they understood user fees. It was only the Area Development Committee (ADC) secretary who indicated that she had no knowledge about user fees and one did not respond. Since almost all opinion leaders understood user fees, it means it was even possible for them to sensitize the public on user fees. The significance of understanding user fees is that leaders, especially the members of the Neighbourhood Health Committee, were in a position to explain to the public about user fees which, as will be seen in the next section, they did not do.

In trying to establish if the leaders were able to pay user fees, the researcher asked them if they fully utilized the clinic facilities or not. Out of 50 opinion leaders interviewed, all but two said that they did go to the health centre when they fell sick. Unlike the public, almost all the leaders had knowledge on user fees and visited the clinics, meaning that they were able to sensitize the public about user fees. Only three opinion leaders: two Patriotic Front leaders and one Baptist Church leader indicated that they did not make use of clinic facilities and services because they usually went to private clinics where they thought the services and facilities provided were of good quality compared to public clinics. During the interview on 8th October, 2008, the Baptist church leader further said that essential drugs were rarely available in public clinics and patients were just given prescriptions for them to buy from chemists, even after paying user fees. It was also established that the majority of the opinion leaders did not go or take their children/dependants to alternative (traditional healers) when they fell sick. The argument is that facilities and services provided by alternative health providers were not as good as those provided in public health clinics. On the overall, 96% of the leaders fully utilized clinic facilities after the introduction of user fees; an indication that they were able to pay user fees.

It was established that leaders fully utilized the clinic facilities because they believed that the quality of services and facilities was good. For instance, a Ward Development Committee Chairman indicated that after the introduction of user fees, there was more improvement in the quality of health services and facilities. He further said that because of the improvements in the quality of health services and facilities, they got encouraged to continue seeking medical attention from the same clinic. Leaders pointed out some areas where they thought there could have been some improvements and where there have been no

improvements after the introduction of user fees. Out of the 50 opinion leaders interviewed, 26% indicated that there was an improvement in the availability of drugs. Five of them said that some improvements were seen in specialist treatment. 26% indicated that there was an improvement in maternal child care. Two opinion leaders said that improvements were seen in the delivery of health services by medical personnel. Four said that there was no improvement at all and 13 or 26% did not respond.

Chart 5.1. Opinion leaders' views on the impact of user fees in terms of improvements in health facilities and services.

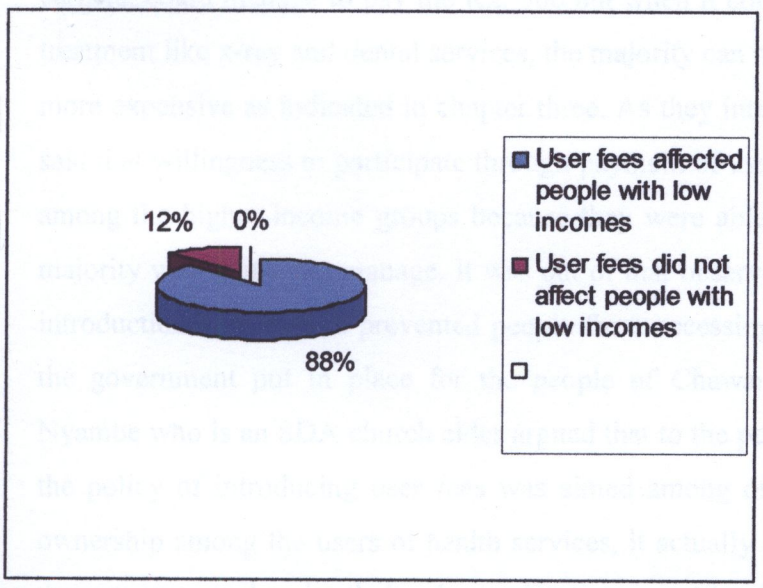


The four leaders (UCZ church elder, two ADC secretaries and a UPND ward chairman) who said that there was no improvement gave a number of reasons. Firstly, the UCZ church elder mentioned during the interview on 13th August, 2008, that in most cases essential drugs were either inadequate or not available for patients. Secondly, the UPND ward chairman said that medical personnel were inadequate and as a result, many cases were not attended to and thirdly one ADC secretary talked of inadequate or non availability of ambulances for referral cases. For instance, the other ADC secretary indicated that the entire Lusaka District had only two ambulances. The leaders who said there were improvements after the introduction of user fees attributed the seemingly inadequate health services and facilities towards the

increase in the number of people who needed the services in Chawama. For instance, the former Neighbourhood Health Committee vice chairperson pointed out that the increase in the number of people seeking medical attention was as a result of mushrooming squatter compounds like, Kuku, Misisi and John Howard which were not provided with clinics. In addition to that Chawama clinic handles cases from other surrounding places like Lilayi, Makeni, and Kuomboka.

How ever, despite the fact that the majority of opinion leaders were happy with the quality of health facilities and services after the introduction of user fees, they had mixed feelings about user fees. 88% of the leaders were ambivalent about user fees. They argued that even if user fees improved services and facilities, on the other hand user fees had led to many people not access quality health services because of poverty. According to the study, 88% of leaders said that the introduction of user fees had affected people with low incomes in accessing quality health services and facilities. Only six indicated that user fees did not affect people with low incomes as chart 5.2 indicates.

Chart 5.2. Leaders' views on whether user fees have negatively affected people with low incomes or not in accessing quality health services and facilities.



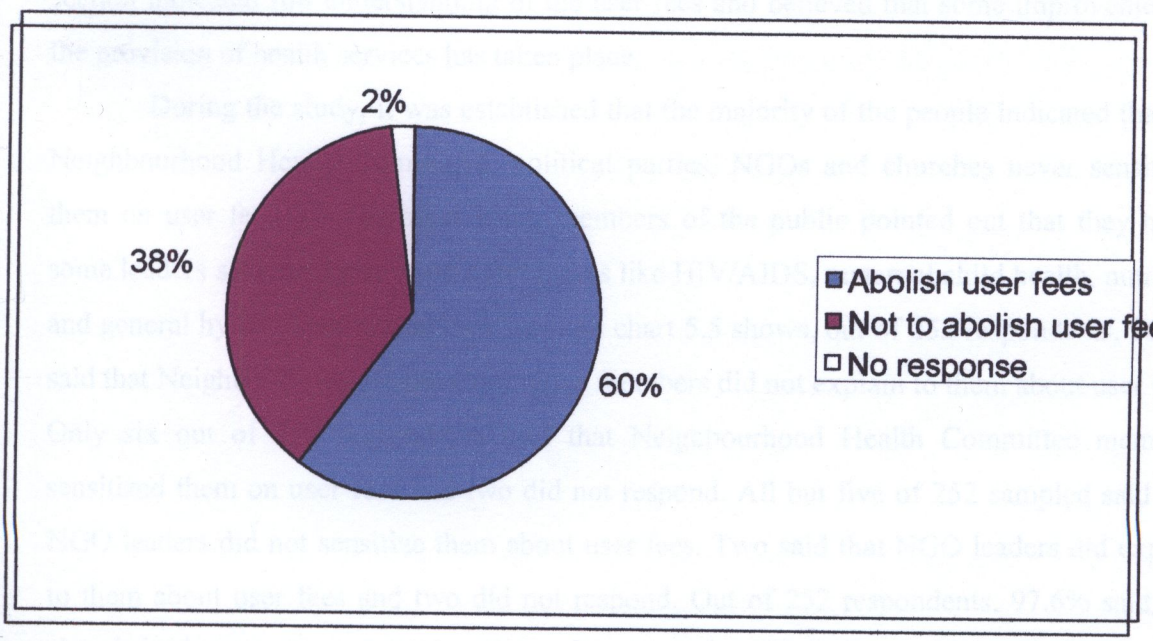
Thus, it can be said that even if the leaders visited the clinics where they paid user fees and fully utilized clinic facilities and services after the introduction of user fees, the majority were not happy about the negative effects of user fees. For example, many religious

and opposition political party leaders said that many people did not access quality health services and facilities because they were poor. The problem of people not managing to pay user fees was also echoed by the NHC Chairman. The Chairman mentioned that as a person who was so close to the people in the community, he knew how user fees had denied many people in accessing quality health facilities and services. He pointed out that it was because the majority are poor; hence they cannot manage to pay user fees. The majority of the opinion leaders indicated that as they interacted with people, they found that the many of them were not willing to participate in paying user fees. Because 88% of the leaders believed that user fees impacted negatively on poor families, they, therefore, felt that user fees should be abolished.

The majority of the leaders emphasized that the Government should intervene and find ways and means of ensuring that the poor who are the majority in Chawama have access to quality health services and facilities. It was learnt from the leaders that in Chawama compound many people earn very low incomes and as a result they can not afford to pay user fees. Others even fail to pay the K2, 500 needed to pay for a person to have a medical scheme at the clinic. The NHC Chairman mentioned that other people, including low income earners, could manage to pay the K2, 500 but when it comes to other user fees for specialist treatment like x-ray and dental services, the majority can not afford because such services are more expensive as indicated in chapter three. As they interacted with the people, the leaders said that willingness to participate through payment of user fees seemed to be more accepted among the higher income groups because they were able to pay user fees compared to the majority who could not manage. It was out of that observation that most leaders felt that the introduction of user fees prevented people from accessing health services and facilities that the government put in place for the people of Chawama. During the interview, Mr. P. Nyambe who is an SDA church elder argued that to the people of Chawama, therefore, while the policy of introducing user fees was aimed among other things at instilling a sense of ownership among the users of health services, it actually bars them from using the facilities that are supposed to be theirs. In her Dissertation, Momba (2006:89) argues that user fees were alienating people from the clinic more than before. During the interview on 14th July, 2008, a widow from Misisi whose name was not given said that most of the people, during the times when they had no money to pay at the clinic simply nursed the patients at home and gave them pain killers such as panadols, aspirin and cafenal.

Because 88% of the leaders felt that user fees denied many people to access health services, it was established that a large number of the opinion leaders said that user fees should be abolished. 60% of the opinion leaders said that user fees should be abolished. 38% said that user fees should not be abolished. One opinion leader did not respond. Out of the 30 or 60% of the leaders who said that user fees should be abolished, 25 or 83.3% of the leaders who were mainly opposition political party and watchtower leaders mentioned that user fees should be abolished for all because many were poor. One ward chairman from an opposition political party said that user fees should be abolished for all because health was a right and four of them who were mainly religious leaders (SDA deacon and church elder, UCZ church elder and ADC secretary) indicated that user fees should be abolished for the poor. Out of those leaders who said that user fees should not be abolished, 18 or 36% said that user fees should not be abolished but just improve services and only one said that user fees should not be abolished in order to supplement government efforts. Most of the leaders who said that user fees should not be abolished were local MMD party leaders and NGO representatives.

Chart 5.3. Opinion leaders' views on continuity and abolishment of user fees.



Most of the leaders sampled, that is 62%, indicated that user fees should be abolished because of their view that many people could not afford due to the low incomes they earned. Another 19 or (38%) felt that if only health facilities and services were to be improved

generally, people's participation in paying user fees would increase .On the overall, opinion leaders felt that there was general public resentment against user fees because of the problem of affordability to pay.

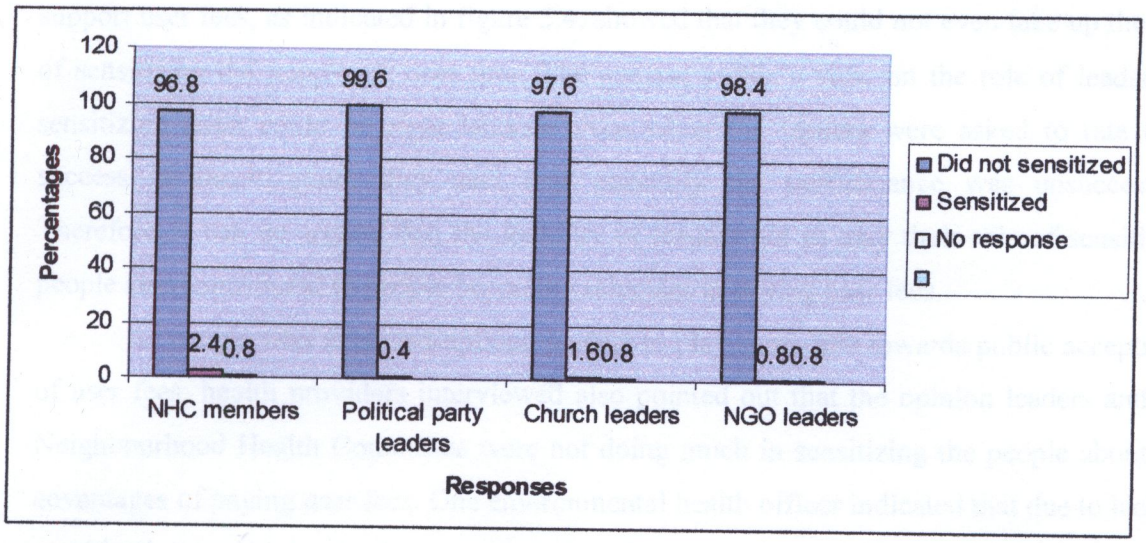
The negative attitude shown by opinion leaders towards user fees was somewhat confirmed by the NHC chairman who during the interview mentioned that the majority of the leaders were for the idea of abolishing user fees because it was evident that many people in Chawama compound earned low incomes, hence they could not afford to pay user fees. He further said that there was resistance against participating in paying user fees from facility users partly because they were not encouraged by opinion leaders to do so.

Opinion leaders' role in impacting people's attitudes towards user fees.

The general acceptance of user fees would require some sensitization on the value of user fees as expected by the clinic so as to encourage people to participate in paying user fees. The task of sensitizing the people on user fees was expected to be carried out by the Neighbourhood Health Committee and other community leaders who as shown in the earlier section indicated full understanding of the user fees and believed that some improvement in the provision of health services has taken place.

During the study, it was established that the majority of the people indicated that the Neighbourhood Health Committee, political parties, NGOs and churches never sensitized them on user fees. On the other hand, members of the public pointed out that they heard some leaders sensitizing them on other issues like HIV/AIDS, maternal child health, nutrition and general hygiene but not on user fees. As chart 5.5 shows, out of 252 respondents, 96.8% said that Neighbourhood Health Committee members did not explain to them about user fees. Only six out of 252 respondents said that Neighbourhood Health Committee members sensitized them on user fees and two did not respond. All but five of 252 sampled said that NGO leaders did not sensitize them about user fees. Two said that NGO leaders did explain to them about user fees and two did not respond. Out of 252 respondents, 97.6% said that church leaders never explained to them about user fees. Only four said that church leaders sensitized them about user fees. Two did not respond. All but one of the 252 respondents said that local political party leaders did not explain to them about user fees and only one indicated that local political party leaders sensitized them on user fees.

Chart 5.4. Respondents' views on whether opinion leaders sensitized them on user fees.



Surprisingly enough, even the NHC members who are supposed to take a leading role in sensitizing people were seen not to have done their part on user fees. During the interview on 23rd July 2008, the Neighbourhood Health Committee Chairman who was concerned with health matters confirmed that as committee members, they did not play their role in sensitizing the people on user fees. He confirmed that the Neighbourhood Health Committee members could not carry out sensitization programmes because they were demotivated due to lack of support from the health authorities and the community at large. He further said that even other leaders never sensitized the people on the value of user fees. The Neighbourhood Health Committee members, just like the other community leaders, are supposed to provide the strongest link between the health center and the community, especially in terms of information flow where health maters are concerned. But when it came to dissemination of information on user fees, nothing much was done. The same was with other opinion leaders. For political party leaders, many people said that they also never talked about user fees.

The position of the church was worse than that of the Neighbourhood Health Committee. Church leaders were only heard talking about other health issues at places of worship but not on user fees. Church leaders were heard talking about, for example, cleaning the clinic premises and not on user fees. NGO leaders were also said to only concentrate on other health maters like water supply and sanitation but they never bothered to sensitize people on the importance of paying user fees. The fact that the majority of the leaders did not

support user fees, as indicated in figure 5.4, showed that they could not even take up the role of sensitizing the people on user fees. The general public's view on the role of leaders in sensitizing them could be right because even when the leaders were asked to rate their success in sensitization, they said that generally the performance was unsuccessful. Therefore, it can be argued that the inability of leaders not to play their role of sensitizing people also contributed to people becoming reluctant in paying user fees.

As people who expected opinion leaders to play some role towards public acceptance of user fees, health providers interviewed also pointed out that the opinion leaders and the Neighbourhood Health Committee were not doing much in sensitizing the people about the advantages of paying user fees. One environmental health officer indicated that due to lack of sensitization by opinion leaders, people were reluctant to pay user fees; hence they could not access quality health services.

A number of reasons were advanced by the opinion leaders and the Neighbourhood Health Committee as to why they were reluctant to sensitize people on the importance or value of paying user fees. Firstly, and as alluded in the previous section, leaders felt that despite the fact that they fully utilized clinic facilities and services, they were not in support of user fees because the user fees adversely affected the majority of the people as chart 5.2 shows. One of the several effects of user fees was that they denied many people, especially the poor to have access to quality health services and facilities simply because they could not afford to pay user fees. The Neighbourhood Health Committee Vice Chairperson agued during the interview on 29th July, 2008, that user fees forced some people to go to unlicensed local drug stores to buy unprescribed drugs which they could afford to buy even when such drugs were expired, hence, exposing themselves to more health risks. He further argued that since many people could not afford to pay user fees, they could not access quality health services and facilities. The Baptist church elder said during the interview on 8th October, 2008 that it was unfair for leaders to access quality health services and facilities whilst their people were dying from treatable diseases simply because of poverty.

The second reason which they gave was that they were not involved in decision making where health matters are concerned. For instance, three civic leaders and four Area Development Committee members indicated that they were reluctant to sensitize people because of lack of co-operation between themselves and health authorities. For instance, the ADC secretary for zone A expressed his concern on the way the user fees for particular

clinics were determined and used. He argued that if indeed the policy regarding the introduction of user fees was intended, among other things to give a sense of ownership of these clinics, leaders and the community at large needed to be involved in decision making and people's degree of involvement should have been much higher than what seemed to be happening. All leaders interviewed said they had no idea as to how the user fees for chawama clinic were determined. To them this indicates an anomaly in as far as the promotion of ownership of health services and facilities by not only leaders but by all the users is concerned. They strongly felt that a deliberate policy must be put in place which should ensure that they are involved in a number of decisions regarding user fees. They felt that they should have a big influence in decisions concerning the amounts of different categories of user fees to be paid at the clinic, including how the money collected as user fees should be used. The argument is that as long as opinion leaders are not involved in decision making on health issues that affect people, they are not expected to render their support.

Conclusion

During the study it was established that most of the leaders understood user fees. It was also found that leaders utilized clinic facilities and services even after the introduction of user fees. As opinion leaders, they were expected to sensitize the people on the value of paying user fees. However, they were not happy about the negative impact of user fees on the poor members of respective communities. The leaders felt that user fees denied the majority of the people access to quality health services and facilities because they could not pay user fees due to poverty. The leaders indicated that even when it came to making decisions concerning health matters, they were not involved. Because of that, they were not supportive of user fees and even felt that user fees should be abolished. Therefore, it can be argued that opinion leaders played a major role in determining people's attitudes towards user fees.

REFERENCES

Area Development Committee Secretary, (13 August, 2008), Chawama: Lusaka.

Baptist church elder, (8 October, 2008), Chawama: Lusaka.

M. Momba (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards" *MPA Dissertation Submitted to the University of Zambia.*

Neighbourhood Health Committee Chairman, (23 July, 2008), Chawama: Lusaka.

Neighbourhood Health Committee Vice- Chairperson, (29 July, 2008), Chawama: Lusaka.

P. Nyambe (Seventh Day Adventist Church elder) (2 September, 2008), Chawama resident: Lusaka.

United Church of Zambia Church elder, (13 August, 2008), Chawama: Lusaka.

Ward Development Committee Chairman, (13 August, 2008), Chawama: Lusaka.

CHAPTER VI

CONCLUSION

This concluding chapter of the study on the establishment of factors that determine people's attitudes towards user fees in high density residential areas focuses on two major aspects. First, it provides the key conclusions of the study findings. Secondly, it outlines the recommendations to the policy makers and the key players in the implementation of the health reforms on some aspects of the implementation process that might require re-visiting and / or where possible changes in the methods of implementation maybe needed in order to improve the performance of health centres.

The basic principle that provided the basis of the study is that the provision of quality health services and facilities that can be easily accessed by all the citizens of a particular country is the essence of any public health policy. The focus of the study was access to health facilities and services in view of the introduction and implementation of user fees as part of the health reforms. With regard to the user fees, the policy makers envisaged that if families and communities took responsibility of their own health situation, accessing health facilities and services would be easy. The study, therefore, tried to analyze the idea that the introduction of user fees as part of the health reforms enhances community participation, which in turn makes it relatively easy to access and improve health facilities. In undertaking this analysis, the study focused on three specific objectives. The first one was to assess the extent to which income, occupation and level of education affect level of access and people's attitudes towards user fees. The second was to determine whether availability of quality health services and facilities influence level of access and people's attitudes towards user fees. The third specific objective was to establish the role opinion leaders play in either rejecting or accepting user fees in high density residential areas and how it affects people's access to services.

Regarding the extent to which income, occupation and level of education affected people's attitudes towards user fees and level of access, it was found that income played a marginal role in determining people's attitudes towards user fees. This is because most people who earned lowest incomes and those who earned highest incomes had no medical schemes and did not visit the clinic. Occupation also played a marginal role in determining

people's attitudes towards user fees because even civil servants who are supposed to educate people on user fees, a larger number had no medical schemes and wanted user fees to be abolished. It was established that education also played a marginal role in determining people's attitudes towards user fees because even if most of the people with tertially education understood user fees and visited the clinics, they wanted user fees to be abolished. On the overall, it was established that across income, occupation and education there is rejection of user fees. However, what seemed to come out is that the rejection arises out of the fact that there was concern that user fees impacted on a number of users particularly those affected by poverty.

The idea behind the introduction of user fees was to improve the quality of health services and facilities meant to be provided to the people and improve accessibility to these services and facilities. Unfortunately, the scenario is different. The negative attitudes towards user fees are also centered on the perception that, there are too many medical expenses without corresponding provision of good quality services and facilities. The situation is coupled with persistent shortage of drugs, medical personnel's bad attitudes towards users, inadequate medical staff, and inadequate medical facilities, especially for specialist treatment. This situation has been observed by the majority of the users, both those with low-incomes and those with high incomes. The prevailing situation is ironical in that it has worsened after the introduction of user fees compared to the time before the introduction of user fees when almost all the people had access to quality health services and facilities. At the same time, despite the deteriorating situation in terms of the quality of services and facilities available and poor conditions of service, health providers are doing their best despite the shortage of medical staff due to the brain drain.

The health providers interviewed also talked of their motivation being low. The reasons cited for low motivation include poor salaries, lack of long-term training opportunities, and inability of the Ministry of Health to provide good working environments. The low levels of motivation manifest themselves through the negative attitudes workers develop towards the performance of their tasks. The study established that health providers have put in practice a "work as you earn principle". To supplement their meager salaries, health workers have to work extra hours at private clinics after knocking off. Such practices make them stressed up because of overworking so much that even as they go for duties the following day, they are already tired. This could possibly have a negative impact on the

effective and efficient delivery of health services to the users. In this regard, most of the users complained about the negative attitude of health workers, especially nurses, towards their jobs and / or users. This could make users reluctant to go to the health centres when they get sick, thereby having a negative impact on users' access to health services and facilities. The other problems are long queues at Chawama health centre which are as a result of increased population in Chawama compound and other surrounding squatter compounds. These long queues are unavoidable and as a result, people can not access health services in a dignified way since on top of being patients needing attention, they are as well stressed up. However, it was established that non-availability of quality health services and facilities was as a result of lack of institutional support.

It was further established that lack of sensitization on the concept of user fees has led people not having confidence in the whole policy. During the study it was established that most of the leaders understood user fees. It was also found that leaders utilized clinic facilities and services even after the introduction of user fees. As opinion leaders, they were expected to sensitize the people on the value of paying user fees. However, they were not happy about the negative impact of user fees on the poor members of their respective communities. The leaders felt that user fees denied majority of the people to access quality health services and facilities because they could not pay user fees due to poverty. The leaders indicated that even when it came to making decisions concerning health matters, they were not involved. Because of that, they were not supportive of user fees and even felt that user fees should be abolished.

The study further established that because the people can not access quality health services as expected, alternative sources of health services and facilities are sought. Among the alternative sources of health services and facilities sought include traditional health providers, private clinics, drug stores, private chemists and religious healers. The majority of users who opt to go to alternative sources are those who can not manage to pay user fees. Since such people are poor, they would rather go to drug stores to buy drugs like panadol, fansidar and aspirin at low prices as K500. Most of these people decide on their own the type of drug(s) to be bought and take without being diagnosed and not even a prescription from a medical doctor. The problem with this practice is that at times they end up taking drugs which they are not supposed to take. Some of these drug stores are owned or supplied

by some medical personnel from health centres. It was also found that some of the drugs they buy are expired.

Some users who opt to go to drug stores or private chemists are forced by the fact that usually drugs which are prescribed are not available at health centres. Hence, they decide to go to drugstores or chemists even before they are diagnosed since they already know the prevailing situation at the clinic concerning drugs. There is also a category of those who do not believe in conventional medicine but would rather go to spiritual or religious healers. The argument is that spiritual powers are above everything and usually when they seek such services, money paid is very little and at times services are free of charge. Other users go to traditional healers even though the number of those who go to traditional healers is small. During the study, traditional healers interviewed indicated that since the majority of those who sought such services were poor, treatment was usually done free and if it meant payments, those were done in kind for those who did not have money.

The findings of the study indicate that the four set objectives have been achieved. The first objective was to assess the extent to which income, occupation and level of education affect level of access and people's attitudes and views towards user fees. The study indicated that income, occupation and education played marginal roles in determining people's attitudes towards user fees. It was established that across income, occupation and education, there is rejection of user fees. However, what came out of the study is that the public rejection of the user fees arises out of the fact that there were concerns that user fees impacted on a number of users, particularly those affected by poverty. No particular income group accepted user fees. No particular occupation group accepted user fees. No particular education group accepted user fees. Therefore, income, occupation and education do not determine people's attitudes towards user fees.

The second specific objective was to establish the extent to which the quality health services people's access to services and their attitudes and views towards user fees. The findings indicated that most of the people were not happy with the quality of services provided at clinics. Facility users said that it was common at clinics to have inadequate or no drugs; inadequate medical personnel and equipment; lack of specialist treatment and ambulance services, even when they were required to pay. A number of people attributed their reluctance to join the medical schemes on account of poor health services. Otherwise, they opted to go to private clinics where they said service and facilities were of good quality.

It was further established that non-availability of quality health services and facilities was as a result of lack of institutional support. Therefore, availability of quality health services determines people's attitudes towards user fees and also affected their access to health services.

The third objective was to establish the views of opinion leaders on the introduction of user fees and the role they play in either the public rejection or acceptance of the user fees, including the effect on access to services in high density residential areas. The findings showed that opinion leaders understood user fees and utilized clinic facilities and services even after the introduction of user fees. As community leaders, they were expected to educate people on the value of paying user fees. However, they felt that user fees impacted negatively on the poor members of their respective communities. The leaders felt that user fees denied the majority of people access to quality health services and facilities because they could not pay user fees due to poverty. Even majority of people indicated that leaders never sensitize them on user fees. The study also indicated that leaders were not involved when it came to decision making where health matters are concerned. Because of that, they were not supportive of user fees and even felt that user fees should be abolished. Thus, it can be argued that opinion leaders played a role in determining people's attitudes towards user fees and even their access to health services.

All in all it can be concluded that user fees impacted negatively on people's access to health services. This is because it was found that a number of people do not access health services particularly those who are affected by poverty especially that there are reports of people who die in their homes since they can not afford to pay user fees. Others do not access health services due to their negative attitudes towards user fees which is as a result of the influence from community leaders who are not supportive of user fees; and non-availability of quality services which are paid for.

BIBLIOGRAPHY

Abel, S.B. and Rawal, J. (2003), " Tanzania – Opposing User Fees," *in African Policy E-joournal. Royal Tropical Institute*; Amsterdam.

Arhin, D. (1992). "Health Financing in Zambia: Approach to Cost Sharing," *Consultancy Report.* London School of Hygiene and Tropical Medicine. London.

Bell, Clive (1973), "Organization and Administration of the Health Services," in Clive Bell (ed.), *The Diseases and Health Services of Papua New Guinea*, Port Moresby.

Booth, D; Milimo, J. T; Shilito, T; and Brock, K. (1995). *Coping with Cost Recovery*, Department of Social Anthropology, Stockholm University: Stockholm.

Central Board of Health/Zambia Integrated Health Programme (2002)
Cost sharing Brief, MOH: Lusaka.

Chuma et al (2008), "Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice" *in International Journal for Equity in Health.* London School of Hygiene and Tropical Medicine.

Daka, H. (2006), " No, It's Not April Fool's: Free Health Care...in Zambia" *in the American Journal of Bioethics*. Taylor and Francis Health Sciences: Toronto.

Deininger,K. and Mpuga, P.(2005), "Economic and Welfare Impact of the Abolition of Health User Fees: Evidence from Uganda". In *Journal of African Economics*, Vol. 14. Social Science Electronic Publishing Inc: Washington D.C.

Dinar, A. (2006), "Africa: User Fees", *African Studies Centre*- University of Pennsylvania: Pennsylvania.

Foster, S. (1993). "Cost and Burden of Aids on the Zambian Health Care System", *Policies to mitigate the impact on health services.* United States Agency for International Development (USAID): Lusaka.

Government of the Republic of Zambia (1994), *A Guide to Zambia Health's Reforms.* Ministry of Health: Lusaka.

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

International Labour Organization (1970), *Narrowing the Gap – Planning for Basic Needs and Productivity Employment in Zambia: Jobs and Skills Programme for* Actions. Study commissioned by MOH with financial support from the study Fund.

Jesuit Centre for Theological Reflection (2002), *Abolish Health Service User Fees?*, Home Publishers: Lusaka.

Kalyalya, D.H. (1995), *User Fees in the Health Sector: Policy, Practice and Perception,* Oxford University Press: London.

Kay, G. (1967). *A Social Geography of Zambia.* London: London University Press.

Kelly, Michael (1991), *Education and Declining Economy: The case of Zambia, 1975 to 1985.* World, Washington DC.

Knauder, S. (1982). *Shacks and Mansions: An analysis of integrated housing policy in Zambia.* Lusaka: Multimedia Publications.

Lake, S. (1990) "Annex B", in *Cost Sharing in the Health Sector: Principles and Practice.* Report of the Ministry of Health meeting held at Fairview Hostel on 16th August, *1990.*

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, B.E.M. (2001) " User- payment, Decentralization and Health Service Utilization in Zambia," in *Pubmed, Health Policy Plan.*http://www.ncbi.nih/gov.

Litvak,I (2001),*User Fees as a Form of Cost Sharing in Development World.* Oxford University Press: London.

Macwan'gi, M. et al (2000), "User Fees and Drugs: what did the health reforms in Zambia achieve?" in *Health Policy and Planning.* Oxford University Press.

Malama,C. et al (2002), " User Fees Impact Access to Healthcare for Female Children in Rural Zambia" in *Journal of Tropical Pediatrics.* Oxford University Press.

Masiye, F. et al (2008) "Removal of user fees at Primary Health Care facilities in Zambia: A study of the effects on utilization and quality of care" in *the EQUINET discussion paper.* Department of Economics, University of Zambia: Lusaka.

Milimo, J.T. and Choongo (1994) "People's Perceptions and Experiences with Feelings on User Fees", in *Cost Sharing in the Health Sector: Principles and Practice.* Report of the MOH meeting held at Fairview Hotel on 16th August: Lusaka.

Ministry of Health (1993), *Health Financing in Zambia: Insurance through prepayment* (draft). Lusaka: Ministry of Health.

Momba, Moderate (2006), "The Impact of Health Reforms on Access to Health Services: A case study of Lusaka and Kafue District Health Boards", *MPA Dissertation Submitted to the University of Zambia*: Lusaka.

National Health Policy and Strategies (Planning Unit) (1991), *"Health Reforms"*. Lusaka: MOH.

Pearson, M. (2004) "The case for abolition of user fees for primary health services", *Africa Focus Bulletin. African Studies Centre- University of Pennsylvania*: Pennsylvania.

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

Rhode, Jon (1984), " Health for all in China: Principles and Relevance for other countries" in David Morley, Jon Rhode, and Glen Williams (eds.), *Practicing Health for all.* Oxford University Press, New York.

Sakinge, K.Beatrice (1995), The Health Staff's Knowledge, Attitudes and Practices of the Health Reforms: A Comparative Study, *MSc Thesis Submitted to the University of Zambia*, Lusaka.

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

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

Sunday Times of Zambia (2005) "Scrap health user fees, demands MP", *Times of Zambia*: Lusaka.

United Nations Development Programme (1992), *Investing in Health.* Washington D.C. UNDP.

van der Geest, S. et al (2000), "User fees and drugs: what did the health reforms in Zambia achieve?" ??? *Health Policy and Planning.* Oxford University Press: London.

Yate, R. (2007), *The Impact of Abolishing User Fees in Africa- Recent Developments in Six African Countries.* UK Department for International Development-Human Development. United Kingdom.

Wilkinson et al (1997), "Health user fees in Sub saharan Africa", in *a British Medical Journal,* London: London School of Hygiene and Tropical Medicine.

World Bank (1994), *Better health in Africa: Experience and lessons learned.* Washington: World Bank.

World Health Organization/United Nations Children's Fund (1978), " Primary Health Care," *A Joint Report by The Director- General of the World Health Organization and The Executive Director of the United Nations Children's Fund*, WHO, Geneva.

Zambia, Government of the Republic of (1965), *An Outline of the Transitional Development Plan.* GRZ. Lusaka.

Zambia, Government of the Republic of (1992*), National Health Policies and Strategies (Health Reforms*). GRZ, Ministry of Health, Lusaka.

Zambia, Government of the Republic of/United Nations (1996), *Prospects for Sustainable Human Development in Zambia: more choices for our people.* Lusaka: GRZ and United Nations systems.

APPENDICES

APPENDIX 1-QUESTIONNAIRE FOR CHAWAMA RESIDENTS

SECTION A: PERSONAL INFORMATION

Date of interview.....

1. Sex

Female	[ ]
Male	[ ]

2. Age

Below 25 years	[ ]
25 - 40 years	[ ]
40 - 50 years	[ ]
50 – 60 years	[ ]
Above 65 years	[ ]

3. What is your marital status?

Single	[ ]
Widowed	[ ]
Divorced	[ ]
Married	[ ]
Separated	[ ]

4. What is the size of your household?.....

5. What is your occupation?.....

6. What is the occupation of your spouse?.....

7. What is your income?

Below 250 000.00	[ ]
K250 000.00 – K500 000.00	[ ]
K501 000.00 – K1 000 000.00	[ ]
Above K1 000 000.00	[ ]

8. What is your spouse's monthly income?

Below 250 000.00	[ ]
K250 000.00 – K500 000.00	[ ]
K501 000.00 – K1 000 000.00	[ ]
Above K1 000 000.00	[ ]

9. What is the highest level of educational attainment?

None	[ ]
Primary	[ ]
Secondary	[ ]
Tertiary	[ ]

10. For how long have you been staying in Chawama?

Below 5 years	[ ]
5 – 9 years	[ ]
10 – 14 years	[ ]
Above 15 years	[ ]

SECTION B – RESPONDENTS' HOUSEHOLD HEALTH STATUS

11. Have you or any member of your family visited the clinic for medical attention in the last six months?

Yes [ ]

No [ ]

12. Have you or any member of your family visited alternative health providers in the past six months?

Yes [ ]

No

13. Are you on a medical scheme?

Yes [ ]

No [ ]

14. If yes, for how long have you been on a medical scheme?

.....

.....

15. If yes, indicate the kind of scheme.

Pre-payment scheme low cost [ ]

Pre-payment scheme high cost [ ]

Paid for by employer [ ]

Paid directly (cash) [ ]

Paid in kind [ ]

Others specify.....

16. Who funds the medical scheme?

.....

.....

17. If you are not on a medical scheme and had to seek medical attention for either yourself or any member of the family, how did you manage to have medical attention?

.....

.....

.....

18. In the past six months has any family member not been able to seek medical attention because he or she could not pay for the services?

Yes

No

19. Elaborate your answer.

.....

.....

.....

.....

20. Do you know any friends or neighbours who could not seek medical attention because he or she had no money to pay for the services?

Yes

No

21. Elaborate your answer.

.....

.....

.....

.....

SECTIONC: RESPONDENTS' ATTITUDE TOWARDS COST-SHARING INTRODUCTION IN HEALTH INSTITUTIONS.

22. What do you understand by user fees?

.....

.....

.....

23. Do you understand why user fees were introduced?

.....

.....

24. What do you think are the benefits of user fees?

.....

.....

.....

25. What is your view about people's access to health services in Chawama Compound with the introduction of user fees?

.....

.....

.....

26. Do you think the rates of payment are reasonable enough for the people to afford to pay?

Yes

No

27. Elaborate your answer.

.....

.....

.....

28. In your opinion, what is the best mode of payment at health institutions?

Directly when people fall sick	[ ]
Pre-payment schemes	[ ]
In kind	[ ]

29. Provide an explanation for your response to question 28.

.....

.....

.....

30. Do you think the introduction of user fees has brought about improvements in terms of availability of drugs, medical staff, specialist treatment etc?

.....

.....

.....

31. What kind of people do not manage to pay user fees?

.....

.....

32. What is your opinion about other health service providers (traditional healers) other than Government Hospitals and Health centres in terms of provision of medical services?

.....

.....

SECTION D: COMMUNITY PARTICIPATION IN DECISION MAKING ABOUT USER FEES.

33. Are you aware about organizations like political parties, churches, NGOs, NHCs etc?

Yes [ ]

No [ ]

34. Have leaders of political parties (MMD, PF and UPND in particular) in your area ever explained to you about user fees?

Yes

No

35. If yes, what views do they have about user fees?

.....

.....

.....

36Have church leaders in your area ever explained to you about user fees?

Yes

No

37. If yes, what views do they have about user fees?

.....

.....

.....

38. Have leaders of the NGOs in your area ever explained to you about user fees?

Yes

No

39. If yes what views do they have about user fees?

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

40. Have leaders of the Neighbourhood Health Committee(s) in your area ever explained to you about user fees?

Yes

No

41. If yes, what views do they have about user fees?

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

42. Should user fees be abolished for everybody or only for certain categories of people? Elaborate your answer.

.....
.....

APPENDIX 2- QUESTIONNAIRE FOR MEDICAL PERSONNEL

SECTION A: BASIC INFORMATION

Date of interview.....

1. Sex

   Female [ ]

   Male [ ]

2. Age

   Below 25 years [ ]

   25 - 40 years [ ]

   Above 40 years [ ]

3. What is your marital status?

   Single [ ]

   Widowed [ ]

   Divorced [ ]

   Married [ ]

   Separated [ ]

4. What is your occupation?

   .....

5. What is the highest level of education you have attained?

   .....

   .....

   .....

SECTION B: RESPONDENT'S HISTORY AT THE HEALTH CENTRE

6. How long have you been working at this health centre? (state years/months)

.....

.....

.....

7. Are you aware of any health reforms in the health sector?

Yes [ ]

No [ ]

8. If yes, which reforms do you know?

Budgetary reform .....

User fee introduction.....

Decentralization of responsibility.....

Others (specify).....

9. Explain about the introduction of user fees.

.....

.....

SECTION C: VIEWS ON THE STATUS OF HEALTH SERVICE DELIVERY SYSTEM

10. What type of clients mostly visits the clinic to seek medical attention?

(a) Men below 65 years

(b) Women seeking medical attention or maternal care

(c) Mothers bringing the under five children

(d) Others specify.....

11. As a health official, in your opinion what do you think has been the impact of user fees at the health centre on access to quality health services?

    (a) Availability of drugs

    (b) Improvement in specialist treatment

    (c) Increase in the number of medical staff

    (d) Others specify.....

12. Elaborate your answer to the above question.....

    .....

    .....

    .....

13. What do you think should be done about user fees and what could be the alternative thing to be done?

    .....

    .....

    .....

    .....

14. Do you think the health centres/clinics are now able to adequately provide for the health services to the people after the introduction of user fees?

    Yes [ ]

    No [ ]

15. Explain on the answer you have given above in question

    .....

    .....

    .....

    .....

    .....

16. What do you think is the impact of user fees on people's accessibility to health services like specialist treatment, drugs etc?

.....

.....

.....

17. Has there been any change in terms of availability of drugs and specialist treatment since the year 1994?

Yes

No

18. Elaborate your answer.

.....

.....

.....

19. For those who are exempted from paying user fees, how many have sort for maternal child care in the last six months?

.....

.....

.....

20. For those who are not exempted, how many have sort for maternal child care in the last six months?

.....

.....

.....

.....

21. In interaction with patients, what kind of reaction comes from patients about user fees?

.....

.....

22. In your opinion, has there been an increase or a decrease in the number of people visiting the clinic after the introduction of user fees? Elaborate your answer.

.....

.....

.....

.....

APPENDIX 3-QUESTIONNAIRE FOR OPINION LEADERS

Respondent

1. Name of Interviewee (Optional) .....
2. Date of Interview .....
3. District .....
4. Constituency .....
5. Name of Health Centre .....
6. Sex of Interviewee .....

A. COMMUNITY LEADERS' PARTICIPATION

1. What organization do you belong to and what position do you hold?

   .....

   .....

2. For how long have been in leadership?

   .....

   .....

3. What do you understand by user fees?

   .....

   .....

4. When were the user fees introduced?

   .....

   .....

   .....

5. In your opinion, what improvement has been brought as a result of the introduction of user fees?

   (a) Availability of drugs [ ]

   (b) Specialist treatment [ ]

   (c) Material child care [ ]

   (d) Medical staff [ ]

   (e) Others specify [ ]

6. Generally, what do you think are benefits of user fees?

.....

.....

7. Do you go or take your children/dependants to the health centre when you or your children/dependants get sick?

   (i) Yes

   (ii) No

8. If the answer to 7 is "Yes", how many times;

   (a) Before the user fees were introduced.

      (a) Always

      (b) Many times

      (c) Occasionally

      (d) Very few times

   (b) After the user fees were introduced.

      (a) Always

      (b) Many times

      (c) Occasionally

      (d) Very few times

9. How would you rate the quality of services you have been receiving from the centre?

   (i) Very poor

   (ii) Poor

   (iii) Average

   (iv) Good

   (v) Very Good

   (vi) I do not know

10. Do you think fees have affected people with low income in accessing quality health services?

    (i) Yes

    (ii) No

11. Elaborate your answer.

.....

.....

.....

12. Has there been an increment or a reduction in the number of those seeking medical attention after the introduction of user fees? Elaborate your answer.

.....

.....

.....

13. Do you know how user fees for your health centre are determined?

(i) Yes

(ii) No

14. If the answer to question 14 above is "Yes" could you briefly describe the process?

.....

.....

15. What role if at all any, do you play in determining user fees?

.....

.....

16. How does the community determine the people who qualify to fall under the "exemption scheme" for the poor?

.....

.....

17. User fees, as part of the health reforms require changing consumer attitudes, what role do you play in ensuring the community is sensitized in understanding the merits and demerits of user fees?

.....

.....

18. In your interaction with people, what are their reactions towards user fees?

(a) Very positive

(b) Positive

(c) Average

(d) Not positive

19. Elaborate your answer to question 16.

.....

.....

20. How do you rate your success in terms of making people appreciate the benefits of user fees?

(a) Very unsuccessful

(b) Unsuccessful

(c) Average success

(d) Very successful

(e) I don't know

21. What do you think are the main factors that could have contributed towards the community to appreciate the benefits of user fees?

.....

.....

22. What factors would you identify to be the major bottlenecks/constraints against the introduction of user fees?

.....

.....

23. What suggestions can you advance for improving peoples' access to quality health services with or without user fees?

.....

.....

24. How could the concept of user fees be appreciated?

.....

.....

25. Should the Government abolish the user fees for all or only for certain categories of people? Give reasons for your answer.

.....

.....

.....

26. What do you think are the effects of user fees?

.....

.....

27. Do you go or take your children/dependants to alternative health providers in order to seek medical attention?

(a) Yes

(b) No

28. If Yes to question 27, what are your views about alternative health providers?

.....

.....

.....

INTERVIEW GUIDE FOR THE NEIGHBOURHOOD HEALTH COMMITTEE CHAIRPERSON

1. Introduction of the committee at the clinic.
2. Knowledge about user fees.
3. Introduction of user fees at the clinic.
4. People's response towards the introduction of user fees.
5. Whether as leaders they support user fees and take their children to the clinic.
6. Views about people's access to health services before and after the introduction of user fees.
7. People's ability to pay for their health services.
8. Exemptions and identification of the vulnerable persons.
9. Challenges and prospects for the committees.
10. Community participation and integration in the health system.
11. Intentions to improve the health delivery services.
12. Determination of users fees at the centre.
13. Other community contributions towards the operations of the health centre apart from user fees.
14. Functions of the committee and its composition.
15. Relationship between the health centre and the committee.
16. The role other organizations like churches, schools, NGOs, Political parties etc in health issues affecting the clinic and the community.