

**THE DELIVERY OF HEALTH SERVICES IN THE ZAMBIAN
DECENTRALISED SYSTEM: A CASE STUDY OF LUSAKA DISTRICT**

BY

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DECLARATION

I WILLIAM KOMBE CHAMA do solemnly declare that this dissertation represents my own work which has not previously been submitted for a degree at this or another University.

Signed: 

Date: ... 10 . 4 . 92

DEDICATION

This dissertation is dedicated to both my late father **WILYMOTT CHISHIMBA MASUMBUKO** who first taught me how to persevere and to **JENOVA GOD** who hears urgent pleas of those who love him.

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This dissertation, reflects the influence of many individuals and it is a pleasure to be able to thank those more closely related with this work. Dr. Kwaku Osei-Rwedia my supervisor, played a significant and inspiring role, especially for agreeing to become my supervisor at the eleventh hour. Dr. A.C.S. Mushinge offered not only valuable comments and criticisms but the needed encouragement that has made it possible to accomplish this study in time. His acceptance of being a reader and the fine comments he provided helped me refine the thoughts and arguments in this study.

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ABSTRACT

This study was an attempt to investigate social services delivery in the Zambia decentralised and integrated system of local government, with particular emphasis on health service delivery. The investigation and analysis focused primarily on Lusaka Urban District Council which was one of the first five urban district councils to be involved in the programme of taking over the running of health facilities from central government.

The study was prefaced by the concept of 'participation' especially Bregha's (1973) basic participation model in social service delivery - a continuum of progressively increasing involvement of local people in the delivery mechanism through information/feedback, consultation, joint planning and delegated authority.

Specifically the study investigated first and foremost, if local people had been made to participate in social services delivery by the introduction of decentralisation in 1981. Secondary, it investigated the extent to which the objective of creating district based, controlled and co-ordinated health service structure had been achieved.

The study tested the following hypotheses: First, that under the decentralised system Party members were more likely to participate in service delivery than non-members. Second, that participation of local people was limited to information/

feedback and consultation. Third, that people did not participate in health service delivery in the district. Fourth, and last that a district based health service structure has not been created.

Data were collected using three instruments: focused interviews using two questionnaires and secondary literature. The first method involved in-depth discussions with key informants. The second questionnaire examined the health workers perceptions and understanding of health delivery in the decentralised system. The second questionnaire explored local people's understanding of decentralisation and their role in the delivery of health service. Secondly literature consisted of published and non-published documents.

A total sample of 150 respondents was selected consisting of five (5) key informants, a stratified random sample of ninety (90) local residents of Lusaka, and fifty five (55) rank and file medical workers in health centres in Lusaka.

Salient findings of the study were that the transference of district health jurisdiction to the Lusaka Urban District Council had attempted to create both a district based health delivery system and a district health organisation. However, decentralisation of health system had not increased local peoples' participation in health services. There was an absence of an articulate local structure through which local residents could get involved in health delivery, and that health workers were

ill-prepared to handle community involvement in health services delivery.

The study concluded that there was no general policy guidelines about local participation in health services delivery in Lusaka. What was required was therefore a broad policy defining the nature of the council's commitment to popular participation and clarifying the boundaries, settings, and problems of such involvement.

With regard to decentralisation of health services, lack of adequate resources especially finance and personnel hampered the exercise. Overall, the decentralisation Act was found to have been over ambitious as it envisaged to do more than the resources and circumstances permitted.

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CHAPTER ONE

INTRODUCTION

SCOPE OF THE STUDY

This study is an attempt to investigate social services delivery in the Zambia decentralised and integrated system of local government, with particular emphasis on health delivery. Although examples are drawn from other district councils in Zambia, the analysis focuses primarily on Lusaka Urban District Council. The Lusaka Urban District Council was chosen as a case study largely for being among the first five urban district councils to be involved in the programme of decentralising health service delivery. Therefore it offers more potential in examining how the decentralised system of health care, introduced following the implementation of the Local Administration Act in January, 1981, has operated.

The study is prefaced by the concept of 'participation' especially Bregha's (1973) basic participation model in social service delivery. This model is a continuum of progressively increasing involvement of local people in the delivery mechanism through information/feedback, consultation, joint planning and delegated authority. The use of this model is relevant because a great part of the confusion that still beshrouds the subject of participation is due to absence of a commonly agreed upon conceptual model. To cut through this frustrating ambiguity and reach at least a beginning of common usage in terminology, I propose to use Bregha (1973) articulated continuum of participation based on increasing involvement.

Social service refers to communal provision that promote individual and group well-being and aid those in difficulty, such as Health. In Zambia social services as we know them today were introduced during the colonial era. Nevertheless, the provision of social services in this country was less than tokenism, precisely because the conception that informed social services provision during the colonial era, was one premised on prevailing notions of colonial and racially segregated social justice (Pim Report: 1938). Under this framework, social services were meant mainly for European settlers; Africans who formed the majority of the population were largely excluded. Hence social service administration pre-occupied itself with orienting those 'natives' in need of such social services to their fate or to rely on traditional systems of welfare (Doyah, 1981: 107).

At independence, it became the responsibility of the new Zambian government to make provisions for the protection, security and development of its citizens. Consequently, the system of corporate responsibility in the form of social services was accelerated. Social services came to be valued as adjuncts to all major societal institutions, were viewed as essential and offered as a 'universal' service (FNDP, 1966-1970).

Despite this change in conception, the provision of social services such as health, continued to follow the colonial legacy of paternalism. Social services continued to be planned, administered and delivered by the central government ministries and departments, with little or no participation by the people,

whose role was not more than that of passive consumers, clients or recipients. It was not until the Third National Development Plan 1976-80, that there was an attempt to move away from this institutional framework towards community involvement in the delivery of health care, especially following the decline of the Zambian economy and adoption of Primary Health Care (PHC) strategy in 1980 (Zambia, Ministry of Health and WHO, Report: 1985).

The opportunity to achieve overall community participation in social services delivery presented itself in the form of a decentralisation policy of 1981. The comprehensive instrument behind this new institutional framework was the Local Administration Act No. 15 of 1980, which inter-alia, provided for an integrated and decentralised local administration structure, and made district council's focal points of the transformation with direct responsibilities to provide social services such as health to the citizens in their respective areas (Local Administration Act, 1980: 99).

The Local Administration Act also implied a fresh attempt to institute new forms of administrative practice, namely, 'popular participation,' intended to overcome the impediments to overall social services delivery in the country (Twumasi and Freund, 1984). For, by altering and initiating administrative practices based on 'popular participation,' local people would once again be actively involved in social services delivery in their respective district councils

(Brooks and Nyirenda, in Mohan 1985: 139). This new arrangement was rationalised in terms of the philosophy of Humanism which emphasised popular participation.

The Local Administration Act No. 15 of 1980, which provided for the decentralised and integrated local administration structure, was also the most comprehensive instrument that modified the delivery mechanism of social services in Zambia. Apart from making district councils responsible for political, social and administrative functions in the district, it shifted a bulk of social services from the central government to district councils. Those social services were spelt out as: community development, health, education, sports, housing and accommodation, public amenities, parks and zoos, voluntary clubs libraries, cultural affairs and social security. All these services were brought under the jurisdiction of social secretary of each district council (GRZ, 1977).

The major reason for this decentralised system of government was to make local people participate in their social and economic betterment and ensure participatory democracy and development through self-reliance (Beyani, 1984: 19).

STATEMENT OF THE PROBLEM

This study aims at investigating first and foremost, if local people have been made to participate in the delivery of social services since the advent of decentralisation in 1981

by examining health service delivery in Lusaka Urban District (LUDC). It is hoped that by looking at one district council, the study will come up with a detailed analysis and interpretation of health service delivery under the decentralised system, thereby contribute greatly to the understanding of the fundamental characteristics of Zambia's decentralisation policy especially its ostensible goal of increasing popular participation by the local people in programmes.

Secondly, the study aims also at investigating the extent to which the intended objective of creating district based, controlled and coordinated health service structure has been achieved. This will entail analysing the implementation of the policy of decentralising the health services, particularly the scope, extent and content of the policy and when and where it has been implemented. Finally the study seeks to contribute toward the development of knowledge on 'popular participation' by examining the applicability of Bregha's (1973) model of participation in social services delivery' to the Zambian setting, there by contributing in reaching "at least a beginning of common usage in terminology" about the subject of participation (Bregha, 1973).

STATEMENT OF HYPOTHESES

This study will test the following hypotheses:

1. Under the decentralised system, Party members in the district are more likely to participate in health service delivery than non-party members.
2. Under the decentralised system, participation of local people in health service delivery is limited to information/feedback and consultation rather than joint planning and delegated authority.
3. Despite the good intentions of decentralisation, local people do not participate in health service delivery at the district level.
4. The intended creation of district based health service structures has not been accomplished yet.

REVIEW OF LITERATURE

There are two groups of literature relevant to this study. Literature on Decentralisation and on Social Service Delivery. We begin with Decentralisation.

DECENTRALISATION: There are several studies done on decentralisation, both outside and within Zambia.

The notable ones are those conducted by Conyers (1982): Lungu (1980), Beyani (1984), Simposya (1985) and Mijere (1985).

Lungu (1980) analysed the problem related to the implementation of the Zambia Public Bureaucracy.

His study, prefaced by the organisation/environment perspective, articulated the problems as:

- (1) Socio-political elements i.e. colonial legacy; power setting and political-economic turbulence.
- (ii) Bureaucratic elements i.e. symbolic structures, goal ambiguity, role confusion, poor co-ordination, inadequate staffing and unethical behaviours of public officials.

His conclusion was that it is important to find out when where and how to implement administrative decentralisation if it is to be effective.

- Conyers (1982) examined decentralisation by looking at four countries that had implemented it. His observations were that decentralisation was a system for encouraging local participation and means of improving the quality of plan preparation and implementation. However, he saw local participation being hampered by lack of adequate participating capacity at the local level.

- Beyani (1984) looked at the legal framework for the decentralised system of government in Zambia, by examining three objectives of the local administration Act 1980, namely: integration of local administration, Party and Government departments; autonomy of district councils and transfer of power to the people. He found

that only the Party has been effectively integrated into district councils, that the autonomy of district councils is undermined by provincial organs, and that the only power transferred to the district council is political which restricts people's participation to institutions of the Party and its members.

- Simposya (1985) assessed the impact of the 1980 decentralisation reforms in respect of horizontal co-ordination and popular participation in planning at both the province and district. He found that lack of financial resources and inadequate staff hampered horizontal co-ordination, and in terms of popular participation that only party members participation in planning has been improved by the 1980 decentralisation in Zambia.

- Mijere (1985) examined the mineworkers resistance to government's introduction of decentralisation in Zambia. His salient findings were that,, miners rejected the decentralised system because they wanted to preserve their status as a labour aristocracy; they feared the decentralised system would concentrate political and economic power in the hands of national and district UNIP leaders; and that it would entrench the alliance of national leadership with international capitalists.

As the foregoing review of literature shows, decentralisation has been ably researched, examined and defended theoretically and through a wider array of generalisation. What is lacking however, are indepth evaluations of the relationship between decentralisation and specific sectors such as social development at the subnational unit. This study will therefore, be unique in its focus on the relationship between decentralisation and social development. In this way this study will give us more in depth knowledge about the way decentralisation has been implemented, especially its ostensible purpose of stimulating both local people and district councils to take the initiative in developing programmes and mobilising their resources in a concerted manner.

SOCIAL SERVICES: The case of social services provision by the local authorities has often been advanced especially in Europe and North America. The justification contains many of the same elements of local knowledge, personal involvement, local control and speed of responsiveness.

- Jackson (1965) holds the view that local government provision of social services inculcates a sense of local responsibility and local patriotism and has an educative effect in nurturing citizens in the practice of self-government and social service delivery.

- Leaper (1968) says if local units are to provide services, certain provisions have to be made; the corporate body must respond in size, resources, and efficiency of organisation to the nature of social needs in question. This local initiative and effort can come through legal enactment or by delegation by central government agencies of their functions to a body at local level.

- Nyirenda (1975) holds that the most conspicuous characteristic of Zambia social services and delivery mechanism is the fact that they have not been sufficiently integrated into the pattern of social organisation of the Zambian people. Consequently, there has been rejection of the majority of social services or where accepted have had adverse effect on beneficiaries. He therefore suggests use of a humanistic approach to social service provision.

- Brooks and Nyirenda (1985) herald the decentralisation system in Zambia by assuming it would have more meaning for the delivery of social welfare services by sufficiently integrating them into the pattern of social organisation of the people. Some of the benefits that decentralisation would bring are assumed as: wider coverage, true partnership, true integration of services, effective utilisation of personnel potentials, improved coordination and relevance of the services to people's needs. However,

the actual relationship of decentralisation and participation is not researched.

OPERATIONAL DEFINITIONS:

DECENTRALISATION: will mean the transfer of legal, political and administrative authority to plan, make decisions and manage public functions from central government to district councils.

SOCIAL SERVICES: will refer to communal provision that promote individual and group well-being and aid those in difficulty such as health and education.

PARTICIPATION: will mean involvement of local people in social services planning and implementation through any of the following techniques; information/feedback; consultation, joint planning and delegated authority.

SOCIAL WELFARE: will refer to those policies and programmes by which government guarantees a definite minimum of social money and consumption rights etc. to its citizens.

DISTRICT COUNCIL: will refer to an autonomous local authority created through the implementation of the Local Administration Act of 1980.

PARTICIPATORY DEMOCRACY: will mean a system of philosophy propounded by President Kaunda in which people are said to have and to exercise power and responsibility for their own individual and group social economic and political welfare.

LOCAL PEOPLE: shall refer to any/all persons residing within the legally established and accepted boundaries of a district council.

METHODOLOGY

Data were collected using three instruments; focussed interviews using two questionnaires and secondary literature. The latter consisted of published and non-published documents.

The first method for collecting data involved in-depth discussions with a number of key informants on various aspects of the study. Two distinct but related questionnaires were also used. The first questionnaire examined the health workers perceptions and understanding of health delivery in the decentralised systems, and its applicability and implications for health service delivery in the district. This questionnaire was also meant to examine awareness by health workers of popular participation, especially the necessity of working together with people in health care programmes, and to assess the opportunities offered to local residents of Lusaka to participate in health care delivery.

To begin with government officials such as the Deputy Director of Medical Services in charge of decentralisation and the Assistant Secretary (Hospital Administration) were interviewed so as to gauge the official perspective of the problem. As representatives of the Ministry of Health, the two gave me the government's official policy on decentralisation

and the Ministry of Health response and guidelines on the transfer of the health services responsibilities to the district councils. Other medical personnel such as the Provincial Medical Officer for Lusaka Province and the medical officer for Lusaka Urban District Council were also interviewed. These two officials supplemented information on the practical implementation of decentralization of health services and its intergration into the structure of Lusaka Urban District Council, including the problems hampering the smooth take-over of health services responsibilities by the district council.

I then interviewed the Social Secretary for Lusaka Urban District Council in his capacity as head of department which initially was responsible for health service delivery. He too, gave me various viewpoints about the problem, including important insights on community participation in health care programmes.

Finally, I interviewed (55) fifty five rank-and-file medical personnel involved in health service delivery (Clinical Officers, Nurses, Public health workers) in Health Centres spread-out in Lusaka Urban. Data from these front-line workers were particularly important, in that, implementation of the policy of decentralisation of health services depended on them, including, in this case, the involvement of local people in all aspects of health services delivery. Their responses were critical in arriving at conclusions pertaining to the scope and

extent of decentralised health services, including insights about the interactions, contacts and relations between health workers and local residents in Lusaka, that were assumed to be central to the success of the policy of popular participation of the local people in health service delivery.

The second questionnaire explored local people's understanding of decentralisation in general and the district council's position vis-a-vis the health of local people. A stratified random sample of (90) ninety respondents was picked from the population of Lusaka. These consisted of three equal groups of local people, namely; (30) thirty party (UNIP) members; (30) thirty non-party members or ordinary respondents and (30) local civil servants (working and living in the peri-urban areas and suburbs of Lusaka). Membership or non-membership in the Party, were important conditions in the selection of respondents from the local populace because I wanted to compare and contrast the responses of Party members and those of non-party members. This comparison was important because one of the hypotheses of the study was that under the decentralisation policy, members of the ruling United National Independence Party (UNIP), were more likely to participate in health services delivery than non-party members, primarily because, they had access to government institutions and structures. The responses of the two categories of respondents would help in clarifying this point and also help to test Beyani's (1984)

argument that decentralisation enhanced the chances of UNIP officials and cadres to participate in programmes in the district.

Local civil servants were included to test Chamber's (1970) characterisation of 'popular participation' as involving local people and local civil servants need to engage in joint planning and action. On the whole, a total sample of 150 was selected.

The second source of data were the primary and secondary sources, comprising both the published and unpublished literature. The primary documents included the Local Government Act of 1965, the village Act of 1971; the Local Administration Act No. 15 of 1980, the 'Blue Book' Lusaka Urban District Annual Reports for the years 1987, 1988 and 1989; Ministry of Health Annual Reports and Seminar Report on Decentralisation. Secondary literature included various documents written by students and colleagues in the University of Zambia. All these documents were important for understanding the Zambian decentralised and integrated local government system and their wide varieties was beneficial both in providing different perspectives to the problem and in the comparison and analysis of evidence. Amongst these sources, the Local Administration Act No. 15 of 1980 and the Ministry of Health's Policy Guidelines on the implementation of decentralised health services were foremost; their stipulations provided the basis for assessing the functioning of the decentralised system and policy of decentralised health services.

The secondary documents included books and articles on social services; health; participation and Zambia's economic and socio-political history. In particular, I have traced the materials concerning the development of health services in Zambia to the late 1890s during the epoch and rule of the Chartered British South Africa Company (BSAC) through Imperial Rule, to the Post Independence period. On social services in general, I have consulted sources which describe social services in industrial and post-industrial societies and those that look at social services from an international comparative perspective. On participation, I have specifically consulted the works of Bregha (1973), Chambers (1970) and Armstein (1965). All these sources have clearly analysed various aspects of social services, health care and participation which were important in enhancing my understanding of the topic under discussion.

ORGANISATION OF THE DISSERTATION

The dissertation is divided into seven chapters; the Introduction serves as Chapter One. This chapter presents the scope and objectives of this study. It also outlines in detail sources of data and their particular significance to the study.

Chapter two traces the evolution of health services in colonial and post-colonial Zambia. It examines the scope and extent of health services provision and assesses the

factors that helped to shape health into an institutionalised system. The chapter also examines the national philosophy of Humanism vis-a-vis health care, contrasting the policy statements with actual practice during the post-colonial era.

Chapter three explores the concept and forms of decentralisation in more detail. It further examines the objectives of decentralisation in Zambia in relation to popular participation by the people, and examines the Local Administration Act of 1980 in detail.

Chapter four assesses the implementation of decentralisation of health services to district councils and examines the rationale behind this implementation. It also examines the district councils' reaction and responses to transfer of health responsibilities to them.

Chapter five, examines the decentralised health services in Lusaka Urban District Council, by analysing health services in relation to the variables of organization, scope, coverage and responsibility.

Chapter six analyses popular participation in health service delivery in Lusaka, and examines participatory approaches being utilised in health service delivery.

Chapter seven, isolates or recapitulates the key points that emerged from this study; these points are organised into brief but concise statements of generalizations in the form of prospects and problems of health delivery under the decentralised system of local government. Recommendations are also made.

CHAPTER TWO

HISTORY OF HEALTH SERVICE IN ZAMBIA

INTRODUCTION

Health services delivery in Zambia could only be meaningfully understood in historical perspective. Therefore, I first discuss the concept of social services and offer a general overview of what constitutes social services, their functions and why health is regarded as a social service. Thereafter, I shall discuss the evolution of health services in Zambia.

DEFINITION OF SOCIAL SERVICES

According to Alfred Kahn (1973) social services are difficult to define because the concept carries with it some ideological baggage (Kahn, 1973: 4). Kahn refers to the lack of unanimity in the conception and use or application of term 'social services,' since this often tends to take on different meanings in different political and cultural contexts'. However, the term 'Social Services' is internationally recognized as covering and referring to essential forms of communal provision (Kahn and Kamerman, 1976: 2) and despite minor differences in terms of reference, the concept is largely used in relation to five basic and familiar services, namely, education, health, housing, income transfers, and employment training (Kahn and Kamerman, 1976). Admittedly,

the names of services, the titles and even the weighting of functions and degree of development, including conceptualization vary from society to society; however, there is no difficulty in communicating about these services and their roles (Kahn and Kamerman, 1976: 5).

Generally, definitions of social services often refer to the scope, the purpose or the characteristics of the social services. Sometimes, however, definitions do refer to all three dimensions (Kahn, 1973: 20).

According to the United Nations, social services is an organized activity that aims at helping toward a mutual adjustment of individuals and their social environment. This objective is achieved through the use of techniques and methods that are designed to enable individuals, groups, and communities to meet their needs and solve their problems of adjustment to a changing pattern of society, and through cooperative action to improve economic and social conditions." (UN: Social Commission Report, 1959: 6). This definition focuses on the scope of social services.

The following definition focuses on purposes: "Social Services may be interpreted as consisting of programmes made available by other than market to assure a basic level of health-education-welfare provision, to enhance communal living and individual functioning, to facilitate access to services and institutions generally, and to assist those

in difficulty and need (Kahn, 1969: 179).

As the above definitions of social services indicate, social services are often targeted on individuals, groups and communities and involve the "rendering of help, the supply of resources, and the implementation of benefits." (Kahn, 1973: 20).

CONCEPTIONS OF SOCIAL SERVICES

Social services appear everywhere in the modern world, and are seen as part of the improved standards of living. In this sense, social services have important functions in any society. Those functions may be categorised as MANIFEST (apparent, conscious) or as LATENT (less visible, hidden) functions.

Manifest functions of social services are all those activities that contribute to personal and group development and socialisation as a substitute for what the community as a whole or the extended family once did (Kahn, 1973: 14). Kahn categorises the objectives of manifest functions of social services as:

- (i) to strengthen and repair family and individual functioning with reference to ongoing roles;
- (ii) to provide new institutional outlets for socialisation, development, and assistance roles that once were but are no longer discharged by the nuclear or extended family; and

- (iii) to develop institutional forms for new activities, essential to individuals, families, and groups in the complex urban society in a manner unknown to a simple society (Kahn, 1973: 17).

This implies that social services are not merely replacements of earlier social forms, but are also new responses to new social situations. They are, therefore, social inventions that address the needs of modern man in his inter-relationships and roles.

Apart from these manifest roles, social services also perform less visible roles, as instruments for redistributive policy. They signify and implement, on a large scale, social change and societal enrichment. As Kahn further adds, "well-designed and effectively delivered social services may meet needs and may even create satisfactions." Yet, social services may sometimes be simply illusions of solutions, and act as smoke screens for diverting political pressure. For example, a nutrition education programme may divert attention from the need for abundant and cheaper food. Therefore, although social services perform important functions, proposals for a given service at a given time need screening. Latent functions especially shed light on issues of timing, focus, and mission of social services.

Thus, social services are all those communal provisions aimed at promoting individual and group-well being and aid those in difficulty. They encompass such communal services

as health, education, housing, as well as programmes of family and child welfare, services to the aged and various assistance counselling programmes, provided in institutions such as hospitals, schools and other similar facilities (Kahn, 1973: 5). The important feature of social services is that they are meant to enhance and facilitate daily living and enable individuals, families, and other primary groups in society to develop, to cope, to function and to contribute to society's development.

It is useful to understand that as social services become more universally available and are more generally employed, they assume independent institutional identities. As a result one talks of health, education or housing. This same independence in institutional identity, works out to mean that such services come to be recognized as applicable to the total population (i.e. they assume the status of a universal service).

HEALTH SERVICE IN THE COLONIAL ERA

Since the history of Western expansion in Zambia is divided into three historical epochs: the pre-colonial era, the time of the British South Africa Company Rule (1895-1924), and the phase of British Imperial Rule (1924-1964), I will also discuss the development of health services in the pre-colonial era, by examining the roles of the Missionaries (1850-1895);

the BSA Co. (1895-1924) and British Colonial Office (1924-1964), in the provision of health services, and further analyse the consequences of the colonial ideology on the health status of Africans and health care practices throughout the colonial era.

MISSIONARY PENETRATION

Western health care services were first introduced into Zambia by the missionaries. When the missionaries first came to Zambia, they entered a land afflicted by disease and served by the individual efforts of the traditional healers (Gelfand, 1961: lx). After years of struggle against disease, they realised the importance of devoting more of their energies to medical work, and thus became the pioneers of the country's modern medicine, especially after the death of David Livingstone. Stimulated by the pioneering work of Livingstone, missionary societies in Europe, such as the famous London Missionary Society and the Church of Scotland, began to send medical missionaries, who settled and practiced south of Lake Tanganyika at Mwenzo, Kawimba and Niamkolo (Gelfand, 1961: 159).

Although these early medical missionaries were the sole purveyors of western medicine in the country, their endeavours made little impression on the health or health practices of the African population in this country. The medical missionaries were initially concerned only with the health of their fellow evangelists (Doyah and Penwell, 1981: 250). This focus soon

changed with the realisation that medical work could be used as an adjunct to evangelization and in undermining indigenous culture and institutions. Thus medical services were extended to Africans on an institutional basis as one missionary noted in 1899:

The usefulness of the medical arm of the missionary service is indisputable. It breaks down opposition, dissipates prejudice, and wins its way to the hearts and homes of the high and low, the rich and poor. It receives the highest official recognition, and thus facilitates the employment of all other agencies. The medical doctor is persona grata even in palaces and halls of state (Doyal and Penwell, 1981: 251).

The significance of the above words can be evidenced by the fact that mission medical work both pre-dates and has out-lived colonial rule and continues successfully in the post-colonial states. Indeed, missionaries introduced also elementary medical training and maternity and child health in this country.

A major weakness of missionary medical work was its overwhelming concern with curative, hospital-based medicine which did little to meet African health needs. This concern with curative services was not by default, rather, as Schulpen points out, it was only the concept of healing that carried religious potency, and the community approach implicit in public health activities was unacceptable to missionaries (and to Western medicine in general) as it allowed little opportunity for direct personal contact (Schulpen, 1975: 42).

It was only maternal and child health with implications for new candidates for baptism that was favoured. Despite this weakness the missions laid the foundation for the expansion of Western medical care which followed at Independence.

BSA CO. RULE, 1895-1924

In 1895 the BSA Co. assumed responsibility for the northern territory, which in 1897 came to be designated as Northern Rhodesia. It was the determination of Cecil John Rhodes that this happened. After obtaining mineral rights from chiefs such as Lobengula of the Ndebele, Lewanika of the Lozi, Mpezeni of the Ngoni, Chitimukulu of the Bemba and Kazembe of the Lunda peoples, he obtained a Royal Charter for his company, the BSA Company from the British Imperial Government.

The Charter was granted to the BSA Company in 1889, authorizing it to administer "the region of South Africa lying immediately to the North of British Bechuanaland and to the North-West of South African Republic and to the West of the Portuguese Dominion" (Ganor, 1964). This region included the present day Zambia, Malawi, and Zimbabwe. The Charter further granted Rhodes the authority and rights to conclude treaties with African chiefs in the territory, and he in turn promised that his company would maintain law and order and promote white settlement.

Disease was a major obstacle encountered by members of the BSA Company sent to explore Zambia and, unlike indigenous populations, Europeans found the country dangerous to their health. (Doyal and Penwell, 1981: 239). As a result of high rates of mortality and morbidity among BSA Company officials, medical personnel became important units for the company. Despite initial reliance on medical missionaries, the company was compelled to start developing a rudimentary medical service in the territory by 1895 (Gelfand, 1961: 158-59).

Initially, the country was served by a handful of doctors directly employed by the BSA. Co. and these were required simply to attend to the immediate health problems of the small white employees and officials of the Company (Pim Report 1938: 288). There was little throughout the BSA Company rule which could be regarded as a medical service, and in fact between 1912 and 1924 the medical staff of the BSA Company were few and dealt only with the cases of European settlers. The medical services as organised and conducted by the Chartered Company, were aptly described by the Chief Medical Advisor to the Secretary of State as 'a garrison service', consisting of a few company appointed medical officers treating a few European settlers associated with the company and concentrated in a few scattered locations (Pim Report 1938: 28-9).

This 'garrison service' included a few public health measures designed to prevent and control the spread of disease that could affect European settlers (Doyal and Penwell 1981: 242-43). The promulgation of the public health rules in March 1914 for example, imposed physical separation of the racial groups, thereby concretising prevailing social relations in environmental and spatial terms. Despite making a few diseases compulsory notifiable, the service lent itself to the selective introduction of 'amenities such as sanitary systems for whites, as Gelfand notes:

The improvement in living quarters of the officials in Livingstone from 1907 was quite striking. The buildings were erected with an eye on the climate; and an adequate water supply and a sanitary system was provided (Gelfand, 1961: 177).

By contrast, there was a systematic denial of public health provisions to the African population in both the expanding urban areas and rural areas, a policy which naturally resulted in a high incidence of disease. In urban areas Africans were regarded as mere sojourners who required no medical attention at all. In the rural areas, Africans were regarded as being outside the jurisdiction of the BSA Company (Gelfand, 1961: Kaplan, 1979: 24).

The BSA Company in recognition of the important role European medical missions were playing, both in the provision of medical care and in undermining indigenous culture and institutions, started offering medical subsidies, a practice

which continues to this day, though for different motives. It also started the licensing of medical practitioners. In particular, the BSA Co. concerned itself only with the health of its employees and officials and white settlers. Its only contribution to health care in this country was in opening up communication routes that eventually enabled medical services to be extended to Africans by later administrations.

BRITISH COLONIAL OFFICE, 1924-1964

The switch from Chartered Company to Crown rule did not improve the health care services for Africans. If anything, it exacerbated the plight of the African population healthwise. Indeed, the dominant European ideology prevailing at the time maintained that the role of a colony such as Zambia was to assist and complement the development of metropolitan economies like that of Britain. The effect of this ideology on the general health of the colonised people was almost universally disastrous (Doyal and Penwell, 1981: 105).

In Zambia, the scale of official medical provision during Crown rule, was for many years derisory. This was in keeping with the limited objectives of colonial health policy as outlined by the British Medical administrators in 1903 (Beck, 1970: 20). This policy originally conceived for East Africa and later extended to later colonies like Zambia, involved three elements. First was the preservation of the

health of European settlers; secondly, keeping the African labour force in reasonable working condition, and last, preventing the spread of epidemics that could endanger the health of European settlers.

The task of preserving the health of Europeans in Zambia was simple in that Europeans were concentrated along the line of rail, the Copperbelt towns and other administrative pockets in the territory. It was therefore possible for the colonial government to direct a large proportion of the available funds towards health personnel and hospitals in areas of white settlement; hence the establishment of hospitals in places like Livingstone, Kalomo, Lusaka, Broken-Hill (Kabwe) and the Copperbelt, including the administrative centres of Fort Jameson, Fort Rosebery, Mbala and Kasama. Since, these facilities were designed on a racial basis, even Africans living nearby could not take advantage of them. Moreover, the vast majority of Africans were in the remote countryside and received almost no western medical attention. Thus, the health problems of the African masses (Apart from a few thousand crucial workers on the mines and railways) were officially neglected, unless where Europeans were themselves threatened by epidemics (Doyal and Panwell, 1981: 242).

The task of keeping the African labour force in reasonable working condition was very much a secondary one. The rule of the colonial office concided with the development of Copper

Mining in Zambia. Many Africans were employed first as migrant labourers. These were given medical services equivalent to first-aid, and those that suffered major diseases were thrown back to the countryside. Later, with the development of mining and acceptance of African settlement in town, African hospitals were opened up for the African miners. However, the majority of Africans were not wage labourer in the mines but peasants who were denied western medical attention.

The third task of preventing the spread of epidemics was a corollary of the overall colonial medical policy. There was an overwhelming fear of epidemics among European settlers, and the solution was seen in terms of physical separation of the whites from the Africans (supposed agents of infection). (Doyal and Fenwell, 1981: 242-45). This objective led to the legal sanctioning of racial segregation in environmental and spatial terms. Thus the colonial state promulgated more Ordinances between 1927 and 1935 which effectively condemned Africans to insanitary conditions.

The introduction of Indirect Rule and subsequent establishment of so-called native-authorities, led to numerous Orders and Rules, relating to the control of animal and human disease, while other health directives were incorporated into law-and-order regulations. The colonial medical department came to be formally divided into curative and preventive wings, but the former predominated. Indeed, all attempts at expanding health services

in Zambia took place within the existing framework of social relations. The structural constraints of colonialism were not challenged. Certain preventive measures were dealt with on a pragmatic, piecemeal basis, while the 'diseases of poverty' that afflicted Africans continued to be neglected. As pointed out earlier, the rapid emergence of the Copperbelt after 1920 was the dominant economic and political factor which affected the provision of health services in this country during colonial rule. Labour migration and wage Labour soared with the growth of the copper economy. By 1930 the number of Africans working in the copper mines had risen to 22,000, with a couple more thousands employed along the line of rail serving the mines and towns that sprang up along the route. Both the mines and railways authorities were compelled to provide medical services to African employees (Kaplan, 1979: 27). Yet, neither the mining companies, the railway nor the colonial government provided adequate facilities and health services for the Africans. In 1937 the Pim Commission reported that the African' medical services were grossly inadequate. The African population was then 1,366,600 (Pim Report, 1938: 290).

In the case of the European population, it may fairly be claimed that reasonably adequate services were given. According to the Pim Commission, "the sites of 10 to 12 medical stations were chosen primarily in the interests of groups of European officials or settlers" (Pim Report, 1938: 290). In

fact, "there were no Europeans out of reach of competent medical assistance," concluded the same Commission.

Disparities in physical facilities were also very pronounced. While European hospitals were very good, those of Africans were in poor shape, as the Pim Commission noted:

The 12 Government hospitals for Natives, only two, those at Ndola and Livingstone are good, while **three, at Fort Rosebery, Mongu and Balovale are primitive especially as regards the operating theatre (Pim Report, 1938: 290).**

Although it was fairly more effective for Europeans, colonial curative or therapeutic medicine was very limited, both in its availability and its effectiveness, among African population throughout the colonial period; it thus played little or no part in the reduction of the national mortality rate among the indigenous people.

In terms of public health services the embryonic public health service was started in 1931 with the establishment of the 'Public Health and Sanitation Wing of the Department of Health. Under the existing law, public duties and responsibilities were delegated to "Local Authorities", that is to say, to the Municipalities of Livingstone and Ndola, to Township Management Boards including Lusaka and Broken Hill, and to a number of District Commissioners (Pim Report, 1938: 291). Yet, these Local Authorities had inadequate resources (both human and financial) with which to discharge fully these

obligations. Consequently, public health services remained very inadequate compared to the needs of the country. To make matters worse, this was at a time when the general standard of health in the country was very low and there was a great variety of diseases among the native population, which could have been effectively combated through public health measures (PIn Report; 1938: 293). The residual nature of public health was summed up in the 1946 Annual Report's reference to Maternity and Child Health:

European maternity and child welfare is dealt with at Clinics at Livingstone, Broken Hill and Ndola, and those are well patronised. In respect of Africans there are neither institutions nor staff specially devoted to this particular work... In rural areas not much can be done until the advance of the education of female Africans makes it possible to train and employ indigenous nurses and midwives (Northern Rhodesia, Health Department, 1946: 3).

Generally, health services saw a gradual but steady expansion throughout the colonial era. This growth was made possible by the growth of the copper industry, because the official view of British rule was that the expansion of medical services in any area depended on the capacity of the Local people to pay for these services. This is reflected very well in the estimates of expenditure on health, which in 1924-25 were only £30,863 but gradually rose to £60,666 in 1930-31; in 1937 they were £65,850, rising to £307,966 in 1947 and passed a million in 1954 (Health Department, Annual Report for 1953: 3).

The increase in national wealth also led to the introduction of Government Urban Clinics Services for Africans which were solely funded and supported by "Beer Hall Profits" or "Canteen Funds" and the Rural Dispensary Services for remote rural areas. Rural dispensaries were not more than first-aid centres, and were wholly staffed by poorly-trained Africans (Health Department, Annual Report for 1946: 18). During the Federation of Rhodesia and Nyasaland (1953-63) health services included curative, preventative, administrative and miscellaneous services, and medical units were reclassified into central, general, and rural hospitals, rural health centres, urban clinics and special institutions (Health Department, Annual Report for 1959: 8).

Like in the era of BSACO, missionary medical work continued to permeate the territory during the Colonial Office rule. Their activities became even more widely spread over the territory than those of the Health Department itself. The main activities of missions in health care were in the domain of curative medicine, though the curriculum of mission schools included instructions in simple hygiene..

Their services were, however, very significant as indicated in Table 1.

TABLE 1: AFRICANS TREATED AT MISSION MEDICAL INSTITUTIONS

YEAR	1940	1941	1942	1943	1944	1945	1946
In-Patients	8,748	9,102	11,017	12,158	13,080	10,589	10,366
Out-Patients	195,537	158,165	230,041	241,444	269,301	281,658	287,983
TOTAL:	204,285	167,267	241,058	253,602	282,381	292,247	298,379

SOURCE: 1946 Annual Report-Health Department, p. 33.

HEALTH STATUS AT INDEPENDENCE

When Zambia attained independence on October 24, 1964, health status in the country ranked as the second worst after Nyasaland in the former Federation of Rhodesia and Nyasaland. The average life expectancy at birth was estimated at 38 years (Health Department, Annual Report for 1964). This was mainly a result of deaths in the first year of life. One in every four babies born died before reaching one year of age. The main causes were diarrhoeal diseases, measles, tetanus, pneumonia and whooping cough. Malnutrition affected more than half of all African children. Malaria epidemics occurred frequently.

The nature of health services bore much of the blame. The country's health system was extremely inequitable and inefficient. Paradoxically, lack of money was not the main problem. The country was relatively well-endowed with funds thanks to the

copper industry. But the health system was severely imbalanced. A majority of the health facilities were concentrated in the urban areas. The health system was designed on racial basis and geared almost exclusively to the needs of the urban people. It was also a curative-oriented service.

in terms of the local authorities' provision of health services, the picture was very pathetic. There was no proper legislative definition of the powers and responsibilities of local authorities in health matters. Only the Local Authorities of Ndola, Kitwe and Mufulira seem to have been involved in operating urban clinics. In terms of Public Health Staff, Lusaka had 2 Medical Officers, 6 Health Inspectors and One trained auxiliary; Ndola had 1 Medical Officer, 4 Health Inspectors, 2 Health Tutors, and 2 Qualified Nurses; Kitwe had 1 Medical Officer, 3 Health Inspectors, and 1 Qualified Nurse on part-time; Livingstone had one part-time Medical Officer and 4 Health Inspectors; Luanshya had 1 Medical Officer on part-time, 2 Health Inspectors and qualified nurses; Mufulira had 1 part-time Medical Doctor, 3 Health Inspectors, and 1 qualified nurse; Chingola had 1 part-time Medical Officer, 3 Health Inspectors and 1 qualified nurse, and Broken Hill had 1 part-time Medical Doctor and 3 Health Inspectors (Health Department, Annual Report for 1962: 28). There were no public health workers in other towns and areas.

HEALTH CARE IN THE POST-COLONIAL STATE, 1964-80

Following independence, the new Zambian government realised early that no country could prosper economically or live in happiness unless it could plan and prepare for a more healthy environment for all of its people. Consequently, it embarked on expanding health services, with the aim of making a comprehensive health service available to all the people of Zambia. This expansion, included: planning, building, training, health promotion, health education and strengthening the system of medical records. Also undertaken were improvements and expansion of infrastructure such as housing, transport, communications, development and other factors critical to achieving a comprehensive health policy (Health Department, Annual Report, 1968: 7). Considerable expansion was especially undertaken in the establishment of hospitals and health centres as Table 2 shows.

TABLE 2: EXPANSION OF HOSPITALS AND HEALTH CENTRES BETWEEN 1966 AND 1971

	1966	1971	% Increase
Hospitals	51	75	49
RH.C/Clinics	343	553	61
TOTAL:	394	628	59

SOURCE: SECOND NATIONAL DEVELOPMENT PLAN, 1971, p. 27

In terms of health service personnel, the situation was encouraging. By 1971, there were over 405 Doctors, 800 Medical Assistants, 1,800 nurses of different categories, 1,000 Dressers, 30 Dentists and 200 technical staff, serving in the health service sector with either G.R.Z., mission of industrial services (SNDP, 1971: 27). In the same year a total of 14,200 beds and cots were available in the health facilities throughout Zambia. By the end of the First National Development Plan (1970) Zambia had expanded her curative health sector to include: maternal and child health, health education, dental, mental, occupational health, Flying Doctor Service and radiological services.

A good start was also made in public health by way of sinking 800 wells, drilling of 360 bore-holes, laying of 50 piped water supplies and 60 dams and weirs by December 1969, thereby improving safe rural water supply systems, vital for safeguarding public health (SNDP, 1971: 13).

From the foregoing scale of expansion and focus of health services, it is evident that the dominant assumption was that curative medicine provided the most appropriate means of confronting the daunting health problem the country faced. The pattern of health care built on the colonial biased structure, came to centre on hospitals, high technology and was dispensed on an individual basis. For, as we have indicated, new hospitals and health centres were built and existing one expanded despite the serious limitations that curative medicine

has in an underdeveloped country like Zambia, lacking the fundamental social and environmental constituents of health such as safe water services and sanitary waste disposal systems. By the end of the Second National Development Plan in 1975, it had become clear that while the curative - oriented health care had short-term beneficial results for individual patients, it had not, in itself, reduced the high incidence of disease nor raised the general level of health of the people in the country. The country continued to experience high morbidity and mortality rates from environmental and behavioral causes and malnutrition, **anaemia** diarrhoeal diseases of the digestive system, measles, respiratory diseases and accidents (MOH Country Health Profile 1978: 12). Moreover, communicable diseases, poor environmental conditions (unsafe water and poor sanitary waste disposal systems) and poverty ranked as the major health problems ravaging the country (MOH, 1978: 13). All these indicated that, less attention was being paid to a broader range of preventive care needs, and that there was uneven distribution of health facilities, with respect to population, and staffing of health facilities, thereby effectively denying the vast majority of people access to health care systems.

At the same time, there was a realisation that the hospital-based health system required money to maintain and by the middle of 1970s Zambia did not have such money, and the existing infrastructure soon began to decay. These problems called for

new thinking about the health care system of the country. Primary Health Care was thus perceived as an easier and cheaper alternative. Thus, as early as 1978, the Party and its Government decided to concentrate on developing a network of basic health services embracing Public Health Care (PHC) and personal health services at primary level, environmental health and sanitary facilities through which an integrated programme of health care could be achieved in the country (Country Health Profile 1978: 7-3). The major objectives of this new strategy was to develop basic health services in rural areas to integrate and expand **preventive** and curative services, and to achieve active co-operation and participation of the local communities in the execution of health programmes.

Officially, PHC was adopted in 1979 as the country's approach towards achieving health for all by the year 2000, through emphasis on prevention of disease and promotion of good health, as well as provision of basic curative services to all. By 1981 the implementation of PHC as the nucleus of Zambia's national health care system began. This was strengthened further in 1983 with the creation of a separate unit within the Ministry of Health to look after PHC (MOH and WHO Joint Evaluation Report, 1984). Other supportive and monitoring structures have since been set at national provincial district and rural health centre levels. For maximum effectiveness, PHC requires greater participation by

the people at community level in all aspects of its planning and implementation and close cooperation by the local leadership at all stages.

CONCLUSION

Social services are programmes made available by public means to ensure a basic level of welfare, enhance communal living and individual functioning and to assist those in difficulty or need. These services are oftentime targeted on communities, groups and individuals. The social services perform both manifest and latent functions, and encompass such communal provisions as health, and are meant to enhance daily living. Once the service is universally available it assumes an independent institutional identity such as health service.

Health services in Zambia were introduced by missionaries. Although initially concerned only with the health of fellow evangelists, they soon realised that medical work could be used in undermining indigenous culture and institutions and pave the way for wider acceptance of Christianity. When the BSA Co. administered the territory, it began providing rudimentary official health services to its employees and settlers, including a few public health measures designed to control epidemics that threatened European settlers' lives. The advent of crown rule in 1924 saw the perpetuation of racially oriented health policies. However due to development

of mining and administration, health services were extended to Africans, especially those employed by the mines and railways. Nevertheless, throughout the crown rule, official medical provision remained derisory. In terms of Public Health Services, these were started in 1931 when a 'Public Health and Sanitation Wing' was created in the Department of Health, and delegated to local authorities of Livingstone and Ndola. Lack of money hampered the full discharge of these obligations by the two local authorities.

After Independence the new Zambian Government embarked on the expansion of curative medical services as it realised that prosperity lay in ensuring a health environment for the people. This strategy, although greatly expanded medical services, did not lead to improved status for all the people. The situation got worse when, due to economic problems, the country found itself unable to maintain the existing health facilities, let alone create new ones. Thus, by 1978, Primary Health Care (PHC) was adopted as the nation's new strategy to ensure health for all by the year 2000. By 1986, with decentralisation in force, the Government transferred health services delivery to selected urban district councils such as Lusaka.

CHAPTER THREE

THE CONCEPT OF DECENTRALISATION AND HISTORY OF DECENTRALISATION IN ZAMBIA

INTRODUCTION

Decentralisation of administration in general, and of health services in particular, may be well understood if the concept of decentralisation is fully extrapolated. Decentralisation as a concept and a system covers a wide range of forms and practices. The notable forms of decentralisation are held to be delegation, deconcentration, devolution, dispersal and privatisation (Rondinelli, 1981 and 1983).

Decentralisation is advocated by governments, agencies and politicians for various reasons. Generally, these reasons are grouped into two main categories: POLITICAL and ADMINISTRATIVE. In this chapter I will try to analyse the concept of decentralisation in general. I shall discuss the various types of decentralisation and objectives of decentralisation in historical perspective and end up at discussing the Local Administration Act of 1980 and its main features.

DEFINITION OF DECENTRALISATION

Rondinelli (1981) defines decentralisation as 'the transfer of legal and political authority to plan, make decisions and manage public functions from the Central Government and its

agencies to field organisations of those subordinate units of government, semi-autonomous public corporations, area-wide or regional authorities, functional autonomous local governments or non-governmental organisations (p. 137).

Mawhood (1983) has also defined decentralisation as the creation of bodies separated by law from the national centre, in which local representatives are given formal power to decide on a range of public matters.

Mijere (1985) characterises decentralisation as a continuum of two types of public administration, namely, deconcentration and devolution. Deconcentration is the delegation of authority within a department, while devolution refers to an inter-organizational transfer of power to local government units and in which lines of jurisdiction are defined by law (p. 174).

The three scholars above demonstrate clearly that there are several ways of defining decentralisation just as there are several ways of implementing it generally, though, decentralisation involves the transfer of power and functions from higher to lower levels of administration. The scope and significance of such transfer depend on the objectives or motives for decentralising power and functions to lower units.

TYPES OF DECENTRALISATION

Decentralisation, as a concept and practice, governs a vast area and takes various forms. Generally, five types of

decentralisation are identified theoretically, as practical application usually involve a mix of the five systems, namely; deconcentration, delegation, devolution, privitisation and dispersal.

- (1) DECONCENTRATION: Involves the transfer of some power to representatives of central government at the regional or local level. This takes various forms. For example, mere shifting of the workload from the headquarters to staff located in outlying areas without power to decide how functions are to be performed; or creating a system of staff who have authority to plan, make certain decisions and adjust implementation of programmes to suit local conditions without contradicting national policies and objectives. Examples include field administration or the local administration in which subordinate levels of government are agents of central authority, and where heads of subordinate units are either appointed by, or directly employed, by the central government. Thus, local functions are supervised and controlled by central ministries (Rondinelli; 1981: 20).

- (11) DISPERSAL: Involves the deployment of employees of central government ministries, parastatals, private agencies to sub-national areas, in order to formally carry out the functions of the government or agency in outlying areas. In this form of decentralisation,

officers only ensure that policies and programmes are implemented at local level in accordance with directives from the head or national office. This type of decentralisation is very common, and is sometimes referred to as geographical decentralisation (Rondinelli; 1981: 20).

- (iii) DEVOLUTION: Involves creation or strengthening financially or legally, subnational unit of government activities which are substantially outside the direct control of the central government (Rondinelli, 1983, p. 21). Devolution involves three criteria:
- (a) local units of government ought to be autonomous and independent with a legal status that makes them separate or distinct from the central government;
 - (b) local units should have a clear and legally recognised geographical boundaries in which they should exercise an exclusive authority to perform explicitly guaranteed or reserved functions; and
 - (c) local authorities should have corporate authority to raise revenues, determine and control expenditure (Rondinelli; 1983: 21).
- (iv) DELEGATION: According to Rondinelli, involves the transfer of planning, decision-making, and management

authority for carrying out specific functions to semi-autonomous organisations acting as arms of the central government at subnational level. Delegation is often prompted by government's inability to provide services deemed as assential by the local people. Delegation represents a more extensive form of decentralisation than administrative deconcentration since it does not involve direct control by delegating authorities. Hence delegation involves power to make plans and decisions regarding operations (Rondinelli 1981; 1983).

- (v) PRIVITISATION: Involves the transfer of central or local government or parastatal or public responsibilities to carry out certain functions either to a voluntary organisation or private enterprise e.g. National Housing Authority in Zambia (Pinch, 1985: 38).

Despite these distinctive forms of decentralisation, its practical application either by governments, parastatals or private agencies, often embraces elements from all these definitions. Hence, the different definitions and forms of decentralisation represent only different degrees of emphasis attached to the term. Most scholars such as Rondinelli, Mawhood, Cheema have found it useful to examine and understand the objectives or motives for decentralisation in order to arrive at fundamental issues of degree and form of the decentralisation programme.

OBJECTIVES OF DECENTRALISATION

Decentralisation of power and functions is advocated by governments, agencies and even politicians for a variety of reasons. Generally, two main arguments are paramount. The first argument stresses the benefits of such a system for the efficient administration of services. The second stresses its contribution to local democracy (Pinch, 1986: 38). Therefore, the objectives of decentralisation can be grouped into two main categories: ADMINISTRATIVE and POLITICAL.

(a) ADMINISTRATIVE OBJECTIVES

Administratively, decentralisation is seen as a means of fulfilling two major functions: improving management at local level and increasing popular participation.

- (1) Decentralisation as a means of improving management at a local level, takes decentralisation as a solution to co-ordination problems as it helps reduce the influence of the vertical hierarchy associated with centrally controlled structures which hinder co-ordination. Advocates of decentralisation for co-ordination such as Esman (1980) argue that centralised control of development programmes are incompatible with local-coordination. They argue further, that to achieve any serious co-ordination at local level, considerable decision-making

authority needs to be transferred to the local level
(Esman, in Cheema S.G., 1980).

Thus, decentralisation of authority to local agencies and individuals, helps to achieve flexibility, in that local programmes are likely to take into account the needs and aspirations of the local people, and that programmes from the top can be altered to suit the needs of the local people, and more quickly.

(11) Decentralisation as means of increasing popular participation. The argument here is that decentralisation encourages community participation in decision-making and acts as a bulwark against the tyranny of an all-powerful central government administration. However, the degree and extent of popular participation depends greatly on the type of decentralisation. More participation of local people is likely, at least in principle, when decentralisation takes the form of devolution because this type of decentralisation results in local structures being controlled by locally elected members. In addition, under devolution, local structures are given formal powers which promote popular participation among the community. These powers include authority to raise revenues, determine and control expenditure, and authority over personnel. Obviously, under these circumstances the majority of the local people would

participate at least, in decisions that pertain to their needs and aspirations.

Furthermore, because decentralisation enables local people to be involved either directly or through representatives, it is said that local programmes are realistic and implementable, since they have both the support and approval of the local people.

(b) POLITICAL OBJECTIVES

Political objectives of decentralisation are subdivided into three main arguments.

(i) Decentralisation as a means of political control.

Here, decentralisation is a tool for achieving country-wide political control, in that it enables a political party or group to extend its activities to outlying regions, including the remote areas of a country. Under this framework, a party would be able to politicise the nation and possibly achieve national unity.

(ii) Decentralisation is also seen as a means of instituting democracy. Decentralisation with political representation is often seen as a way of enabling decision-making units to be in close contact with the wishes of their electorate and be responsive to their needs. Precisely, decentralisation is seen as a means of implementing democratic rule.

(iii) Decentralisation is also seen as a means of promoting national unity and political stability. By facilitating participation of various groups in the decision-making process, decentralisation enables the various groups in society more especially, the discontented groups to actively participate in decisions that relate to resource allocation.

DECENTRALISATION IN ZAMBIA

The history of decentralisation in Zambia can be traced back to the early administration of the British South Africa Company (B.S.A. Co.). The imposition of a new socio-economic and political structure involved the creation of administrative, mining and marketing centres and many other settlements. Administratively, the territory was sub-divided into North-Western and North-Eastern Rhodesia, with specific districts and sub-districts in each of the two wings. On the whole, the BSA Co. rule was based on a deconcentration of power to company officers and European Native Commissioners. This policy also made use of tribal chiefs as agents of the company in administering native affairs.

Crown rule (1924-60) saw the adoption of a policy of INDIRECT-RULE as a measure of self-government on part of African in tribal areas. This led to the appointment in 1929, of Provincial and District Commissioners and tribal

chiefs to oversee and administer native affairs. The same year saw the promulgation of the Native Authorities Ordinance and Native Courts Ordinance as legal frameworks for implementing indirect rule in rural areas. Urban areas were meanwhile catered for by the Municipal Corporations Ordinance and Township Ordinance of 1927 and 1928, respectively. Thus administration of rural and urban areas was separated. Specifically, the Native Authority Ordinance and the Native Courts Ordinance meant tribal chiefs and native councils became the authorities for their respective areas (N.A.O. No. 32, 1929: 23). Chiefs became executive and judicial authorities in tribal and customary matters.

Accordingly, the system of Indirect Rule provided for decentralised provincial and district administration. Powers of administration were devolved upon Provincial and District Commissioner's, chiefs and village headmen (N.A.D. No. 32, 1929: 2, 3). The fact that those powers were exercisable either concurrently or alternatively by District and Provincial Commissioners, meant that a system of decentralised administration was effective under Indirect Rule, since commissioners were free from bureaucratic central control (Beyani, 1984: 15).

As already noted, Urban Authorities developed along a different path. Beginning with the village Management Boards of 1911 and 1913, a base was laid for local government in urban areas. It was on this base that the 1927 Municipal Corporation

Ordinance and the Township Ordinance of 1929, and Hina Township Ordinance of 1932 were enacted. Pursuant to these legal frameworks, municipal councils started to be created, first in 1928 in the form of Livingstone Municipal Council and Ndola in 1932 (Hindel, 1950: 182-83).

As a further move in consolidating decentralised administration, provincial councils were established in 1936 under the Chairmanship of provincial commissioners. These were regional administrative bodies, whose functions were to consider provincial annual estimates for submission to government, and to recommend on policy matters of roads, schools and agriculture. In 1943, six African provincial councils integrating rural and urban administration were set up. Those performed advisory roles to government on African customary matters such as marriage law (Hindel, 1950: 191).

All these indicate that the British policy of Indirect Rule in rural areas involved a form of decentralisation, known as devolution, while in urban areas local government was exercised. This set-up persisted up to 1964 when the territory gained independence.

LOCAL GOVERNMENT IN THE POST-COLONIAL STATE

Following independence, the Local Government Act (1965) was enacted which brought the municipal, township and rural councils under one umbrella, the Ministry of Local Government.

Ordinance and the Township Ordinance of 1929, and Mine Township Ordinance of 1932 were enacted. Pursuant to these legal frameworks, municipal councils started to be created, first in 1928 in the form of Livingstone Municipal Council and Ndola in 1932 (Hindel, 1950: 182-83).

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FUNCTIONS OF COUNCILS BEFORE 1961

LOCAL GOVERNMENT IN THE POST-COLONIAL STATE

Under the Local Government Act of 1965, councils were Following independence, the Local Government Act (1965) was enacted which brought the municipal, township and rural councils under one umbrella, the Ministry of Local Government.

In all 43 rural, 16 township and 8 municipal councils were established of which three were city councils.

Although under the Act (1965) these councils were corporate bodies, they were, however, subjected to greater control by the central government. Most functions had to be approved by the Ministry of Local Government, such as estimates of capital and recurrent expenditure (Greenhood and Howell, 1980: 172-82). Even matters relating to hiring and firing of council staff was 'subject to the final authority of Local Government Service Commission (Greenhood and Howell, 1980: 170).

Under the same Act, councils were democratised as positions like councillor, mayor or chairman had to be elected by universal suffrage. Practically anyone aged 21 or more and residing in an area was eligible to vote in local government elections. This was amended in 1970, providing for appointment of mayors and chairmen by the Minister of Local Government. In another amendment of 1975 the old system of electing mayors and chairmen of councils was re-adopted, seemingly with considerations of preserving participatory democracy.

FUNCTIONS OF COUNCILS BEFORE 1981

Under the Local Government Act of 1965, councils were assigned limited functions. These functions fell into general ones for all the councils to exercise, and specific functions

assigned to particular categories of councils.

The general functions of all local authorities under this Act were to perform civic functions, mainly establishing and maintaining streets, bridges, and waterways, preparing and administering schemes for the encouragement of community development. Specific functions were categorical. The Act empowered the City, Municipal and Township Councils to establish and maintain services for the generation, distribution and supply of electricity and provide housing in their jurisdictional areas. On the other hand, rural councils were authorised to protect crops, provide storage and preservation facilities for agro-produce; to establish and maintain grazing grounds for animals; to establish local forests and woodlands; and also to establish rural mail service (Local Government Act, 1965: Section 65 and 66).

However, apart from the foregoing mandatory functions, local authorities were required to perform other important functions, such as erecting and managing markets, promoting and safeguarding public health standards so as to prevent outbreaks of diseases. The latter role entailed enforcement and monitoring of community sanitation and hygiene, especially in relation to refuse disposal, clearing of surrounding, digging of pit-latrines, etc. (Local Government Act of 1965: Part viii).

The foregoing catalogue of functions of the council as outlined in the Local Government Act of 1965, had serious implications for the performance of Councils in the area of local development. It meant that local government in Zambia, in general, and local authorities in particular, were only carriers of centrally planned functions; they were disregarded as institutions for policy formulation and implementation of development programmes, including the important area of social services delivery, despite councils being much closer to the people. In short, they were constrained by the Act which limited their jurisdiction and scope of functions.

Ironically, even the 1968 administration reforms announced by President Kaunda emphasised the role of the Party and Central Government departments over and above Local Authorities in development and administrative policy. The 1969 decentralisation reform ushered in the District Governor (DG) as new head of the district. The D.G. was to be responsible for co-ordinating development activities and general supervision of government agencies. At the provincial level, a Cabinet Minister was assigned to do similar duties (Republic of Zambia, 1978: 35).

The 1969 administrative reforms also merged the provincial and district administrative department with staff of the Ministry of Local Government, under the district governor. By so doing, the powers of provincial and district government

were increased. Participation of people through the party machinery and decentralisation of civil service was advocated by the President, so as to allow the poor majority to participate in decision-making, planning and implementation of programmes and projects.

However, the 1969 reforms were 'decentralisation within centralism,' because it made political control at both provincial and district levels even stronger than before. The party emerged supreme and began to control civil service, councils and parastatals. Power came to rest with the District Governor and most functions of the District Secretary (DS) were given to the D.G. (Government CIRCULAR No. 13, 1969). This inevitably, led to the crisis of co-ordination and supervision that dogged district administration for several years.

SIMANCE WORKING PARTY

The third landmark in the historical process of decentralising power in Zambia was the appointment of a working Party, commonly referred to as the Simance Commission, after its Chairman A.J.F. Simmance, in December of 1971. The terms of reference included:

- i. To review the present system of decentralised administration;
- ii. To analyse the possible advantage of radical decentralisation of administrative authority and financial authorities; and

- iii. To advise on appropriate staffing and training arrangements to ensure that the system of decentralised administration is manned by personnel competent to contribute effectively to the task of development administration (Simance Commission, 1972: 1).

The Commission was charged with the responsibility of conducting its investigations within the Philosophy of Humanism and to promote the principle of Humanism in its recommendations. The Commission presented its findings, conclusions and recommendations in 1972. Some of the more important ones were:

- i. That, provincial district and rural administration had deteriorated since independence, due to the transfer of qualified personnel to central institutions in Lusaka.
- ii. Antagonism had arisen between local politicians and civil servants due to encroachment of the politicians in civil service realms.
- iii. That the structures of decentralized administration were not working properly because executive authority 'remained' entrenched at the centre.
- iv. That local councils relied on the Central Government grants due to poor revenue base; hence recommended formation of new District Councils which would integrate Rural and Township Councils.
- v. That DGs be appointed as Chairmen of District Councils and District Development Committees.
- vi. That the new councils should have legal status and powers to enact by-laws and collect revenue for payment into the general revenues of the Republic (Simance Commission 1972: 7-24).

Clearly, the Simance Commission initiated a national debate on decentralisation, as it made people aware of the concept of

decentralisation and the significance of local governments in Zambia.

HUMANISM AND DECENTRALISATION

In 1967, Humanism was formally endorsed by the Party as the official national philosophy and ideology of Zambia. The basic principle of Humanism, was the participation of the people in their own affairs, not only through their elected officials, but also by their involvement in the affairs of their lives, as President Kaunda emphasised:

We have therefore, decided to have the type of democracy in which citizens participate not only through citizens representative but also by their own direct involvement in the decision-making process hence the importance we attach to decentralization of all forms of power institutions (Kaunda, 1974: 9).

Thus from the ideological standpoint of Humanism, decentralisation was a practical way of involving the citizens directly in decision-making. Structures were to be formed at all levels from village to national through which people would express their opinions about the policies and programmes of the nation.

THE LOCAL ADMINISTRATION ACT OF 1980

The Local Administration Act No. 15 of 1980 was the second law since independence to be enacted for the purpose of

establishing local government structure, the first having been the village Act of 1971 (Mijere, 1985: 185). Whereas the village Act of 1971 meant to give statutory powers to villagers and village headmen to decide on development projects, the Local Administration Act of 1980, meant to "provide a legal framework for an integrated and decentralised local administration system." (Bayani, 1984).

This Act integrated the institutions of the district council, the district committee, the provincial council and the provincial committee into a unified system of local administration (Bayani, 1984). It also incorporated the powers and responsibilities of the City, Municipal, Township, Mine Townships, and Rural Councils in the new District Councils, which became statutory bodies, empowered to initiate economic, political and social development in their respective areas (LAA 1980: 99). Thus the district council became "the focal point of the transformation." On close examination, one identifies three central objectives of the Local Administration Act of 1980. The first objective was to integrate all local governments into the new district, namely, the district council. The second objective was to regulate and establish a unified system of selecting councillors and leaders for the district council; this was meant to overcome the impediments to a united district leadership; and the third objective was the equal sharing of district resources by all wings of the district (Mijere, 1985: 186).

To realise these objectives the Local Administration Act created two pivotal and mutually supporting institutions of local administration at the District level in the form of

- (a) The District Council and
- (b) The District Committee.

These two institutions were meant to be the cornerstones of the decentralized system of local administration and were linked to similar institutions at the provincial level namely, the provincial council and provincial committee (L.A.A. 1980).

1. THE DISTRICT COUNCIL

The district council was established by the Act as a new primary institution of local administration for every district in Zambia. As a creature of statute, the district council is a corporate body with perpetual succession and a common seal. According to Article 9 of the Local Administration Act, 1980, membership of the district council was to be made up of District Governor as Chairman, District Political Secretary, two District trustees, all Ward Chairman, one representative from Trade Unions Movement, one representative from the security forces and one representative of the chiefs in the district. All members were to be called councillors.

Before a person became a councillor, he or she had to fulfill three criteria or qualifications:

- (i) one must be a member of the Party (UNIP),
- (ii) one must qualify for election to the National Assembly, and
- (iii) one must receive prior approval of the Central Committee of the Party.

By this Act, the District Governor was made head of Party and Government administration in the district.

Under the new setting, the functions of the new district council were numerous and extensive and were patterned on the philosophy of Humanism's so called five main areas of human endeavour. They included, inter-alia, administration of the district in political, economic, scientific and technological, social and cultural and defence and security fields. Since January 1981, the district council has discharged its functions through an administrative machinery known as District Secretariat, headed by the District Executive Secretary. Members of District Secretariat have particular functions assigned to their offices by the Act. For example, the Social Secretary is assigned the responsibilities of providing residents with social services including health services (L.A.A. 1980).

2. THE DISTRICT COMMITTEE

This was established under section 51 of the Local Administration Act of 1969. This Committee is composed of

- (i) the District Governor as Chairman;
- (ii) the District Political Secretary as Vice-Chairman;
- (iii) Representatives of each of the Security Forces in the District;
- (iv) two District Trustees appointed by the Provincial Committee and approved by the Central Committee;
- (v) representatives of women's league and Youth League.

It is this committee that incorporates Party organs into the local administration at the District level.

The District Committee has extensive responsibilities in local administration. It is empowered to perform the following roles:

- (i) guide and supervise all development activities in the district and to consider proposals for district development plans.
- (ii) encourage the people of the District to work hard in a spirit of self-reliance.
- (iii) carry out any other measures or acts which in its perception is in the best interests of the party, the Government and the residents of the District.
- (iv) Submit Quarterly progress reports to the Provincial Council on District Development Programmes, Security and the enforcement of law and order in the District, and the operations of the party, the Government and public institutions and organisations in the District.
- (v) Submit development plans to the Provincial Council for approval (Local Administration Act, 1980).

It is quite evident from this set up that the District

Committee plays an extensive role in local administration. It has a guiding and supervisory role over political and development activities in the District.

From the foregoing discussion on the two basic institutions of local administration, one would deduce that theoretically, the people of the district were to be given powers to select their representatives democratically and that local people would be the custodians of the new district council. At face value, the Act allowed all the people of the district to participate in the district's economic, social and cultural, scientific and technological, defence and security development (Mijere 1985: 193). People's participation in areas such as the delivery of essential health services was clearly visible under the decentralised and integrated system of local administration (Brooks and Nyirenda in Mohan, 1985: 141). The differences between what the Act provided for and the practical realities of the new set up is at the core of this study.

CONCLUSION

There are, as we have seen several ways of both defining and implementing decentralisation. However, by and large, decentralisation involves some form of transfer of power of functions from a higher level authority to a lower level structure. Its form will depend on the desired objectives.

Theoretically, five forms of decentralisation have been identified. First, Deconcentration which involves transfer of some power to representatives at a regional or local level, without the authority to decide how functions are to be performed. Second, Delegation which involves transfer of authority for carrying out specific functions to a semi-autonomous organ at a subnational level. Third, Dispersal which involves deploying staff to subnational offices in order to easily carry-out the functions in outlying areas. Fourth, Privitisation which involves transfer of public responsibilities to carry out certain functions either to a voluntary organisation or private enterprise and, fifth, devolution, which involves creation legally of subnational units of government which are substantially outside the direct control of the central government.

Decentralisation objectives are held to fall into two categories, political and administrative. In Zambia, although decentralisation is as old as the colonial history the most fundamental experiment was the 1980 Local Administration Act which integrated the activities and responsibilities of the local authorities into new district councils, and made these councils the fulcrum of economic and political development as well as the delivery authorities for social services including health care. In the next Chapter, I explore the implementation of decentralisation of health services.

CHAPTER FOUR

IMPLEMENTATION OF THE DECENTRALISATION OF HEALTH SERVICES

INTRODUCTION

Following the introduction of the Local Administration Act and its implementation in January 1981, the functions of Public Health were required to be transferred to the district councils throughout the country as stipulated by the Act. Consonant to this statutory requirement, the Ministry of Health set up a 'Decentralisation unit' whose terms of reference included overseeing the orderly transfer of health services delivery to the new district council (MOH Seminar, 1987: 1). The decentralisation of health services had to conform to the provisions of the Act, hence the programme involved a clear delineation of functions between the district, provincial and national officers. In this chapter, we take a look at the practical implementation of the policy and discuss reasons why certain decisions were taken.

GUIDELINES ON DECENTRALISATION OF HEALTH SERVICES

(1) DISTRICT LEVEL

All functions performed by the Ministry of Health at the district level were to devolve to the district council. Through the Social Secretary's department, the council was to take full responsibility of all health matters in the district such as:

- (1) establishing the health needs of the people in the district.

- (ii) establishing health care priorities for action
- (iii) identifying and maintaining up-to-date records of appropriate resources necessary for developing primary and secondary health care systems in the district.
- (iv) preparing health (care) plans for the district and monitoring their implementation to ensure success.
- (v) maintaining effective communication with health workers in the district and with the provincial health management team.
- (vi) monitoring and supervising resource allocation (i.e. funds, personnel, drugs) and submitting quarterly reports of all health activities taking place in the district to the district council and the Provincial Medical Officer (MOH, Seminar Report, 1987: 21-22).

The District Health Team under the decentralised system would consist of:

- District Medical Officer
- District Dental Officer or Dental Assistant
- Principal Medical Assistant
- Primary Health Care Officer
- Health Inspector
- Health Education Officer
- Public Health Nurse
- Pharmacist or Pharmacy Technician
- Hospital Administrator
- Staff of District Hospital & Health Centres (MOH, Report, 1987: 25).

Furthermore, the district council would take over all assets used in the provision of health services at the district, including: buildings, offices, stores, equipment, vehicles and other assets. In addition, the purchase of drugs would be the responsibility of the district council.

The district council in the new system of health services delivery was meant to become the 'District Headquarters' for health, bringing all health workers in the district under its umbrella. The essence of this programme was to integrate health practitioners and to create a district based health care delivery system.

PROVINCIAL LEVEL

The decentralisation of health services also provided for the creation of a Provincial Health Team in each province, consisting of:

Provincial Medical Officer

Primary Health Care Co-ordinator

Principal Medical Assistant

Nursing Officer

Health Inspector

Pharmacist

Senior Dental Officer (MOH, Seminar Report, 1987: 22).

The work of this team would be to co-ordinate the activities of district health teams in the province and also

to perform the following duties:

- (i) Prepare the provincial health plan and monitor its implementation in consultation with district health teams in the province.
- (ii) Assess and distribute health manpower in the province as required.
- (iii) Assess the province's drug and medical supplies requirements and distribute them appropriately.
- (iv) Prepare the provincial health budget.
- (v) Submit quarterly reports of provincial health activities to Permanent Secretaries at both the Province and the Headquarters (MOH, Seminar Report, 1987: 23).

In addition the provincial health team through the Permanent Secretary would control provincial health institutions. These institutions were spelt out as comprising all General Hospitals in each province.

MINISTRY HEADQUARTERS

The Ministry of Health Headquarters was to function as the national overall authority over health services delivery. It was to continue being responsible for national health planning, manpower training, bulk purchase and delivery of drugs to both provincial and district distribution centres, national inspectorate and national institutions. In addition, the ministry of health would co-ordinate planning of all health facilities in the country, including health centres and

private surgeries, and would remain the custodian of national health policy (MOH: 1987: 23-4).

Furthermore, the Ministry of Health would continue to control (and manage) national health institutions comprising:

Public Health Laboratories

University Teaching Hospital

Chainama Hills Hospital

Chainama College of Health Sciences

Arthur Davison Hospital

Ndola Central Hospital

Kitwe Central Hospital

Pneumoconiosis Medical and Research Bureau

Mwachisompola Health Demonstration Zone and

Liteta Hospital (MOH, Seminar Report; 1987: 24).

These guidelines provided the administrative framework for the implementation of decentralised health services in Zambia by the Ministry of Health. The comprehensiveness of the duties of the district council in health service delivery meant that the Government's major concern in pursuing the policy of decentralisation of basic health care services delivery was to improve the quality and content of health care services at the local level. The critical stage in the entire programme was actual implementation of this policy at the district. Its implementation, reception and accessibility at the district level would determine whether the policy was an innovation or

merely a political gimmick, given the type of consequence anticipated in terms of the health status of the majority of the people.

IMPLEMENTATION OF THE POLICY OF DECENTRALISATION

The implementation of the policy of decentralising health services should be seen and understood within the Zambian political economy in the 1980s. By 1980 the Zambian economy had deteriorated. Zambia, according to the findings of the Government appointed Muchangwe Commission, was economically poor at the time it initiated the decentralised system. The state of the economy was the central issue in the implementation of decentralisation, a point the ZCTU emphasised in their petition to the Secretary General of the Party:

The ZCTU seriously believes that the Zambian economy, as reflected in its revenue through the national budget which cannot even sustain the present operations, will certainly be further handicapped and incapable of managing the proposed local government administration whose costs will be heavy (ZCTU, 1980: 5).

In a nutshell, decentralisation was an expensive programme and since the Zambian economy was on continual decline, the introduction of the new, over ambitious system was economically unrealistic.

Against this background, it is not surprising that five years elapsed before the Ministry of Health finally resolved

to implement the decentralisation of health services. Even when the ministry of health resolved to go ahead with the policy, consideration of costs and manpower made it design guidelines for implementation that were contradictory to the main Act of decentralisation (Interview with Dr. W. Lungu, Jan, 1991). At the core of these guidelines was a pragmatic determination by the Ministry to ensure that an orderly transfer of health responsibilities took place (MOH, Seminar Report, 1987: 27).

To begin with, the Ministry, deliberately decided that only those district councils with a developed infrastructure, manpower, and capacity to provide an acceptable, equitable and accessible health care service to their communities would be allowed to take over the running of health services in their respective areas (Interview with Deputy Director of Medical Services, Decentralisation Jan, 1991). Hence, only urban district councils along the line of rail qualified. Although this was a clear departure from the provision of the 1980 Act, it reflected the reality that there was no money to decentralise health services to all district councils in the Republic.

Second, the Ministry of Health further decided to implement the policy in stages, even in the urban district councils. The first phase which commenced on January 1, 1986 saw the Ministry of Health handing over the management of health services to the District Councils of Lusaka, Kabwe, Ndola, Kitwe and Livingstone.

At the same time, the Ministry initiated dialogue with the remaining District Councils on the Copperbelt, aimed at preparing them to take over the health services. Subsequently, health services delivery was handed over to the District Councils of Chingola, Mufulira, Chililabombwe, Kalulushi and Luanshya by January 1, 1988. Due to lack of resources, there was no corresponding action taken concerning the rest of district councils in the country; at the time of writing the status quo was the same. Thus the decentralisation of health services which was meant to be countrywide became an urban based and selectively implemented programme, contrary to the provisions of the Act.

However, between 1989 and 1990, the Ministry of Health introduced a project known as: "Strengthening effectiveness of District Health Systems vis-a-vis Primary Health Care," whose main objective was to strengthen the health care system in rural district councils, with a view possibly of devolving the health care responsibilities to these councils once they have developed the required infrastructure and capacity to shoulder them (MOH, 1990: 2). The main components of this donor sponsored project have included expanding curative services, environmental hygiene, primary health care (PHC) and promoting rehabilitative services. By January 1991 only two districts: Luwingu in Northern Province and Lundazi in Eastern Province, had been involved as pilot districts. Plans were, however, underway

to extend this project to at least one district in each of the remaining seven provinces, using the experiences gained in Luwingu and Lundazi (as reported by Dr. W. Lungu, Jan. 1991). The fact that this project is a donor sponsored one, is indicative of the serious lack of finances on the part of the Zambian Government to complete implementation of the policy. The financial problems which beset the implementation, show that the Act was over ambitious in its intentions. It proposed to do more without due regard to the availability of resources.

However, the inability by Central Government to provide adequate resources with which to implement decentralisation; has reinforced spatial and market inequalities and has failed to redress the already existing imbalance between rural and urban district councils. Apart from lack of resources, the urban bias of the health services, there was also a professional bias. This type of bias, make professionals want to introduce or implement any new practices, programmes or ideas among better off areas or people or better-served families, communities or as in this case better off district councils along the line of rail. It is likely that it was this sort of bias which prompted officials in the Ministry of Health to look for and find that only urban district councils along the line of rail had the capacity, and had the infrastructure to handle services (Chambers, 1983: 13-23).

Surely, had the officials used other parameters such as population, location, and need, more district councils could have qualified especially provincial centres.

The case of bias is further reinforced by the responses of the affected urban district councils. These responses indicated that even the so-called capable district councils, did not have the necessary 'infrastructure' and 'capacity' to undertake health services responsibilities. They lacked finances, equipment, manpower, transport etc. to run the services with.

DISTRICT COUNCILS RESPONSE TO DECENTRALISATION OF HEALTH SECTOR

The urban district councils including those of Kitwe, Ndola and Lusaka responded rather negatively to the transfer of health care functions from the Ministry of Health to them. (MOH, Seminar Report, 1987).

This was particularly so between (1986-87) when after the handover many officials in the district councils wasted no time in pointing out to the authorities that their district councils were not ready to shoulder these extra responsibilities without massive injection of financial and other resources (MOH, Seminar Report, 1987: Appendix 1, 2, 3, 4, 5). Almost all district councils involved in the programme in the first phase and those that were earmarked to take over later, were unanimous in the view that the transfer of health

responsibilities should be accompanied by adequate resources, especially finance with which to run these services, because the councils did not have the resources to meet the extra obligations. For example, Mufulira District Council demanded that in order for it to take over the urban clinics, the Central Government had to:

- (i) Provide additional vehicle to be used for ambulance services and for Maternal and child health and distribution of drugs.
- (ii) Upgrade and give additional staff to certain clinics, especially Chibolya Clinic.
- (iii) Clarify disciplinary procedures for government seconded staff.
- (iv) Appoint a medical officer to take charge of handed over clinics.
- (v) Provide adequate funds for maintenance of buildings (MOH, Seminar Report, 1987: Appendix 6).

Similarly, Chingola District Council cited problems of transport, personnel, security, procurement of drugs as well as equipment, as requiring prior solutions before the take over of health services could be effected (MOH, Seminar Report, 1987: Appendix 7).

Those responses did not only reflect the prevailing mood in specific district councils but was the general attitude of all those district councils involved in the take over programme. At a seminar on "Decentralisation of Health Services" in May, 1987 held at Baluba Motel the participants, drawn mainly from

affected district councils on the Copperbelt and midlands, re-affirmed this point saying:

the implementation of decentralisation of health services to district councils had come at a time when the councils were facing grave financial difficulties, hence there was need for greater Central Government financial and other support (MOH, Seminar Report, 1987: 67).

Furthermore, district councils' reports on urban health centres handed over to councils in 1986, revealed that the councils lacked the 'capacity' as well as the 'infrastructure' to undertake the programme on their own.

Livingstone District Council requested the Ministry of Health, among other things, to surrender members of staff; give at least two vehicles to the Council; attach a pharmacy technician to the Council; and provide funds for the maintenance of buildings, purchase of drugs and wages for classified daily employees (MOH, Seminar Report, 1987: 85).

The Medical Officer of Health for Lusaka Urban District Council also alluded to the problems of personnel, maintenance of buildings and equipment, procurement and distribution of pharmaceuticals, transport, and other procurements as requiring urgent solution. On finance, he wrote:

For the last seven years the percentage of the health grant to the Public Health Budget given to Lusaka Urban District Council has gradually been reduced from 3.38 per cent in 1980 to 0.11 per cent in 1986. Given the fact that Lusaka

Urban District Council revenues are unlikely to increase in years to come, the need for the Ministry of Health to give Lusaka Urban District Council 100% grant on the services the Ministry of Health has forced council to take over cannot be over-emphasised (MOH, LUDC, 1987).

The story was the same in other district councils involved in the programme. This is shown by the fact that the supposed capacity, infrastructure and manpower did not exist in the selected councils just as it did not exist in those councils left out.

The foregoing responses of the district councils to the decentralisation of health sector and transfer of health facilities should be understood within the overall context in which the implementation of the local government decentralisation and integration was undertaken.

The implementation of decentralisation on January 1, 1981 had revealed that the new district councils did not possess the capacity needed to administer the various affairs of the district besides health. For example, between 1981 and 1986 when they were asked to take over the management of health services, it became increasingly clear that district councils lacked sufficient finances to run their services adequately. Decentralisation was not accompanied by the financial self-reliance of the councils. The fact that the major source of revenue and control was the central government led to the fears expressed by council officials that the delivery of health services would deteriorate

unless sufficient resources were urgently committed to the programme.

At the same time, the decentralisation of health services was being implemented in urban district councils, when the Zambian economy was in shambles, and many district councils, if not all, did not have a strong economic infrastructure capable of generating sufficient revenue to help run the expanded health services. Given the gravity of this situation, it was clear that the transfer of health care responsibilities to the district councils would aggravate the budgetary problems and seriously compromise the quality of health services offered to the communities.

On the other hand, the negative reaction of public health workers in the councils to the decentralisation of health services seems to have been prompted by professional interests. First under the Local Administration Act the Department of Public Health was reduced to a section under the Social Secretary (L.A.A., 1980). This subordinate of 'public health' and 'professional health' workers was a potentially frustrating factor, which seemingly could have led to public health officials over emphasising the problems in a bid to frustrate the smooth implementation of the new programme. Second, given the low morale among public health workers, the new and extra functions under the decentralised health delivery system were seen as extra burden and not as new challenges,

especially that the units transferred were in everyway more extensive than what traditionally had come to be regarded as public health services in the councils. In Livingstone, for example, on January 16, 1986, nine urban health centres were handed over to the district council. Prior to this the Livingstone District Council had operated only two clinics, one of which was mobile (KOH, 1987: 73). The transfer involved shifting tremendous responsibility beyond the usual chores of most public health units in almost all district councils. Given the inertia of public workers, very few public health workers were willing or ready to accept these new and expanded responsibilities.

CONCLUSION

The implementation of decentralisation of the health sector was launched when the Ministry of Health made two important decisions: to establish a 'decentralisation unit' to oversee the smooth implementation of the decentralisation programme, and to handover the management of health services at the district to the five urban district councils along the line of rail. By January 1, 1986, the District Councils of Kitwe, Ndola, Kabwe, Lusaka and Livingstone agreed to take over the work of delivering health services to the communities in their respective areas of jurisdiction.

This handover of health services responsibilities to these district councils was in accordance with the statutory provisions

of the Local Administration Act which inter-alia, provided for the shift of social services responsibilities from the central government to the new district councils and the Social Secretary's Department specifically. However, the implementation of the programme in selected urban district councils was a departure from the statute. The decision to exclude rural district councils although pragmatic, was arbitrary and inconsistent with the general policy of decentralisation. It reinforced the existing spatial and market imbalance between rural and urban areas. It also reflected the urban and professional bias of the officials in the Ministry of Health.

Furthermore, the policy of decentralising health services delivery, was not enthusiastically received by district council structures. Arguments about inadequate finances, manpower, capacity and infrastructure were voiced against the take over bid by district councils. Those concerns had some merit since from the very beginning implementation of overall policy of decentralisation had been accompanied by a display of lack of resource base and capacity necessary to administer the affairs of local government by district councils, which had been forced to rely on central government for the much needed finances. The gravity of the financial ills afflicting district councils could be one reason why they reacted with hostility rather than enthusiasm, to the transfer of health service responsibilities by the Ministry of Health.

Overall, decentralisation entailed availability of financial and human resources from central government. Yet, the Act was conspicuously ambiguous about sources of finances for district councils. The traditional sources of funds for councils had proved to be insufficient, hence they could not be expected to have adequate funds to administer new and expanded responsibilities. Thus, decentralisation was from the very beginning beset by problems: human and financial. Above all, the Act, did not give councils real power (financial and policy making powers were not decentralised).

CHAPTER FIVE

DECENTRALISED HEALTH SERVICES IN LUSAKA

INTRODUCTION

Lusaka Urban District Council was among the first five urban district councils along the line of rail to be involved in the take-over exercise of health service responsibilities from the Ministry of Health. On January 1, 1986, the management and control of urban health centres in Lusaka, devolved to Lusaka Urban District Council. This transfer meant that the day-to-day running of the urban clinics, including monitoring and supervision of staff, drugs, medical supplies, equipment and buildings, at least, theoretically, became the responsibility of the Lusaka Urban District Council.

In this Chapter, I will discuss the nature of the decentralised health services in Lusaka, by analysing the take over of urban clinics and examining the health services in relation to the variables of organisation, scope, coverage and responsibility.

ORGANISATION OF HEALTH SERVICES

Perhaps the most important variable in analysing the decentralised health services in Lusaka is organisation in the district. This is important because organisation is the means of translating the objectives of the health plan into practical action. Good organisation assures that health

workers perform to their potential and that different health care components are delivered in a unified manner, thereby enhancing effectiveness. Programmatic aspects of organisation have taken place in Lusaka Urban which have respectively, changed and enhanced the organisation of public health services since the advent of the decentralisation of health services.

First and foremost, decentralisation of health services, has increased the number of health centres belonging to Lusaka Urban Council. Prior to the hand-over, Lusaka Urban Council operated only a single clinic at the Civic Centre. As a result of the hand-over, the following urban health centres, became officially, Council health facilities:

Bauleni	Kanyama
Chainda	Kalingalinga
Chawama	Lilayi
Chelston	Makeni
Chilanje	Mandevu
Chipata	Matero Main
George	Matero Reference
Kabwata	Mtendere
Kamwala	Railway

The transfer of eighteen health centres to LUDC changed enormously the organisational structure of public health in Lusaka by creating a district based organisation in which skill,

responsibility and expertise could be dispersed. One manifest result of decentralisation of health services, has been the shift in control of health centres or delivery points to Lusaka Urban Council. However, there has been no corresponding improvement in effectiveness and efficiency of health care as evidenced by recent epidemics of Cholera that have ravaged the city in succession.

Second, decentralisation of health services has increased LUDC's scope of health services being provided to the residents of Lusaka. Prior to the decentralisation of health services, Lusaka Urban District Council confined itself primarily to provision of mundane public health services of refuse collection; burial services; meat, food and building inspection. Only one clinic based at the Civic Centre provided some curative and preventive health care, although these were often erratic.

However, as Appendix I shows, the type of health services now offered, include curative preventive and primary health care. These services however, are not new in that they were set out initially by the Ministry of Health which controlled and ran the urban health centres in Lusaka. Infact, due to lack of finances, the scope and quality of these services continue to be dismal compared to the needs.

Overall, LUDC has failed to organise an effective public health service despite taking over the responsibility from the Ministry of Health. For example available evidence

indicate that refuse has not been collected from townships for the past 7 or so years.

Third, under the terms of decentralisation, management of all assets and services was to devolve to the district councils. However, as shown in Table 3, our findings indicate that there has been no consistency between these provisions and the actual practice obtaining in Lusaka District. As Table 3 indicates, the Ministry of Health still performs the duties and functions which by now (five years after transfer) should be done by Lusaka Urban District Council. This means that Decentralisation has not been as successful as envisaged in the Act. With very little exception, the majority of health workers are still employed by the ministry instead of them being transferred to Lusaka Urban District Council.

TABLE 3: RESPONSIBILITIES OF MOH AND LUDC AS REPORTED BY HEALTH WORKERS IN LUSAKA DURING INTERVIEWS

TASK	MOH	LUDC	MOH/LUDC	DONT KNOW
Maintenance of Building	70%	10%	10%	10%
Funding of Health Services	20%	10	60	10%
Procurement of Drugs	30	60	10	-
Staffing	75	25	-	-
Monitoring/Supervision	30	60	10	-

Further, MOH, through the Provincial Medical Officer, continues to purchase drugs, maintain both health centres and staff houses, and monitor and supervise staff. These practices are indicative of the failure to achieve the purpose and objectives of decentralisation and means the policy has not been successful.

Finally; although public health initially operated under the Social Secretary's department of LUDC, it has since 1990, been reorganised as a separate department headed by the Medical Officer of Health. This has once again elevated the status of public health and resolved the continuous wrangles that existed between staff over concerns of seniority, professionalism, control and co-ordination. More important, it has made possible, the eventual integration of health personnel and resources into a district health organisation, capable of combating health problems and to translate the Lusaka health plans into practical action.

Infact one can argue that district organisation with the ability to deliver health services in Lusaka is emerging, based in the District Council's Public Health Department. It is beginning to manifest itself in the increase in number of delivery points; geographical distribution of delivery points and common control. However, the failure by LUDC to take charge of such important areas as purchase of drugs and pharmaceuticals, control of staff and maintenance of health facilities, reflect a failure to create a district based health care system.

CHAPTER SIX

POPULAR PARTICIPATION IN HEALTH DELIVERY IN LUSAKA

INTRODUCTION

In this chapter, I will analyse popular participation in health service delivery in Lusaka, using the variables of: interaction, exchange, decision-making, responsibility, performance relationship and representation. Second, I will examine participatory approaches being utilised in health service delivery by analysing the health workers' perception of popular participation, its form and effect on health services delivery, and the relationship between health workers and local people in communities of Lusaka.

POPULAR PARTICIPATION IN HEALTH SERVICES DELIVERY

As earlier indicated, one of the objectives of decentralisation in Zambia was to strengthen popular participation in Local government programmes. Since decentralisation of health sector is an outgrowth of this overall policy, its central objective is to initiate popular participation in health care activities, especially in Primary Health Care.

Participation of the people in health service delivery is important for a number of reasons. First, because health care is a central concern of all people, it is vital that both the people as health consumers and health workers, are

involved in shaping both public health policy and practice in their community. Second, the people and health administrators, tend to have different viewpoints on health and its management, hence both perspectives need to be synthesized through participation to bring out maximum effectiveness.

Most important, participation of the people in health services delivery has far reaching effects on the creation of a district based health care system. First, it makes people in the community and their leaders to be acquainted with the problems pertaining to health care in their district.

Second, it allows dialogue and negotiation between the Community and the District health authorities, thereby ensuring that health services are consonant with identified health needs of the people.

Third, participation ushers in a target or community oriented focus, responsive to the needs of the community as opposed to the traditional focus on district - wide, comprehensive health care programme. In short, popular participation can make professional health workers and administrators sensitive to the health needs of the people in the various location of the district (such as shanty compounds and peri-urban areas) whose health problems may be immediate and requiring prompt solutions.

With these brief remarks about participation, I now examine in detail, popular participation in the decentralised

health services in Lusaka Urban District. This analysis looks at local people's perceptions of their involvement in health delivery activities since the commencement of decentralised health system.

ANALYSES OF LOCAL RESIDENTS RESPONSES TO DECENTRALISED HEALTH SERVICES

I shall discuss in this section the perception and attitude of local residents to the decentralised health services in Lusaka. These responses are a collection of the local people's views in the townships of Lusaka and were collected in interviews in: Mtendere, Kalingalinga, Cheslton, Mandevu, Libala and Chilenje South. All the local residents interviewed in these townships had stayed in the townships for over eight years. I grouped the interviewees into three equal groups of thirty each i.e. 30 local civil servants, 30 party members and 30 non-party members to judge if there were differences and to draw general conclusions. I interviewed 90 local residents in total, with 15 interviewees from each of the six townships, broken up into 5 Party members, 5 non-Party members and 5 local civil servants. Their mean ages were 46 for the combined sample of 90. Eighty-five percent of these were married and had children -Ninety percent of the interviewees said that they had been to school, 90% of local civil servants having been to college; 76.6 percent of ordinary or non-Party member to secondary school and

90 percent of Party members to primary school. Overall, eighty-five percent of the local residents combined had an annual income of over 36,000 Kwacha per annum, although almost fifty percent of Party members were self-employed. My conclusion was that the sample was well balanced as it was composed of people who at least would more likely be aware of civic matters and reflect reasonably on issues and aspects of health care in their respective townships and in Lusaka as a whole.

1. INTERACTION

Among the 90 local residents interviewed, 90 percent of whom live within walking distance to health centres, as high a percentage as 89 said they had no say and no forum for expressing their viewpoints on health services in the the district in general and their beighbourhoods in particular. Instead, there was widespread and pronounced ignorance among these local residents about the services of the Public Health Department of LUDC. Eighty percent emphatically denied having had any interaction or contact with health workers, except during the Cholera epidemic in 1990. This is indicative of the minimal interaction between the local people and health workers, outside the health centre.

2. EXCHANGE

Hand-in-hand with lack of interaction is the lack of

dialogue between the local people and health workers. Ninety percent indicated that they were not consulted at all by health authorities in the Council whenever health programmes were being planned or implemented in their communities. Also 76.7 percent thought there was no relevance between certain health services provided in their communities to the health needs of these communities, and 67.8 percent attributed this to lack of assessment of community needs prior to the launching of the services. For example, provision of maternal and child health at Kalingalinga Clinic minus curative services.

3. DECISION-MAKING

With respect to decision-making, the three categories of local residents interviewed (Party members, non-Party members, and local civil servants) responded differently. Members of the ruling Party (UNIP) indicated that they were sometimes informed in Party meetings either at Section, Branch or Ward level, and during annual District Party Conferences about health programmes in the district. This was not the case with non-Party members who consistently maintained that they were not given any information or chance to talk, or contribute ideas on health services in their neighbourhoods or district.

On the other hand, all categories of local residents (i.e. 70 percent of Party members, 90 percent of non-party members and 63.3 percent of local civil servants), felt that there has been no marked change in the district council's response to health care needs of the community following the transfer of health responsibilities to LUDC. Informants further argued that the responses continue to be sluggish and health workers still adhere to the 'professional' and 'central planning' views in planning health services in Lusaka.

The study also assessed people's participation in specific areas of health, such as planning and design; management; development and implementation; maintenance, monitoring and evaluation of health services, and facilities in the district. All categories of local residents indicated that they were not significantly involved in any of these tasks as Table 4 shows.

TABLE 4: DEGREE ON NON-INVOLVEMENT IN HEALTH PLANNING AND IMPLEMENTATION ACCORDING TO CATEGORY OF INFORMANTS

TASK	PARTY MEMBERS	NON-PARTY MEMBERS	LOCAL CIVIL SERVANTS
Planning and Design	53.3%	93.3%	86.6%
Management	70	90	87
Development and Implementation	73.3	93.3	86.6
Maintenance, monitoring and Evaluation	60	90	87

One of the hypotheses of this research was that involvement of Party-members in district council programmes is almost assured. Thus the lack of involvement of party members in health services delivery in the district is therefore of significant curiosity. Table 4 displays an extremely high percentage of party members not involved in the management, development and implementation as well as maintenance, monitoring and evaluation of health services and facilities. one possible explanation could be that only leaders at Section, Branch etc. are used in the Health Committees which exclude participation of not only non-party members but also ordinary party members.

4. RESPONSIBILITY

As Table 5 shows, there were similarities in the responses of all categories of informants with regard to the question of who should be responsible for health services delivery in the communities of Lusaka.

TABLE 5: DEGREE OF RESPONSIBILITY FOR HEALTH SERVICES AS PREFERRED BY LOCAL RESIDENTS

RESPONSIBLE	PARTY MEMBERS	NON-PARTY MEMBERS	LOCAL CIVIL SERVANT
Central Government	53.3%	60%	60%
District Council	30	26.2	33.3
The People	13.3	10	0.6
All the above	3.4	-	6.1

Almost all categories of informants felt that the central government should be responsible for the delivery of health services in the district. One of the major points to note here is the large proportion of party-members in favour of central government taking responsibility for health services delivery (53.3%). Since decentralisation was introduced by their party (UNIP), one would have expected party members to support it. Similarly, local civil servants expressed ignorance about the raison d'être of decentralisation. Their responses demonstrate first, that the implementation of decentralisation, in general, has not been publicised enough for the people to understand fully its objectives. Second, that the continuous financial problems and paucity of resources in the District Councils like Lusaka and their inability to run social services adequately, have created a 'confidence crisis' in the people, about the councils' ability to deliver adequately, health care services (LUDC, S.S.D., 1990: 1).

5. PERFORMANCE

It has been the general assumption that decentralisation of health services would lead to marked changes in the performance of the public health departments of the district councils in the country. Data on the local people's perception of the effects of decentralisation of health care in Lusaka does not, however support this assumption at all as Table 7 shows.

TABLE 6: PERCEIVED EFFECTS OF DECENTRALISATION ON HEALTH SERVICE DELIVERY IN LUSAKA

EFFECT	YES	NO	DONT KNOW
Improved health	11.1%	83.3%	5.6%
Improved health awareness	10	73.3	16.7
Increased efficiency	16.1	82	2.9

The high percentage of negative responses from Lusaka residents underscores the claim that decentralisation of health services has not been accompanied by improvements in health care delivery. One can therefore argue that the district council has only taken over the place and problems left by the Ministry of Health. For example, if we take the issue of people's involvement in health affairs, 93.3 percent of local residents rated this as being very low. Low involvement was attributed both to the negative attitude of health workers toward popular participation (60%) and to the vagueness of participatory slogan (53.3%).

Furthermore, among health units only curative services were singled out as being more effective, with 87 percent approval rating. This indicates that most local residents in Lusaka come into contact with health authorities only when they fall sick and visit the health centre or clinic. It also reflects the inadequate delivery of preventive care (e.g.

Primary Health Care). Overall 70 percent of local residents felt that decentralisation has so far been disappointing in that it has failed to increase people's participation in health services delivery in LUDC.

6. RELATIONSHIP

A key element in the delivery mechanism of health services is held to be the relationship between health workers and the community. To be successful, health workers ought to maintain good relations with local communities (Lartson and others, 1984: 42). A good relationship is vital for effective collaboration between health workers and local people, and this calls for skills of human relations.

The study found that 81 percent of the local residents characterised the relationship between health workers and local people as poor, and emphatically felt health workers were indifferent to the local people especially the poor residents of the shanty compounds and site and service areas because they held them to be ignorant and illiterate. This does not argue well for effective partnership in health care work.

7. REPRESENTATION

Participation is important in that it allows citizens the right to influence government decision-making and

provides for local self-government to the 'average' citizen. This study found that there is still adherence to the traditional political structure of 'ward' format. The Ward Chairman is still regarded as the legitimate representative of the people in the district council. Even at the section, it is only the local political leaders who are co-opted into the health committees (where the latter exists). Local residents who are not members of the Party are not even eligible to elect the Ward Chairman even though they are in the majority. This has led to misrepresentation of local residents' interests.

With regard to representation, 81 percent of non-Party members and 70 percent of local civil servants felt that ward chairmen should not be the only ones representing the people in the district because they represent only minority partisan interests and have proved, over the years, to be concerned only with the interests of Party members who elect them. Instead, these local residents preferred direct dialogue and involvement with health authorities through other formal and informal structures besides those of the Party. Finally, on a subsidiary question of power to the people, 93.3 percent of the local people were convinced that district council functionaries were hostile to the concept of 'power to the people', arguing that officials in the council continue

to ignore the local people and do things without consulting the local residents of Lusaka. Seventy percent of them understood 'power to the people' to mean that 'local people in the district should be the custodians of power and authority and hence must be actively involved in civic programmes undertaken by the district council'.

This brief survey demonstrates the absence of popular participation in health services delivery under the decentralised health system. The variables considered also demonstrate differences in terms of participation in council programmes within the local population. Party-members are better placed even in this disadvantaged situation. Clearly membership in the ruling Party (UNIP) gives one a leeway to get involved in district council programmes. Therefore, party membership is a significant factor in influencing the local residents' participation in health services delivery in Lusaka.

PARTICIPATORY APPROACH

As noted earlier, the central objective of decentralisation of health services was to initiate participation of the people in health service delivery. Bregha (1973) has noted that concepts like participation have no commonly agreed upon conceptual model, hence different meanings are attached to

participation. He further notes that participation takes on a wide variety of forms, depending upon the actors and the philosophy they are attempting to translate into action. To Bregha, participation is a continuum of increasing involvement, ranging from Information/Feedback, Consultation, Joint Planning, to Delegated Authority (Bregha, 1973: 18-28).

However, in its broadest sense, participation refers to local people's involvement in decision-making, implementation, enjoyment of social benefits and evaluation of programmes or services. To help grasp the participatory approach being utilised in health service delivery in Lusaka and to assess whether it corresponds to any one of the four types of participatory techniques on Bregha's continuum, we will examine the responses of health workers in Lusaka to questions on popular participation.

To obtain the attitudes of health workers to the new system, I asked questions about popular participation. The health workers interviewed in the health centres were both employees of LUDC and seconded staff from the Ministry of Health and consisted of twenty-five nurses (public health, midwives and institutional care) fifteen clinical officers and fifteen public health workers (health assistants and inspectors). The majority of the health workers had two to four years training and the average years spent on the job was six years. Majority had worked for over five years in the health centres I found

them in. Thus, most if not all interviewees were field workers constantly interacting face to face with the local residents of Lusaka.

1. MEANING OF POPULAR PARTICIPATION

Since popular participation in health services delivery can only be realised if health workers consciously encourage it, it is important to find out their understanding of the term 'popular participation.'

In the sample of 55 health workers, 32.7 percent understood popular participation 'as the participation of local people in decision-making,' while 65.4 percent understood it as 'Local people and health workers working together'. Similarly, 85.4 percent of health workers felt that popular participation was a good and desirable thing in health service delivery. Forty-nine percent felt participation was important because it made the work of health personnel easier, while 36.4 percent felt participation allowed the community's involvement in health programmes, making them interested in health issues. Thus health workers do understand the concept of popular participation including the desire to let people participate in health services delivery.

2. PARTNERSHIP

On the question of who they worked with in the community,

36.4 percent of health workers said they usually worked with local party leaders, while 60 percent said they worked with fellow health workers in the delivery of health services. Thus, the ordinary local residents who can contribute ideas, money, materials, labour and skills are otherwise not seen as partners in this process. This lack of popular involvement in health work demonstrates that there is probably no established, viable local structures through which the ordinary local resident can be enticed to participate in health service delivery. It also means that health workers are not interested in constructive collaboration and partnership with local people, but to use local Party Leaders to gain entry into communities. Indeed, the alliance of local party leaders and health workers cannot and does not amount to popular participation. It largely reinforces the traditional representative view of participation, that subordinates the role of the majority to mere bystanders instead of making them partners in the delivery of health services.

3. FORM OF PARTICIPATION

The health workers interviewed were divided on the question of the form of popular participation they would favour in health services delivery. Sixty-nine percent of the informants preferred JOINT PLANNING (a situation in which health officials and citizens assume essentially equal roles and responsibility in the process of comprehensive or specific problem-solving);

while 20 percent preferred INFORMATION/FEEDBACK (health authorities put out information about health services, and the people give a feedback on health services) (Bregha 1973: 18-23). This indicates that a majority health workers prefer joint planning despite the absence of general policy guidelines about health services delivery vis-a-vis the form and nature of input by the local people. It also indicates that popular participation, is seen by health workers as an essential and necessary ingredient in health services delivery in Lusaka.

4. EFFECTS OF POPULAR PARTICIPATION

The study attempted to measure health workers' perception of what effect popular participation would have on health service delivery in the district. Table 6 represents a summary of these perceived effects.

TABLE 7: HEALTH WORKERS PERCEPTION OF EFFECTS OF POPULAR PARTICIPATION ON HEALTH SERVICES DELIVERY

<u>EFFECT</u>	<u>YES</u>	<u>NO</u>	<u>DONT KNOW</u>
Better Services	50	5	-
Greater efficiency	48	7	2
Increased relevance	51	4	-
Wide coverage	49	5	1
Confusion and inefficiency	7	48	2

As demonstrated above, health workers are unanimously aware of the advantages of popular participation in health services delivery. This reflects the influence of their training and that of the new health strategy of Primary Health Care which emphasises community participation. This also confirms our earlier observation, that health workers are not encouraging local people to participate in health activities because they do not see community participation as necessary. Otherwise, there is a willingness on the part of Lusaka residents to participate in health services delivery.

Furthermore, 67.2 percent of health worker informants were convinced that many local residents in Lusaka were aware of their right to participate in health affairs. In addition 60 percent said they get requests about health services from local people, especially those pertaining to environmental health and maternal and child health. With regard to the manner of raising health issues publicly, 60 percent indicated that health issues were never raised publicly in the district. Instead 83.6 percent indicated that health issues are raised in Section, Branch, Ward and District meetings. These meetings are open only to UNIP members and hence they could not be regarded as public fora at all.

5. RELATIONS WITH COMMUNITY

Unlike local residents, health workers indicated that they

had a good relationship with the local people in the communities in which they worked. With specific reference to this aspect, 74.5 percent affirmed that there were no potential or actual disagreements about health issues between health workers and the local people. Eighty percent of health workers said they cooperated well and worked together with the local people, especially on programmes like immunisation campaigns and environmental health. This contrasts sharply with the opinions of the local people (80%) who consistently indicated that they had poor working relations with the health workers.

Although health workers (interviewed) were positive about relations with the community, their actual performance brings into question the basis of their positive posture. For example, 60 percent of these informants indicated that health workers only met and discussed health issues with local Party leaders, as opposed to 30.9 percent who indicated that they met and discussed with local people. The contention is that there can be no good relations between health workers and the local people if a majority of them (60%) make no deliberate efforts to cultivate and encourage this rapport. Those health workers cultivating this rapport seem to be very few (30.9%).

6. ATTITUDE TOWARD LOCAL PEOPLE

If health workers in Lusaka are to become partners with the local people, there is need for them to get to know each

other and each other's difficulties. This interchange can only grow if it is encouraged by those aware of the need for dialogue. The health workers are obviously in such a position. Therefore, the attitudes of health workers toward the local people are critical for the proper functioning of this relationship. Findings in the study show consistently, that the attitude of health workers toward the local people is negative. This is particularly evident in the health workers' preference of local leaders instead of ordinary local citizens. Sixty percent said they preferred to discuss and work with local leaders, as opposed to the local ordinary citizens, arguing that these had influence among the local people and know how to communicate with their people. Yet, health workers are trained in effective communication skills and human relations to be able to handle people unaided. Besides, to be effective, health workers need to go beyond this conservative approach and discuss with the actual people whose health they purport to preserve, not with proxies. Traditional conservative approaches or means of community involvement have long been tried and found wanting. Hence as new strategies are evolved in health care provision, new approaches to community participation are also called for.

The foregoing analysis indicates that there is no particular approach being followed to effect popular participation in health service delivery in Lusaka. Similarly, none of the

current ad hoc experiments in participation conform to any of the participatory techniques Bregha (1973) has propounded on citizen participation in social services.

CONCLUSION

The transfer of district health jurisdiction to the Lusaka Urban District Council has brought certain developments. It has attempted to create both a district-based health delivery system and a district health organisation, responsible for district - wide health care. Meanwhile, decentralisation has brought about integration of expertise and skill into the Council's Public Health Department.

However, a particular shortcoming of the decentralisation of health system in Lusaka has been the failure to realise the central objective of increasing local participation in health services. Not only is there absence of an articulate local structure through which local residents could get involved directly, but also health workers are ill-prepared to create and utilise opportunities that would lead to greater community involvement in health services delivery. By adhering to the conservative approach of participation through Ward Chairman, health authorities in LUDC have failed to utilise the many opportunities the new system offers, of making health care delivery the business of each and every citizen in Lusaka.

Particularly, there are problems in ensuring local participation in health service delivery. Tension and confusion exist in many areas, (i.e. vis-a-vis who is in control, who is to represent local people's interests and how to maintain proper balance between local community residents and professional control). These are areas clouded in confusion, despite rhetorical statements about popular participation.

There is no general policy guidelines concerning local participation in health services in Lusaka. In short, although there are ad hoc and unofficial undertakings to involve local people, there is no district council official policy pertaining to local participation in health service delivery. Rather, health workers are left to design their own methods of dealing with local residents, even though many of these workers are not clear on what the precise role of the local people is supposed to be.

It is important to recognise that none of the instruments or tools used by district health authorities for promoting community participation (such as health committees or section, Branch and Ward Councils) are capable of stimulating the process of popular participation so as to encourage closeness between health workers and the community. Put simply, the LUDC cannot involve the local residents in health care responsibly and constructively in the absence of a broad policy on the subject applicable to all health units.

Without the formulation of such a policy, it is inevitable that experiments undertaken in isolation, sometimes on the spur of the moment or under temporary local pressure would confuse both health workers and the community. Furthermore, because of the lack of general policy guidelines, there is the danger of inconsistencies among different units of public health, each experimenting with popular participation in its own way and for its own purposes.

What is required is a firm but broad policy that goes beyond pious statements about the desirability of local participation. The basic elements and problems of local maximum involvement must be brought together in one major policy that define the nature of the Council's commitment to popular participation and clarify the boundaries, settings, and problems of such involvement. Such a policy would assist greatly in the formulation of the fundamental characteristics of local participation in LUDC.

CHAPTER SEVEN

CONCLUSION: DISCUSSION AND IMPLICATIONS

The Zambian Government enacted the Local Administration Act of 1980 as part of a strategy of decentralising government administration and political control. District Councils were empowered to examine the needs of the district and to initiate necessary development programmes to address these needs. Thus, this Act, was the most comprehensive instrument ever designed for the conduct of Local Government in Zambia. It made district councils focal points of the transformation with responsibilities, which among others, included delivery of social services, foremost of which was/is health care, transferred to selected district councils beginning from 1986.

The implementation of decentralisation of health services had been hampered in large measure by the lack of adequate resources, especially finance and personnel. Thus, the decision by the Ministry of Health to implement the decentralisation programme in selected urban district councils was pragmatic. This is because, at the time of implementing the decentralisation programme, there was practically no money with which to undertake the programme nation wide.

Another significant factor that contributed to the problem was the Act itself. In all its intentions the Act was very ambitious as it envisaged to do more than the resources and circumstances permitted. For example, although it designated

practically all district councils as the fulcrums of socio-economic and political development, many of these did not possess the capacity nor resources to administer the statutory responsibilities conferred upon them. In the end, all district councils came to rely on the Central Government for finances and manpower with which to run their affairs.

This study has demonstrated that by the time of adopting decentralisation the country was broke. The economy had collapsed and the social infrastructure was severely battered. In addition the central government was becoming increasingly unable to provide adequate resources with which to maintain and service the existing facilities. It was within this weakening economy and desperate situation, that Ministry of Health proposed to transfer the health services delivery to financially weak district councils with the aim of making the latter fully responsible for district wide health care needs. This was received with mixed feelings by the Councils concerned.

This study has argued that the district councils' opposition to the transfer of health services responsibilities, should be understood within the Zambian political economy, especially in the 1980s. Decentralisation was launched in January 1981, amid the economic decline, and at a time when district councils' lacked the necessary capacity and resource base with which to administer the new affairs of the district. The major source of revenue and controls for the new district

councils remained the Central Government, hence when Councils were asked to assume additional health care responsibilities they opposed this although it was already provided for in the same Act that created district councils.

The response of the district councils to the decentralisation of health services has been examined and explained in two basic ways. First, the councils opposed decentralisation of health because they had insufficient resources to commit to this programme. Second, public health workers in district councils saw the extra responsibilities as burdensome, especially as these duties were more extensive and demanding.

On popular participation, this study has demonstrated that although popular participation was one of the central objectives of decentralisation in Zambia, there was no general policy guidelines on how local people would participate in local programme. Thus, there is no particular approach in use for soliciting local people's participation in programmes by the council.

Hence, the whole issue is still riddled with inconsistencies and ad hoc attempts by Council workers at popular participation. What is required therefore, is a policy that would define the nature of popular participation and clarify the settings, boundaries, structures, and channels of participation.

Concretely, this study has explored and analysed decentralised health services in LUDC. Despite the numerous problems

still being encountered, a common integrated health system is emerging in Lusaka. The transfer has brought together different health workers and units under one umbrella. This reflects a move toward the emergence of a district based health service delivery organisation, as Lartson and others have noted:

In a health organisation a simple common integrated system is needed to bring together a number of separate systems concerned with the movement of drugs, supplies, people, information, referrals and cash. (Lartson and others, 1984: 106).

However, the present health care system of LUDC is based on providing structural facilities in the form of health centres rather than on health care. Instead of good health of the people being the enjoyment of a disease-free environment, the Council has elected good health to become synonymous with the provision of a health centre in various locations in the city. Because of this, there has been only a modest impact on the health of the majority of people in greater LUSAKA.

In conclusion, this study suggests that, the problems and shortcomings observed in the implementation of decentralised health services are not unique to LUDC; they pervade all those District Councils that have taken over the delivery of health services on the Copperbelt and along the line of rail. In all these Councils, there are insufficient human and financial resources for administering health services equitably and adequately, and also absence of a general policy on popular

participation.

The study further establishes the need for more research on the role of district councils in the development processes, especially rural district councils. In many of the district councils, social services were introduced and flourished at the height of economic prosperity and central government control. Yet, the Government neglected the rural and peri-urban areas and instead expanded the infrastructure and social services in urban areas. Rural councils remained significantly small and inarticulate, with limited independent sources of finance. The fundamental question is, can rural district councils provide the social services to their communities as provided for under the 1980 Act? Further studies in the situation of those councils may show that rural and urban councils will respond unevenly to the provision of social services to their people. This study had discussed the problem faced by urban district councils that have taken over the running of health services responsibilities in the face of national and local economic malaise.

RECOMMENDATIONS

From the foregoing discussion, there are several measures that are necessary to enable the district councils provide health services adequately:

- (i) The public health units should be reconstituted as distinct department outside the social secretary's office. This will elevate the status of public health and once again allow health professionals discharge there functions properly.
- (ii) The department of public health must be adequately funded to enable it administer the various units.
- (iii) Adequate personnel, especially public health workers, must be engaged, and these be put directly under the district councils. The tendency to have some health workers controlled and paid by the Ministry of Health undermines both the intentions of decentralising the administration and also control of such staff by district council authorities like the medical officer of Health.
- (iv) The district councils must formulate a general policy on popular participation to enable health workers to be guided on how to involve the local residents in the provision of health care.
- (v) New structures must be developed in the communities through which health personnel and local people will meet and plan for the health needs of the communities. These structures should be free of political affiliations and should embrace members of different pressure groups and chosen by the people. Such

democratic and broad-based structures should be the mouth piece of the people and the means for channeling information and feedback from both the people and the district councils.

- (vi) The district councils must pay particular attention to promotion of primary health care and implement without delay community based health programmes that emphasise good environmental and sanitary measures to avoid the break-out of epidemics like cholera. In the same vein, the district councils should enact by-laws that will safeguard public health and enforce existing regulations concerning public health.

APPENDIX 1: LIST OF CLINICS AND SERVICES PROVIDED BY LUDC

CLINIC	SERVICES PROVIDED
1. Bauleni	Curative, MCH, Family Planning
2. Chainda	Curative, MCH, Family Planning
3. Chawama	Curative. MCH, Maternity
4. Chelston	Curative. MCH, Family Planning, Maternity
5. Chilenje	Curative, MCH, Family Planning, Maternity
6. Chipata	Curative, MCH, Family Planning, Maternity
7. Civic Centre	Curative, MCH, Family Planning, International Vaccinations
8. Kabwata	Curative, MCH, Family Planning
9. Kamwala	Curative, MCH, Family Planning
10. Kanyama	Curative, MCH, Family Planning, Dental, Maternity
11. Kalingalinga	MCH, Maternity, Family Planning
12. Lilayi	Curative, MCH, Family Planning
13. Makeni	Curative, MCH
14. Mandevu	Curative, MCH, Family Planning
15. Matero Main	Curative, MCH
16. Matero Reference	Curative, MCH, Family Planning, Maternity
17. Mtendere	Curative, MCH, Family Planning
18. Railway	Curative, MCH, Family Planning
19. George	Curative, MCH, Maternity, Family Planning
20. Kaunda Square	Curative, MCH, Family Planning

SOURCE: Compiled By Author Based on information from Lusaka District Committee Report of July, 1989.

DELIVER OF HEALTH SERVICES IN THE DECENTRALISED SYSTEM

QUESTIONNAIRE A

FOR
HEALTH SERVICE WORKERS

ADMINISTRATIVE DATA:

NAME:

CODE:

HEALTH UNIT:

BACKGROUND INFORMATION:

1. TYPE OF COUNCIL

Urban	- 1	_____	1
Rural	- 2	_____	

2. STATUS:

Council Employee	- 1	_____	
M.O.H.	- 2	_____	2
Other specify	- 3	_____	

3. CATEGORY OF WORK:

Administrative	- 1		
Medical	- 2		
Para-medical	- 3	_____	3
Nursing	- 4	_____	

4. LENGTH OF SERVICE IN THE DISTRICT:

Less than 2 years	- 1		
Less than 5 years	- 2		
Over 5 years	- 3	_____	4
Over 10 years	- 4	_____	

5. WHAT KIND OF HEALTH WORKER*

Generalist	- 1	_____	
Specialist	- 2	_____	5
Multi-Discipline		_____	

6. WHAT IS THE MAJOR HEALTH CONTENT OF YOUR SERVICE UNIT?

Developmental	- 1	_____	
Curative	- 2	_____	
Preventive	- 3	_____	
Social Care	- 4	_____	6

7. HOW DO YOU DELIVER HEALTH SERVICES IN YOUR UNIT?

Single Unit Delivery System	- 1	_____	
Fragmented Delivery System	- 3	_____	
A Combination of Both	- 3	_____	7

8. ARE THE FUNCTIONS AND ACTIVITIES OF YOUR HEALTH UNIT RELATED TO:

8.1 Overall District Health Objectives?

Yes	- 1	_____	
No	- 2	_____	8.1

8.2 Specific Objectives of the Ministry of Health

Yes	- 1	_____	
No	- 2	_____	8.2

8.3 The Health needs of the Local People?

Yes	- 1	_____	
No	- 2	_____	8.3

(Awareness of Decentralisation)

9. WHAT DO YOU UNDERSTAND BY THE CONCEPT OF DECENTRALISATION OF HEALTH SERVICES?

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

10. DO YOU THINK THIS POLICY OF DECENTRALISATION HAS TAKEN OFF?

Yes	- 1	_____	
No	- 2	_____	10

If Yes, How?

.....

If No, Why?

.....

11. DOES THE STRUCTURE OF DECENTRALISED HEALTH SERVICES PROVIDE
..... FOR THE DELIVERY OF HEALTH SERVICES IN THE
DISTRICT.

11.1 Flexibility:

Yes - 1

NO - 2

11.1

11.2 Continuity:

Yes: - 1

No - 2

11.2

11.3 Innovation:

Yes - 1

No - 2

11.3

11.4 Adaptability:

Yes - 1

No - 2

11.4

12. DO FOLLOWING ARRANGEMENTS AND DEVICES FOR PROVISION OF
HEALTH SERVICES EXIST IN THE DISTRICT?

12.0 Regulatory and Standard Setting Activities
and Procedures

Yes - 1

No - 2

12.0

12.1 Assigning Responsibility to Particular Health
Personnel/Unit

Yes - 1

No - 2

12.1

12.2 Monitoring Activities By Officials/Citizens

Yes	- 1	_____	12.2
No	- 2	_____	

12.3 Health Service/Program Evaluation

Yes	- 1	_____	12.3
No	- 2	_____	

13. DO YOU HOLD DISTRICT HEALTH TEAM MEETINGS

Yes	- 1	_____	13
No	- 2	_____	

14. HOW OFTEN ARE DISTRICT HEALTH TEAM MEETING HELD?

Never	- 1	_____	14
Once Every Month	- 2		
Once Every Quarter	- 3		
Twice Per Year	- 4		
Over Three Times Per Year	- 5		

15. HOW OFTEN DO YOU ATTEND THESE MEETINGS?

Never	- 1	_____	15
Rarely	- 2		
Sometimes	- 3		
Very Often	- 4		
Always			

16. HOW IS THE ATTENDANCE AT DISTRICT HEALTH TEAM MEETINGS?

Excellent	- 1	_____	16
Good	- 2		
Fair	- 3		
Poor	- 4		

17. IN YOUR OPINION ARE HEALTH UNIT HEADS

Cooperative	- 1	_____	17
Hostile	- 2		
Ignorant	- 3		
Indifferent	- 4		

(Decisions and Accountability)

18. WHO MONITORS THE ACTIVITIES OF YOUR HEALTH UNIT?

Council Officials	- 1		
Lay Citizen Groups	- 2		
Consumer Groups	- 3	_____	18
M.O.H. Officials	- 4	_____	

19. WHO HAS THE ULTIMATE AUTHORITY AND RESPONSIBILITY TO DECIDE ON HEALTH SERVICE ISSUES IN THE DISTRICT?

The District Council	- 1		
District Health Team	- 2		
Health Specialists	-33	_____	19
The Local People	- 4		
Provincial Health Team	- 5	_____	

20. HOW DO YOU IMPLEMENT HEALTH DECISIONS?

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

21. TO WHOM ARE YOU ACCOUNTABLE?

The Local People	- 1		
The District Council	- 2		
The M.O.H. - Province	- 3	_____	21
District Health Team	- 4		
All the Above	- 5	_____	

22. WHO PLANS THE HEALTH SERVICES IN THE DISTRICT

The District Council	- 1		
The District Health Team	- 2		
The M.O.H.	- 3	_____	22
The people, Council and Health Staff		_____	

23. HOW ARE HEALTH SERVICES PLANNED IN THE DISTRICT?

Sector Planning	- 1		
Special Planning Structure	- 2		
Multi-Service Team	- 3	_____	23
District Health Team (Participation)	- 4	_____	

24. WHAT DO YOU UNDERSTAND BY THE TERM 'POPULAR PARTICIPATION?'

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

25. DO YOU THINK PEOPLE'S PARTICIPATION IS A GOOD THING?

Yes	- 1	_____	
No	- 2	_____	25.0

25.1 If Yes, why?

.....

25.2 If No, why?

.....

26. DO YOU EVER GO AND TALK TO THE LOCAL PEOPLE ABOUT NEED FOR THEM TO PARTICIPATE IN HEALTH ISSUES?

Never	- 1		
Rarely	- 2		
Sometimes	- 3	_____	
Very Often	- 4	_____	26
Always	- 5	_____	

27. WHO DO YOU USUALLY WORK WITH IN HEALTH SERVICE DELIVERY?

Local Party Leaders	- 1		
Council Officials	- 2		
Traditional Rulers	- 3	_____	
The Local General Public	- 4	_____	27
Other Health Workers	- 5	_____	

28. WHAT FORM OF PEOPLE'S PARTICIPATION WOULD YOU FAVOUR IN YOUR HEALTH UNIT?

Information/Feedback	- 1		
Consultation	- 2		
Joint Planning	- 3	_____	
Delegated Authority	- 4	_____	28

29. IS THE M.O.H. ENCOURAGE PEOPLE'S PARTICIPATION IN HEALTH SERVICE DELIVERY?

Yes	- 1	_____	29
No	- 2	_____	

If Yes, How?

.....

If No, Why?

.....

30. WHAT DO YOU THINK WOULD BE THE EFFECT OF LOCAL PEOPLE'S PARTICIPATION IN THE DELIVERY OF HEALTH SERVICES OFFERED BY YOUR UNIT?

30.0 Better services:

Yes	- 1	_____	30.0
No	- 2	_____	

30.1 Greater Efficiency:

Yes	- 1	_____	30.1
No	- 2	_____	

30.2 Increased Relevance:

Yes	- 1	_____	30.2
No	- 2	_____	

30.3 Wider Coverage:

Yes	- 1	_____	30.3
No	- 2	_____	

30.4 Confusing and Inefficiency:

Yes	- 1	_____	30.4
No	- 2	_____	

31. ARE LOCAL PEOPLE AWARE OF THEIR RIGHT OF PARTICIPATION IN HEALTH PROGRAMS IN THE DISTRICT?

None of them	- 1	_____	31
Some of them	- 2	_____	
Majority of them	- 3	_____	
All of them	- 4	_____	

32. DO YOU GET ANY QUESTIONS, REQUESTS ABOUT HEALTH SERVICES FROM LOCAL PEOPLE?

Yes - 1 _____
No - 2 _____

32

If Yes what kind
.....
.....

33. DOES THE DISTRICT HEALTH TEAM ENCOURAGE LOCAL PEOPLE TO PARTICIPATE IN HEALTH SERVICE DELIVERY?

Yes - 1 _____
No - 2 _____

33

If Yes, How?
.....
If No, Why?
.....

34. ARE ISSUES PERTAINING TO HEALTH SERVICES IN THE DISTRICT RAISED PUBLICLY?

Sometimes - 1 _____
Always - 2 _____
Never - _____

34

35. HOW ARE SUCH ISSUES RAISED PUBLICLY?

Public Meeting - 1 - 1 _____
Ward, Branch, Section meeting - 2 _____
District Council Meetings - 3 _____
District Party Conferences - 4 _____
Other, (Specify) - 5 _____

35

(Relationships)

36. ARE THERE DISAGREEMENTS ABOUT HEALTH ISSUES BETWEEN THE LOCAL PEOPLE AND HEALTH WORKERS?

Yes - 1 _____
No - 2 _____

36

If Yes, over what issues is there disagreement;

.....
.....

37. SHOULD PEOPLE MONITOR THE ACTIVITIES OF THE HEALTH PERSONNEL IN THE DISTRICT?

Yes - 1
No - 2

_____ 37

38. ON WHAT HEALTH MATTERS DO YOU COOPERATE AND WORK TOGETHER WITH THE LOCAL PEOPLE?

.....
.....

39. DO YOU EVER TAKE THE INITIATIVE IN MAKING CONTACT WITH THE LOCAL PEOPLE?

Yes - 1
No - 2

_____ 39

40. WHEN YOU VISIT IN THE COMPOUNDS/VILLAGES, WHOM DO YOU SEE?

Party Leadership - 1
Traditional Rulers - 2
Local Civil Servants - 3
Local People - 4

_____ 40

41. DO YOU EVER WORK WITH ANY NGO IN THE DISTRICT?

Yes - 1
No - 2

_____ 41

(Attitude)

42. WHAT IS THE ATTITUDE OF HEALTH WORKERS TOWARD LOCAL PEOPLE?

Favourable - 1
Unfavourable - 2
Passive -

_____ 42

Why is this so?

.....

43. WOULD YOU CONFINE REPRESENTATION TO POLITICAL OFFICIALS IN DISCUSSIONS ABOUT HEALTH?

Yes:
No:
Not sure:
AHY:

44. WHO WOULD YOU PREFER TO WORK WITH IN HEALTH SERVICES EFFORTS?

The M.P.	- 1		
Local UNIP Leaders	- 2		
Traditional Leaders	- 3	_____	44
The People themselves	- 4	_____	
Local Civil Servants	- 5		

Why?

45. HOW WOULD YOU DESCRIBE HEALTH PERSONNEL'S ATTITUDE TOWARD POPULAR PARTICIPATION IN HEALTH SERVICE DELIVERY?

Amenable	- 1		
Hostile	- 2	_____	45

46. IF HOSTILE, WHY ARE STAFF SO INCLINED?

Staff are experts and know better	- 1		
No confidence in local people	- 2	_____	
No effective/capable local people	- 3		
Time Consuming and inefficient	- 4	_____	
Other (Specify):			

47. WHAT CONTRIBUTION WOULD YOU LIKE LOCAL PEOPLE TO MAKE TO YOUR WORK?

None	- 1		
Money	- 2	_____	
In-kind	- 3		
Gratitude	- 4	_____	47
Take Part	- 5		

(General)

QUESTIONNAIRE B:

PARTY MEMBER

NON-PARTY MEMBER

LOCAL CIVIL SERVANT

NAME OF WARD:

COUNCIL

1. SEX

Male - 1 _____ 1
Female - 2 _____

2. EDUCATION

Did not attend school - 1 _____
Grade 1- 5 - 2 _____ 2
Grade 6 - 7 - 3 _____
Form 1 - 3 - 4 _____
Form 4 - 5 - 5 _____
College - 6 _____
University - 7 _____

3. OCCUPATION

Self employed - 1 _____
Unskilled worker - 2 _____ 3
Skilled worker - 3 _____
Managerial - 4 _____
Other (Specify) - 5 _____

4. LENGTH OF STAY

Less than 2 years - 1 _____
2 to 5 years - 2 _____
6 to 10 years - 3 _____ 4
11 to 15 years - 4 _____
16 to 20 years - 5 _____
Over 20 years - 6 _____

5. Does a Health Centre exist in your area?

Yes - 1 _____
Never hear of it - 12 _____ 5
Not sure - 3 _____
No - 4 _____

6. Do you know the functions of the Health Centre?
- | | | | |
|-----|-----|-------|---|
| Yes | - 1 | _____ | |
| No | - 2 | _____ | 6 |
7. Do you know what the Decentralisation Act 1980 is all about?
- | | | | |
|-----|-----|-------|---|
| Yes | - 1 | _____ | |
| No | - 2 | _____ | 7 |
8. Do you have any say on health matters in your neighbourhood?
- | | | | |
|-----|-----|-------|---|
| Yes | - 1 | _____ | |
| No | - 2 | _____ | 8 |
9. Do you know the new set-up in the District Council Administration?
- | | | | |
|-----|-----|-------|---|
| Yes | - 1 | _____ | |
| No | - 2 | _____ | 9 |
10. CIVIC MEETINGS
- Does your length of stay affect your participation in community matters?
- | | | | |
|-----|-----|-------|----|
| Yes | - 1 | _____ | |
| No | - | _____ | 10 |
11. How often are there community/civic meetings in your area?
- | | | | |
|---------------------------|-----|-------|----|
| Never | - 1 | _____ | |
| Once every month | - 2 | _____ | |
| Twice per year | - 3 | _____ | 11 |
| Three times per year | - 4 | _____ | |
| Over three times per year | - 5 | _____ | |
| Once per year | - 6 | _____ | |
12. How often do you attend these meetings?
- | | | | |
|------------|-----|-------|----|
| Never | - 1 | _____ | |
| Rarely | - 2 | _____ | 12 |
| Sometimes | - 3 | _____ | |
| Very often | - 4 | _____ | |
| Always | - 5 | _____ | |

13. Do experts in health matters from District Council come to talk to you about good health?
- | | | | |
|------------|-----|-------|----|
| Never | - 1 | _____ | 13 |
| Rarely | - 2 | _____ | |
| Sometimes | - 3 | _____ | |
| Very often | - 4 | _____ | |
| Always | - 5 | _____ | |

14. AGENDA

Do you discuss health issues with Council workers/
Councillors/people?

- | | | | |
|--------|-----|-------|----|
| Always | - 1 | _____ | 14 |
| Rarely | - 2 | _____ | |
| Never | - 3 | _____ | |

15. Do you make recommendations to your District Council about health services needed in your area?

- | | | | |
|-----|-----|-------|----|
| Yes | - 1 | _____ | 15 |
| No | - | _____ | |

16. Do such recommendations receive the Council's action?

- | | | | |
|------------|-----|-------|----|
| Sometimes | - 1 | _____ | 16 |
| Always | - 2 | _____ | |
| Not at all | - 3 | _____ | |
| Don't know | - 4 | _____ | |

17. Are you consulted before health programmes are implemented in your area?

- | | | | |
|-----|-----|-------|----|
| Yes | - 1 | _____ | 17 |
| No | - 2 | _____ | |

18. Do health services programmes in your area meet health needs of the area?

- | | | | |
|-----|-----|-------|----|
| Yes | - 1 | _____ | 18 |
| No | - 2 | _____ | |

19. DECISION MAKING

When health services are introduced in your area/ward are they explained to you in advanced?

- | | | | | |
|--|--------------|-----|-------|----|
| | Sometimes | - 1 | | |
| | Some of them | - 2 | _____ | 19 |
| | Not all | - 3 | _____ | |
20. Has there been any marked change in the Council's response to your request for health services since the introduction of Decentralization?
- | | | | | |
|--|----------|-----|-------|----|
| | Yes | - 1 | | |
| | No | - 2 | _____ | 20 |
| | Somewhat | - 3 | _____ | |
21. Are Council workers now responsive to your needs and suggestions?
- | | | | | |
|--|-----|-----|-------|----|
| | Yes | - 1 | | |
| | No | - 2 | _____ | 21 |
| | | | _____ | |
22. Do you participate fully and effectively in decision-making regarding the following:
- (i) Planning and Implementation of Health
- | | | | | |
|--|-----|-----|-------|---|
| | Yes | - 1 | | |
| | No | - 2 | _____ | 1 |
| | | | _____ | |
- (ii) Management of Public Health Matters
- | | | | | |
|--|-----|-----|-------|----|
| | Yes | - 1 | | |
| | No | - 2 | _____ | 11 |
| | | | _____ | |
- (iii) Design and Implementation of Health Projects
- | | | | | |
|--|-----|-----|-------|-----|
| | Yes | - 1 | | |
| | No | - 2 | _____ | 111 |
| | | | _____ | |
- (iv) Development, setting and maintenance of Health Centres and other Health Facilities in the area.
- | | | | | |
|--|-----|-----|-------|----|
| | Yes | - 1 | | |
| | No | - 2 | _____ | iv |
| | | | _____ | |
23. Who do you think should be responsible for Health Services in your area?
- | | | | | |
|--|----------------------|-----|-------|----|
| | The government | - 1 | | |
| | The District Council | - 2 | _____ | 23 |
| | The people | - 3 | | |
| | All the above | - 4 | _____ | |

24. PERFORMANCE:

Has the Health Situation of the people changed since the introduction of Decentralization?

Yes for the better	- 1	_____	24
Yes for the worst	- 2	_____	
Not at all	- 3	_____	
Don't know		_____	

25. What has been the effect of Decentralization on Health Service Delivery in your area?

Improved health conditions			
(i)	Yes	- 1	_____
	No	- 2	

Improved health awareness			
(ii)	Yes	- 1	_____
	No	- 2	

Greater Efficiency			
(iii)	Yes	- 1	_____
	No	- 2	

26. How would you rate the level of people involvement in Health Affairs in your area?

High	- 1	_____	26
Average	- 2	_____	
Low	- 3	_____	
Poor	- 4	_____	

27. What are the problems hindering people's participation in Health Services?

Unwillingness of people to participate	- 2	_____	27
Vagueness of Participatory Democracy	- 2	_____	
Irrelevance of the Participation Scheme	- 3	_____	
Negative Management Attitude	- 4	_____	
All the above	- 5	_____	

28. Do you think, the Social Secretary's department is working

Yes	- 1	_____	28
No	- 2	_____	
Don't know	- 3	_____	

29. Do you think, the Social Secretary's Department is working well?

- | | | | |
|------------|-----|-------|----|
| Yes | - 1 | _____ | 29 |
| No | - 2 | _____ | |
| Don't know | - 3 | _____ | |
- If No Why?
-

30. Which Social Service Unit do you think is most effective?

- | | | | |
|-----------------------|-----|-------|----|
| Health | - 1 | _____ | 30 |
| Education | - 2 | _____ | |
| Community Development | - 3 | _____ | |
| Housing | - 4 | _____ | |
| None of them | - 5 | _____ | |

31. How do you feel about the new decentralised structure?

- | | | | |
|--------------------|-----|-------|----|
| Very satisfactory | - 1 | _____ | 31 |
| Satisfactory | - 2 | _____ | |
| Very disappointing | - 3 | _____ | |
| Disappointing | - 4 | _____ | |
| Don't know | - 5 | _____ | |

Why?

.....

32. COMMUNICATION

Are you informed about important social/civil issues by the Council?

- | | | | |
|-----------|-----|-------|----|
| Always | - 1 | _____ | 32 |
| Sometimes | - 2 | _____ | |
| Never | - 3 | _____ | |

33. Are you informed of any major decisions taken by the District Council?

- | | | | |
|-----------|-----|-------|----|
| Always | - 1 | _____ | 33 |
| Sometimes | - 2 | _____ | |
| Never | - 3 | _____ | |

34. Are you aware of your right to participate in Civic Matters?

Yes	- 1	_____	34
No	- 2	_____	

35. RELATIONSHIPS

Are there conflicts between the people and the Council Staff?

Yes	- 1	_____	35
No	-	_____	

Why?

36. Should people monitor the activities of the Council?

Yes	- 1	_____	36
No	- 2	_____	

37. ATTITUDE

Would you like the Ward Chairman to be the sole representative of the people in the District Council?

Yes	- 1	_____	37
No	- 2	_____	
Not sure	- 3	_____	

Why?

.....

38. Who should run the Social Services?

Central Government	- 1	_____	38
Local Government	- 2	_____	
Voluntary/Private Groups	- 3	_____	
All the above	- 4	_____	
The people themselves	- 5	_____	

39. What form of people's participation would you favour?

Information/feedback	- 1	_____	39
Consultation	- 2	_____	
Joint planning	- 3	_____	
Delegated Authority	- 4	_____	

40. Is the Council encouraging the concept of 'Power to the People?

Yes	- 1	_____	40
No	- 2	_____	

If Yes How?

If No Why?

41. Do you think the residents in general are sufficiently involved in decision making regarding Civic Matters?

Yes	- 1	_____	41
No	- 2	_____	
Don't know	- 3	_____	

42. How should your District Council be managed?

The D.E.S. himself should manage	- 1	_____	42
The D.E.S. and other secretaries should manage	- 2	_____	
The Secretariat should consult with the people but people should not have power to make decisions	- 3	_____	
The people should participate in managing the Council			

43. What do you understand by 'power to the people?

The people share in power only	- 1	_____	43
The people share in power and authority	- 2	_____	
The representative democracy	- 3	_____	
People make all decisions	- 4		
Never heard of the slogan	- 5		

44. What changes would you recommend in the area of health delivery?

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

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