

**THE COST-SHARING POLICY AND HEALTH SERVICE DELIVERY IN
LUSAKA'S SHANTY COMPOUNDS: A CASE STUDY OF
CHAINDA AND KALIKILIKI (1992 - 2005)**

BY

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Requirements of the Degree of Master of Public Administration (MPA)**

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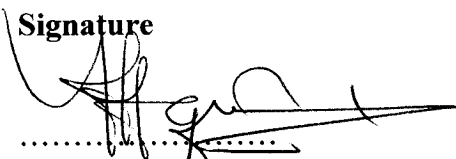
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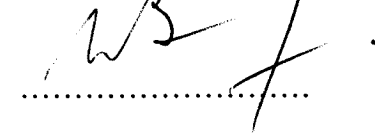
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ABSTRACT

This study aimed at assessing the effects of the policy of cost-sharing on the utilization of health care services in the particular localities of Chainda and Kalikiliki shanty compounds of Lusaka Urban District from 1992 to 2005. More specifically, it determined the extent to which the households used the In and Out-Patient Services, and the reasons for utilization and non utilization of health services. A comparison of the extent to which the findings of the study relate to the national situation was also done.

A purposeful systematic sample of 100 households was drawn from Chainda and Kalikiliki shanty compounds which were selected as the study population on the basis of low income, thereby representing the low income shanty compounds in Lusaka Urban. The heads of the households were interviewed using a structured questionnaire.

The results presented in this study established that the general impression regarding the health service utilization levels, the quality and quantity of health services in the Chainda and Kalikiliki shanty compounds is of a declining trend especially in terms of attendance. The findings also reveal that there has been a distinct deterioration in the quality of the services provided at public health facilities which has been associated with the introduction of user fees. The low income households in the shanty compounds could not afford to contribute to their health care services and thus, defeating the purpose of the Primary Health Care (PHC) as the services were not only unavailable, but also inaccessible.

The study found that utilization of health care services was influenced by a number of factors namely, fees charged, perceived quality of care, availability of alternative providers, income of the local population, private costs such as transport, and the availability of drugs.

The study points to the proposal that, as a way forward, user fees should be charged according to different economic levels in the locality. The study also proposes improvement in the supply of drugs, medical and surgical items in all public health facilities regardless of its level and put in place monitoring mechanisms. Furthermore, it is proposed that other means should be found of subsidising medical and surgical supplies to health facilities, as well as partnering with some private business agencies or individuals who are economically sound. Finally, extensive meetings should be held between the government and its collaborating partners to come up with other sources for financing health services.

This research work is dedicated to my only daughter Cecilia Sungata who gave me the moral support and encouragement and without whose love, patience and prayer, my studies would not have been possible.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BI	Bamako Initiative
CSO	Central Statistical Office
DANIDA	Danish International Development Agency
HIV	Human Immunodeficiency Virus
H/H(h/h)	Household
JICA	Japan International Cooperation Agency
LCMS	Living Conditions Monitoring Survey
LDHMB	Lusaka District Health Management Board
MMD	Movement for Multi-party Democracy
MOCDSS	Ministry of Community Development and Social Services
MOFED	Ministry of Finance and Economic Development (now Ministry of Finance and National Planning)
MOH	Ministry of Health
NHPS	National Health Policies Strategies
PHC	Primary Health Care
PSRP	Public Sector Reform Program
SAP	Structural Adjustment Programme
SPSS	Statistical Package for the Social Sciences
SWAP	Sector Wide Approach of Planning
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTH	University Teaching Hospital

CHAPTER ONE

INTRODUCTION

BACKGROUND

Beginning from the early 1970s, the health sector experienced a sustained decline in the quality of services accompanied by serious deterioration in health indicators. For instance, under-five mortality rate rose from 150 deaths per 1000 births in 1985 to 202 deaths per 1000 births in 1992. Also, between 1981 and 1992, hospital admissions for tuberculosis (TB) rose nearly three-fold (6, 744 to 18, 647) and reported deaths from TB rose from 680 to 3, 561 (over fivefold). Another significant trend was that in 1990, Zambia had achieved universal child immunization with 80 percent of its children having been fully immunized, but by 1992, the coverage had fallen to about 20 percent (National Health Policies and Strategies Act, 1993).

Following the election of the Movement for Multiparty Democracy (MMD) into office in 1991, the Ministry of Health embarked on a wide ranging assessment and mapping of the future of the health sector. The assessment included a review of the role of the government as the main provider and financier of health care in the country, the role of the non-governmental/private health sector and the individual in the health care system. It also included an assessment of the resources required to arrest the decline in Zambia's health indicators (National Health Policies and Strategies Act, 1993).

The assessment had shown that there existed a gap between the increasingly severe health problems that were being faced by the population and the limited resources available to the health system to respond to them. Limited resources included manpower, finances and infrastructure. Other factors included the centralised system of management and the provision of health services as separate packages instead of integrated service delivery. Given the limited resources, government felt that it could no longer afford to continue financing the health

services alone without seeking assistance from the private sector, individuals and other stakeholders (National Health Policies and Strategies Act, 1993).

In order to address the funding limitation mentioned above, government developed a Health Reform Policy whose implementation started in 1992 under the framework of the Sector Wide Approach of Planning (SWAP), which takes a holistic development view of the sector. In the SWAP, resources from government and other stakeholders are pooled so as to ensure efficient utilisation of resources. The mission of the health sector is to significantly increase life expectancy in Zambia by creating environments and encourage life styles that support health. The financing of the basic health care package is a priority to try to reduce both morbidity and mortality rates and contribute to poverty reduction (MOFNP, 2002). The vision of the health reforms in Zambia is to *“provide equity of access to cost-effective, quality health care as close to the family as possible”* (CBOH, 2001: 75).

The main thrust of the Health Reform Policy was better management and improvement in quality and quantity of health care service delivery. A key provision in the new Health Reform Policy was that *“every able-bodied Zambian with an income should contribute to the cost of his or her health”* (National Health Policies and Strategies, 1991: 42). To achieve this, financing mechanisms in the health sector were reviewed. Cost sharing was introduced aimed at: 1) increasing community partnership in health care service delivery, 2) creating greater accountability of health care providers to the community and, 3) improving quality of care through raising extra revenue at the local level. The concept of cost sharing involved contribution by patients to the costs of delivering health care services through user fees and prepayment schemes (National Health Policies and Strategies, 1991).

Cost-sharing and not full cost recovery represents an opportunity for Health Institutions to tap some community resources that could complement low public

funding. Increased community partnership in planning, management and delivery of health care services is a cornerstone of the Cost-Sharing Policy. The ultimate benefit of cost sharing, it was envisaged at inception, would be the improvement in health care services. Therefore, in order to facilitate smooth implementation, the Government of the Republic of Zambia developed a legal framework for cost sharing through the 1985 Health Services Act (National Health Policies and Strategies, 1991).

As its implementation proceeded, the Prepayment Scheme also allowed for payment in-kind and seasonal payments especially in rural areas. In-kind payment involved paying agricultural products, labour and any other tangible items. Seasonal payments involved paying farm produce that are readily available in a particular season (National Health Policies and Strategies, 1991).

However, the key component of the Health Reform Policy is that all people should make a contribution for good quality health care. It requires everyone in Zambia with an income to contribute towards maintenance of his or her health. It requires people's participation in improving their quality of life and gaining power to master their affairs for health improvements. Government envisaged that, by fully participating in the improvement of their health through cost-sharing, individuals, families and communities would become self-reliant (National Health Policies and Strategies, 1991). Therefore, in the health sector, cost-sharing meant that the beneficiaries of public health services, who previously received almost free medical care, would henceforth contribute minimally to the financing of health care service delivery. Thus the new policy denied beneficiaries their assumed dependency status.

The key objectives in the overall health reform process in Zambia include both equity and sustainability in health financing. In the Ministry of Health (1991: 58), the National Health Policies and Strategies (NHPS) state that “...*the challenge for health systems is to establish sustainable financing systems that will consider*

equity as well as sufficient beneficiary involvement". Recent versions of the Strategic Plan refer to a specific vision for health financing reform: *"to mobilize resources through sufficient and sustainable means, and to ensure efficient use of those resources in order to promote equity of access to cost-effective, quality health care as close to the family as possible"* (MoH, 1991:63). "Equity of access" also forms part of the overall reform vision and within the NHPS, there are references to the need to achieve "equity of health opportunities". Equity in health has many dimensions, such as equity in distribution, access and need. Within health sector reform literature, the concept of equity is often based on the notion of need. This implies that the distributions of systems' resources should be guided not only by the criteria of equal distribution but by consideration of resources to need.

Therefore, cost sharing aims at mobilizing resources to supplement government contributions so as to improve the quality of health care services. It was expected that the financial burden of healthcare would be shared with the beneficiaries to enhance government's financial capacity and to improve the quality of health care services. Cost sharing in health reforms was also expected to create incentives to encourage patients to use preventive and primary health care (PHC) services and discourage the use of more costly hospital services for common illness. Cost sharing also aimed to encourage people to become more responsible for their own health care by sharing in the cost of services they received. This means that consumers are not charged for unused services and they could supplement unavailable services by using the alternatives. In other words, cost sharing increases the public's appreciation of health care services and prevents overuse (Quick and Musau, 1994).

Health Reforms have been in place since their inception in 1992. It was assumed that every able-bodied Zambian should contribute to the improvement of their health through cost sharing regardless of their ability to pay user fees.

STATEMENT OF THE PROBLEM

Striving for equity in health care financing is a policy goal that is explicitly enshrined in Zambia's health-care financing policy. The health financing reforms with cost sharing policy as a cornerstone was initiated in 1992 introducing out of pocket charges for users of health care services at all public facilities (Ministry of Health, 1993). Previously, health care services were free at the point of use. These charges, referred to as user fees, were advocated as an additional source of revenue for a health sector that was undergoing severe economic difficulties. Thus, patients are required to contribute directly to the cost of providing health care services. The draft financing policy of 1998 and the National Strategic Plans of 1995-1999 and 2001–2005 recognizes the widespread poverty and income differentials that exist within the Zambian society (Ministry of Health, 1998; Ministry of Health, 1995; and Ministry of Health, 2001). In the National Strategic Plan of 2001–2005, the government has articulated a national health care exemption policy to address equity and public health concerns related to access to health care.

However, ensuring equity in financing is more challenging in a resource-constrained health system like Zambia's, which relies heavily on private revenues such as donors. Public spending on health care in Zambia accounts for 33% of the total health sector resource envelope (Ministry of Health, 2006). With such low levels of expenditure in the face of escalating national health needs, local user fee has become an important source of financing, but achieving equity with regard to access to services remains a challenge (Gottret and Schieber, 2006; Hsiao and Liu, 2001).

Evidence shows that between 1993 and 2005 little success was achieved with regard to improving access to health care services by all. For example, evidence from the Zambia Demographic and Health Survey (DHS 2001/2002), gathered through a nationally representative household (H/H/hh) survey, indicates that 22% of urban and 30% of rural patients were turned away from health facilities

because they could not pay for services upfront. Other studies based on household surveys (Diop et al, 1998; Hojortseberg, 2003) offer further evidence that a significant proportion of the poor population cannot seek care at public health facilities when they fall sick, partly on account of their inability to pay user fees.

However, it remains an empirical question as to exactly how the introduction of cost sharing policy has impacted on utilisation of health care services and health equity. Low income households are facing several other barriers to seeking health care services, such as traveling long distances to facilities, poor transportation means and poor quality of care. Although a number of reviews have been undertaken, it has still remained unclear how the Cost-Sharing Policy has affected the health of the low income people especially in an urban setup. Therefore, this study aimed at examining the factors that influence low income groups to participate in delivering health care services in an urban setting. The study also endeavoured to investigate to what extent the national findings are replicated at the local level of Chainda and Kalikiliki shanty compounds in the City of Lusaka.

STUDY OBJECTIVES

Main Objective

To assess the effect of the policy of cost-sharing on the utilization of health services in the particular localities of Chainda and Kalikiliki shanty compounds of the City of Lusaka from 1992 to 2005.

Specific Objectives

To determine the extent to which the households used the In and Out-Patient Services.

To determine reasons for utilization or non utilization of health care services.

To compare the extent to which the findings relate to the national situation.

CONCEPTUAL FRAMEWORK

User fees refer to the payment of out-of-pocket charges at the time of use of health care regardless of the individual's income in addition to those they make through taxes. The aim of user fees is to inculcate in the people a sense of partnership and ownership in the provision of health services.

Nolan and Turban (1995) identified two broad models of user fee systems that African countries have adopted. There is the standard model and the Bamako Initiative (BI) model. The standard model assumes that fees not only produce resources but also offer efficiency and equity benefits. Efficiency benefits result from the introduction of price signals, which offer patients incentives for using referral system appropriately, and facilitate the reallocation of resources to more cost effective primary health care. The equity benefits results from the use of resources in ways that benefit the poorest (such as improvements in coverage and quality of primary-level care), and from the use of exemptions or differential charges within the systems to protect the poor from their full burden.

In contrast, the BI model emphasizes that revenues should be raised and controlled at the primary level through community-based activities that are national in scope. The BI model sees community participation in management as the critical mechanism for ensuring that revenues are used in ways that address the persistent quality weakness of primary care, and that the health system is accountable to the users of health care services. The community determines the financing mechanism that is adopted, which might be a user fee system, prepayment, some form of local taxes or out-of pocket payment.

Out-of-pocket expenditure is defined as *"any direct outlay, including gratuities or in-kind contributions that households make for services and goods from health practitioners, pharmacists, medical supply vendors and others"* (Gottret and Schieber, 2006: 37). Out-of-pocket expending consists of official fees charged by service providers. They also include user charges for publicly provided services

and consumables such as drugs and medical supplies or under-the-table payments as a gift for services (Preker and Langenbrunner, 2005).

The Prepayment Scheme is a type of social financing arrangement whereby people spread the risk and cost of medical care by pooling resources through prepayments to the facilities. Prepayment is voluntary. There are two types of prepayment schemes, namely, Pre-Purchase Discount Cards and Pre-Payment (Insurance) Scheme. The Pre-Purchase Discount Cards is a type of scheme which involves a discount card that enables the individual to prepay for health care. The number of visits is dependent on the number of coupons on the card. The card has no expiry date and can be shared so that benefits can be mutually enjoyed by non-paying family members and friends (National Health Care Financing Policy, 2004).

Pre-payment Insurance Schemes on the other hand, require individuals/households to pay a premium to a health centre on regular basis during the period of cover, thus allowing for advance purchase or purchase on an installment basis. The scheme offers unlimited access to medical care services for all prepaying individuals. Prepayment relieves households of uncertainty and ensures compensation should a loss occur. Prepayment breaks the link between expected health expenditures and ability to pay. It is a critical mechanism for attaining equity objectives between the low and high income households (National Health Care Financing Policy, 2004).

The present study attempted to identify and analyse key words such as cost-sharing (which includes direct and indirect costs and payments), low income and shanty compound. The underlying assumption is that cost-sharing will make available additional resources for health services and that participation by the individuals and families will improve commitment, thereby successfully contribute to the quality, quantity and accessibility of health care service delivery.

Furthermore, it is assumed that cost-sharing will improve utilization of health care services. Cost-sharing should be understood in the context of buying health services (at a subsidized price) by the low income group every time the need arose. Cost-sharing should also be understood in terms of paying an agreed amount of money for health care services while the remaining amount is paid by another person/party. It is only upon the payment of the agreed amount of money that the patient can access the needed health care services.

Direct and indirect costs and payments are incurred by households in their use of health care services. Gottret and Schieber (2006), referred to direct payments as user payments which are directly linked with health care seeking whereas indirect costs are not connected with the act of obtaining health care. Direct payments should be understood to include opportunity costs of the individual's and household's time in lost wages, work at home and studying; transport costs to and from the health care provider; and costs that the patient and accompanying relatives or friends incur for food and lodging while seeking and obtaining care. Others include the purchase of drugs and other medical supplies made in connection with the medical problem for which health care services was sought; and the user fees charged by the provider which are either retained by the provider or are forwarded to the government treasury. Furthermore, indirect costs should also be understood to mean payments that are made irrespective of people's actual use of health services. These include taxes that individuals and households pay; contributions made by people to mandatory or voluntary health insurance and other payment schemes.

Low income is understood in the context of an income that is below an agreed amount of money, goods or services for a basic food basket per unit of time for a family of a number of people, referred to as the poverty line. This means that low income groups should reflect living below the poverty line.

Shanty compound is understood in the context of an area that is unplanned and not serviced by government. It is an area where houses are generally set very close together, where the standard of construction is very poor and which suffers from inadequate transport facilities. There is high unemployment level with increased morbidity and mortality rates especially among the under five children. The study should be understood in the context of low income people staying in shanty compounds who are living below the poverty datum line, a situation which makes it difficult for them to buy or pay for health care services at the expense of food.

LITERATURE REVIEW

National policymakers cite raising revenues as their main objective for introducing user fees. Subsidiary objectives stress that revenues are needed to improve services, for example, by improving drug availability and the general quality of health care and extending coverage (Nolan and Turbat, 1995).

Although never explicitly identified as an objective of user fees, the desire to raise revenue and improve services can presumably be related to a concern to enhance the sustainability of health care service delivery. Financial sustainability was defined by La Ford (1995) as generating sufficient reliable resources to enable continued and improved provision of health care for a growing population. This is the capacity of the health care services to be rendered effectively over time with minimum of external inputs. La Ford further explained that in order to achieve sustainability of the health care service delivery, capacities are required to do the following:-

- (i) Secure sufficient resources to enable improvements in the effectiveness of health care;
- (ii) Use resources effectively and efficiently to meet health needs;
- (iii) Perform these functions on a continuous basis; and
- (iv) Perform these functions with minimum inputs.

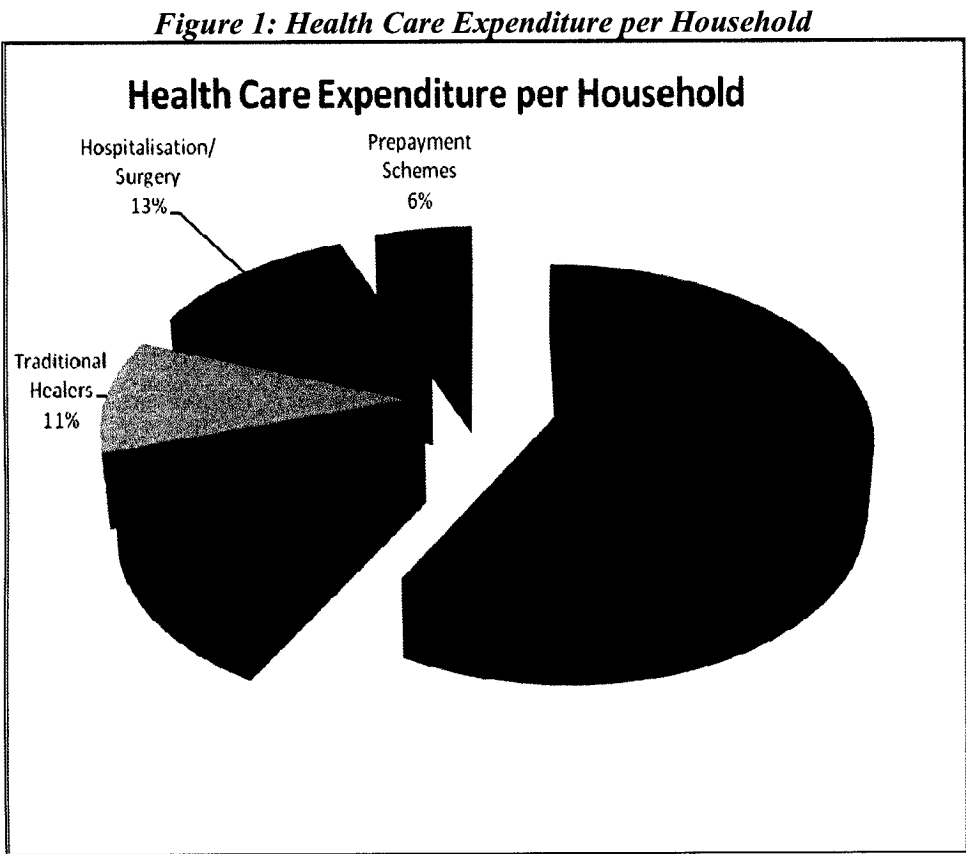
In other words, generating revenues through some sort of financing mechanism, especially user fees, is insufficient by itself to ensure sustainability and improvement in quality and equity in the provision of health care service delivery.

Shaw and Griffin (1995) suggested that when revenues from user fees are used to improve the quality of services, it generates efficiency and equity gains through their impact on utilization. However, Singh (2003) had a different view when he asserted that the application of user fees is seen to price the poor out of the market with potentially dreadful consequences for their health status than the relatively better off. He argues that introducing fees for a service increases the price of health care faced by households. He concluded that in order to maintain levels of utilization of health care in spite of higher fees for health care services, the share of household income allocation to health care must increase. As a consequence, a reduction in consumption of other commodities occurs. According to Singh, for the poorer households where health expenditure may already be a significant proportion of consumption expenditure, any additional layouts to health care services at the cost of other basic consumption needs may not be viable. Accordingly, such households may reduce demand for utilization of the particular health care service, which may lead to increased morbidity and mortality among that category of citizens. He concluded that introducing fees for a service increases prices faced by households. An increase in price causes households to reduce demand or utilization of health care services. The increase in the price of health care services caused by user fees is much higher for the low income group than the other groups.

By concluding that user fees increase prices faced by households thereby reducing demand or utilization of a particular service, Singh appropriately took into consideration the low in-come group in society. The poor H/Hs, who are already spending a significant proportion of their meager income on health care services, may be unable to spend any additional cost brought about by user fees. This

finding was significant to the study because it aims to establish whether Sigh’s conception on the issue is supported by the situation in the research area.

Data from the Living Conditions Monitoring Survey (LCMS) in Seshamani et al (2002) revealed that the largest single expenditure item on health in households was drugs. This is in spite of no official fee for drugs in government facilities. Figure 1 below shows the total health care expenditure per household divided into expense categories.



Source: Zambia’s Health Reforms Selected Papers 1995 – 2000 pg 70

An average of 58 percent of household health care related expenditures was on medicines accounting for the largest expenditure item. The second largest expenditure was on hospitalization and surgery, which amounted to a share of 13

percent, while 12 percent were spent on hospital fees. Almost as much, that is 11 percent was spent on traditional healers. Finally, only 6 percent was spent on pre-payment schemes.

The data above confirms that households are spending large amounts of their income on drugs alone. Even though drugs do not have an official fee, they are the most expensive item of health care services. This was significant to this study as it showed the proportion of the cost of drugs to other services that are faced by the low in-come group in the shanty compounds of the City of Lusaka. However, the authors did not take into consideration whether the high expenses on drugs could have contributed to the rate of accessibility to health care services of the low income households in urban areas. To what extent this situation applied to Chainda and Kalikiliki was a point of concern to the present study.

Gilson (2000) revealed that by introducing a culture of paying for services, cost sharing has promoted a strong concern for the quality of health care among the population of South Africa and Zambia, and this could have provided a foundation for demanding greater accountability from the health system. This is reflected by the need by the people in these two countries, to get drugs from the health facilities after paying instead of a prescription. Moreover, the people did not expect to be told to buy other health items such as gloves, needles and syringes after paying user fees at health facilities. The strong concern for quality of health care that had developed among the population in the study area of South Africa and Zambia, thereby demanding greater accountability from the health system was an achievement by cost sharing as a strategy. Creating greater accountability of health care providers to the community was one of the three aims of cost-sharing that was aimed at providing quality, quantity and accessibility of health care service delivery. However, the non availability of drugs and other essential health care items such as gloves, needles and syringes, could have prevented the attainment of the main objective of cost sharing as a financing mechanism. This was relevant to this study as the poor quality of health

care services could have contributed to the rate of accessibility especially by the poor households in shanty compounds in the City of Lusaka. This study therefore, sought to establish whether the poor quality of health care services contributed to the rate of accessibility of the low income group of Chainda and Kalikiliki.

Various studies conducted by the World Bank (1994), Daura et al (1998) and Lake et al (2000), have revealed that the introduction of cost-sharing prevented a large proportion of poor people from gaining access to health care services. Poor people did not seek health care services because they could not afford to pay user fees. This resulted in a reduction in the number of people accessing health care services; consequently, low revenues were collected at local level. Low revenue meant that funds required to improve the quality of health care services were insufficient.

Study findings (World Bank, 1994; Daura et al, 1998 and Lake et al, 2000) have also shown that health care services are not affordable because in addition to user fees and prepayment schemes, the cost of a number of other items has to be borne by the patient. For example, patients have to pay registration fee, consultation fee, laboratory and other investigation charges, costs for non-available materials such as gloves, needles and syringes and drugs prescribed. Buying drugs from commercial pharmacies could be expensive especially for poor households. Transport charges for people living in urban areas are an additional cost. Transport charges could have been affordable had the health care services been free.

In describing user fees as a financing mechanism, Arhin-Tenkorang (2000) concluded that user fees increased the financial barriers disproportionately faced by the poor when seeking health care services. According to Arhin-Tenkorang, user fees have placed an impossible financial burden on low in-come households. He stated that balancing households' expenditures on health against that of food,

education, clothing and transport is a formidable task, not only to the poor but to everybody. However, the task is more formidable by the poor than the other categories of households. There is a reduction in the consumption of other household goods through the diversion of resources. Arhin-Tenkorang suggests that countries that have introduced user fees as a health sector financing strategy, do not suggest it to be an efficient method of financing.

In his conclusion, Arhin-Tenkorang took into consideration the aspect of the low in-come households to for-go consumption of other essential needs such as food, education, clothing and transport in order to consume health care services. This information was useful to this study because it gives a hint on the possibilities of the impact of user fees on the study area. If user fees act as a financial barrier for low income households, then as a financing mechanism, it could be an inefficient strategy for raising extra revenue especially when dealing with the poor households.

Arhin-Tenkorang further observed that when the government of Ghana introduced user fees and prepayment schemes, an exemption policy was introduced that was aimed at protecting equity of access to the health care service delivery of the low income people. The introduction of the exemption policy did not improve much in equity of access of health care services of the poor people. He cited a survey of 'community perceptions' of the health reforms in Ghana in 1995 that had shown that there was a feeling of "us" the poor versus "them" the rich amongst those that had been denied access to the new health market. He, therefore, concluded that the policies had failed to protect the income and access to health care services of the poor people. Arhin-Tenkorang's observations and conclusion were significant to this study because we wished to establish whether the introduction of the exemption policy for Zambia's health reform programme had a similar effect or not on households of the City of Lusaka's shanty compounds and why?

Another study carried out in Ghana by Gilson and Thomas (2002) exposed the fact that, even after the introduction of prepayment schemes and exemption policy, there had been little improvement in the level of accessibility to health care services. Similarly, studies conducted by World Bank (1994), Lake et al (2000) and Singh (2003), revealed that there had been a decline in patient flows (of about 60 to 80 percent) at health centres following the introduction of user charges even after the initiation of prepayment schemes, in-kind payments and implementation of exemption policy. For instance, a study by Diop et al (2000), using the Living Conditions Monitoring Survey data, found that 24 percent of the people accessing health care services from public institutions were wrongly denied exemptions, while the socioeconomic distribution data showed that 46 percent of exemptions were granted to patients among 40 percent of lowest income groups and patients in the top 40 percent income categories received 31 percent of the exemptions.

Mwabu and Wangiombe (1995) are also of the same view when they described exemptions and in particular waivers that they were not systematically implemented and were not effective as a means of protecting vulnerable social groups and the poorest of the poor. They noted that even if official fees were exempted or waived, the poor and vulnerable still ended up paying for the drugs, transport, small charges (e.g. cards, materials) and bribes. They observed that the exemption scheme was poorly implemented partly because accountability mechanisms were not put in place and also because health service providers did not follow procedures that were often unclear to them. Therefore, they concluded that a lack of clear criteria and policy guidelines for identifying people who were eligible for waivers resulted in ad hoc decisions, without clear records or follow up.

Van der Geest et al (2000) argued that one of the objectives of introducing cost-sharing was to involve the users in the service and foster ownership. their study conducted in Senanga and Lusaka Districts of Western and Lusaka Provinces,

respectively, had shown that the people did not see user fees in the context of community involvement. To them user fees were a sign of disowning and excluding them from running health centres. This was more especially since the communities were not involved in the decision to introduce user fees. He concluded that the chances for community involvement “in its old form are now slimmer than 20 years ago” unless a ‘fee for service’ form of community involvement is introduced that promises good quality product of health care services. Involving communities in decision making in the service and to foster ownership through cost sharing was an important objective. However, communities have their own interpretation of cost sharing when they are not directly involved in deciding in matters that affect them especially financial issues. The findings of Van der Geest et al’s study on this issue were important to this study because they helped us to focus on the rate of participation in determining on the success or failure of the program. The extent, to which Chainda and Kalikiliki households were involved in deciding the introduction of user fees, helped in determining the reason for greater use or non use of the health care services.

On the issue of pre-payment facility, Preker and Carrin (2004), suggest that the primary determinant of households to prepay is their willingness to do so. Among others, economic factors influence households’ willingness to prepay. The economic perspective states that households’ willingness to prepay depends on their belief that by so doing, they will gain economically or in health care or both. This entails that the expected benefit has to be greater than the cost.

Preker and Carrin (2004) stated that user fees were a major contributing factor to high incidence of out-of-pocket payment by households at the time of illness because of the impossibility to make financial provisions for illness-related expenditures. They argued that this was the case because of the uncertainty about the timing of illness, the unpredictability of health care costs during illness and the low and irregular income of households. They, therefore, concluded that

besides having been largely unsuccessful in raising significant resources, user fees have contributed significantly to increasing the exposure of poor households to financial risks associated with illness. This situation could have been prevailing in the low income shanty compounds of Chainda and Kalikiliki.

The rationale for introducing health care charges and related exemption and waiver procedures in the public sector in Tanzania was to generate additional revenues, to improve the availability and quality of health care services, to strengthen the referral system and rationalize utilisation of health care services and improve equity and access to health care services (MOH, 1995). The report stated that the principle was that revenues were to be retained by, and used at the facility level on items directly related to improving the availability and quality of health care services. Revenues generated from user fees were also meant to supplement government budget allocations. However, the 2003 Health Public Expenditure Review indicated that the cost sharing had contributed relatively little to the sector resources envelope: no more than 2 percent of recurrent costs (MOH, 2003).

Studies by La ford (1995) and Nolan and Turbat (1995) suggested that revenue generation from user fee policies in public facilities would likely be inadequate to address the large and growing gap that was causing the quality shortfalls that exist in public health facilities in many African countries. Singh (2003) in his study, concluded that the predicted levels of resource mobilization were not realized and that, in fact, revenues raised from implementing user fees fell well short of estimates, being on average 7% of non-salary costs rather than the anticipated 15%. He observed that this had limited both the envisaged increase in utilization, through an improvement in the availability of drugs, as well as reallocation of resources, through exemption schemes to protect the poor.

To conclude, the literature review addressed a number of issues. First is that user fees as a financing mechanism increases the financial barriers faced by the poor when seeking health care services. Secondly, that even though other measures can be put in place in order to lessen the burden such as prepayment schemes and exemption policies, there was little improvement in equity of access to the health care service delivery. Thirdly, that user fees only increase prices faced by households especially the poor who spend a larger portion of their income on health care services generally and drugs in particular. Fourthly, that even though a strong concern for quality of health care among the population may be created, this does little in terms of accessibility to health care services.

The above scenario clearly showed that the aims of cost-sharing have not only been a failure in its attempt to improve the quality, quantity and accessibility to health care services, but have also worsened the health status of the low income group. In addition, user fees have even reduced further the economical status of the already poor people in society. This situation might not been any different from the study area, as the Chainda and Kalikiliki households could have been experiencing the same difficulties. It is for the above reasons that this study was undertaken to assess the impact of cost-sharing policy on the low income group.

SIGNIFICANCE OF THE STUDY

Cost-sharing was initially introduced without sufficient regard for the level of user-charges that the poor could afford. People living below the poverty line could only afford to pay a token charge. Various studies done by Daura et al (1998) and Lake et al (2000) revealed that even after the introduction of prepayment schemes, in-kind payment and exemption policy based on age and disease, there was still a reduction in the utilization of public health institutions. Seshamani et al (2002) found that in 1999 there were 15,589 beneficiaries of the official need-based exemption scheme, which represented only 0.16 percent of the overall population. In agreement, a study by Daura et al (1998) concluded that the poor sometimes do not receive care because they are unable to pay. This

clearly showed that even though mechanisms for protecting the poor from the financial barrier to health service access imposed by fees were put in place, they have generally proved to be ineffective, thereby rendering this study relevant.

METHODOLOGY

Chainda and Kalikiliki shanty compounds were selected as the study population on the basis of low income households, representing the low income shanty compounds in the City of Lusaka.

Sample Size and Sampling Design

The study selected a sample size of 100 households using the purposive systematic sampling design. This consisted of 50 households from Chainda and 50 households from Kalikiliki.

Using sketch maps for each of the compounds which have been conveniently demarcated into sections and zones, the researcher purposively and systematically selected houses for the research. Chainda and Kalikiliki compounds are demarcated into eight sections and zones respectively. The sample was purposefully selected because the study was looking for individuals who have sufficient knowledge on the topic of cost-sharing and this was systematically done for the purpose of objectivity, reliability and validity of data. Each section and zone comprises approximately 150 households. In each section and zone, 5 households were selected. In order to select the households the researcher started with purposively selecting one section/zone which acted as starting point for the study. Having arrived at the starting point, the researcher randomly selected the 5 households in each section and zone by picking the fifteenth (15th) household in every thirty (30). When a household was picked, the head was interviewed.

Instruments of Data Collection

Quantitative data was collected through the use of structured interviews with 100 heads of households which were personally administered by the researcher. This

was to ensure uniformity in the administration of the instruments and consequently, the reliability and validity of data collected.

Secondary data was derived from documents and reports from the Ministry of Health (MOH), Lusaka District Health Management Board (LDHMB), library, donors and partners including the United States Agency for International Development (USAID) and Danish International Development Agency (DANIDA). Secondary data was also collected from historical writings.

Data Analysis

The primary data was analysed using the Statistical Package for the Social Sciences (SPSS Version 11.0). Secondary data was analysed manually by the researcher. Microsoft Excel was used to create the figures.

STUDY LIMITATIONS

Every research is constrained by varying factors ranging from logistical to financial constraints. These constraints tend to inhibit the gathering of research data (Nkwi et al, 2001). In light of the above, this study was not exceptional; it might have encountered the following potential biases and limitations:-

- a). There was the general difficulty in penetrating the compounds due to lack of cooperation from some of the local leaders. Some community members refused to answer the questionnaire altogether and had to be replaced, while some could have given false answers.
- b). The researcher collected data alone. There could have been some biases arising from the researcher and her position as a common community member cannot be ruled out.
- c). There is a possibility that some of the secondary data used, might have been incomplete and inaccurate.

LAYOUT OF THE DISSERTATION

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CHAPTER TWO

THE CONTEXT OF URBAN SHANTY COMPOUNDS IN THE CITY OF LUSAKA

INTRODUCTION

This chapter gives a brief history of shanty compounds in Lusaka province and district. It also gives a brief socio-economic background of the City of Lusaka with an inclination to shanty compounds. This is to help readers understand clearly the locale of the study and the context of the shanty compounds of Lusaka.

GROWTH OF SHANTY COMPOUNDS IN ZAMBIA

Zambia with a land area of 752,614 square km and a population of just over 10 million, is a country on the Central African Plateau with an average altitude of 1,000 to 1,400 meters above sea level. Zambia is generally considered to be a Southern African country, because of its strong social and economic ties with the countries in the Southern African sub-continent rather than those in Central and Eastern Africa. The country lies between latitudes 100 and 180 south and 220 and 330 east. It is landlocked and shares borders with eight neighbouring countries, namely Angola, Democratic Republic of Congo, Tanzania, Malawi, Mozambique, Zimbabwe, Botswana and Namibia, (UNDP, 2001).

In 1963, 20 per cent of Zambia's population lived in urban. However, rapid and large scale urbanization has been taking place in Zambia since independence. The proportion of the population that lived in urban areas almost doubled during the 1965-80 period from 23 percent to 43 percent, making Zambia the second most urbanized country in Sub-Saharan Africa. In 1980, 78 percent of all urban dwellers were concentrated in ten large towns and cities along the Copperbelt (World Bank, 1984). The Copperbelt and Lusaka Provinces, with proportions of 92 percent and 82 percent respectively, are the two most urbanized provinces within the country (UNICEF, 1986). Since then, rapid urban population has continued to grow, (World Bank, 1993). However, as a third world country, one

quarter of Zambia's population live in urban shanty compounds. The JICA (2003) also affirms that the population of the City of Lusaka is concentrated in shanty compounds where approximately 1 million low income people live. Two major factors that have contributed to the rapid rate of urban growth are the rural-urban migration in search of employment opportunities and the high fertility rates within these areas.

The rapid urbanization during the past three decades has been accompanied by the growth of shanty compounds (squatter settlements) which make up to ten percent of the population in major towns such as the City of Lusaka. High population densities have exerted enormous pressure on available housing, health and other social services. Residents in shanty compounds often live in sub-standard housing units which lack basic services such as health facilities, water and sanitation (World Bank, 1993). Lack of access to social amenities such as quality water and sanitation services have had severe consequences on the health status of a significant proportion of the population. This has led to high morbidity and mortality from among others, diarrhoeal diseases and parasitic infections, which have been particularly critical in low income groups in shanty compounds (Government Republic of Zambia, 1990).

Due to the rapid population growth, provision of formal employment has been hindered. Employment in the formal sector has been declining since the mid 1970s which, in turn has led to the growth of the informal sector. The informal sector has been an important source of employment within urban areas, particularly for the poor in shanty compounds. This was confirmed by the 1986 Labour Force Survey which indicated that 64.5 percent of the total economically active labour force were engaged in informal sector activities, including petty trading and marketing of charcoal, fuel wood, beer, second-hand clothes and other commodities.

SOCIO-ECONOMIC CONTEXT OF ZAMBIA

In terms of socio-economic context, economic activities of the two shanty compounds can only be analyzed by first examining the broader performance of the Zambian economy. Economically in 1991, Zambia adopted an open, private sector-led economy which entailed minimum government control. The government adopted the Structural Adjustment Programme (SAP) in 1991 in order to bring macro-economic stability. In this case, the government put in place some economic measures that included liberalization of trade and prices, removal of subsidies, privatization of public sector enterprises, public sector reforms, a reduction in public spending and liberalization of market and price of agricultural produce (World Bank, 2000).

However, some of the economic measures instituted such as public sector reforms, reduction of public spending and privatization of public sector enterprises resulted in increased unemployment in the country. To exemplify this, the Public Sector Reform Programme (PSRP) led to the retrenchment of as many as 15, 000 workers by the end of 1998. Unemployment levels in urban areas rose from 16 percent in 1990 to 26 percent in 2000. Most of the workers were employed by the agricultural sector which accounted for 72 percent of the workers in that year. Furthermore, other sectors recorded declining levels of employment, (JICA, 2003). The mining sector that recorded a decline from 3 percent in 1990 to 1 percent in 2000 can exemplify this. Similarly, the World Bank (2000) reported that due to the collapse in economic performance of the country, many of the benefits of being in urban had been eroded with the majority of the population living below the poverty datum line. A Household Budget Survey which was conducted earlier on by the World Bank (1987) indicated that within urban areas, the average income of households in high income groups was about six times greater than that of households in low income group in shanty compounds. The survey further revealed that overall, the wealthiest five percent of Zambian households received over 30 percent of the total income, while the poorest 60 percent of households received 20 percent.

THE DEMOGRAPHIC STRUCTURE OF THE CITY OF LUSAKA

Lusaka is the capital and largest city of Zambia that is located in the south central part of the country. According to the 2000 census, the city has a population of 1, 084, 703. The City of Lusaka is in Lusaka Province, which is the central province of Zambia hence making it the most densely populated and tribally diverse region, (Williams, 1984).

The City of Lusaka has been the fastest growing city in the post independence period. This can be attributed to its role as the administrative center of a newly independent country whose leaders were keen to play a role in international affairs. As a result, the City of Lusaka had to provide facilities to hold international conferences, such as the summit for the heads of states of the Non-Aligned Movement held in the City in 1970, followed by the Commonwealth Heads of State summit in 1979. The City is also the financial and commercial center (Williams, 1984).

The City of Lusaka started as a railway siding in 1905, when the railway line that was constructed primarily to transport copper from Katanga Province in the present day Democratic Republic of Congo to the seaports of South Africa reached Lusaka. The original size of the City of Lusaka, which was under the jurisdiction of the Village Management Board which was established in 1913, was a narrow strip of land along the railway line. It was 5 km in length and 1.5 km wide with the railway line being the centre of the area of the jurisdiction of the Lusaka Village Management Board (Williams, 1984). The city has been extended to 360 km², while a recently completed integrated development plan proposes to extend the city boundary to bring the Lusaka International Airport and a substantial amount of rural land within the city boundary (Mulenga, 2003).

The rapid growth of the City began in 1931 when it was designated as the new capital administrative centre of Northern Rhodesia, as Zambia was then called. The City was centrally located on the main north-south axis of the railway line.

The Great Uhuru (Tanzam or Tazara) railway connects the City and Dar-es-Salaam. It is also the intersection of the main roads to the north and south, and east and west. The City is located at the junction of the Great North Road (to Tanzania) and the Great East Road (to Malawi). The City is also within easy reach of the Copperbelt, the country's economic heartland. In addition, the City had substantial underground water resources which could provide the city with adequate water throughout the year (Mulenga, 2003).

The census conducted for the City of Lusaka in 1931 gave a total population of 2,433. By 1946 the population of the City of Lusaka had risen to 18,909. The population was growing at an annual growth rate of 15 percent. The African population in the city grew most rapidly after 1948 after the passing of the African Housing Ordinance 1948 which granted Africans the right to reside in towns with their families. Before 1948 Africans were treated as temporary residents in urban areas. Short-term employment contracts and urban residence permits were granted to the African population since they were expected to return to their rural homes at the end of the employment contracts. The African women and their children were not allowed to accompany the husbands and fathers. However, in spite of restrictions placed on the residence of Africans in urban centres, an urbanized African population emerged. It is generally believed that Africans have always accounted for at least 80 percent of the population, while the European population had never exceeded 20 percent of the population (Wood et al, 1986).

In order to have a clear picture of how the population of the City of Lusaka has changed over the years, table 1 illustrates the population for the period 1963 to 2000. The table has also given the growth rates and proportions of the national and total urban population.

Table 1: Population of Lusaka 1963 – 2000

Year	Population	Annual Growth Rate	Percentage of National Population	Percentage of Total Urban Population	Percentage of Large Urban Areas
1963	123, 146	-	3.5	17.2	18
1969	262, 425	13.4	6.5	22.0	23.5
1974	421, 000	9.9	9.0	25.3	27.2
1980	535, 830	4.1	9.4	21.9	28.2
1990	769, 353	3.7	10.4	26.5	-
2000	1, 103, 413	4.0	10.7	-	-

Source: Understanding Slums: Case Studies for the Global Report on Human Settlements 2003.
A Case of Lusaka, Zambia (2003) pg 3

Table 1 clearly shows that the population of the city increased most dramatically after 1948. The statistics show that between 1963 and 1969 the population grew by over 13 percent and added nearly 140, 000 people to the population of the city. This resulted in the doubling of the city's population from 123, 146 in 1963 to 262, 425 in 1969. The population of the city also doubled between 1969 and 1980, from 262, 425 to 535, 830. However, the population growth rate reduced in the post 1980 period because of the slowdown in the expansion of employment mainly as a result of the reduction of the rural-urban migration.

According to Mulenga (2003), the slowdown in employment was as a result of the economic stagnation and decline that began in 1974 and continued up to the 1990s. The poor economic conditions lead to the decline of rural-urban migration which was one of the three main sources of population increase in the city. The other sources of population growth of the city were natural increase and the extension of the city boundaries. The people who migrated from the rural to urban areas in the 1960s and 1970s were predominantly young people who have

been able to sustain the city's higher population growth rate by natural population increase. This has resulted in a higher population growth rate in the City of Lusaka compared to the National growth rate. Natural population growth rate in Zambia was 3.0 percent per annum during 1969 to 1980 and 3.2 percent during 1980 to 1990 compared to 6.2 percent and 5.9 percent for the City of Lusaka during the same inter-censal periods. Consequently, high population growth rate in the City of Lusaka will continue due to three main factors. Firstly, there is high fertility rate among Zambian women which is at 6.7. Secondly, there is dominance of the young in the population with 46 percent of Zambian population being under 15 years. Thirdly, there is high proportion of reproductively active women. About 50 percent of all women are in the child bearing age of 15 – 49.

As the population of the City of Lusaka increased, so was the growth of shanty compounds. This resulted in thirty-two (32) regularized informal settlements (shanty compounds) in which over 70 percent of the city's population live, namely the following:-

Bauleni, Chainda, Chaisa, Chawama, Chazanga, Chibolya, Chikolokolo, Chipata, Chunga, Desai, Freedom, Garden, George, Jack, John Howard, John Laing, Kabanana, Kalikiliki, Kalingalinga, Kamanga, Kanyama, Kuku, Lunda, Mandevu, Marapodi, Mazyopa, Misisi, Mtendere, Ngombe, Nyerere/Cook, Paradise, and Soweto.

The population of the City of Lusaka is diverse and consists of people from all the ethnic groups found in Zambia. A small proportion of European and Asian origin is also found in the city. Most of the migrants to the city were from the Eastern Province, followed by Northern and Southern Provinces with about 36 to 39 percent, 13 percent and 12 percent respectively. Eastern Province dominated mainly because of the City having been the nearest urban centre as well as limited employment opportunities in Eastern Province. In terms of languages spoken in the City, Nyanja was the *lingua franca* in the 1960s and 1970s. However, Bemba

has taken ground in the City of Lusaka, probably due to new immigrants from the Copperbelt Province (Wood et al, 1986).

It is against the above historical background that the two shanty compounds in this study evolved. Both Chainda and Kalikiliki are situated 35 km and 27 km on the east of the Lusaka central business district, respectively. Chainda shanty compound has a population of 25, 000 people. The shanty compound has 25 percent of its adult residents unemployed. Kalikiliki has a population of 21, 000 people with 17 percent of the economically productive age group unemployed. Access to water and sanitation in both compounds are grossly inadequate. Majority of the people live in mud block homes with thatched or Zinc sheet roofs. The main economic activities in these shanty compounds include beer brewing, marketeering, salaula trading, and formal employment in government departments, district council and non-governmental organizations (Mulenga, 2003).

THE ECONOMY OF THE CITY OF LUSAKA

The City of Lusaka's economy has become more diversified with its physical expansion and population growth. The City has commercial farmers who provide higher order services which include financial and technical services, construction and manufacturing activities. Manufacturing activities include food processing enterprises such as milling, meat processing and production of essential commodities such as detergents and other domestic chemical products. The service sector is the largest employer of the city's labour force (Wood et al, 1986).

According to Wood et al (1986), services and administration have consistently accounted for most of the formal employment in the city. The authors suggest that even if the economy is more diversified than that of the country, it is weak. This is the case because most of the sectors are underdeveloped. For instance, basic manufacturing activities such as food processing and beverages, and leather goods dominate the manufacturing activities. The transport and communication as well as hotel and restaurant sectors are underdeveloped too. The probable

reason for the underdevelopment of the sectors mentioned above could be attributed to the internal orientation of the Zambian economy prior to the recent macro-economic reforms. The construction sector has tended to perform well during periods when the national economy has been buoyant and declined during the years of economic stagnation and decline.

According to Wood et al (1986), although the economy of the City of Lusaka can be said to be somewhat diversified than the national economy, just like the national economy, it only provides formal employment to a small proportion of its labour force. To exemplify this, the Integrated Development Plan for Lusaka put the number of people in formal employment in the city at 120, 233 or 35 percent of the labour force. The rest of the labour force (65 percent) earns its livelihood from informal economic activities, which predominantly consist of unregistered and unregulated small-scale non-agricultural activities ranging from petty trading to metal fabrication and wood processing. The bigger part of the informal economic activities is in trading. However, the Zambia: Lusaka Urban Sector Profile (2007) has estimated that 9 percent of the City's population is engaged in formal employment. The major reason for this is that the local economy has been drifting towards the private sector and self-employment since the liberalization of the economy in the early 1990s.

The households in Chainda and Kalikiliki shanty compounds have not been spared by the high unemployment rate which is closely associated with some of the negative impacts of SAP. Self-help employment, in these circumstances, has been the major source of income for the majority of households. The JICA (2003) affirms that 44.7 percent of people engaged in the informal sector were in retail business and 36.7 percent in farming, fishing and hunting business.

Profiles of the people in the compounds as compiled by the Lusaka City Council indicated that the majority of the people were engaged in the informal sector as opposed to the formal sector. JICA (2003) further stated that most of the people

in the shanty compounds survive on petty trading, selling charcoal, welding, beer brewing, carpentry, tailoring, crushing stones and other economic activities which are carried out on self-employment basis. A comparison between females and males revealed that the major economic activities for females were beer brewing, petty trading, tailoring, preparation and selling food and working as a maid whereas males were mainly involved in plumbing, welding, vehicle repair, bricklaying and carpentry. A smaller proportion of the populace living in the shanty compounds was engaged in the formal sector.

HOUSING IN THE CITY OF LUSAKA SHANTY COMPOUNDS

The African Housing Ordinance was passed in 1948 to stabilize the African urban population. Prior to this, the Zambian men who had migrated from the rural areas to work in the mines were not allowed permanent residence in urban areas. And as such, they were employed on contract basis so that they can go back to their villages to engage in farming activities. However, most of the workers did not go back to their rural homes. Therefore, the African Housing Ordinance allowed African workers in urban centres to live with their families. However, this worsened the shortage of housing for the African workers as their families joined them in the urban centres. Government then provided for self-help African Housing on the outskirts of the main urban centres. To this effect, the Private Locations Ordinance was passed which did not insist on the statutory building materials. Nonetheless, this was essential as most Africans were generally lowly paid and could not, therefore, afford to build houses that met the urban housing standards prescribed in the Town and Country Planning Act. As a result, the African workers built houses and pit latrines on the plots using cheaper unconventional building materials. Water was provided on communal basis rather than on individual plots (Mulenga, 2003).

However, housing crisis continued to rise leading to the growth of many unauthorized settlements on the farms located on the edge of the town boundary. Armor (1957), quoted by Mulenga (2003), reported that the number of persons

housed in unauthorised locations was 44 percent of the total Lusaka Urban African population. These shanty compounds were not provided with any municipal services. They lacked the essential social and physical infrastructure such as schools, health facilities as well as essential utilities such as individual water supply, electricity, access to roads and security services. Most of the houses in the unauthorised urban shanty compounds were built out of mud bricks for making walls, cardboard, tins and plastic materials and even grass for roofing. The unconventional building materials made the shanty compounds vulnerable to outbreaks of fire and collapsing in the event of floods. The biggest problems for low income groups of the shanty compounds were vulnerability to ill health, more especially because of lack of access to clean water and safe sanitation facilities. The quality of environmental conditions in the unauthorised shanty compounds also degenerated progressively with increased population. The situation was made worse by lack of garbage collection services and transport infrastructure and services. Lack of access to clean water and sewerage facilities has subjected residents of shanty compounds to the use of untreated water from shallow wells, and pit latrines. In some instances, open bush is used for disposal of human waste which pollute the environment, making shanty compounds extremely uncomfortable places to live. The residents in the shanty compounds are vulnerable to both respiratory diseases and diarrhea. Consequently, vulnerability to ill health has undermined the productivity of the residents of the shanty compounds.

According to Mulenga (2003) the productivity of the residents of shanty compounds is also grossly undermined by lack of adequate access to appropriate infrastructure and services. For instance, the shanty compounds do not have roads and adequate access to public services, schools and health facilities. The residents generally walk long distances to the official residential areas to have access to any of the essential infrastructure and services. Even though shanty compounds were considered hideout for ant-social and criminal activities, no law enforcement agencies were provided.

PREVALENCE OF POVERTY IN THE CITY OF LUSAKA

Many studies have been conducted to ascertain the prevalence and severity of poverty levels in Zambia in general and Lusaka in particular. For instance, the 1998 Living Conditions Monitoring Survey revealed that poverty has risen in Zambia to 83 percent from 69 percent of the population in 1996. Urban poverty has increased from an estimated 4 percent of the urban population in 1974 to 26 percent in 1991, 46 percent in 1996 and 56 percent in 1998. The urban poor in the City of Lusaka live in shanty compounds which do not have any public services. Although poverty in the city, like elsewhere, is complex and due to both personal and societal factors, lack of access to wage employment in the formal sector seems to be the major cause of poverty. The table below reflects the welfare status by employment sector of the heads of households.

Table 2: Welfare Status by Employment Sector of the Heads of Households
Poverty Levels

Employment Sector	Percentages of Poverty		
	Extremely Poor %	Moderately Poor %	Non Poor %
Formal	45	19	36
Informal	60	15	25
Unemployed	62	13	25
Inactive	61	13	26
Not Stated	64	14	22

Source: Understanding Slums: Case Studies for the Global Report on Human Settlements 2003. A Case of Lusaka, Zambia (2003) pg 10

From the table above, it can be noted that heads of households who were in formal employment headed the majority of households that were not poor. Similarly, the unemployed and those in informal sector headed most of the extremely poor households. The studies clearly indicated that households headed

by people working in the formal sector are less likely to be poor than those headed by the unemployed or those working in the informal sector. Therefore, since most of the people who live in the shanty compounds of the City of Lusaka work in the informal rather than the formal sector, large proportion of the households in Lusaka shanty compounds are certainly poor while only a few are likely to be non-poor (Central Statistical Office, 1999; LCMS Report, 1998).

LIVELIHOODS OF THE CITY OF LUSAKA SHANTY COMPOUND RESIDENTS

Mulenga (2003) stated that shanty compounds of the City of Lusaka have provided shelter to people in intermittent wage employment and those in informal sector since the 1940s. The majority of the people in these categories most likely tend to be unskilled or semi-skilled. Most of the residents in the shanty compounds of the city are therefore generally poor as they are not likely to earn high wages when in formal employment. Similarly, those in informal employment tend to be characterized by low capital input and low returns. He maintained that due to the decline in the availability of formal wage employment, the majority of the residents of the shanty compounds of the City of Lusaka work mainly in the informal sector. He further argued that those without any practical skills engaged in piecework and small-scale trading activities. Generally, women and young people are involved in trading at markets within the shanties and in the main city markets. According to Mulenga, the semi-skilled and skilled men with practical skills such as carpentry and metal fabrication earn a living by making household items such as furniture and other usable things for sale.

Mulenga (2003) explained that among the residents of the shanty compounds of the City of Lusaka is a small proportion of retired people who have decided to settle permanently in Lusaka. Such people are most likely to be the main retail traders in shanty compounds depending on the sectors they worked and the amount of terminal benefits they might have received. A few women and young people engage in anti-social and criminal activities such as stealing, selling drugs

and prostitution. Mulenga further stated that residents of shanty compounds were involved in a variety of livelihood activities which also changed according to seasons and overall economic conditions and individual circumstances.

Having stated the above, it becomes necessary to note that cost-sharing was initially introduced to address the funding limitation that was faced by health institutions in providing health care services. The government envisaged that through the contribution by patients to the cost of their health through user fees and pre-payment schemes, there would be improvement in the quality, quantity and accessibility of health care services. However, given the economic background of the country in general and the low income group in urban area of the City of Lusaka, especially the shanty compounds of Chainda and Kalikiliki, it became a great concern to this study to find out the gravity of cost-sharing in the study area.

CHAPTER THREE

COST-SHARING AND HEALTH CARE SERVICE DELIVERY

IN CHAINDA AND KALIKILIKI

INTRODUCTION

This chapter presents and interprets the findings of the study with regard to the effect of cost-sharing on health care service delivery for the residents of Chainda and Kalikiliki shanty compounds in the City of Lusaka. Each specific element is discussed with respect to the specific objectives that were formulated in order to assess the effect of the cost-sharing policy on health care service delivery in shanty compounds. The elements are household details (such as the size of the household, sex, age, nature of employment and levels of income of heads of households); health care facilities (with focus on the incidences of illness, sick household members who accessed health care services and the type of health facility used is made); utilization and/or non utilization of health care facilities are discussed; cost of health care services with particular attention to transport costs, ability of households to purchase prescribed drugs, medical and non-medical items; measures put in place by households to meet medical bills and their coping strategies; and comparison of the study findings with findings at the national level.

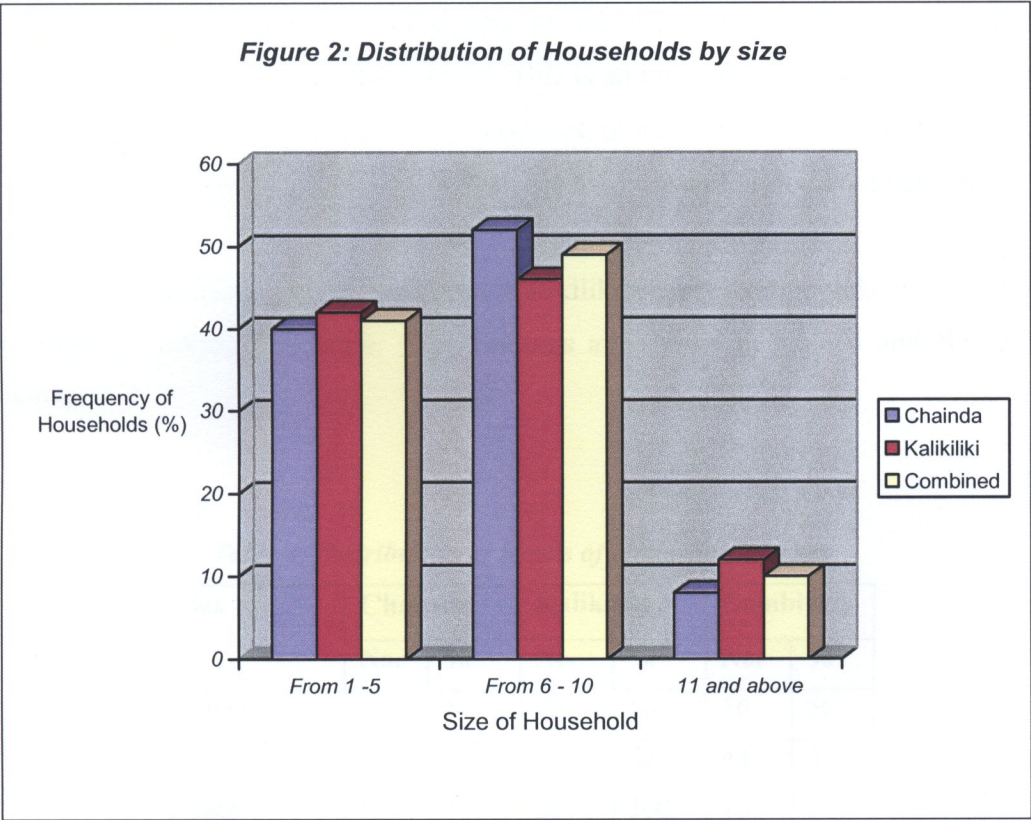
HOUSEHOLD DETAILS

The families of the 100 households that were interviewed varied in sizes as reflected in table 3 and figure 2 below:

Table 3: Distribution of Households by size

Household Size	Chainda		Kalikiliki		Combined	
	Number	Percent (%)	Number	Percent (%)	Number	Percent (%)
1 – 5	20	40	21	42	41	41
6 – 10	26	52	23	46	49	49
11 and above	4	8	6	12	10	10
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

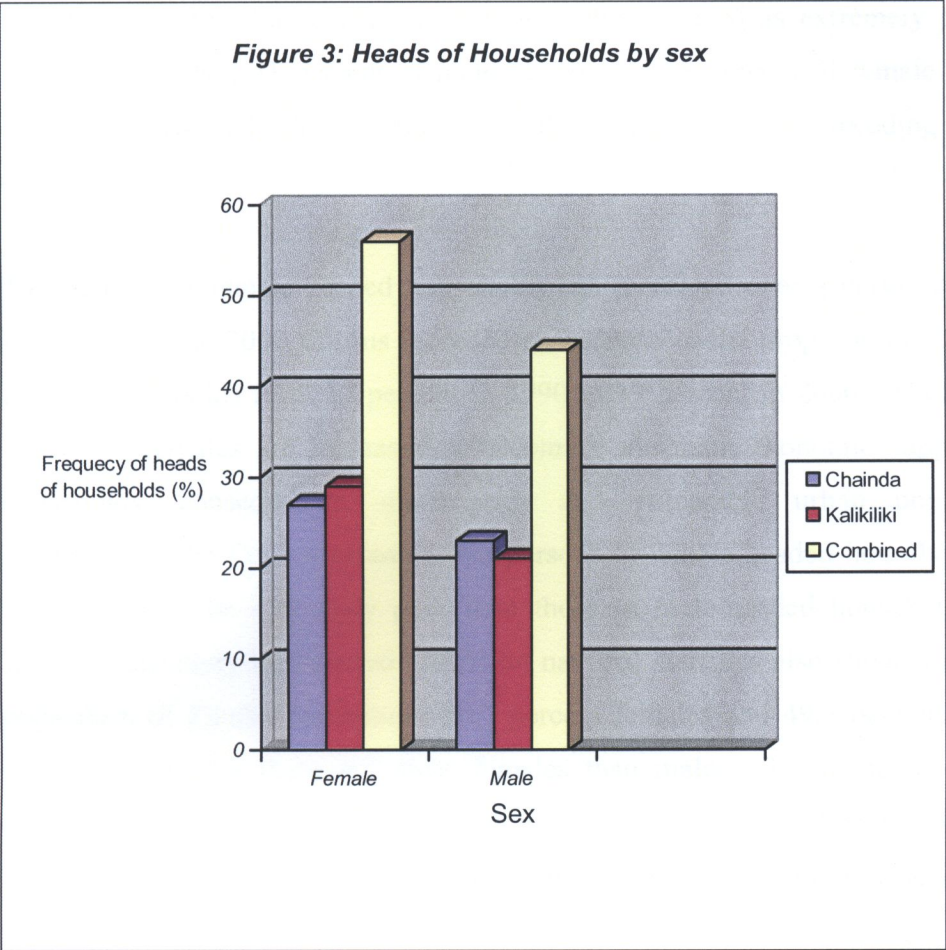
One in every ten (10%) households in the study area had family sizes of eleven and above members, with 49 percent of Chainda and Kalikiliki residents constituting households with big family sizes of between six to ten members. Almost four in every ten (41%) households had family members ranging from one to five. Therefore, it can be argued that households in these shanty compounds are generally large. These findings are consistent with family size distribution in the shanty compounds in Zambia in general and the City of Lusaka in particular. For instance, the 1995 Central Statistical Office Survey quoted by Mulenga (2003) revealed that residents of self-help improved, authorized and unauthorized settlements in the City of Lusaka live in only one or two rooms and yet the average household size is about 5 to 6 persons. The large household size causes overcrowding, consequently making the low income residents more vulnerable to air borne diseases such as tuberculosis. This is an indication that poor residents in Chainda and Kalikiliki shanty compounds are more likely to fall sick, therefore, seek health care services more often than the medium and high income groups.

The 100 households of Chainda and Kalikiliki shanty compounds were either headed by a female or male. The findings are shown in table 4 and figure 3 below.

Table 4: Distribution of Heads of Households by sex

Sex	Chainda		Kalikiliki		Combined	
	No.	%	No.	%	No.	%
Female	27	54	29	58	56	56
Male	23	46	21	42	44	44
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

In Chainda and Kalikiliki shanty compounds, 56 percent of the households were headed by females with 44 percent, being male-headed. It can be stated that, the majority of the households in Chainda (54%) and Kalikiliki (56%) shanty compounds are headed by females. This is an indication that most of the residents in these areas are very poor as most of the female-headed households are economically disadvantaged and therefore vulnerable. According to the World Bank (1994), it is reported that in identifying the poorest households, those headed by women head the list. Female headed households are also characterized by a large number of household members living together at a given time. The study findings for CSO (1994) were in conformity when they revealed that about

76 percent of the Zambian population was characterized as extremely poor in 1993 and in 1996, 41 percent of male-headed and 58 percent of female-headed households reported a drop in their standard of living during the preceding 5 years (SCO,1997).

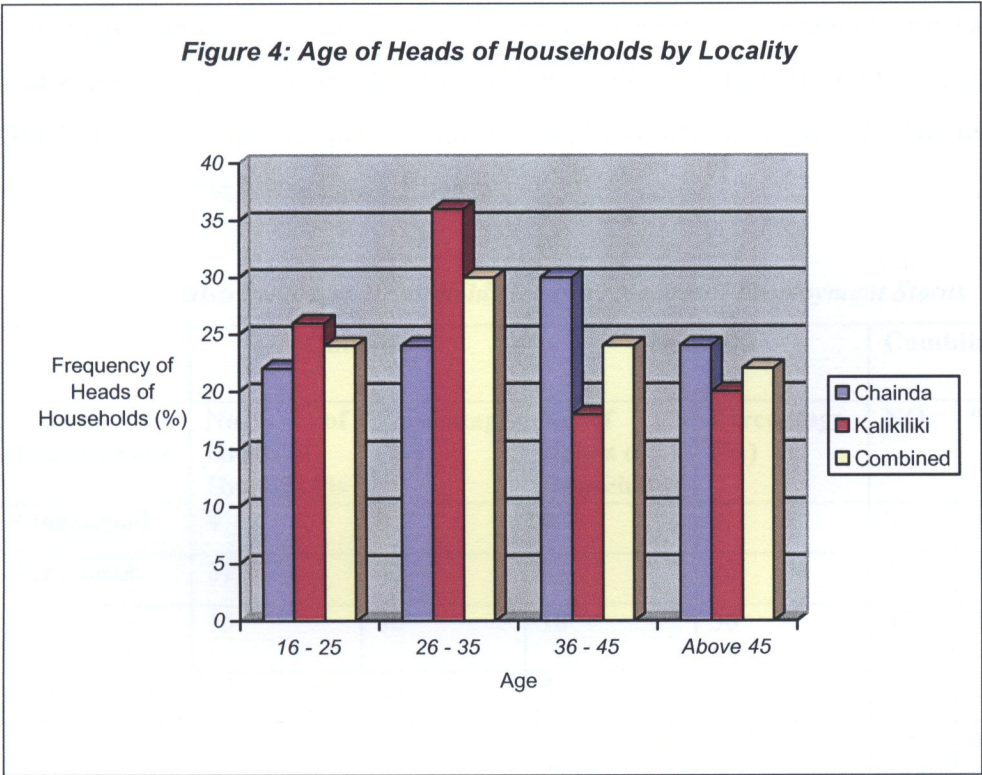
The number of female-headed households has increased over a period of time. For instance, the 2000 Census recorded an increase in the proportion of female-headed households from 17 percent in 1990 to 19 percent in 2000. This means that more females are increasingly becoming the main economic support for households, consequently, more poor and vulnerable urban population. Furthermore, the Census revealed that persons in female-headed households are more likely to be extremely poor than those in male-headed households. In addition, the study by Ndonyo (2005) on national statistics also showed that the population of Zambia constitutes 50.7 percent females and 49.3 percent males, demonstrating that there are more females than males. From the discussion above, it can be concluded that the proportion of households unlikely to afford the medical bills is high. This has a negative impact on the utilization of health care services.

Of importance is the age composition of the population. The age of the heads of households determines whether or not they are in the economically active age group. Table 5 and figure 4 below show the age distribution of the heads of households.

Table 5: Age distribution of Heads of Households by Locality.

Age of Heads of Households	No. of Heads of H/H by Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
16 – 25	11	22	13	26	24	24
26 – 35	12	24	18	36	30	30
36 – 45	15	30	9	18	24	24
46 and Above	12	24	10	20	22	22
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Although the figures above show that the ages of the heads of households for all the age groups are evenly distributed the age group of 26 to 35 years was the largest representing 30 percent heads of households. The age groups from 16 to 25 and from 36 to 45 represent 24 percent each of the heads of households with 22 percent falling in the age group above 45 years.

The figures above reveal that most of the households were headed by economically active age groups. This is a relatively young age group of heads of households expected to contribute to the economical growth of the country. This age group of household heads is in conformity with the national figures on the economically productive age group as reported by SCO (1995). An interesting characteristic of this age group is that, it is also a sexually active group. This has a bearing on the number of households considering that majority of the heads of households are females who are vulnerable and economically very poor. The ability to meet medical bills becomes of paramount importance.

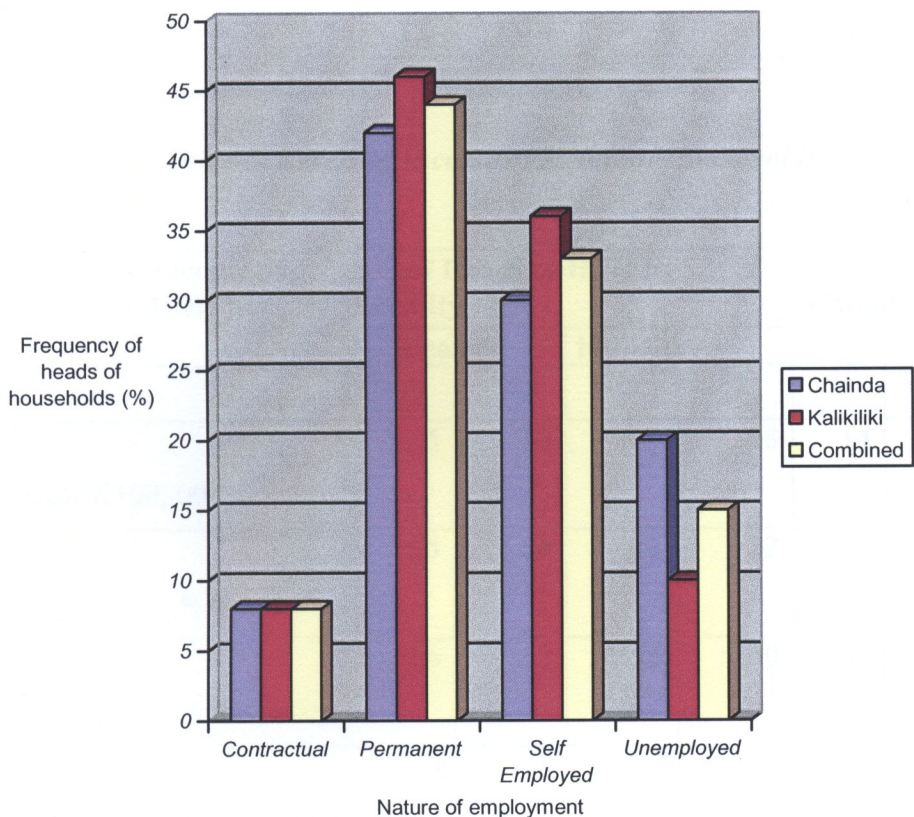
The study assessed the nature of employment of heads of households in Chainda and Kalikiliki compounds. The study categorized the nature of employment into four, namely contractual, permanent, self employed and unemployed. The results are shown in table 6 and figure 5 below.

Table 6: Distribution of Household Heads by Nature of Employment Status

	Chainda		Kalikiliki		Combined	
Nature of Employment	No. of Heads of Households	Percentage (%)	No. of Heads of Households	Percentage (%)	NO.	%
Contractual	4	8	4	8	8	8
Permanent	21	42	23	46	44	44
Self Employed	15	30	18	36	33	33
Unemployed	10	20	5	10	15	15
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 5: Household Heads by Nature of Employment



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Overall, 8 percent of the heads of households were engaged in contractual jobs and 44 percent had permanent jobs. In both Chainda and Kalikiliki shanty compounds, 33 percent of the heads of households were self employed while 15 percent were unemployed.

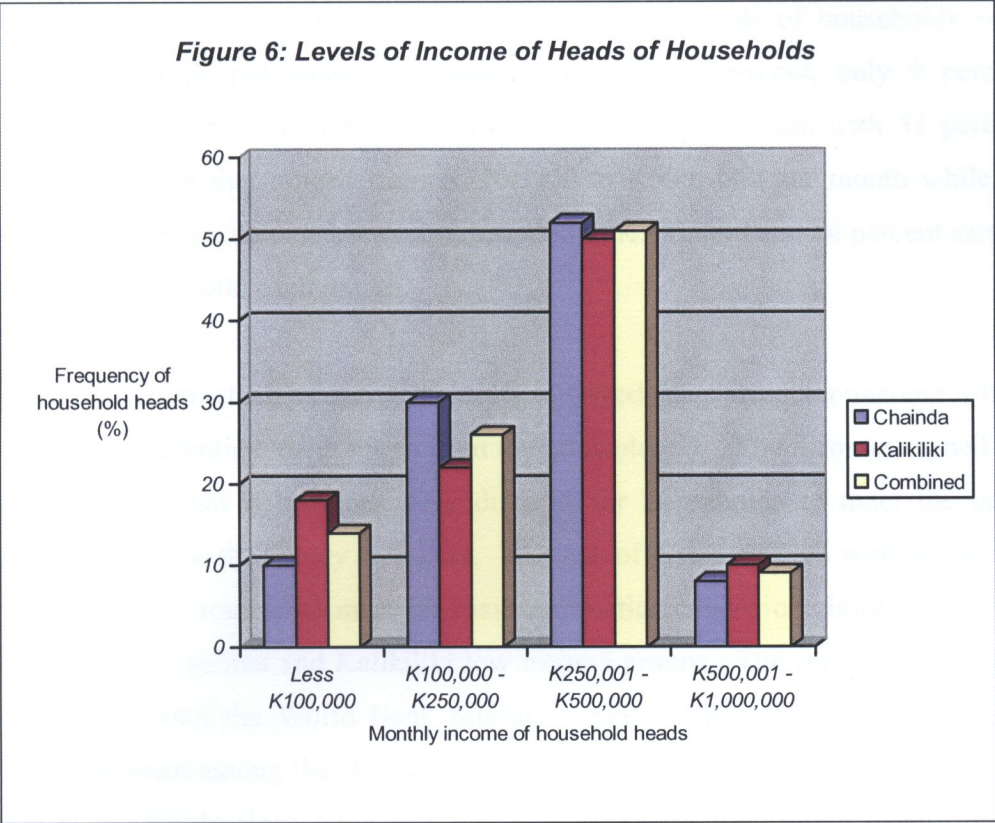
Looking at the nature of employment of household heads in the two shanty compounds, it was important to consider the level of income they made by the end of each month. Table 7 and figure 6 below illustrates the findings of the study.

Table 7: Levels of Income of Heads of Households

Levels of Income of Heads of H/Hs per month	No. of Heads of H/Hs by Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
Less K100, 000	5	10	9	18	14	14
K100,000 – K250,000	15	30	11	22	26	26
K250,001 – K500,000	26	52	25	50	51	51
K500,001 – K1,000,000	4	8	5	10	9	9
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 6: Levels of Income of Heads of Households



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

The results above reveal that the majority (51 %) of the heads of households earned an income ranging from K251, 000 to K500, 000 and only 9 percent of the heads earned an income between K500, 001 to K1, 000, 000 per month. The heads of households with permanent jobs constituted the largest group representing 44 percent.

On aggregate, heads of households in the age groups of 16 to 25 (24%), 26 to 35 (30%) and 36 to 45 (24%) were 78. This indicates that about 78 percent of the household heads were in the economically productive age group of 16 to 45 years, while 22% were above 46 years. Although 78% of the heads of households were in the economically productive age group, only 44% were in formal permanent employment with 33% being self employed, (total 77%), while the rest (15%)

were unemployed. Even though 77 percent of the heads of households were either in formal permanent employment or self-employment, only 9 percent earned an income from K500, 001 to K1, 000,000 per month with 51 percent earning income that ranged from K250, 000 to K500, 000 per month while 26 percent earned an income between K100, 000 to K250, 000 and 14 percent earned less than K100, 000 each month.

Those on contractual jobs and the self-employed have irregular income which does not differentiate them much from the unemployed. The incomes earned are meager such that it becomes very difficult for households to meet the basic requirements for the family members. The lack of permanent job with an income that enables a household meet its basic necessities creates conditions of severe hardship for Chainda and Kalikiliki low income groups. The study results are in conformity with the World Bank findings. According to World Bank (1994), unemployment among the shanty town dwellers has been high for many years but has risen sharply since 1992 and currently, prospects for growth in the formal sector are grim. Furthermore, the incomes of many of those with formal sector jobs are below the poverty line, making it necessary for them to try to earn additional income by engaging in informal sector activities.

The study observed that all the heads of households with permanent jobs were males. This reflected the unsteady income females in shanty compounds are subjected to. This has left the female-headed households in Chainda and Kalikiliki shanty compounds to resort to petty trading and other coping strategies to obtain income. The self-employed are also engaged in petty trading activities such as selling charcoal, welding, beer brewing, carpentry, tailoring, crushing stones and other economic activities which are carried out on self-employment basis.

It should be noted that the income of a family means the income of the head of a particular household. From the scenario given above, it can be argued that residents of Chainda and Kalikiliki compounds are in the low income group, hence being economically disadvantaged compared to other income groups. It can further be argued that because the low income group is economically disadvantaged, it has limited the purchasing power of the residents of Chainda and Kalikiliki shanty compounds. This means that the households have to choose between or among items to purchase, thereby foregoing many equally important needs in their lives.

Therefore, to expect the households of the Chainda and Kalikiliki shanty compounds to actively contribute to the cost of their health as was stipulated in the key provision of the new Health Reform Policy that *“every able-bodied Zambian with an income should contribute to the cost of his or her health”* (National Health Policies and Strategies, 1991: 42), was a farfetched expectation especially that only 46 percent were in formal permanent employment with 18 percent being either unemployed (10%) or engaged in temporary unstable contractual jobs (8%). Even those in formal employment had low income with only 9 percent receiving salaries ranging from K500, 001 to K1, 000, 000 per month. Given the low income of the households in the study area, the residents could not afford user fees because they are poor.

To confirm the findings, a number of studies that have been conducted have revealed similar results. A study by MOFED (1998) stated that poverty in the context of Zambia is defined as lack of access to income, employment opportunities and freely determined consumption of goods and services, shelter, clean water, education and health and other basic needs of life. The study results by Riley (1993) are also in support as they revealed that the urban households in Zambia have economically deteriorated in the past two decades and the urban poor have been hit hard because of their dependence on wage employment for income.

Arhin-Tenkorang (2000) affirmed when he concluded that the low income households for-go consumption of other essential needs such as food, education, clothing and transport in order to consume health care services because this was the prevailing situation in Chainda and Kalikiliki. Households were having a meal per day and had withdrawn children from school to engage them in petty trading in order to contribute to raising funds for health care services. Furthermore, as correctly observed by Arhin-Tenkorang, the exemption policy has failed to protect the income and access to health care services of the poor households in the study area.

Similarly, the World Bank (1994) conducted a Zambia Poverty Assessment on the rural and urban areas. The study results had shown that poverty in urban Zambia was as a result of failing employment and income coupled with rising prices. According to the author, poverty was generally characterized by stress periods which occurred in both the formal and informal sector workers when awaiting the next income. Stress adversely affected dietary intakes and leads to essential expenditures having to be postponed or foregone. Furthermore, the study revealed that one quarter of Zambia's population now lives in urban shanty towns. Most of them are living below the poverty line and child malnutrition (stunting) rates are as high as 46 percent in some areas (JICA, 2003). The author also revealed that only a fairly small minority of the available urban work force was in formal sector employment. Unemployment level in shanty compounds in urban areas has been high for several years and has been rising since 1992. Additionally, many heads of households with permanent jobs in the formal sector earned incomes that were below the poverty line. Therefore, it became necessary for the heads of households to try to engage in informal sector activities in order to earn additional income.

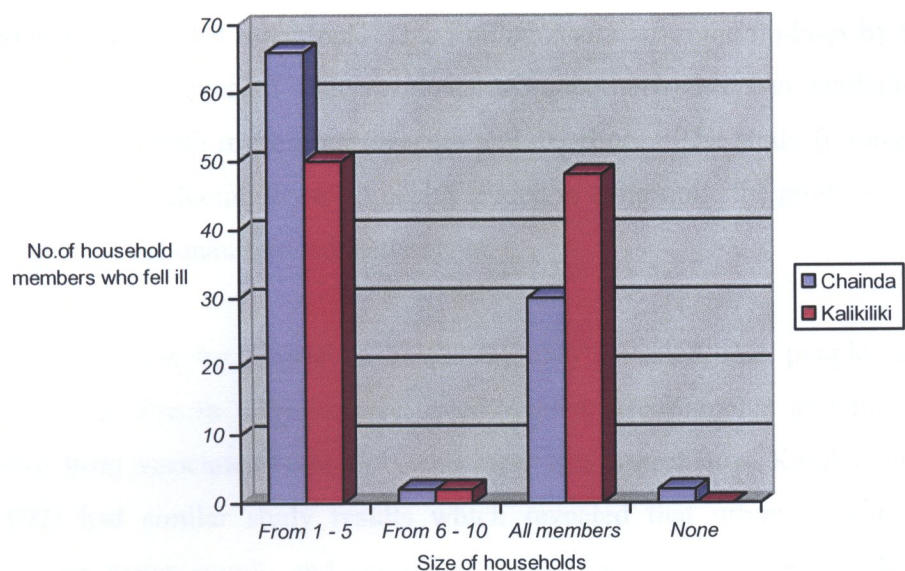
Health need is among the many needs of the low income group of Chainda and Kalikiliki shanty compounds. The study inquired on the number of family members who had fallen sick the year preceding the study which is reflected in table 8 and figure 7 below.

Table 8: Distribution of h/hs by incidence of illness year preceding the study

No. of H/H members sick	Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
1 – 5	33	66	25	50	58	58
6 – 10	1	2	1	2	2	2
All Members	15	30	24	48	39	39
None	1	2	0	0	1	1
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 7: Households by incidences of illness(%) by year preceding the study



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Almost all the households reported a family member having fallen sick in the year preceding the study, except for 2 percent of the households who reported none. About 66 percent of the households in Chainda compound had family members ranging from 1 to 5 who had fallen sick in the last twelve (12) months preceding the study, while Kalikiliki had 50 percent. Of all the households interviewed those with family members ranging from 6 to 10 reported sick by a specified period were about 2 percent in both Chainda and Kalikiliki shanty compounds. Nearly one third (30%) of the households in Chainda and almost half (48%) in Kalikiliki had reported that all members had fallen sick during the specified period of time.

From afore mentioned, it can be argued that the low income group of Chainda and Kalikiliki compounds are prone to infections because of large family sizes that live in small houses, consequently, overcrowding results. Families living in overcrowded houses are vulnerable to communicable diseases such as diarrhoea and respiratory tract infections. This finding is similar to the findings by Mulenga (2003) which revealed that residents of unauthorised urban settlements are vulnerable to both respiratory diseases and diarrhoea. The study findings further revealed that vulnerability to ill health tended to undermine the productivity of the residents of the unauthorised settlements.

The conclusion by Gaisie et al (1993) also revealed that people in shanty settlements live in dirty, smoky, overcrowded environments and thus tend to suffer from associated respiratory and other health problems. Kaluba and Mwale (1992) had similar study results which revealed that urban housing without adequate water supply and sanitation represents a major threat to health and survival because of the threat of diarrhoea, dysentery and cholera.

Findings of the study by the MOH (1995) in Tanzania between 1989 and 1991 on the potential of introducing user fees in public health facilities, indicated that the poorer sections of the population were the main users of government health services and that these services were far from free. In fact, people incurred significant costs to purchase essential medicines and other small items that were often not in stock at the health facilities. It can, therefore, be concluded from the findings of the study that the low income groups are more susceptible to infections especially communicable diseases, thereby utilizing the health facilities more frequently than the other groups.

EFFECT OF COST-SHARING ON HEALTH CARE SERVICE DELIVERY

Use of Health Facilities

In all the households visited during data collection, heads of households were asked to state if any member of their families were sick during the past twelve (12) months preceding the study, and if so whether medical care had been sought. Almost all the households reported some members of the family falling sick in the past twelve months.

The households that reported sick family members during the specified period were asked whether the patients had sought health care services for the ailments. Table 9 and figure 8 below shows the findings.

Table 9: Distribution of Sick Household Members Accessing Health Care Services

Sick H/H members who accessed health care services	Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%		%
1 – 5	32	64	43	86	75	75
6 – 10	0	0	0	0	0	0
All Members	8	16	0	0	8	8
None	10	20	7	14	17	17
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

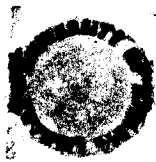
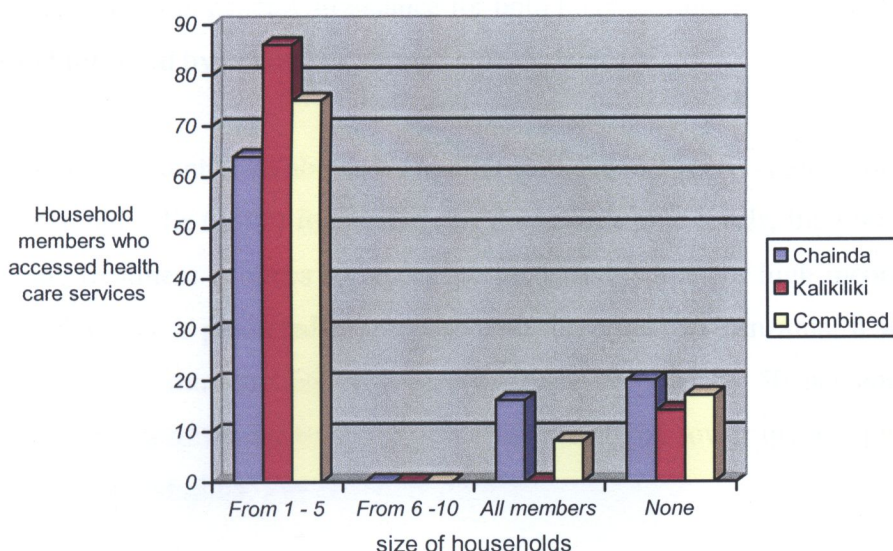


Figure 8: Sick Household Members Accessing Health Care Services



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

The figures above show that 75 percent of all the households in both shanty compounds with family members ranging from 1 to 5 falling sick had visited a health care facility. Nearly one in every ten (8%) of the households with all members falling sick in the specified period of time did not access any health care services. Households with sick family members that did not visit a health care facility were 17 percent in both Chainda and Kalikiliki shanty compounds.

From the study findings above, it can be argued that the introduction of user fees for health care services had increased the price of the care faced by Chainda and Kalikiliki households. The introduction of user fees caused the low income group to reduce the demand or utilization of the health care services, consequently a fall in the utilization because the income of these households is meager. For the residents of Chainda and Kalikiliki shanty compounds, it can be concluded that

the demand for health care services, like the demand for most goods, is dependent on the level of income. The findings of the study are similar to the results of the large study in Zambia by Blas (2001) for a 5 year period found a dramatic decrease of 1/3 in general attendance for both hospitals and PHCs over a two-year period followed by continued, though slower decrease.

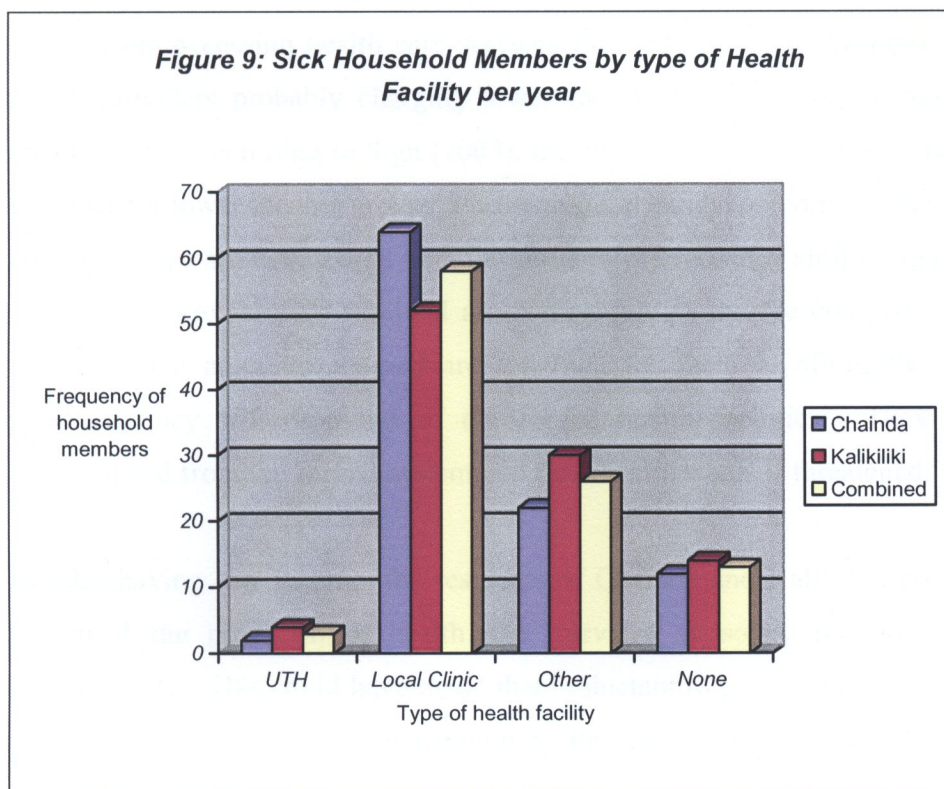
The findings mentioned above are similar to those in Niger. A study in Niger by Chawla and Ellis (2000) found that, for the low income levels, the probability of seeking treatment declines as prices are increased, while for high income levels, the probability is predicted to increase with the price. In Tanzania, it was found that, after the introduction of fees, attendance dropped by 50 percent in three government hospital in Dar es Salaam used mainly by lower income populations (Hussein and Mujinja, 1997).

Those who were sick and had accessed health care services were asked the type of health care facility they visited. Table 10 and figure 9 below illustrate the findings.

Table 10: Distribution of Sick Household Members by type of Health Facility per year

No. of H/Hs using type of health facility	Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
UTH	1	2	2	4	3	3
Local Clinic	32	64	26	52	58	58
Other	11	22	15	30	26	26
None	6	12	7	14	13	13
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

The results above illustrates that the sick household members who sought tertiary health care services from the University Teaching Hospital were 3 percent. Almost six in ten (58%) of Chainda and Kalikiliki residents visited the local clinic which provides Primary Health Care services while 26 percent had other alternatives where they accessed health care services. It is interesting to note that 13 percent of all households in both shanty compounds did not seek any health care services at all.

The results above suggests that when user fees were introduced, some of the low income households of Chainda and Kalikiliki shanty compounds reduced the demand for health care services from public health facilities resulting in a fall in

utilization. However, the residents found alternative health service providers or other means of accessing the health care services. In other words, there was a switch from accessing health care services from public health facilities to other health providers probably charging lower fees which the lower income group could afford. According to Sigh (2003), the switch to other health care providers is higher for lower income groups. Furthermore, it can be noted that when the low income groups are dissatisfied with the services offered, they shift to other health providers where services received are comparable to the fee charged. Also, if they feel that amounts charged are too high for them to afford the services provided, they will drop out of the formal health facilities. They become marginalized from the formal system and their health status is threatened.

Besides having low income, the residents of Chainda and Kalikiliki compounds perceived the provision of health care services as solely the government's responsibility. This could have made them reluctant to pay user fees. Therefore, it can be suggested that this perception by the low income households could be one of the reasons for the decline in demand for the public health facilities with no accompanying shifts in the use of other health care service providers as is evidenced by the 13 percent of the households who did not seek any health care services.

Mwabu and Wangiombe (1995) noted that the introduction of user fees where none existed before may create perceptions of high percentage increase, so that any charge is accompanied by a decline in demand for public health care services.

The study results above are similar to the findings in the 1996 Living Conditions Monitoring Survey which had also shown that 57 percent of individuals who were sick during the two weeks preceding the survey did not seek any form of care and that the probability of not seeking health care services was 28 percent higher in the lowest income group than the higher groups.

User fees had a similar impact on in-patient admission too. Shipili (1993), cited in Seshamani et al (2002), found that data on admissions at the University Teaching Hospital for the period of March 1992 to March 1993 had declined substantially after in-patient charges had been introduced. He further revealed that this pattern was reinforced by a corresponding increase in the number of bodies “brought in dead” over the same period. He, therefore, suggested that people were perhaps no longer able to access health care services because they could not afford it. Furthermore, the instances of unclaimed corpses also increased after the introduction of user charges as people failed to collect the bodies of their deceased for burial because they could not afford to pay mortuary charges and other related costs. Similar declines in admissions following the introduction of user fees have been documented in a number of hospitals in Zambia (Kalyalya et al, 1998).

Therefore, it can be concluded that introduction of user fees not only changes the health status of households, it also creates expectations for better services. Households review their ranking of preferences to reflect the cost of services and quality of services across the various providers of health care services. These are indicated by shifts across the various providers and/or complete drop from the formal health sector, (Table 10 and figures 9 above).

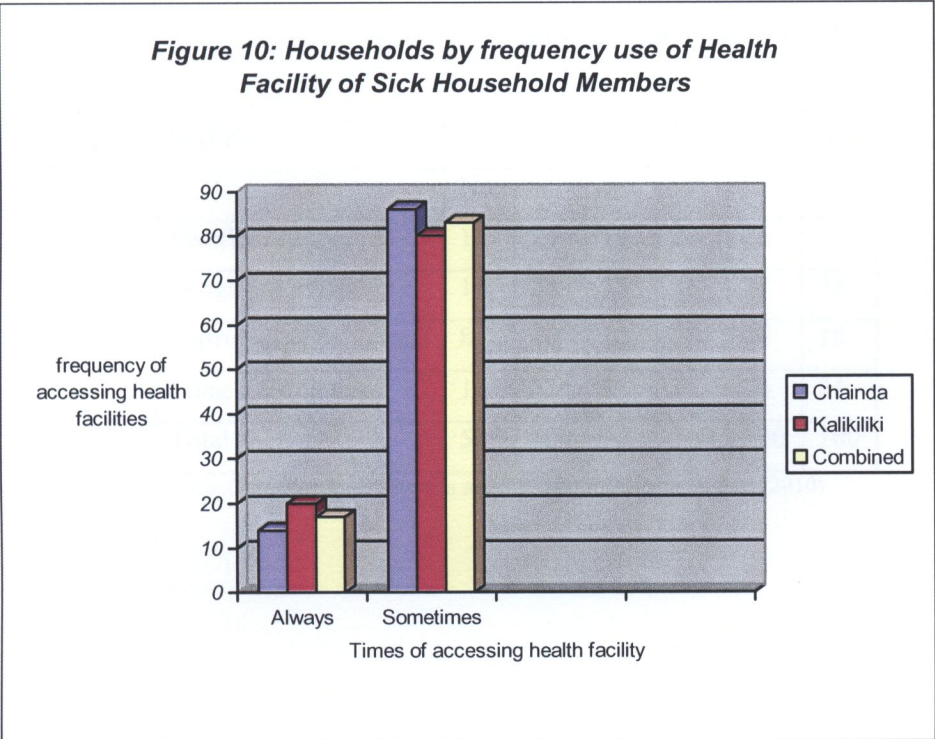
Reasons for Utilization or Non-Utilization of Health Care Services

An inquiry was made on the frequency of use of health care services whenever household members fell sick. The figures in table 11 and figure 10 below illustrate the findings.

Table 11: Households by frequency use of Health Facility of Sick Household Members

Frequency	Locality					
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
Always	7	14	10	20	17	17
Sometimes	43	86	40	80	83	83
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

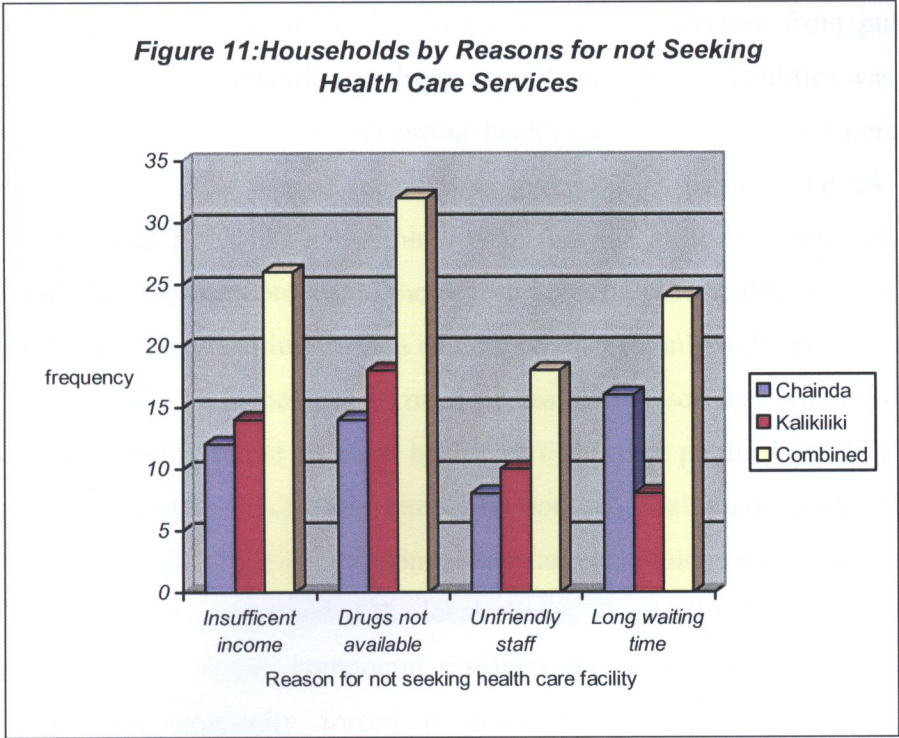
Heads of households were asked whether they always visited a health care facility whenever, a family members fall sick. About fourteen (14) percent of households in Chainda indicated that they always used a health care facility whenever a family member fell sick while in Kalikiliki shanty compound, 20 percent stated that they also did. However, a larger proportion of both Chainda and Kalikiliki households indicated that they sometimes visited a health care facility whenever a family member fell sick representing 86 percent and 80 percent of the residents respectively. Overall, only 17 percent of the low income group of the two shanty compounds always sought health care services whenever there was a patient in the household with 83 percent not always visiting a health care facility.

Various reasons were given regarding the frequency of using a health care facility. Table 12 and figure 11 below reflects the reasons mentioned by heads of households.

Table 12: Distribution of Households by Reasons for not Seeking Health Care Services

Reasons	Chainda		Kalikiliki		Combined	
	No.	%	No.	%	No.	%
Insufficient Income	12	24	14	28	26	26
Drugs not available	14	28	18	36	32	32
Unfriendly health staff	8	16	10	20	18	18
Long waiting time	16	32	8	16	24	24
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Households in both Chainda and Kalikiliki gave a variety of reasons for not accessing health care services. The main reasons were insufficient income, unavailability of drugs in health care facilities, unfriendly health staff and long waiting time. In Chainda, 12 percent of the households mentioned insufficient income to pay user fees as one of the reasons for not using health facilities while 14 percent in Kalikiliki also gave the same reason. Households who cited unavailability of drugs in health care facilities were about 14 percent in Chainda and 18 percent in Kalikiliki. Unfriendly health staff at health care facilities as a reason for not accessing health care services was stated by 8 percent of Chainda households and 10 percent by Kalikiliki low income households. In Chainda, 16 percent of the households indicated that long waiting time at health care facilities was one of the reasons they did not always seek health care services, while 8 percent of households in Kalikiliki cited this as a reason too.

the information and perceptions that households and individuals have about their relative efficacy. In other words, the level and quality of health care services that is actually provided at the health care facilities is important.

Seshamani et al (2002) were right in concluding that if health facilities are bereft of drugs or qualified doctors, if the various health and health-related costs are high, if health facilities are afar, if waiting times for patients at health facilities are protracted and if health services in general are poor resulting in low curative outputs, then there is bound to be a depressing impact on health demand. Potential patients would prefer either not to seek health care services at all or indulge in self-medication or seek the services of those providers from whom their own perceived benefits are optimized. However, such behavioural tendencies could lead to health expenditures that do not produce commensurate health outputs.

Cost of Transport to Health Centre

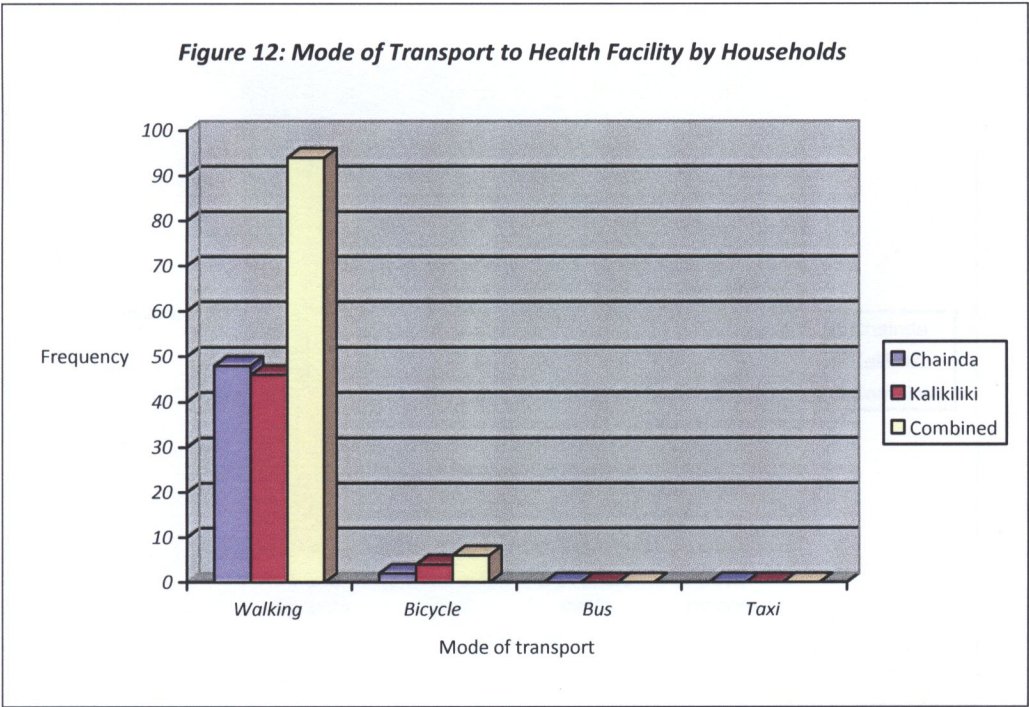
All the households said they spend less than K50, 000 on transport for them to access health care services. The main public health care facilities in both localities of Chainda and Kalikiliki shanty compounds are between 5 km to 10 km. The health care facilities are within the recommended distance by the Government of Zambia, which is a radius of 12 km for any given catchment area (National Health Policies and Strategies, 1991). The health care facilities are within walking distance. This means that residents of the two shanty compounds did not need to use public transport in order to access primary health care services from their local clinics. In this case, transport expenses did not add to health care service costs. However, in situations where the patients are too sick to walk or when referred to UTH, a tertiary health institution for specialist treatment, transport costs are inevitable. In such a scenario, transport costs added to health care service cost making it very expensive for the low income group of people in

Chainda and Kalikiliki shanty compounds. The results of the study for the choice of the mode of transport to health care facility and the reasons are illustrated in table 13 and figure 12, as well as table 14 and figure 13 below respectively.

Table 13: Distribution by Mode of Transport to Health Facility by Households

Mode of transport	Chainda		Kalikiliki		Combined	
	(No.)	%	(No.)	%	(No.)	%
Walking	48	96	46	92	94	94
Bicycle	2	4	4	8	6	6
Bus	0	0	0	0	0	0
Taxi	0	0	0	0	0	0
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

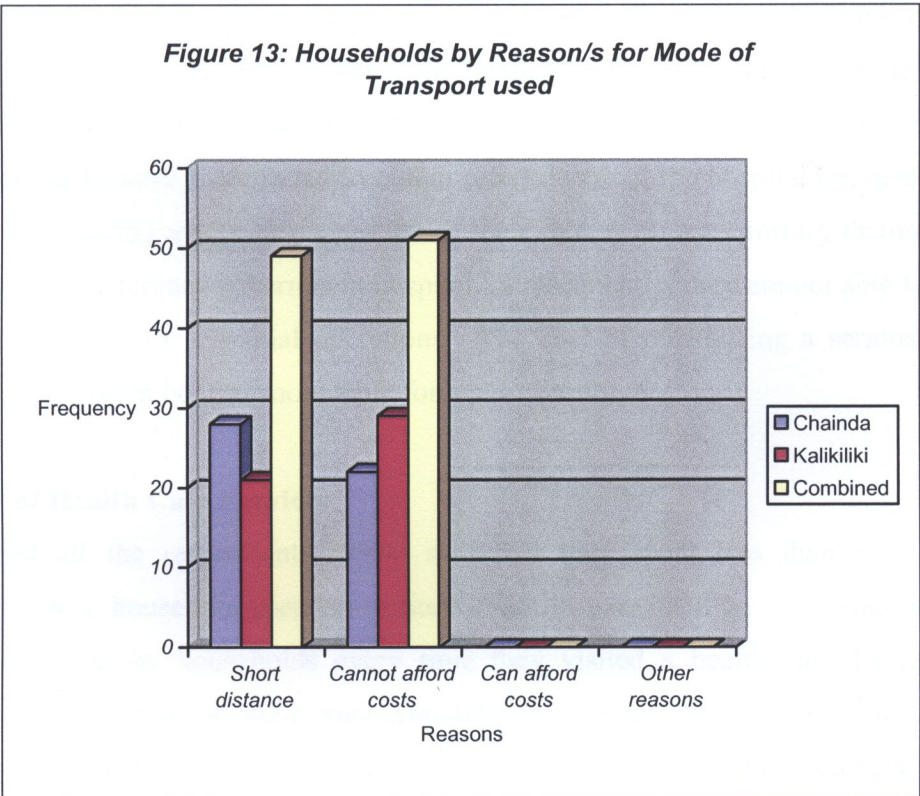


Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Table 14: Distribution of Households by Reason/s for Mode of Transport used

Reason/s	Chainda		Kalikiliki		Combined	
	NO.	%	NO.	%	NO.	%
Distance is short	28	56	21	42	49	49
Cannot afford transport costs	22	44	29	58	51	51
Able to afford transport costs	0	0	0	0	0	0
Others reason/s	0	0	0	0	0	0
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

It was interesting to note that even if the local clinics were within the recommended PHC distance of health care facilities in a catchment area, about half of the respondents indicated that they could not afford transport costs. The reason they cited for the means of transport used to access the local health care facility is that it was very expensive for them to meet transport costs. They stated that they walked to the clinic, not because the distance is short but that they cannot afford to use or hire a taxi, bicycle, private car, to name but a few. They further stated that when an individual is sick, they are usually too weak to walk, thus the need to use a vehicle. In very serious cases, the household members resort to borrowing or hiring a wheelbarrow to ferry their sick relative to the local clinic. It was at this point that respondents requested for an ambulance to be allocated to their local clinic stating that it will ease transportation problems.

The University Teaching Hospital which is out of reach has implications for emergency referral care especially that the ambulances are severely lacking and are expensive. Ambulance services require payment of the charge before services can be provided. This has increased the financial difficulties in accessing tertiary health care services for Chainda and Kalikiliki residents. The residents of the two shanty compounds have failed to obtain referral care at the hospital because they end up spending a significant portion of their money on transporting themselves to the distant tertiary government hospital. Subsequently, they are not able to pay all the fees or for essential operations. The cost of transferring a seriously ill patient can often be insurmountable for a poor family.

Cost of Health Care Services

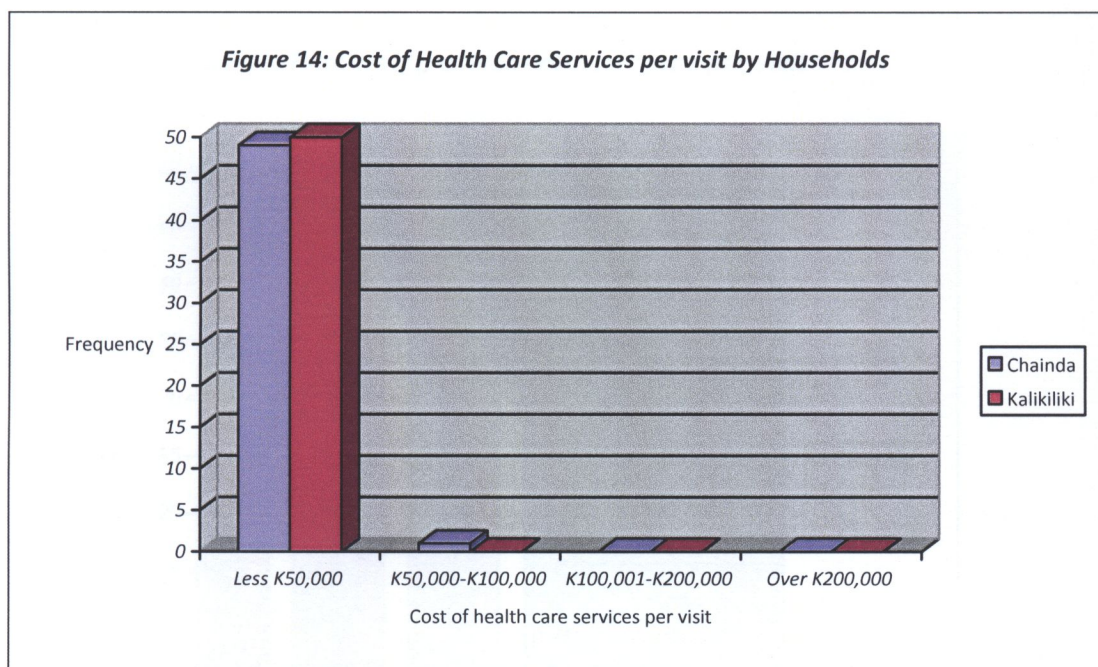
Almost all the respondents (99%) said that they spent less than K50, 000 whenever a household member visited a health care facility. The amount of money spent by households every time they visited a health care facility in proportion to their income is approximately 20 – 50 percent for 40 percent of the households with an income of less than K250, 000 per month. This is a very large amount of money for these households which require trading off with other basic

needs. For a household to spend 20 - 50 percent of its monthly income on each visit made to the health care facility is extremely expensive. This implies that many households in Chainda and Kalikiliki cannot afford the cost of health care services. According to Russell (1996), there is no accepted definition of ‘affordability’ in economics. However, 5 percent of income has come to be regarded in some policy discussions as an ‘affordable’ level of expenditure on health care services. The above scenario is illustrated in table 15 and figure 14 below.

Table 15: Cost of Health Care Services per visit by Households

Cost of Health Care Services	Chainda		Kalikiliki		Combined	
	NO.	%	NO.	%	NO.	%
Less than K50, 000	48	96	50	100	98	98
K50, 000 – K100, 000	2	4	0	0	2	2
K100, 001 – K200, 000	0	0	0	0	0	0
Over K200, 000	0	0	0	0	0	0
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

All the respondents (100%) said that whenever they visited a health care facility, they paid for registration fees, consultation fees, investigation charges, non available medical items such as needles, syringes and gloves. In addition to these payments, they are given prescriptions to buy drugs.

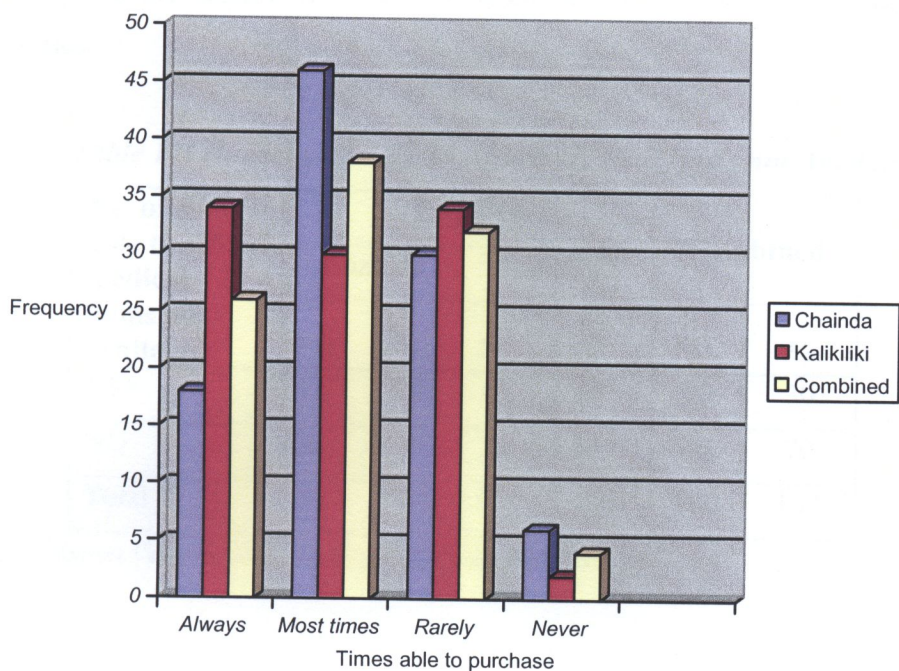
However, when an inquiry was made to establish the affordability of the non-medical items, table 16 and figure 15 below demonstrates the findings.

Table 16: Purchasing of Non-Medical Items per visit

No. of times medical supplies are bought	Chainda		Kalikiliki		Combined	
	NO.	%	NO.	%	NO.	%
Always	9	18	17	34	26	26
Most Times	23	46	15	30	38	38
Rarely	15	30	17	34	32	32
Never	3	6	1	2	4	4
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 15: Purchasing of Non-Medical Items per visit



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

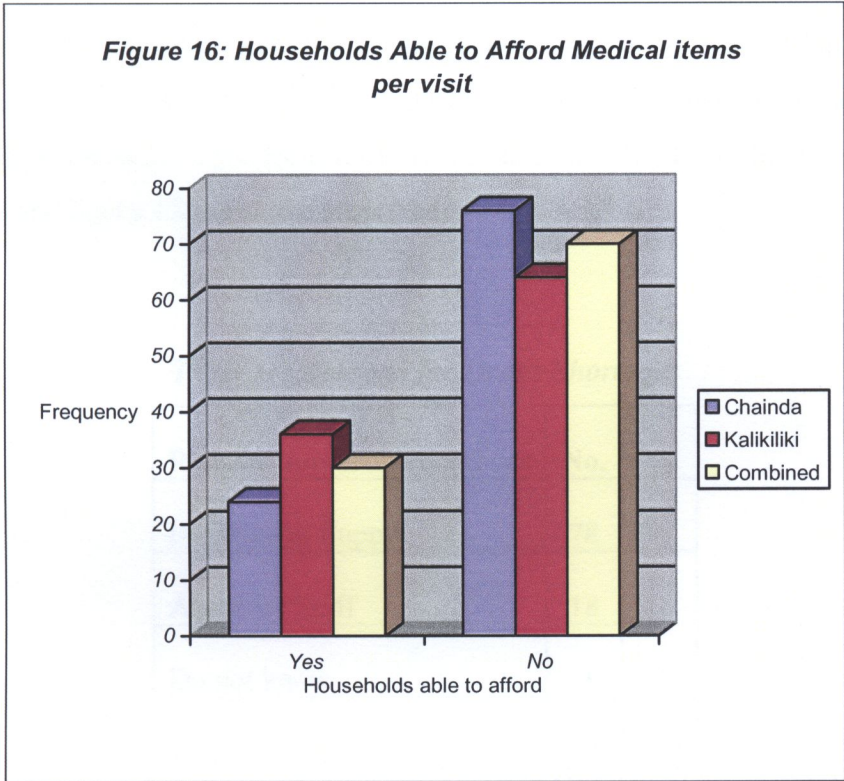
The figures above demonstrate that households in the two shanty compounds who indicated that they were always able to purchase the required non-medical items every time they visited a health care facility were 26 percent. Almost four in every ten (38%) households indicated that they could manage to buy non-medical items most of the times when requested to do so. While 32 percent of the households rarely managed to purchase the required non-medical items, 4 percent never afforded. However, it was interesting to note that, the households that indicated that they were able to purchase the non-medical items required most of the times or rarely, were able to manage only after borrowing some money in very serious conditions. In times such as this, households engaged in all sorts of activities to look for money to meet medical bills.

Households were not only required to purchase the non-medical items but also non available medical supplies. Table 17 and figure 16 below demonstrate the findings on the affordability of none available medical supplies at health care facilities.

Table 17: Households Able to Afford Medical Items not Available

No. of H/Hs able to afford medical items not available	Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO	%	NO.	%
YES	12	24	18	36	30	30
NO	38	76	32	64	70	70
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

On average, there were 30 percent of households that were able to purchase non-available medical items with 70 percent reporting their inability to afford the cost of the medical supplies that were not readily available in health care facilities. The study finding is not surprising because the households of the Chainda and Kalikiliki compounds earn meager income coupled with large families. The situation is compounded with an environment that is not conducive to live in, as they are denied the basic sanitary and safe water services. The overcrowding in houses makes them prone to air borne diseases. This pathetic situation makes the low income residents in these shanty compounds more susceptible to communicable diseases such as tuberculosis, cholera, dysentery and other diarrhoeal diseases. This implies that households in the residential areas such as Chainda and Kalikiliki are expected to seek health care services more often than other residential areas. However, this was not the case for households in Chainda and Kalikiliki residents as they could not afford the costs of non-available medical items.

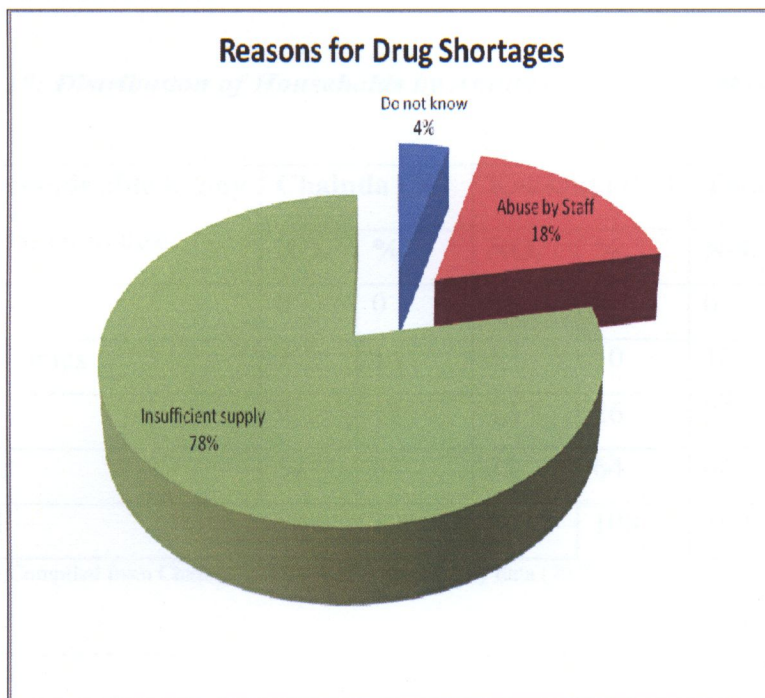
Generally, the situation concerning drugs was similar in both Chainda and Kalikiliki compounds. Every household (100%) indicated that drugs were not available at the health care facilities most of the time. To illustrate the scenario, table 18 and figure 17 below are presented.

Table 18: Reasons for Drugs Shortages

Reasons for drug shortages	No.	%
Insufficient Supply	78	78
Abuse by Staff	18	18
Do not know	4	4
Total	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 17: Reasons for Drug Shortages



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

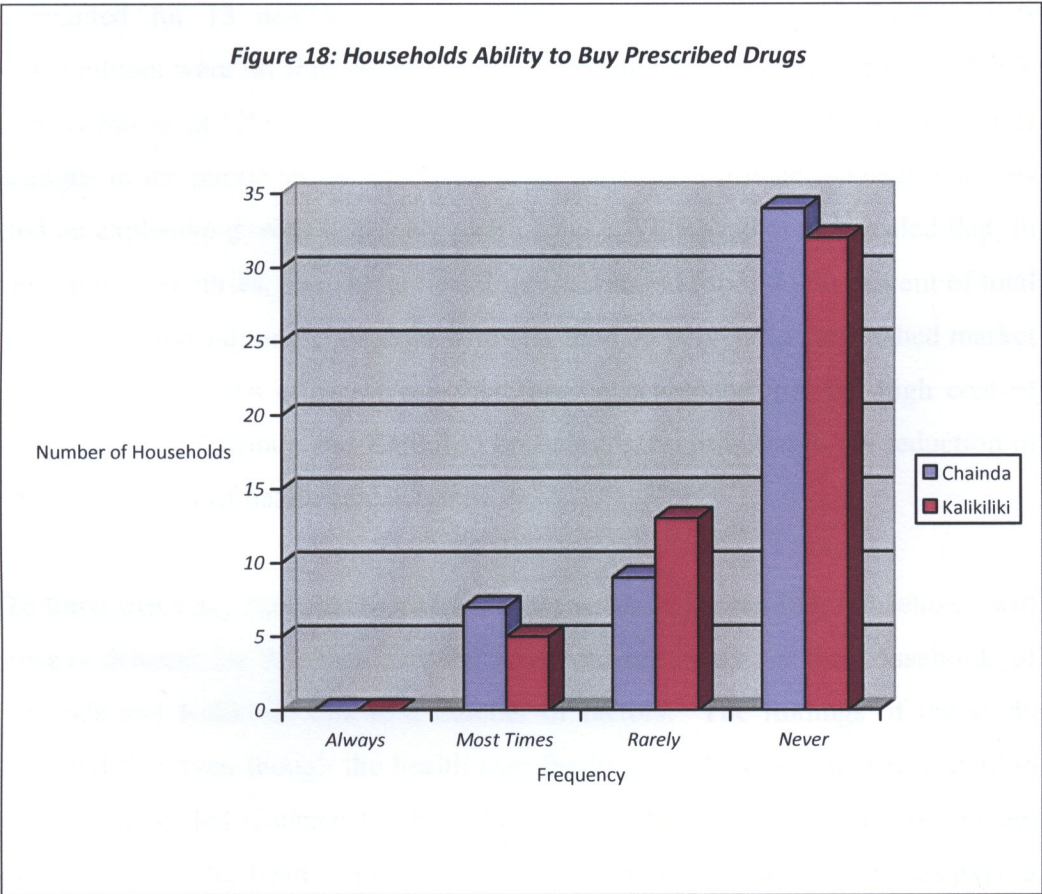
Almost eight in every ten (78%) of the household heads stated that the reason for non availability of drugs most of the time was that there was insufficient drug supply due to poor drug supply chain by the Government. A smaller number of people (18%) said that shortages of drugs were due to abuse by health staff. Abuse of drugs by staff was cited as one of the reasons for shortages of drugs at health care facilities because, according to the heads of households, most of the times when prescriptions were issued, the patients were told to purchase drugs from specific drug stores in the same locality. However, no inquiry was made on this issue by the researcher but it is an area that can be investigated if Health Reforms have to deliver the intended quality health care services. The rest of the respondents (4%) expressed ignorance.

An inquiry was made on the ability of households to purchase the prescribed drugs. The results are reflected in table 19 and figure 18 below.

Table 19: Distribution of Households by Ability to Buy Prescribed Drugs

Households able to buy prescribed drugs	Chainda (%)		Kalikiliki (%)		Total (%)	
	NO.	%	NO.	%	NO.	%
Always	0	0	0	0	0	0
Most Times	7	14	5	10	12	12
Rarely	9	18	13	26	22	22
Never	34	68	32	64	66	66
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

The study results revealed that no single household was able to always afford to buy the prescribed drugs. However, 12 percent of households in Chainda and Kalikiliki were able to procure the prescribed drugs most of the times. Only 22 percent of the households rarely managed to procure the prescribed drugs. It is sad to note that, most of the households (66%) in both compounds never afforded the drugs prescribed for them. The major reason cited for the inability to purchase the prescribed drugs was the lack of sufficient funds by the household heads.

Prescriptions were one of the major concerns as no single household was able to always afford to buy the prescribed drugs. This was the case with the findings by Seshamani et al (2002) which revealed that drugs were the most expensive item of health care services in spite of no official fee. The findings revealed that 58 percent of household expenditure was on drugs, hospitalisation and surgery accounted for 13 percent, 12 percent was spent on hospital fees. Other expenditures were on traditional healers (11%) and Pre-payment Schemes (6%). Whitehead et al (2001), found similar results. According to the authors, user charges in the public sector have lead to an increase in private medical practices and an explosive growth in private pharmacies. Whitehead et al revealed that, in developing countries, pharmaceutical drugs accounted for 30 to 50 percent of total health care expenditure, compared with less than 15 percent in established market economies. To this effect, it can therefore be concluded that the high cost of drugs faced by Chainda and Kalikiliki households, contributed to the reduction in the accessibility of health care services.

To think that since health is one of the basic needs in human life, households will always demand for it whenever need arose did not apply for the households of Chainda and Kalikiliki due to a number of factors. The findings of the study revealed that even though the health care facilities in the study area were within the recommended distance for PHC facilities, sick household members did not always demand for health care services due to shortages of drugs. Besides paying

for consultation, registration and investigation fees, households were given prescriptions instead of drugs. This could have contributed to the low utilization of health care services. The above scenario was the case in the study done by Seshamani et al (2002). The authors correctly observed that, the demand for health care services is influenced by the agency relationship between doctor and patient which is influenced by the availability of health care services and the quality of health care services provided. They concluded that people are not likely to demand for health care services from institutions, even when they exist within a walkable distance if they do not have adequate drug supplies.

The households of Chainda and Kalikiliki had to make choices between paying for health care services and other basic needs in life especially food. Therefore, when these households managed to pay user fees at any particular visit at the health care facility, they expected to receive a 'full' package of quality and quantity health care services. The households did not expect to be given prescriptions instead of drugs or told to provide non-medical supplies if a given medical or surgical procedure had to be performed on them. Such inadequacies in both the quality and quantity of health care services could have contributed to the reduction in the utilization of health care facilities.

The above scenario confirms the situation revealed by Gilson (2000) who argued that, although the introduction of cost-sharing has promoted a strong concern for quality health care services among the population of South Africa and Zambia, thereby providing a foundation for demanding greater accountability from the health system, the non-availability of drugs and other non-medical supplies contributed to the reduction in the demand for health care services. This renders cost-sharing an ineffective financing mechanism.

The study results in Chainda and Kalikiliki have confirmed the conception of Sigh (2003) who concluded that user fees increases prices faced by households, especially the poor, thereby reducing demand or utilization of a particular service.

The poor households in the study area, who were already spending a significant proportion of their meager income on health care services, were unable to spend any additional cost that was brought about by user fees.

The findings of Morogor Rural, Mbeya and Kilombero Regions in Tanzania on quality of care through the eyes of patients indicated that if able, the poor were willing to pay for better quality of care but services were not improving. Besides health centres and dispensaries being small, understaffed and long waiting times, medicines were in short supply causing most patients to by-pass the lower levels of health care to seek hospital treatment (Tiban debange and Mackintosh, 2002). Furthermore, the results of the study had shown that from the patient's perspective, a constant supply of essential drugs is a prerequisite to the credibility of health care services and quality of health care provided. For example, findings from the TADREG's study cited in Tiban-debange and Mackintosh (2002), indicate that for a large majority (87 percent), a constant supply of drugs and medical supplies is very important to improved health care services. They also revealed that at lower level health care facilities did not charge official fees, most complaints focused on lack of drugs and supplies (an issue on quality) and not on the informal fees people were required to pay. The study further revealed that even when the poor are able to find money for basic care, their inability to purchase these medicines makes treatment actually impossible. Drugs are often found to be more affordable at government facilities but they run out quickly. They are more available in drug stores, pharmacies and private facilities but people generally cannot afford to buy them there. Consequently, this makes it impossible for them to get effectively treated. Thus the poor people opted not to seek treatment at all or resorted to the traditional healer.

The findings above are not surprising because the majority of the people in the shanty compounds were either unemployed or had very low income, while most of the households are female headed who are mostly economically disadvantaged and are therefore vulnerable. The findings by the World Bank (1994) can

exemplify this. The World Bank (1994) reported that the poorest households were those headed by women and that these female headed households usually had large families living together at a given time. Female headed households were usually extremely poor than male-headed households. It is therefore not surprising that 91 percent of the households reported borrowing money commonly known as ‘kaloba’ in order to pay for the health care services. ‘kaloba’ is a business venture commonly practiced in shanty compounds where someone lends money to clients who have to repay with the same amount borrowed for interest. This perpetuates debt that is almost always unsettled leading to borrowers losing some of their property or asserts to the lender.

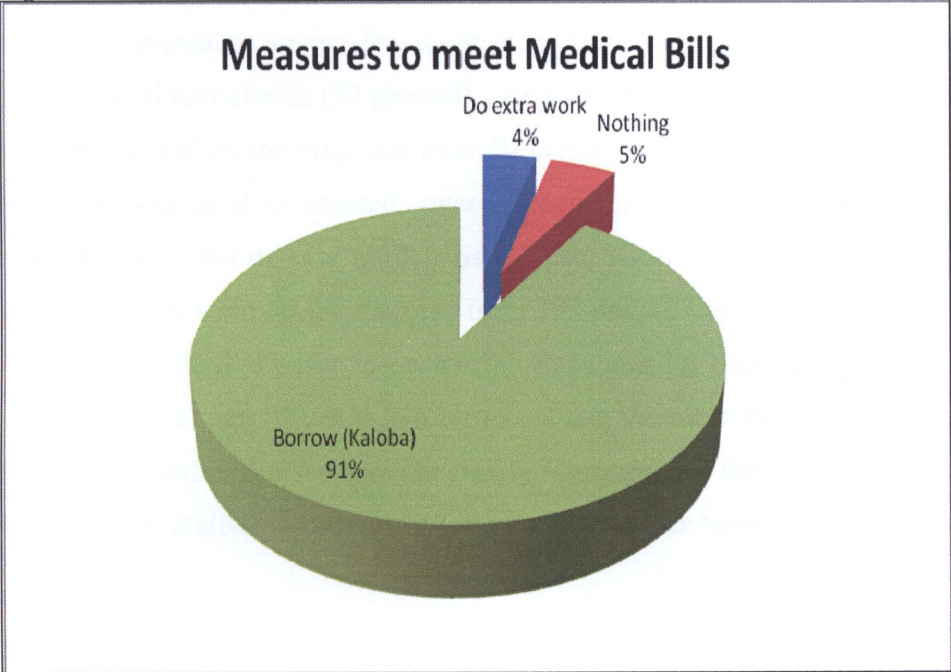
It is worthwhile to note here that heads of the households in the two shanty compounds had devised measures to cushion some of their economic hurdles by borrowing money in form of “kaloba” (91%), while some (4%) opted to do some extra works such as gardening and cleaning household surroundings in the neighbouring low residential areas, in this case, New Avondale and Ibex Hill for Chainda compound and Kabulonga, and Woodlands for Kalikiliki. About 5 percent chose to do nothing concerning their economic situation. Table 20 and figure 19 illustrate the findings.

Table 20: Measures Put in Place to Meet Medical Bills

Measures put in place to Meet medical bills	NO.	%
Borrow Money (Kaloba)	91	91
Do extra work	4	4
Nothing	5	5
Total	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)

Figure 19: Measures to Meet Medical Bills



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

In the studies conducted by Fabricant et al (1999) on the implementation of the Bamako Initiative model in Sierra Leone, similar findings were revealed. The studies found that demand from all income levels for medical treatment and marketed drugs in a sample population were highly income inelastic. The authors concluded that the high degree of equal use of services by the rich and poor should not be interpreted to mean that the poor and the rich can equally ‘afford’ the prices paid, but rather that the poor made great efforts to obtain money in the event of illness.

From the above discussion, it can be stated that one of the important indicators for determining non-affordability is the need to seek assistance from friends or family members and relatives, borrow money, sell household assets, send children to eat food with neighbours or relatives, get children out of school and get opportunity to pay later or otherwise raise funds through ‘kaloba’. The 1998 Living

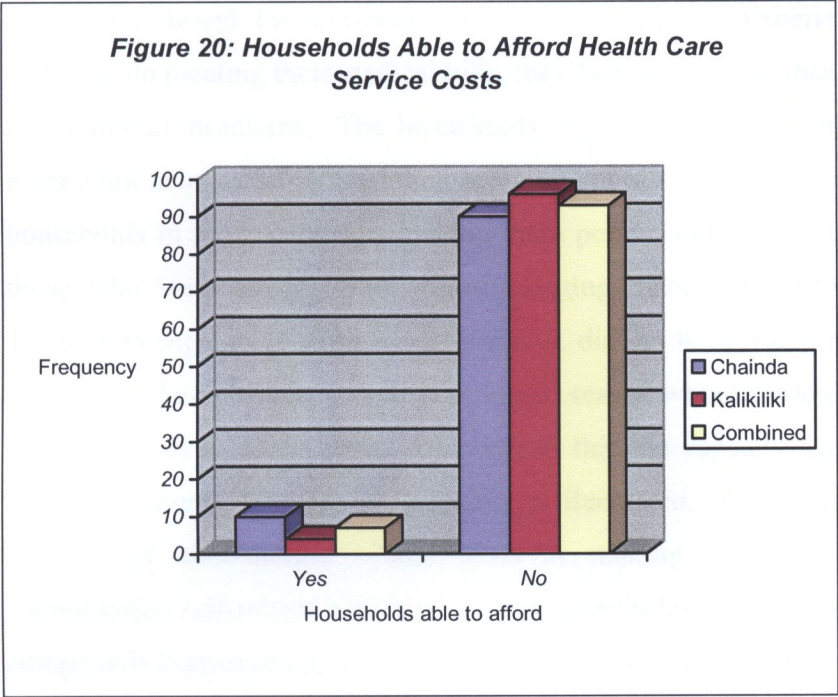
Conditions Monitoring Survey shows that poverty associated with food security was more prevalent among female-headed households (61 percent) compared to male-headed households (52 percent). As a result, malnutrition is on the increase with many studies showing that over 50 percent of Zambian children under five were malnourished or stunted, over 20 percent underweight, about 4 percent wasted. With the disease burden rising, data shows that both child and infant mortality rates were on the increase from 191 and 107 in 1992 to 197 and 109 in 1996 per 1, 000 live births respectively. Estimates for maternal mortality rate in 1996 show 649 per 100, 000 live births. It can therefore be suggested that cost-sharing for health care services are clearly regressive for the shanty compounds of Chainda and Kalikiliki because it has posed a heavier burden on the low income group.

Inquiry on generally the affordability of health care service costs was made. Table 21 and figure 20 illustrate the findings.

Table 21: Households Able to Afford Health Care Service Costs

No. of H/Hs able to afford health care services costs	Locality				Combined	
	Chainda		Kalikiliki			
	NO.	%	NO.	%	NO.	%
YES	5	10	2	4	7	7
NO	45	90	48	96	93	93
Total	50	100	50	100	100	100

Source: Compiled from Chainda and Kalikiliki field survey data (2010)



Source: Compiled from Chainda and Kalikiliki field survey data (2010)

On aggregate, 93 percent of the households in Chainda and Kalikiliki shanty compounds could not afford the costs of the health care services while a small proportion of households (7%) reported their ability to afford health care services. The residents of both compounds reported that the cost of treatment is the biggest health care problem faced and is an acute household problem. The residents’ ability to pay for health care services has decreased thereby being denied treatment because of lack of cash to pay for drugs and medical supplies. In some instances, a few households reported being sent away when they did not manage to pay for the health care services at the public health facilities. When asked whether they had any knowledge of the existence of the exemption scheme, the households expressed ignorance.

However, although the households in the study area were experiencing economic hardships in meeting their medical bills, they had put in place measures to cushion the economic problems. The households were borrowing kaloba or engaged in extra work in an effort to meet their economic hurdles. Nonetheless, kaloba drove households in more debt thus making them poorer and increased the poverty of those who were already poor, disadvantaging them even more economically. Those who engaged in extra work, however, did not have a steady income as this was seasonal employment, especially in rain season where gardening and cleaning of homesteads could be done. This meant that the capacity and ability to earn sufficient income to meet the medical fees fluctuated. This situation defeats the purpose of cost-sharing which aims at making individual, families and communities self-reliant because, instead households in Chainda and Kalikiliki compounds borrowed kaloba that made them more indebted.

Consequently, Chainda and Kalikiliki households were kept in perpetual poverty and continued having difficulties in accessing basic health care services. This resulted in household members having longer periods of sickness, thereby staying away from income generating activities or resorting to cheaper means of treatment which endangered their lives. When one's life is endangered, this could result in death. If it is the bread winner affected, their death leads that particular household in more poverty. More poverty will mean that a household will not afford user fees. This becomes a vicious circle of sickness and perpetual poverty. This is an interesting finding from a policy perspective as it is indicative of inaccessibility to health care services for the poor. Furthermore, when residents of Chainda and Kalikiliki could not afford user fees, about 26 percent used other alternatives to health care facilities while 13 percent did not seek any health care services. Alternatives to health care facilities included traditional herbs and procurement of drugs from drug stores in their locality.

The findings by Gilson (2000) confirmed the above study results when they revealed that charging patient's basic health care hits the poorest members of society the hardest. Many fall into debt or simply do not seek care from public health care facilities. The author observed that charging patients may encourage poor people to treat themselves with traditional medicines or with drugs bought from a peddler instead of attending a clinic. He further observed that often courses of treatment will not be completed due to the cost of the drugs. He then concluded that user fees are the most regressive form of health care financing available as they contribute to the unaffordable cost burdens imposed on poor households and they represent one facet of the social exclusion experienced by these households.

Similarly, Whitehead et al (2001) observed that private drug vendors, especially in Asia and parts of Africa, tended to cater for the poor people who cannot afford to use professional services. These vendors, who are often unqualified, frequently do not follow prescribing regulations. In parts of China and India, drug vendors can be found on nearly every street corner. He, therefore, concluded that the limited access to professional health care services, and aggressive marketing of drugs on an unregulated market have not only generated an unhealthy and irrational use of medicines, but also wasted scarce financial resources especially among poor people.

Whitehead et al (2001) further observed that rises in out-of-pocket costs for public and private health care services are driving many families into poverty, and increasing the poverty of those who are already poor. This magnitude situation which they referred to as "the medical poverty trap" has caused severe effects which are felt by the poor households that are denied health care services because they cannot afford them and whose sickness goes untreated. The households are at risk of further suffering and deterioration in health. The authors cited examples in many areas such as the Caribbean and India. According to the authors, between 14 and 29 percent of people who reported illness in the Caribbean,

indicated that they did not seek care because of lack of funds for treatment or transport. In some Indian rural areas, 17 percent of people who reported illness did not seek care, of whom more than a quarter cited financial reasons.

Untreated sickness among the poor people is recorded not only in countries with serious economic difficulties, but also in those with high and stable economic growth. China can exemplify this. In household surveys in rural China, 35 to 40 percent of people who reported that they had had an illness did not seek health care, with financial difficulties cited by poor people as the main reason. Additionally, 60 percent of people referred to hospital by a doctor never contacted the hospital because they knew they could not afford to pay the high user charges (Whitehead et al, 2001).

It is for this reason that those in authority should find other means of raising finances from the local communities that will be reasonably affordable to all the income groups in society. Considerable means of all economic groups of people including the low income households in Chainda and Kalikiliki should be able to contribute meaningfully to their health care services.

This is supported by Chiduo (1991) who argued that although people have to pay for the public health care services; it should be borne in mind that public health care is no longer a 'privilege' but rather a 'right'. He further argued that government as a guardian of its citizens is obliged to see to it that the status of a person does not block his/her access to public health care services. The author advised that the able-bodied should pay within their means in order to bear some of the cost of the services they use, instead of charging people that are very poor for public health care services.

Therefore, it can be argued that the dramatic and continuing fall in general attendance at health care facilities after the introduction of user fees is likely to be attributed to two main factors. First, given the high proportion of extremely poor

people in the Zambian population, and the worsening economic situation during the period, even small increases in the cost of health care services would have affected demand. In the community part of their study on referral process in Lusaka, Atkinson et al (1999) found that 37 percent of the respondents resorted to self medication because they lacked the money to go to the health centre, not because of the nature of illness. Similar findings are reported from a qualitative study on the impact of user fees in two urban and rural health centres (Va der Geest et al, 2000). The level of fees charged probably determines whether and for which conditions people seek health care services, depending on their economic situation. Second, the general liberalization of the economy made certain substitute services widely available, such as drugs.

Similar dramatic drops in use of out-patient services following the introduction or increase in fees have been documented in Ghana (Waddington and Enyimayew, 1990), Eritrea (Asbu, 1999) and Tanzania (Hussein and Mujinja, 1997). In Zambia, single clinic or district studies support the conclusion of a dramatic decline in attendance earlier on in the reform (Kahenya and Lake, 1994). The sharp decline in attendance could be a result of user fees being charged to people who were supposed to be exempted. An evaluation of the health care cost scheme for the needy found a severe lack of operational criteria on whom to exempt (MOCDSS, 1996), while Kalyalya (1995) found in the four districts he studied that the poor were not, in practice exempted from paying.

COPING STRATEGIES

As a result of the worsening poverty situation, households in Chainda and Kalikiliki shanty compounds have been compelled to resort to a number of coping strategies. Some of the coping strategies are not socially or environmentally sustainable. This has caused a lot of misery among the low income households. This misery is always increasing. Some of the coping strategies include reducing on food intake by frequency and amount, sending children away to live with relatives or to eat with nieghbours, erosion of household security through

depletion of assets and indebtedness caused by borrowing (kaloba), deprivation of children's right to education by pulling them out of school and the loss of human dignity by begging from friends, relatives and others.

The children who are pulled out of school are used to raise extra income for the household by putting them on the streets to sell food stuffs. Others are used as cheap house maids and garden boys. This could be contributing to violence against children. Taking into account the fact that about 70 percent of the Zambians are living below the poverty line and that Zambia is one of the highly urbanized countries in the Sub-Saharan Africa with an economy that is performing poorly, it is not surprising that there is high unemployment level that has contributed to malnutrition among the under five children especially in shanty compounds such as Chainda and Kalikiliki. The 1998 Living Conditions Monitoring Survey supports the above scenario. The survey shows that poverty associated with food security was more prevalent among female-headed households (61 percent) compared to male-headed households (52 percent).

Many studies have shown that malnutrition has increased. It is estimated that more than 50 percent of under-five children in Zambia are malnourished. Estimates also indicate that over 20 percent of children who are under five years are underweight with 4 percent wasted. Infant mortality rate has also increased from 107 in 1992 to 109 in 1996 per 1, 000 live births, while child mortality rates has increased from 191 in 1992 to 197 in 1996 per 1, 000 live births (Republic of Zambia, Ministry of Finance and National Planning, 2005).

Similar results were revealed by Preker and Langenbrunner (2005) which indicated that poor households with limited asserts resort to a number of short-term survival strategies to pay for health care services, especially in times of emergencies. This further impoverishes them and contributes to their long-term vulnerability. They listed a number of coping strategies among others are using their own savings (if they had any), possible contributions from relatives,

engaging in petty trade, selling critical asserts such as crops, animals, land and their labour, borrowing money, taking a loan and bonding their asserts.

COMPARISON OF THE FORGOING FINDINGS TO THOSE AT THE NATIONAL SITUATION

To what extent do these research findings compare with those at national level? This component will high light a number of the study's findings and relate them to those at national level.

The study findings revealed that out of the total of 100 heads of households, 56 percent are female headed while 44 percent are headed by males. These results demonstrate the prevailing situation in the communities of Zambia where many households are headed by females. In a study on Zambia Poverty Assessment by the World Bank (1994), the findings were that there are more female headed households than males. There were about 87 per cent poor households headed by females than those headed by males.

The study revealed that about 78 percent of the households are in the economically productive age group of 16 to 45 years, while 22 percent are above 45 years. However, only 46 percent of the economically productive age group is in formal permanent employment with 36 percent being self employed, while the rest are unemployed. These results are similar to those found by Muneku (2002) which indicated that the unemployment level in the country is at 22 percent, although critics claim that this is an understatement because official statistics categorize subsistence farmers and unpaid family members as being unemployed. If one had to consider only those employed in formal sector and those in gainful employment in the informal sector the unemployment rate can be said to be over 60 percent. The high unemployment level has negatively affected the standard of living of the majority of Zambians especially those living in compounds because they have difficulties in meeting medical bills.

The research results indicated that 83 percent of the households, whose family members had fallen sick, had used a health care facility in the past 12 months while 17 percent did not. The type of health facility used by most of the household members who were sick was the local clinic with 58 percent. Only 3 percent of those who were sick used the University Teaching Hospital which provides tertiary health care services while 26 percent used other facilities and 13 percent did not seek any health care. These findings were also similar to the research results by Diop et al (1998) and LCMS (1998) who found that among the individuals who reported to have suffered from an illness during two weeks preceding the LCMS survey, 41 percent chose to seek health care and 33 percent used self medication and the remaining 26 percent neither sought health care nor used self-medication. The results further showed that among those who sought health care, the choice of provider varied. The findings were that 35 percent chose to seek health care at a hospital, 63 percent at a health centre/clinic and 2 percent went to a traditional healer.

However, 83 percent of the households reported that they do not always use a health facility whenever a family member falls sick. Reasons for not using health facilities by households were that the income is insufficient to pay user fees (26%) and that of unavailability of drugs at the health centres (32%). The rest of the respondents, which is 18 percent and 24 percent, stated that the attitude of staff at clinics prevents them from using the health facility while others pointed out that they wait for long periods of time on queues only to be given prescriptions respectively.

The above reasons stated by people in the study of not seeking health care services from clinics are also alike to the research findings by Le Grand (1982), Gertler and van de Gaag (1990) and Timyan et al (1993) cited in Seshamani et al (2002) were that access cost was probably the largest determinant of seeking health care services which include a combination of factors such as distance to health facilities, waiting time at the facility and time for consultation, out of

pocket payments with traveling costs. The report further revealed that costs of access are usually an important explanatory factor for differences in health care utilization between different social groups. The other reasons include non availability of drugs which meant patients getting prescriptions to purchase drugs from pharmacies after paying all the fees demanded for at the health centre. A number of patients also stated that the non seeking behaviour of health care services by patients was due to the bad attitude of some nurses towards them.

Seshamani et al (2002) concluded that cost-sharing can reduce utilization of health care services. The results of the study showed that cost-sharing can reduce utilization of both curative and preventive care, and that women and children are the most affected. Similar results were found in this study.

All the households (100%) said that whenever they visited a health facility, they paid for registration fees, consultation fees, investigation charges, non available medical items such as needles, syringes and gloves. In addition to these payments, they are given prescriptions to buy drugs. Related results were found by Seshamani et al (2002). In their study, the researchers noted that people were requested to pay registration fees, laboratory investigation, x-rays and tests charges. Among other things, people seeking health care services were asked to pay consultation fees and provide other medical items if certain procedures were to be conducted.

Studies by Arhin-Tenkorang (2000) demonstrated that user fees increased the financial barriers disproportionately faced by the poor when seeking health care services. According to Arhin-Tenkorang, user fees placed an impossible financial burden on low in-come households. He stated that balancing households' expenditures on health against that of food, education, clothing and transport is a formidable task. There is a decrease in the consumption of other household goods through the diversion of resources. The findings of the research can exemplify this when about 6 percent of the households indicated that they purchased the non

available medical supplies every time they visited a health facility while 32 percent stated that they rarely did, although 38 percent of the households could afford most of the time. The study results also revealed that 30 percent of the households were unable to pay or buy the commodities while 70 percent indicated that sometimes they managed only after borrowing some money from friends, relatives and 'kaloba' in very serious conditions.

The study results were that all the households (100%) indicated that drugs were not readily available at the health facility most of the time which lead to majority of the patients (73%) being given a prescription every time they visited a health facility. Although prescriptions were given to the patients every time they visited a health facility, all the households said that they did not always afford to purchase the drugs prescribed because they did not have sufficient funds. These findings relates to the national situation that was revealed in the study on the Living Conditions Monitoring Survey (LCMS) by Seshamanin et al (2002), that the largest single expenditure item on health in households was drugs in spite of no official fee for drugs in government facilities. The study further revealed that many households were spending huge amounts of their income on drugs alone, thereby being the most expensive item of health care services. Similar studies by the same authors also showed that in Lusaka, Kitwe and Eastern Province over 50% of household health expenditure was on drugs.

CHAPTER FOUR

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This section summarizes the conclusions of the study findings and makes recommendations based on the study results. The conclusions are based on the evidence from the results and are closely tied to the specific objectives. The purpose of the study was to establish the extent to which the policy of cost-sharing affected the utilization of health care services of the low income group in the particular localities of Chainda and Kalikiliki shanty compounds in the City of Lusaka.

CONCLUSIONS

The conclusions are based on the study findings and have been made in relation to the specific objectives:-

- 1 To determine the extent to which the households used the In and Out-Patient services.
 - i. The study revealed that the low income group did not seek health care services because they could not afford to pay user fees. As a result, there was a reduction in the number of people accessing health care services thereby recording low revenues at local health centres.
 - ii. It was revealed that because of low revenues raised at local health centres, there were insufficient funds to improve the quality and quantity of health care service delivery at these health facilities. Study results of the low income residents of Chainda and Kalikiliki indicate that sick members did not seek health care services from the local clinics because of the perceived poor quality of services.
 - iii. Study results showed that, although the exemption policy was introduced to ease the burden for the low income group, the situation

did not change as the health facilities continued to record a reduction in the number of people accessing the health care services. The people were not only paying user fees and/or schemes, but also a number of other medical and surgical items.

- iv. The study results revealed that the majority of households in the shanty compounds earned an income less than K500, 000-00 per month, making it difficult to meet medical bills.

2 To determine reasons for utilization or non utilization of health care services.

- i. Lack of drugs at health facilities resulted in patients being given prescriptions to buy their own medicines from pharmacies. However, no single household could always afford to purchase the drugs from pharmacies as they were expensive.
- ii. Utilization of health care facilities was influenced not only by the fees charged for services, but also by the perceived low quality of care, the availability of alternative providers, the low income of the local population and the private costs such as transport costs of accessing health care services. Nonetheless, the non-availability of drugs appeared in several instances to be an important factor explaining responses to non-accessibility of health care services. The main reason for non availability of drugs most of the time was that there was insufficient drug supply due to poor drug supply chain by the Government.
- iii. The study results revealed that the households were only able to meet medical bills only after borrowing money (kaloba), sold some household property, or engaged in extra income generating activities to raise the required amount of money. However, kaloba always left households deeply in debts.

- iv. Besides having low income, the residents of Chainda and Kalikiliki shanty compounds perceived the provision of health care services as solely the government's responsibility. This could have made them reluctant to pay user fees.
- v. The findings showed that the introduction of user fees where none existed before created perceptions of high percentage increase, such that the charges were accompanied by a decline in demand for public health care services.
- vi. Other reasons for non utilization of public health facilities were unfriendly health staff and long waiting time.
- vii. There are high proportions of extremely poor people in the Zambian population and the worsening economic situation in the country affected demand. The level of fees charged probably determines whether and for which conditions people seek health care services, depending on their economic situation.
- viii. The general liberalization of the economy made certain substitute services widely available, such as drugs from drug stores or peddlers and traditional practitioners.

3 To compare the extent to which the findings relate to the national situation.

- i. The study results revealed that only 44 percent of the households were in permanent jobs. These results are similar at national level which indicates that unemployment level in the country is high especially among the shanty town dwellers and has been rising sharply since 1992.
- ii. The research results indicated that the majority of households had family members who had fallen sick and had used a health care facility a few months preceding the studies, while a few households did not. The results further showed that among those who sought health care

services, the choice of provider varied. The same types of health facilities were used both in the current study and at national situation. They used local clinics, the University Teaching Hospital and traditional practitioners, while others did not seek any health care.

- iii. Results for the current study and at national situation are that households did not always use a health facility whenever a family member fell sick because of insufficient income, unavailability of drugs at the health centres, the attitude of staff at clinics and long waiting time on queues only to be given prescriptions.
- iv. Findings of both the study and national situation revealed that H/Hs paid for registration fees, consultation fees, investigation charges, non available medical items such as needles, syringes and gloves.
- v. Results showed that user fees increased the financial barriers disproportionately faced by the poor when seeking health care services and that they did not always afford to purchase the drugs prescribed because they did not have sufficient funds. The studies further revealed that many households were spending huge amounts of their income on drugs alone, thereby being the most expensive item of health care services.

RECOMMENDATIONS

The following recommendations were made based on the evidence from the study findings:-

- i. Since the Exemption Policy that was put in place did not seem to yield the intended results, user fees should be charged according to different economic levels in a locality. This could be done by the relevant authorities coming up with charge sheets for health care services according to the economic status of the community. Residential areas act in some ways as a guide in the economic status of individuals in society.

- ii. Government to improve supply of drugs, medical and surgical items in all health facilities regardless of its level. This can be achieved by increasing financial/budgetary allocation to the procurement of drugs. Drugs should be put as a priority on health facility supplies. Supplies of medical and surgical items should be among the priorities too. Government should not leave the exercise of supplying drugs, medical and surgical items to specific health care facilities. To ensure that drugs, medical and surgical items are being utilized effectively, government should put in place monitoring mechanisms.
- iii. Government should find other means of subsidizing medical and surgical supplies to health facilities because many Zambians (about 70%) are living below the poverty datum line. To achieve this, government should identify cheaper sources such as China and India, without compromising quality.
- iv. Government should partner with some private business agencies or individuals who are economically sound to provide health care services to the majority populace who are not economically able. This can be attained by government identifying business corporate such as the banks. Instead of such business institutions running promotion of cars, buses, shopping vouchers, to name but a few, they can supplement government efforts in supplying drugs, medical and surgical items.
- v. Government to carry out extensive consultative meetings with its collaborating partners to come up with other sources for financing health care services. Government can achieve this by identifying specialists in various relevant fields such as pharmacologists, technicians and scientists and send them abroad for more training in order to establish manufacturing industries to make the required items locally.

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APPENDIX

APPENDIX 1: QUESTIONNAIRE

Preamble

To the respondent:

The questionnaire on the evaluation of cost sharing during the Health Reforms (1992-2005) has been made as a requirement for obtaining a Master of Public Administration (MPA) degree at the University of Zambia. The researcher is requesting you the respondent to be as free as possible as you answer the questions. The information given will be treated with high confidentiality and used specifically for the intended purpose. The researcher wishes to thank you the respondent in anticipation for your willingness to answer the questionnaire.

Date.....

1. Location

[1.1] Chainda compound

[1.2] Kalikiliki

2. Household

No.....

Personal Details

3. Sex

[3.1] Male.....

[3.2] Female.....

4. Age

[4.1] Between 16 – 25

[4.2] Between 26 – 35

[4.3] Between 36 – 45

[4.4] 46 and above

- 5. Religion
 - [5.1] Pentecostal
 - [5.2] Catholic
 - [5.3] Protestants
 - [5.4] Moslem
 - [5.5] None of the above

- 6. Employment
 - [6.1] Self employment
 - [6.2] Formal permanent employment
 - [6.3] Formal contractual employment
 - [6.4] Unemployed

- 7. Income per month
 - [7.1] Less than K100, 000
 - [7.2] Between K100, 000 – K250, 000
 - [7.3] Between K250, 001 – K500, 000
 - [7.4] Above K500, 000

Household Details

- 8. Household Size
 - [8.1] Alone
 - [8.2] 2 – 5
 - [8.3] 6 -10
 - [8.4] Above 10

9. Household members who were sick in the last twelve months

[9.1] 1 -5

[9.2] 6 -10

[9.3] All household members

[9.4] None

10.0 Use of Health Facilities

10.1 How many household members used health facilities in the last twelve months?

[10.1.1] 1 -5

[10.1.2] 6 -10

[10.1.3] All household members

[10.1.4] None

10.2 Type of health facility used in the last twelve months

[10.2.1] clinic

[10.2.2] mini hospital

[10.2.3] University Teaching Hospital (UTH)

[10.2.4] All of the above

[10.2.5] None of the above

[10.2.6] others specify

.....

.....

.....

10.3 Do you always use the health centre every time a household member becomes sick?

[10.3.1] Yes

[10.3.2] No

10.4 Give reason/s for your response to question 10.3

[10.4.1] income sufficient

[10.4.2] income not sufficient

[10.4.3] drugs and material such as gloves, needles, syringes always available

[10.4.4] none availability of drugs, gloves, needles and syringes

[10.4.5] others specify

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

11.0 Cost of transport to Health Centre

11.1 How far is the Health Facility from your home?

[11.1.1] less than 5 km

[11.1.2] between 5 – 10 km

[11.1.3] between 11 – 15 km

[11.1.4] between 16 – 20 km

[11.1.5] more than 20km

11.2 Access to health centre

[11.2.1] Walking

[11.2.2] Riding a bicycle

[11.2.3] Using public minibus

[11.2.4] Booking a taxi

11.3 How much money do you spend on transport when accessing health services?

[11.3.1] less than K50, 000

[11.3.2] Between K50, 000 – K100, 0000

[11.3.3] Between K100, 001 – K200, 000

[11.3.4] Above K200, 000

11.4 Are you able to afford transport costs?

[11.4.1] Yes

[11.4.2]No

11.5 Give reason/s for your response to question 11.4

[11.5.1] Distance is short

[11.5.2] Cannot afford transport costs

[11.5.3] Able to afford transport costs

[11.5.4]Others specify

.....
.....

12.0 Cost of Health Services

12.1 Has any member of your household been admitted before in any of the health centres?

[12.1.1] Yes

[12.1.1] No

12.2 How much money do you spend every time a member of your household goes to the nearest health centre when they are sick?

[12.2.1] less than K50, 000

[12.2.2] Between K50, 000 – K100, 0000

[12.2.3] Between K100, 001 – K200, 000

[12.2.4] Above K200, 000

13.0 What do you pay for at your health centre?

[13.1] Registration fee.

[13.2] Consultation fees

[13.3] Investigation charges

[13.4] Non available items such as needles, syringes and gloves

[13.5] Drugs

[13.6] Others specify-----

141.0 How often are you asked to buy non available medical items such as needles, syringes and gloves?

[14.1.1] Never

[14.1.2] Rarely

[14.1.3] Most of the time

[14.1.4] Always

14.2 Do you afford to buy non available medical items such as needles, syringes and gloves?

[14.2.1] Yes

[14.2.2] No

15.1 Are the drugs always available at your health centre?

[15.1.1] Yes

[15.1.2] No

15.2. Give reason/s for your response to question 15.1

[15.2.1] Insufficient supply of drugs by government

[15.2.2] Insufficient funds from government

[15.2.3] Abused by health staff

[15.2.4] Others specify -----

15.3 How often are you given a prescription when you visit your health centre?

[15.3.1] Never

[15.3.2] Rarely

[15.3.3] Most of the time

[15.3.4] Always

15.4 Do you afford to buy the drugs prescribed?

[15.4.1] Never

[15.4.2] Rarely

[15.4.3] Most of the time

[15.4.4] Always

16.0 Are you able to afford charges at the health centre and buy what you are requested to?

[16.1] Never

[16.2] Rarely

[16.3] Most of the time

[16.4] Always

17.1 Have you been sent away from the health centre for non payment of service charges?

[17.1.1] Yes

[17.1.2] No

17.2 How many times were you sent away from the health centre for nonpayment of service charges?

[17.2.1] Never

[17.2.2] Rarely

[17.2.3] Most of the time

[17.2.4] Always

- 17.3 Do transport costs deter you from accessing health service?
- [17.3.1] Yes
- [17.3.2] No
- 17.4 How often do transport costs deter you from accessing health services?
- [17.4.1] Never
- [17.4.2] Rarely
- [17.4.3] Most of the time
- [17.4.4] Always
- 18.1 Do costs of health services deter you from accessing health service?
- [18.1.1] Yes
- [18.1.2] No
- 18.2 How often do costs of health services deter you from accessing health services?
- [18.2.1] Never
- [18.2.2] Rarely
- [18.2.3] Most of the time
- [18.2.4] Always
- 19.1 Do costs of non available medical items such as needles, syringes and gloves deter you from accessing health service?
- [19.1.1] Yes
- [19.1.2] No

19.2 How often do costs of non available medical items such as needles, syringes and gloves deter you from accessing health services?

[19.2.1] Never

[19.2.2] Rarely

[19.2.3] Most of the time

[19.2.4] Always

20.0 What measures have you put in place to ensure accessibility to health facilities?

[20.1] Borrow money from neighbours

[20.2] Do extra work to earn more money

[20.3] Pay in installments

[20.4] Pay in kind

[20.5] Others specify

21.0 What would be your comment on cost-sharing for health service delivery?

22.0 Can you give any suggestions for improvement?

Thank you for answering the questionnaire