FACTORS AFFECTING DELIVERY OF QUALITY HEALTH SERVICES IN ZAMBIA: THE CASE OF MANDEVU RESIDENTIAL AREA

BY

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A dissertation submitted to the University of Zambia in partial fulfilment of the requirements of the degree of Master of Public Administration

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DECLARATION

I, TOWELA KAONGA, declare that this dissertation represents my own work and that it has not been previously submitted for a degree, diploma or other qualifications at this or another university.

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APPROVAL

The dissertation of Towela Kaonga has been approved as part of the requirements for the award of the degree of Master of Public Administration by the University of Zambia.

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ABSTRACT

The Zambian government faces great problems in the provision of good health care services to its people. To respond to this Zambia has been in the process of an ambitious program of health sector decentralization by adopting successive policies in past years. For example, the "National Health Policy' enacted in August 2012. This policy is committed to the attainment of equity of access to cost effective quality health services as close to the family as possible. The overall objective of the study was to investigate the factors that affect the quality of service delivery in public health facilities in Mandevu residential area. while the specific objectives were: To identify the factors that affect service providers in the delivery of quality health services in Mandevu residential area and to identify the factors that affects the users in accessing high quality health services.

The study used a survey method with a total sample of 166 respondents. These consisted of 100 households, 50 health care professionals from 4 purposively selected health facilities that serve Mandevu, 2 focused group discussions were conducted consisting of 6 and 4 members respectively and 6 key informants. The key informants consisted of: The District Medical Officer, In-charge of Chipata First Level Hospital and the Medical Superintendent, In-charge of Mandevu, Chaisa and Matero Reference Health centre. The study employed quantitative and qualitative method of data collection. Questionnaires were used to collect data from households. Quantitative data was analysed using Statistical Package for Social Sciences while qualitative data was analysed using thematic review.

The study established that the main factors that affect provision of quality health care in Mandevu residential area were; quality and number of staff, job satisfaction and this was determined by pay and conditions of service, funding and this was found to be insufficient and irregular which stifles planning. Other factors included inadequate infrastructure, high population of users and availability of medical and surgical supplies The study found out that the main factors that affect accessibility by local people were; lack of a health facility in Mandevu except for a paediatric clinic for children aged zero to fourteen. This compromises the quality of services of surrounding clinics as they deal with huge numbers of patients making these clinics over crowded. Long queues and waiting time, lack of information and distances were also key factors that hinder

accessibility by local people.The study recommended that the Government should build a health facility in Mandevu, increase the number of staff in surrounding clinics accompanied by better conditions of service and strengthen the financial muscle of clinics.

Key words: Quality, Healthcare, Lusaka, Zambia

DEDICATION

To

CHARLES KAONGA

I dedicate this dissertation to my father Charles Kaonga, the man who taught me and still continues to teach me the value of education and hard work. You instilled in me at a tender age the values of hard work, diligence, excellence and respect for people regardless of their social status. These have propelled me to where I am today. You also instilled in me a reading culture that has opened up my world to all new things. You are indeed the best dad in the world. I love you dad.

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ABBREVIATIONS

AIDS	Acquired Immune deficiency Syndrome
AHF	Aids Health Foundation
ARIs	Acute Respiratory Infections
ART	Anti - Retro Therapy
CIP	Capital Investment Plan
CBOH	Central Board of Health
CHW	Community Health Workers
CSO	Central Statistical Office
ECD	Early Childhood Development
EMCT	Elimination of Mother to Child Transmission
GMT	Growth Monitoring Programme
HIV	Human Immune-deficiency Virus
JICA	Japan International Corporation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of health
NHC	Neighbourhood Health Communities
NHSP	National Health Strategic Plan
OPD	Out Patient Department
ORS	Oral Rehydration Salts

SPSS	Statistical Package for Social Sciences
UNDP	United Nations Development Programme
UTH	University Teaching Hospital
VCT	Voluntary counselling and Testing
VMMC	Voluntary Medical Male Circumcision

CHAPTER ONE

INTRODUCTION

1.1 Background

Delivery of quality health care is vital in improving the duration and quality of life experienced by people world over. To achieve this, the nation's leadership must mobilize to address critical uncertainties on how best to organize, finance, and deliver quality public health services to all people. Access to proper health care facilities is an essential basic need. If health is an asset and ill health a liability, protecting and promoting health care is central to the entire process of poverty reduction and human development (World Bank, 2002).

The general state of healthcare in Zambia is poor (Operational Implementation manual, 2011). The Zambian government faces great challenges in the provision of good health care services to its people. Most health care facilities in Zambia are below acceptable standards with limited screening and testing capabilities. The poor state of the health system in Zambia is not a new problem. Zambia has been in the process of an ambitious program of health sector "decentralisation." Zambia has been implementing health reforms since the 1992 policy under the framework of the Sector Wide Approach (SWAP), which takes a holistic development view of the sector (World Bank, 2002).

In 1995, the National Health Service Act was enacted. It called for a significant change in the role and structure of the Ministry of Health and called for the establishment of an autonomous health service delivery system. This led to the creation of Central Board of Health (CBoH) (Jeppsson, 2000). The mandate of the CBoH was to "monitor, integrate, and coordinate the programs of the Health Management Boards" (International Insulin foundation, 2014). In 2006, the CBoH was abolished and its functions taken on by the Ministry of health (International insulin foundation, 2014).

The country has also been developing and implementing successive National Health Strategic Plans (NHSPs) since 1995. An example is the National Health Strategic Plan 2011 to 2015.The 2011-2015 National Health Strategic Plan (NHSP), aimed at reducing the disease burden and accelerating the attainment of the Millennium Development Goals and other national priorities. The NHSP represents a departure from past interventions as

it places emphasis on addressing certain key areas such as; human resource crises; improving the state of the health care infrastructure; nutrition, HIV/AIDS, control of epidemics, and health education; and increasing access to basic environmental health facilities such as water and sanitation, electricity, and telecommunication. The plan advocates for an increased interest and focus establishing very effective, strong, and sustainable partnerships among all key stakeholders involved in health service delivery in Zambia (CSO, 2013-14).

The main priority areas of the 2011-2015 National Strategic Plan can be summarised as; human resources, health service delivery interventions, clinical care and diagnostic service priority interventions. For example, one of its objectives was to reduce the population/nurse ratio from the current 1,864 to 700 by 2015 (CSO, 2013-14).

Zambia has adopted successive health policies in past years. The National Health Policy was also enacted in August 2012. The National Health Policy for Zambia seeks to respond to many problems in the health sector. It has been developed within the context of the Vision 2030 and has taken into consideration other relevant national, regional and global health related policies, protocols and strategic frameworks, including the Millennium Development Goals (MDGs). This policy is committed to the attainment of 'equity of access to cost effective quality health services, as close to the family as possible (GRZ, 2012).

The health sector has made tremendous progress such as strengthened health systems, improved access to health care and improved health outcomes. However, Changes in the political, economic, social, technological and epidemiological profile of the country has posed new problems for the health sector. Problems faced by the health care system are the inequitable access to public health between provinces and between urban and rural areas. Household expenditure on health varies according to location. Poor households spend the highest proportion of their income on health, which can be up to 10% of household income. Shortage of human resources is also another key problem affecting the health care delivery in Zambia. The main contributing factors to these problems are brain or skill drain and the impact of HIV/AIDS on health workers (GRZ, 2012).

Furthermore, due to poor equipment certain ailments requiring specialized treatment are sent to South Africa, India and other parts of the World. There has been a rise in non-communicable diseases that require specialist treatment and Hi-tech medical equipment, inadequacy of infrastructure development to meet the demand and the state of medical equipment in some public health institutions is poor. There has been a slow pace of the existing private health sector to grow and fill the gap in the provision of specialised treatment. An increasing portion of Ministry of Health (MOH) resources over the last years is going to administration rather than service delivery (Project Implementation Manual, 2011).

With an ever-growing population, provision of quality health care is a major problem. The population for Lusaka Province increased from 1,391,329 in 2000 to 2,198,996 in 2010 (CSO, 2010). Compounds in Lusaka District are home of tens of thousands of people squeezed into a few square kilometres. The population is therefore, at high risk of illnesses such as cholera and many challenges that all affect health. These include; lack of sewers and inadequate latrines, undisposed garbage and lack of reliable water mains among others. Compounds generally face poor quality healthcare due to large population depending on limited health facilities.

1.2. Statement of the problem

Health is one of the priority sectors that contribute to the wellbeing of a nation. The Zambian government continues to make a lot of investments in the health sector as it is one of the prerequisites for sustainable economic growth. In the period between 2006 and 2013, according to (Health Policy Project, 2016) government health expenditure as a percentage of Total Health Expenditure (THE) increased from 38% to 58%. Ideally with a well-functioning health system every user is supposed to be attended to in the shortest possible time and received the necessary diagnostic tests and treatment. According to the National Strategic Plan 2011 to 2015, Zambia has made significant progress in most key areas of health service delivery and health support systems. For instance, both Maternal and Neonatal Mortality rate reduced in the period of 2006 to 2010. According to the Zambia Demographic and Health Survey (ZDHS, 2013-2014), Under Five mortality also declined from 119 per 1000 live births to 75 per 1000 live births (CSO, 2013-2014). Health Management Information Systems (HIMIS) records that, hospital malaria

fatalities decreased from 24.6 per 1,000 admissions in 2014 to 19 per 1,000 admissions in 2016.

However, in spite of this progress, the general state of healthcare in Zambia faces many problems (Project Implementation manual, 2011). Most public health centres in Zambia seem to be marred by poor and slow moving services. The country has remained under significant pressure to decrease the disease burden and improve the health status of Zambians (GRZ, 2012). The high disease burden in Zambia is compounded by poor quality of services in some public clinics and hospitals, high poverty levels, and the poor macroeconomic situation (CSO, 2013-2014).

1.3 Study Objectives

1.3.1. *General Objectives*

To investigate the factors that affects the delivery of quality of health services in public health facilities in Mandevu residential area.

1.3.2. *Specific Objective*

1. To identify the factors that affect service providers in the delivery of quality health services in Mandevu residential area.
2. To identify the factors that affects the users in accessing high quality health services.

1.4 Research Questions

1. What are the factors that affect service providers in delivering quality health services?
2. What are the factors that affect users in accessing high quality health services?

1.5 Rationale

The study is of great value as it is a course requirement in the Master of Public Administration programme. Therefore, it is a mandatory task in the completion the Masters Programme.

Furthermore, the results of the study may positively contribute to scholarly research, practice, interventions, and policy.

The study will provide a body of knowledge on the factors affecting delivery of quality healthcare in high density areas, particularly Mandevu residential area. This information will be relevant to scholars, the general public, the international donor community and indeed the government. This will enhance any interventions to provide direct support to the health facilities as the key problem areas will be highlighted.

It will also help the Ministry of Health to gauge the effectiveness of the National Health Policy (2012) in providing quality health services to users. The Ministry of Health has given itself a mandate to provide "equity of access to cost effective quality health services, as close to the family as possible". Therefore, this research will provide information as to whether the policy is on the right track to achieve what it set out to do and also provide information on what has been achieved and what is yet to be achieved.

1.6 Conceptual Framework

1.6.1 Introduction

This study adopted a conceptual framework on delivery of quality health services focusing on factors affecting Services Providers and Users. The framework explains delivery of quality health services by looking at the concepts of: medical supply, infrastructure, modern technology, human resources and financial resources. In addition, it looked at the concepts affecting users in accessing quality health care, which include; physical barriers, economic barriers and attitudes of service providers.

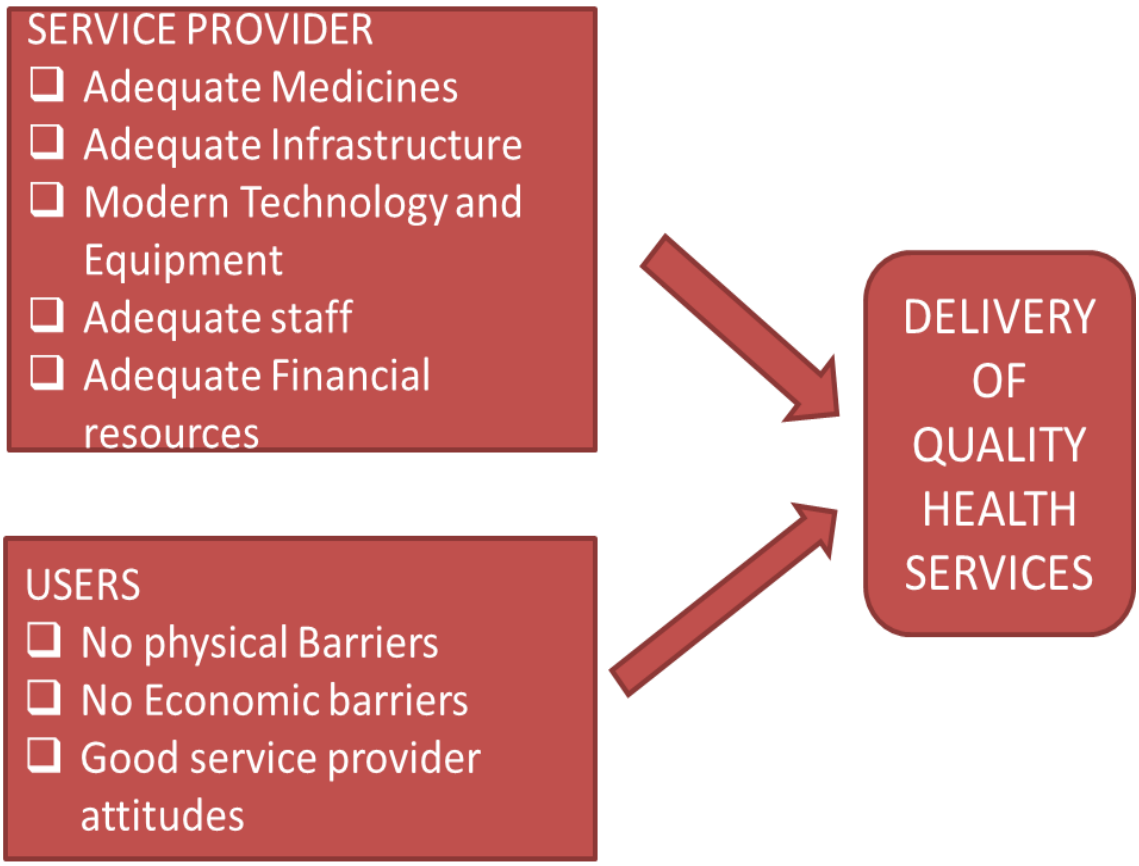


Figure 1.1: Conceptual framework of factors affecting delivery of quality health services

(Source: Researcher's Conception)

1. **Medicines and Medical Supply**; - This study refers to medicine as any substance or combination of substances which may be administered for therapeutic, diagnostic or preventive purposes (NHS, 2017). Medical supplies include drugs, vaccines and equipment used in medical facilities. Adequate supply of medicines is important for any medical facility to run efficiently and effectively. Availability and access to essential vaccines, drugs and other medical supplies is critical in the provision of health services. It is therefore, essential to ensure continuous mobilization and funding for procurement of essential drugs and medical supplies (GRZ, 2012).

2. **Infrastructure**; Infrastructure refers to the building and structure of the medical institution. Infrastructure also encompass how equitably distributed health infrastructures are in a particular area. Adequate infrastructure is vital as it allows for enough operating space for medical personnel. Inadequate health facilities at a particular health center will lead to problems of overcrowding, long queues and poor ventilation.

3. **Equipment and Modern Technology**; Technology refers to the basic equipment and technology that allows the service providers to produce the desired results. Adequate equipment is essential in providing high end diagnostic and surgical services. Equipment for support service such as generators, laundry, kitchen, is also in short supply in many of the public health facilities (GRZ, 2012).Other forms of technology looks at technology for data storage and management systems. Good record keeping of patients records with modern technology will ensure easier retrieval of the same and this will reduce on cost in terms of time spent retrieving lost files.

4. **Human Resource (Staff)**; This study refers to Human Resources as people who work in Hospitals, Clinics and various health centres and their supervisors. Highly skilled physicians, nurses, administrators, and ancillary staff are critical to producing high-quality outcomes and effective quality improvement hence hospital growth (Argote, 2000). To facilitate service quality and growth, hospitals must implement effective human resource strategies involving selective hiring, and retention of physicians and nurses (Cohen and Levinthal, 2001). It is also important that the health workers are in right numbers. Well managed human resource and highly motivated staff will lead to high quality service delivery. People are motivated by various factors; however, money is also a very important motivator.

5. **Financial Resources:** These are monies available for spending which health facilities need to provide quality health care**.** Adequate financing to improve health service provision is cardinal. In particular, there is a need to distinguish "good costs" that improves organizational capabilities and quality service delivery from "bad costs" that increase bureaucracy hence becoming obstacles to service delivery (Sun and Shibo, 2005).

Quality health service delivery is also achieved when users have access to the health services.

Access can refer to the availability, accommodation, affordability and acceptability of health services (HNP, 2011). It is the potential ability of an organization's potential clients to obtain its services. Several factors can act as barriers to access such as:

Physical barriers, economic barriers and attitudes of care givers:

These barriers can be broken down into: 1. fees users are expected to pay and whether they can afford them or not (Economic barriers). Poverty is a major problem experienced by users in accessing health care. In Zambia up to 59% of people are living below the poverty datum line and this has clear health implications. 2. The distance to the nearest health post (physical barriers). Transportation is another problem faced by users in accessing healthcare. 3. The poor attitudes of health personnel can also be a key factor in accessing quality healthcare. Users might shun seeking care and treatment if they are not treated with courtesy and respect. When these barriers are absent, users can access high quality services and experience high user satisfaction.

1.6.2 Quality Health Service Delivery

In modern day and in different spheres of life there is a demand for quality goods and services. Improving quality leads to a reduction in delays, wastage and lowers cost. Quality, however, because of its subjective nature and intangible characteristics, it is difficult to define. Quality healthcare is a subjective, complex and multi-dimensional concept. How one defines, quality depends on the perceptions of that particular individual and the context within which it is used (Mosadeghrad, 2014). No single universally accepted definition exists. Quality can mean 'degree of excellence. It can also mean the totality of features about characteristics of a product or service that bear on its ability to satisfy stated or implied needs.

However, according to Mosadeghrad (2013), quality in healthcare can be defined as "consistently delighting the patient by providing efficacious, effective and efficient healthcare services according to the latest clinical guidelines and standards, which meet the patient's needs and satisfies providers. This is the definition that was adopted in this

research paper. In a nutshell quality health services must meet the needs of the users and at the same time satisfy the service provider.

1.6.3 Utilization of Health Services

Utilization looks at whether the available services are being used by the residents of the area. It is possible that a health facility can be nearby but because of poor services, residents do not utilize it and opt to use an alternative one even if it might be further. According to the Health, Nutrition and Population discussion paper for World Bank (2011), utilization means access and use by those in need. Therefore, quality must also consider the level of utilization by the local people.

1.6.4 User Satisfaction

Patients' perception of satisfaction is an aspect of healthcare quality that is being increasingly recognized for its importance. Patients' satisfaction often reflects their perception of the health care offered (outcome) as well as the process of giving that care, compared to their expectations (Carr-Hill 1992, Copeland and Scholle, 2000). There are different factors that contribute to patient's satisfaction with health services. Modern-day consumers of health are better educated and informed than ever before, and this has led to the need to address the aspects of service most readily appreciated and what perceptions they hold about what satisfies them, and what does not. Users can be dissatisfied with things such as physical environment, waiting rooms, pharmacy, and attitude of doctors among others.

1.6.5 Summary of Conceptual Framework

The conceptual framework has shown that quality service delivery may be achieved when there is adequate medical supply, infrastructure, equipment, adequate employee capacity. Factors that would hinder quality health care are on the part of users with regards to accessibility are economic barriers, physical barriers and poor attitudes by care givers. Quality health services must meet the needs of the users and at the same time satisfy the service provider. Quality healthcare will give rise to higher user satisfaction and utilization.

1.7 Literature Review

In an attempt to contribute to the improvement of basic healthcare in Zambia, a primary health care project was conducted by kamwanga et al. (1999). The main aim of this study was to *Investigate the factors which inhibit or facilitate health reforms in both rural and urban Zambia* and ultimately contribute to the improvement of basic health care. The study was divided into an exploratory and evaluative phase. It was conducted in three provinces namely; Lusaka, Western and North Western. Research methods included; household cross sectional survey, informal in-depth interview, exit interviews with patients and review of records in the period 1990 to 1996. Results of this study indicate that studies of care need to take into account the various aspects of care, type of health facility and different settings within which health facilities are located. One critical area is the lack of sufficient drugs at health centres. Access to health facilities, especially in rural areas is reported to be limited. Finally, people hold the view that cost-sharing has a negative impact on the utilisation of health services.

The conclusions of Kamwanga's study were relevant to this research as they focused on how to improve basic health provision. The weakness of Kamwanga et al's research was that they did not administer questionnaires to key officials working for Ministry of Health such as District and Provincial Medical officers thus the findings had certain gaps. It is not enough to only interview users and service providers leaving out other relevant key informants. This proposed study, however will have comprehensive knowledge on factors affecting delivery of quality services in public health facilities.

Shikabi, (2013) conducted a study on *factors hindering primary health care delivery in Chibombo district.* The study concluded that some of these factors included; inadequate infrastructure, low medical supplies, lack of equipment, low budgetary allocations, and also the physical and economic barriers faced by users. The sample size of this study was 130 respondents. These consisted of 100 households, 20 staff in charge of health facilities, 4 chairpersons of Neighborhood Health Committees (NHCs), 3 Community Health Workers (CHWs), 2 councilors and the District Medical Officer.

This research is related to shikabi's study, as it also attempted to identify factors that affect provision of quality health services. Shikabi, however, conducted the research at a district level this proposed study intends to look at a particular residential area of Mandevu. This study therefore, has built on the findings of Shikabi's research and had found out that the health facilities in Chibombo face more or less the same challenges as those on Mandevu.

Bbaala (2007) conducted a study on '*The impact of attrition of healthcare professionals on Zambia's health care delivery system: the case of University Teaching Hospital".* The study concluded that due to attrition the effectiveness and efficiency of public health system in Zambia has reduced. Attrition can affect the provision of quality health services due to issues such as inadequate time spent with patients due to work overload, closure of certain units of the health facility due to shortage of staff and increased use of inappropriate health professionals among others.

Bbaala's research is related to this study has it brought out a very important factor that can affect provision of quality health services which is worker attrition. This research has improved on the study as it has conducted a case study of Mandevu residential area so as to observe the effect of staff shortages on a community.

Siachisa, (2009) conducted a study on "*Impact and public perception of health service user fees: The case of high density residential Chawama compound*". Siachisa concluded that people's reluctance in paying User fees is influenced by a number of factors such as income, occupation, education, availability of quality services and sensitization. Due to these factors people resort to alternatives sources of health such as traditional healers, private local drug stores, chemists and private clinics among others.

Siachisa's research is related to this research as it highlights the economic factor that affects provision of quality health care as it limits accessibility. This research attempted to improve on Siachisa's study as it attempts to explore other factors that can affect quality service delivery besides cost of services provided.

Tennard (2009) conducted research on *health reforms and health care delivery in Lusaka Urban district.* The aim of his study was to establish the failures of health reforms in ensuring effective health care delivery in Lusaka Urban District. He took a comparative study of health care services offered by different health care facilities in Lusaka urban district so as to make a balanced assessment of the performance of the health facilities under the health reforms in ensuring effective health care delivery. Tennard's study is relevant to this research in that it is also focusing on the performance of public health facilities. From this study it was concluded that a number of issues still remained unresolved in spite of the numerous reforms. Some of these issues include; staff motivation and equity of access to health care, setting of quality standards without involving stakeholders among others. This study has added to the body of knowledge and was more specific and by focusing on a particular residential area so as to understand its various dimensions.

Wanjau (2012), conducted a study on *the factors Affecting Provision of Service Quality in the Public Health Sector at National Hospital Kenyatta* in Nairobi Kenya. The study was aimed at investigating the role of employee capability, technology, communication and financial resource in the provision of service quality in the public health sector. The paper reviewed existing literature and experiences on public health service provision and quality management. The methodology was such that both quantitative and qualitative sources of data were utilized. The sample was distributed as follows: A total of one hundred and three respondents, comprising of sixteen doctors, thirty-two nurses, twenty nine clinical officers, fourteen laboratory technologists and twelve pharmacists. Data was collected using closed and open ended questionnaires. The findings of this research were that employees' capacity, low technology adoption, ineffective communication channels and insufficient fund affect delivery of service quality to patients in public health sector affecting health service quality perceptions, patient satisfaction and loyalty.

Wanjau's research was related to this research as it was focusing on factors that can affect quality of service provision such as employee capacity, low technology adoption, ineffective communication channels and insufficient funds. The shortfall of the research by Wanjau is that the respondents were various professionals in the healthcare provision,

covering the comprehensive process of healthcare provision from diagnosis to treatment. This research had several gaps in that it only determined the state of healthcare delivery from the perception of the staff and not the users themselves. This study, however, also distributed questionnaires to the users so as to get a balanced view and hence fill that gap.

Couper and Hugo (2005) conducted a study in South Africa that aimed at exploring and documenting what assists a rural district hospital to function well, and how the lessons learned may be applicable to similar hospitals all over the world. A cross sectional exploratory study was conducted using in-depth interviews with 21 managers of well-functioning district hospitals in two districts in South Africa. Results resulted in the identification of three clusters namely; Teams working together for a purpose, foundational framework and values and health service and the community. Much can be learned from the experience of these managers. The vital issue is the development of a team in the hospital with a vision of giving patients priority and respect and working in and with the community to achieve optimal health care in the district hospital.

This research by Couper and Hugo was relevant to this study in the sense that it provided a wealth of knowledge and insight concerning ingredients for successful management of health facilities. And it also offered methods which can assist the development of positive relationships between health workers and patients and create team work within a facility. Couper's research was very much related to this study as it also aimed to show how reduced problems faced by both service providers and users can enhance effective delivery of services. However, the gap in Couper's research which this study has to fill is that this research also interviewed service users and not just managers of health facilities so as to get a balanced view.

The health Policy and Planning in London conducted a thematic review of empirical studies to explore *the factors that improve upon priority setting at hospital level.* Priority setting refers to the distribution of resources among competing programs and patients or patient groups (McKneally, 1997). A systematic search of PubMed, EBSCOHOST, Econlit databases and Google scholar was supplemented by a search of key websites and

a manual search of relevant papers, references list. The first step in the literature search resulted in a total of 2659 papers. However, most of these were excluded and a total of 24 papers were identified from developed and developing countries to synthesize and examine the findings of selected papers. The findings suggest that priority settings in hospitals are influenced by firstly, contextual factors such as decision space, resource availability, financing arrangements, availability and use of information, organisational culture and leadership. Secondly, priority setting processes that depend on the type of priority setting activity, thirdly, content factors such as priority setting criteria and fourthly, actors, their interests and power relations.

The findings of the thematic review of empirical studies were incomplete as it only gave ideas of issue areas requiring attention but with no conclusive findings. The thematic review acknowledged that there is need for studies to examine the identified issues and the interplay between them in greater depth and propose a conceptual framework that might be useful in examining priority setting practices in hospitals. This literature therefore, clearly showed the value of undertaking the research. Its major recommendation was to intensify research at the meso level as it has been neglected for example at clinics. Therefore, this research attempted to fill the gap and has thus provided sufficient information on factors hindering quality health service delivery at meso level.

A paper by kaseje (2006) revealed that an appropriate, robust, and sustainable model for improvement in health system performance is essential in order to reverse the declining trends in health and development status and break the vicious cycle of poverty and ill-health in Africa. Furthermore, Kaseje argued that national government resource scarcity is another key factor in poor health care. Poverty is another key factor affecting public health service delivery. The UNDP Human Development Report (2004) and the World Bank World Development Report (1997) estimated that 54% of the total population of Sub Saharan Africa is living in absolute poverty. This poverty limits access to services, increasing vulnerability, while ill health directly affects productivity, especially in labour-intensive economies. The human resource crisis in the health sector is another contributing factor to poor health delivery. The human resource crisis is caused by many

factors such as inadequate production in some countries, inability to hire in others, brain drain, poor motivation, conflict of interest, corruption, and misuse of resources—including time—in most countries (kaseje, 2014).

Kasaje's paper was relevant to the study as it provided a framework on the role of poverty, inadequacy of human resource and limited resources on public health service delivery in Africa. This is related to the study as it helped provide a guideline on the problems faced by users in accessing public health services and also the problems faced by service providers in the provision of services. The research built on this literature and narrowed it down to a health centres in a community instead of making a broader analysis on the whole Africa.

Bradley and colleagues (2011) did a discussion paper on behalf of World Bank called 'Improving the delivery of health services; A guide to choosing strategies'. The paper argued that sufficient funding and efficacious technology may be necessary conditions for achieving health gains, but experience in many countries confirms that they are not sufficient. Effective and efficient service delivery is the point at which the potential of the health system to improve lives meets the opportunity to realize health gains. Health service–delivery performance means access and use by those in need; adequate quality of care to produce health benefits; and efficient use of scarce resources.

The paper prepared for world bank was important to this research as it identified that service delivery performance also involves accessibility and utilization by those in need and not necessarily the availability of health services. This paper also highlighted on the fact that adequate resources and equipment may be present but they may not be used effectively, hence, bring about underperformance. The study sought to build on this information and verify if these conclusions are true in the area of Mandevu and in this particular period.

Mjaria (2009-10) did an analysis of factors affecting the provision of quality health services by the government to the population in Somaliland. The study was undertaken as a cross-sectional survey of identified stakeholders supporting the health sector in

Somaliland, including the Ministry of Health and Labour staff, the UN and international agencies directly providing financial and technical support to health care operations. In total, the sample size target was 40 respondents. This study identified several factors that affect service provision and some of these included; Inadequate supervision by managers, Staff preferring to refer patients to private services offered, cost of services, lack of drugs / supplies, lack of equipment, poor infrastructure / road network, inadequate transportation services and poor coordination of supporting agencies among others.

Mjaria's study was relevant to this study as it brought out factors that affect service quality from the perspective of international donors such as United Nations and other international agencies. The identified gap in this study is that it only received views from stakeholders supporting the health system and neglected the users. Furthermore, this study was conducted in a different cultural and environmental setting of Somaliland, with different demographic and environmental factors from Zambia. The other gap identified is that, Mjaria's study did not focus on the factors affecting service provision that have to do with accessibility for example physical and economic factors.

The above literature was reviewed in an attempt to explore the different authorities in the subject of interest. From the reviewed literature, there is clear evidence that no study of this nature has been undertaken in Mandevu residential area. Different studies similar to this one have been done but none looking at factors affecting delivery of quality healthcare in Mandevu residential area. Similar studies conducted in Zambia include: Shikabi's study on Factors hindering delivery of Primary healthcare in Chibombo District, Bbaala's study on impact of attrition of healthcare professionals on Zambia's healthcare delivery system: the case of University Teaching Hospital, Siachisa's study on impact and public perception of health service user fees: the case of high density Chawama compound among others.

The reviewed literature provided the study with a wealth of knowledge and theoretical insights on what affects delivery of quality health care in public health facilities. The reviewed literature enabled the study to adopt a more ideal methodology for the study. It helped to establish that to identify factors that affect quality it is not enough to collect

views from service providers, however, views from users must also be explored. Quality is a multi-dimensional concept and might mean different things to different people, however, it is important to note that quality is not just about providing a good service but also involves accessibility and utilization by those in need.

Furthermore, according to the reviewed literature several factors that may affect delivery of quality healthcare in public health facilities included: inadequate infrastructure, low medical supplies, lack of equipment, low budgetary allocations, physical and economic barriers faced by users. Labour attrition has also affected the efficiency and effectiveness of the public health system. Low staff motivation is also a key factor and the setting of quality standards without involving key stakeholders. Other factors include ineffective communication channels, which affect patient's perception, satisfaction and loyalty. Poverty, government resource scarcity, misuse of resources, corruption, conflict of interest and inadequate supervision of managers are also driving forces of poor quality healthcare especially in Zambia and Africa at large.

1.8 Methodology

1.8.1 Study Design

This research used both exploratory and descriptive non – experimental cross sectional design and was carried out in an uncontrolled and natural setting of Mandevu compound in Lusaka district. The study used descriptive study design as it explored factors that affect provision of quality health care. It also used exploratory design, as it is a small-scale study being taken over a short duration of time. In addition, a study of that nature had not been undertaken before in that area. The study was a cross sectional study as it will gave a pictorial presentation of the situation at one point in time. Cross sectional studies are undertaken once only to get the state of affairs at that point in time.

Both qualitative and quantitative methods were employed. Quantitative design was employed to collect statistical information that can be presented on tables, bar graphs and pie charts. Quantitative data was obtained through the use of closed ended questions to both users and service providers. Closed-Ended questions are questions which provide a

list of responses from which the respondent must pick an option that applies to them. The advantages of quantitative data are that; it allows information to be produced in form of statistics. Quantitative data also allows the researcher to measure and analyse data. On the other hand, the disadvantage of quantitative data is that the context of the study may be ignored, as it might not be able to discuss the meaning things have for different people as qualitative data does.

Qualitative data on the other hand was employed so as to get more in-depth information and personal experiences. Qualitative methods were used as a research of such a nature has not been undertaken before in Mandevu residential area, hence, qualitative methods gave the researcher more freedom for the research to develop more naturally. Qualitative data also gave the researcher more freedom to gain detailed and rich data given through unique personal experiences through their description of issues. This is specifically vital in social sciences as it deals with issues that affect society every day, and cannot be merely reduced to statistics. The main disadvantage of the qualitative method of study is that it is very time consuming and might take a lot of time to be completed. Furthermore, in the course of the study the researcher might become heavily involved in the process and might end up having a subjective view of the study and its participants. This ultimately might affect the researcher's presentation of findings as it may have a bias connotation. Using such a mixed design ensured that the weakness of qualitative data were minimized and supplemented by quantitative data

1.8.2 Study Site and Population

The research was conducted in Mandevu residential area. It is situated 5.8 kilometers north of the Lusaka City Centre (Mwanza, 1998). Like many compounds in Lusaka District, Mandevu township is home of tens of thousands of people squeezed into a few square kilometres. Mandevu means 'beard' in the local language, Nyanja. It is said that Zimbabweans had settled there years ago and they had the habit of shaving their heads but leaving their beards to grow (Katebe, 2010). Most of the households are self-built and owner occupied though others are rented out to tenants. The compound came about after independence when there was a growth of movement into the city for greener pasture.

Mandevu residents are served by the nearest hospital Chipata First Level hospital in Chipata residential area. Mandevu also has a Paediatric Health Centre with a catchment population of 93,535 and serves Chaisa, Mandevu and Marapodi and in 2005, an anti-retroviral therapy clinic was also opened in the area.

Residents of Mandevu Township mostly depend mainly on Chipata Health Centre which was recently turned into a first level Hospital. Chipata First Level Hospital as at 2012 it had a total of 50 beds and a catchment population of 133, 392. The health facility is about nine kilometers from the District Medical Office (Ministry of Health, 2013). Residents of Mandevu also depend on Chaisa Health Centre and Matero Reference First Level hospital. The respondents were the residents of Mandevu compound and the staff of Chipata First Level Hospital, Chaise Clinic and Matero Refrence as they also serve the area.

This study was conducted in this area due the high density nature of the area and the apparent disease burden on the health facilities.

1.8.3. Data Collection Instruments and Procedure

In order to gather the necessary information required in the study, the data collection method employed involved the use of semi structured questionnaires and interview guides. The questionnaires consisted of both closed ended and open ended questions. This is because closed ended questions are easy to answer and analyse. Closed ended questions were used to collect quantitative data while open ended questions will be used to collect qualitative data.

The questionnaires were not self-administered as most of the respondents were not literate in English language and hence the questions had to be translated. The questions were explained to the respondents in the language they were most conversant with either Nyanja or Bemba and the responses recorded by the researcher. In the case that the respondents understood English the questionnaires were given to them to respond on their own.

Focus Group Discussions were also used to get the actual feelings and sentiments of the people. These were organised and conducted in the market area. This location was

chosen as it was convenient and representative of the population and included both buyers and sellers. The main aim of the Focus Group Discussions was simply to reinforce the findings in the interviews held at household level. These were aided by an interview guide. The responses of the participants were recorded by the researcher. The advantage of the Focus group discussion is that people were able to provide in depth responses and detailed descriptions of their experiences at the various health facilities. The disadvantage of the focus group discussions was that people were not free to give information that is confidential in nature because there were too many people.

Furthermore, interviews were used to collect information from key informants. This was aided by a semi structured interview guide. This contained a list of questions that the interviewee had to respond to. However, it was flexible in the sense that the researcher was free to ask any question not indicated on the interview guide. The researcher wrote down the responses as the key informant responded. The advantages of the interviews were that it allowed the researcher to get in depth information and detailed descriptions about the problem at hand. It also allowed the researcher to probe further when not satisfied with a certain response. Interviews also allowed the researcher to rephrase the question and ask it in different ways to achieve clarity. On the other hand, interviews also had their own limitations. Sometimes the people being interviewed were not able provide the accurate information one needed and these also proved to be costly in terms of time and resources.

1.8.4 Sample Size and Sampling Procedures

A total sample of 166 respondents was sampled. 100 households from Mandevu compound were selected to which a questionnaire was administered. The study employed systematic sampling to select 100 households and a questionnaire was administered to every 5^{th} household. Two focused group discussions were conducted consisting of 6 and 4 members respectively. The method of selecting these was purposive sampling. Ten (10) health staff from Mandevu Pediatric Clinic, 20 health staff from Chipata first level Hospital, 10 from Chaisa Clinic, 10 from Mandevu Paediatric Clinic and 10 from Matero Reference First Level Hospital was asked to respond to a questionnaire. The method of selection was purposive sampling. This method was used because only the available and

willing health personnel were interviewed. Out of the 50 questionnaires distributed to the clinics 3 were not returned as the health personnel lost them. This brought the total sample of health personnel to 47.

6 key informants were interviewed; the method employed was purposive sampling method. As these were subjectively selected because they were believed to have the information, the researcher required. An interview was administered to the District Medical Officer. Other interviews were conducted with the: In-charge of Chipata Clinic and the Medical Superintendent, In-charge of Mandevu, Chaisa and Matero Reference. During interviews, an interview guide was used and responses were recorded accordingly.

8.5 Data Processing and Analysis Methods

Analysis of Quantitative Data

Firstly, the data collected using questionnaires was checked for uniformity, consistency and accuracy. This was done at questionnaire level and after data entry has been done. The raw data that was collected was subjected to coding and each questionnaire was assigned a number. Coding is the process of assigning numbers to responses in the questionnaire that have been answered. Then the raw data was entered into the computer programme called SPSS software. SPSS stands for Statistical Package for Social Sciences (SPSS), which was used to facilitate analysis of quantitative data. Upon entering the data into SPSS software, the next step was data cleaning. This is the process which involved checking for inconsistencies in data that had been collected. Furthermore, from the entered data analysis can begin through the generation of frequency tables, charts and graphs were produced from this and then used to formulate the interpretation. Data is imported into excel to be able to produce graphs, charts and tables.

SPSS was used as it is the most user friendly data analysis software that is readily available. It is widely used in social, economic and health research institutions. It is also

used in Monitoring and Evaluation, decision making, project planning and implementation and also useful in demographic projections.

Analysis of Qualitative Data

Qualitative data was derived from interviews, focused group discussions and loosely structured questions (open ended questions). As data was being collected analysing and processing of data had also began and was being mentally processed into themes and patterns. Upon collection of all the data a great wealth of data was generated. However, not all of it was meaningful. Therefore, after reviewing all the data as a whole, some of the data which the researcher found irrelevant to the study was discarded. The next step was the identification of meaningful patterns and themes.

The qualitative data was analysed using thematic review. Thematic Review involved a situation where data was grouped into themes that will help answer the research question. These themes naturally emerged as the study was being conducted. Once the themes were identified it was easy for the researcher to group the data into thematic groups so that the meaning of the themes can be analysed and then connected back to the research question. Content analysis was also used because the researcher went through the contents of the in-depth explanations that were attained from the key informant and analysed factors affecting quality of healthcare services, organised them into logical and meaningful categories, made connections between and among categories and explained the link between categories. Data was presented in narrative form.

1.8.6 Ethical Considerations

The research proposal was submitted to the University of Zambia Ethical Committee for review before data collection resumed for the main study. Full ethical clearance was granted by the University of Zambia- Directorate of Research and Graduate Studies Ethical Committee. Furthermore, permission to conduct the study was obtained from the Ministry of Community Development Mother and Child Health. The Ministry and particularly the District Medical office had no objection to the study and gave authority to collect data from Mandevu Paediatric Clinic, Chipata First Level Hospital, Chaisa Health Centre and Matero Reference First Level hospital. All the ethical issues were

taken into consideration. Effort was made to make the respondents understand the purpose of the study. Consent was sought to collect data from respondents either verbally or in writing and they had a choice whether to participate or not after the purpose of the study was explained to them. Ethical issues such as misconduct and falsifications were also observed by the author. The data was strictly used for the intended purpose as outlined in the report and anonymity, confidentiality and privacy were observed during data collection. To ensure confidentiality, upon dissemination of results the names of the participants shall not be linked to the research.

1.8.7 Time Frame

This research was conducted from April 2016 to May 2017. Hence, it was conducted over a period of one year and a month.

1.8.8 Limitations

The limitations included; the delay on the part of ethical committee to give a go ahead to conduct the study.

The other limitation was the unavailability of respondents in clinics. Mostly the target health personnel were busy attending to patients making it difficult to spare a few minutes and respond to the questionnaires. As a result, the questionnaires had to be left at the various facilities so respondents can respond to them in their free time. This led to delay in getting responses from respondents after questionnaires were dropped off. Other health personnel lost the questionnaires therefore, compromising on the sample selected. As a result, the sample size reduced

The other limitation was the shying away of certain health personnel from responding to the questionnaire as they felt their responses might compromise on their job security. A lot of questions bordered on the challenges they faced in the execution of their duties that compromise on quality.

Another limitation was the reluctance of some medical staff to reveal certain key information as they were uncomfortable with the topic and regarded it to be political. As a result, certain essential information was not collected and thus not included in the thesis.

When it came to collecting data among the households the main limitation was the language barrier. Hence, the questionnaire had to be interpreted and this was time consuming.

1.8.9. Organisation of Dissertation

The report is divided into five main chapters. Chapter one of the report introduces the research topic. It includes sections such as: background information, research objectives, and research questions, Significance of study, conceptual framework, literature review and methodology. Methodology highlights the road map used to conduct the research. This mainly involves; data collection techniques and instruments. Methodology also encompasses data compilation and analysis methods. Chapter two; Outlines the social – economic profile of the area and availability of health facilities in Mandevu residential area. Chapter three covers factors affecting service providers the delivery of quality health services. Chapter four covers factors that affect users in accessing high quality health services. Chapter five gives conclusions of findings and makes several recommendations.

CHAPTER TWO

SOCIAL-ECONOMIC PROFILE OF MANDEVU RESIDENTIAL AREA AND AVAILABILITY OF HEALTH FACILITIES

2.1. Introduction

Mandevu is situated 5.8 kilometers North of Lusaka City Centre. Like many compounds in Lusaka District, Mandevu township is home of tens of thousands of people squeezed into a few square kilometers. Mandevu means 'beard' in the local language, Nyanja. It is said that Zimbabweans had settled there years ago and they had the habit of shaving their heads but leaving their beards to grow (Katebe, 2010).

During the copper boom that followed the country's independence, Zambia's cities developed quickly and, from a spatial viewpoint, inefficiently (Urban Slums Report: The Case of Lusaka, Zambia, 2003). Hence, like other urban centres it experienced phenomenal growth in its population, which resulted into a housing crisis, which was evident in the growth of unauthorised settlements on the farms located on the edge of the town boundary. This led to the mushrooming of shanty compounds such as Mandevu. The most likely drivers for immigration into Lusaka were that the city had substantially higher economic prospects, more opportunities for higher education and higher chances of having wage employment. The on-going urbanization trend was causing growth in informal settlements in Lusaka city. The housing standards in unauthorised settlements were also extremely poor. They lacked access to clean water and sewerage facilities. The residents of unauthorised urban settlements were, therefore, vulnerable to both respiratory diseases and diarrhoea. Vulnerability to ill health also undermined the productivity of the residents of the unauthorised settlements.

Poverty levels are worse in informal settlements than elsewhere in the city and health is generally poor. The overall current trend is that migration is on the decline due to reduced economic prospects in the city. Poverty and unemployment with poor quality health are apparent in modern slums (Lusaka City State of Environment OutLook Report, 2008).

2.2. Social-Economic Background of Mandevu Residential Area.

Mandevu is a high density area with majority of people being self-employed and running their own businesses. The main business unit is the large market with people selling different items from food stuff to furniture. The poverty levels in the country have been steadily increasing over the last two to three decades mainly due to the high levels of population growth. The majority of the total estimated city population resides in unplanned settlements. This is due to decline in availability of formal wage employment.

Living Conditions Monitoring Surveys and Participatory Poverty Assessments undertaken so far, suggest that poverty is widespread in Zambia and Mandevu is not an exception. According to the Living Conditions Monitoring Survey 2015, majority of Zambians are classified as poor. In the Zambian context, poverty is defined as lack of access to income, employment opportunities, and entitlements, including freely determined consumption of goods and services, shelter, and other basic needs. The poverty situation in the country has remained more pronounced in rural areas than in urban areas mainly on account of recurring drought spells and increased agricultural input costs over time (78 percent and 28 percent, respectively) (CSO, 2016).

People in Mandevu fall in the intermittent wage employment and are self-employed. Most people in these categories tend to be usually unskilled or semi-skilled (Hansen, 1980). The majority of people who live in the self-help housing areas of Lusaka are therefore generally poor, because they are not likely to command high wages when they take up wage employment, while their self-employment activities tend to be characterized by low capital input and low returns (Hansen 1980). People in Mandevu without practical skills generally engage in piece work and small scale trading activities. A piece work is any type of employment in which a worker is paid a fixed rate regardless of time. Women and young men trade in the markets and others at other city markets. Furthermore, Semi-skilled and skilled men with practical skills such as carpentry and metal fabrication, on the other hand, earn a living by making household items such as furniture and other usable things for sale. The market is marred by skilled men making different household furniture, such as kitchen units, beds, wardrobes, and couches among others.

Livelihoods in Lusaka slums are dynamic. People engage in a variety of livelihood activities, which also change according to seasons and overall economic conditions and individual circumstances (Mulenga, 2003).

The study found that from the households that were interviewed, 65% were not in employment and only 35% were in employment as shown in Figure 2.1 below. Those in employment were either formally or informally employed. And out of those that are employed 74% earn K2000 and below. With the high cost of living this figure does not give a very good prospect for good quality life.

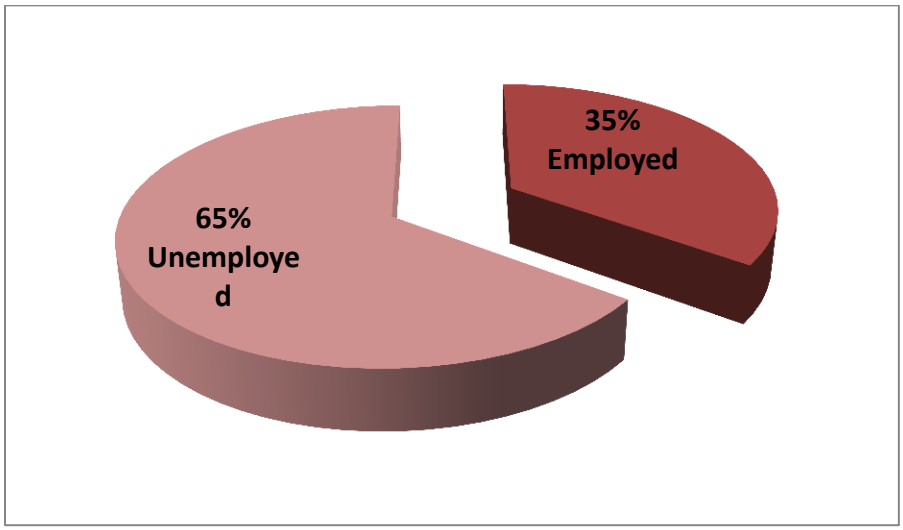


Figure 2.1 Distribution of respondents by employment status

Source: (Primary Data)

Mandevu houses thousands of people in a few square kilometers. Most houses in the area are self-built and owned by the local people. Houses are mostly informal, are not made from formal plans, and are generally built by the resident(s). Therefore, there is no proper planning in terms of housing. Poverty and the lack of a sustainable housing policy have led to urban growth being absorbed into informal settlements. The housing, health, and environmental conditions in the growing informal settlements such as Mandevu are extremely poor.

The majority of the residents live in the self-help improved, authorized and unauthorized settlements. However, the poorest seem to be concentrated in the settlements that provide the least expensive housing that the poorest perhaps find affordable.

The basic determinants of better health, such as access to water, and sanitation, are still in a critical state in Zambia. Limited access to water and sanitation facilities accompanied by poor hygiene is associated with skin diseases, acute respiratory infections (ARIs), and diarrheal diseases, the leading preventable diseases (Demographic Health Survey 2013-2014). Mandevu is challenged with lack of sewers and inadequate latrines, undisposed garbage and lack of reliable water mains among others. Urban growth has resulted in increased amounts of waste. The main waste stream is domestic waste which accounts for 80 percent of total waste (Lusaka City Council, 2008). The council has limited capital and technical resources to handle waste especially in unplanned settlements such as Mandevu. It is not strange to find hips of undisposed waste in market places and around households. This is usually accompanied by bad stenches. A research done by Lusaka City Council (1997) found that over 90 per cent of people in squatter compounds use basic unprotected pit latrines, which pollute the groundwater drawn from the shallow wells; over 60 per cent of households share latrines. Furthermore, there is no systematic waste collection.

Commuter buses going to and from town are the main transport system. Residents can easily catch a bus along the main road. With a bus one is able to connect and also get to the city Centre and disembark either at Lumumba bus Station and Kulima Tower Bus Stop. Buses though public are owned by private individuals as a form of business. Most people do not own private vehicles as they have a small monthly income that barely takes care of their basic needs.

Education is the gateway to better employment and improved household income as more qualified people tend to command a higher wage. Mandevu compound has a high number of people without a grade 12 certificate. Advancement to advance further in studies is mainly due to lack of financial muscle to fund studies.

The Figure 2.2 below shows that majority of people in Mandevu only go up to secondary education without progressing to tertiary education either college or university. One per cent of the total number of 100 respondents has been to university, 3 per cent of the total sample had been to college, 42 per cent completed their senior secondary education, 25 per cent only went up to grade nine, 22 percent went up to grade seven and 5 % had never been to school.

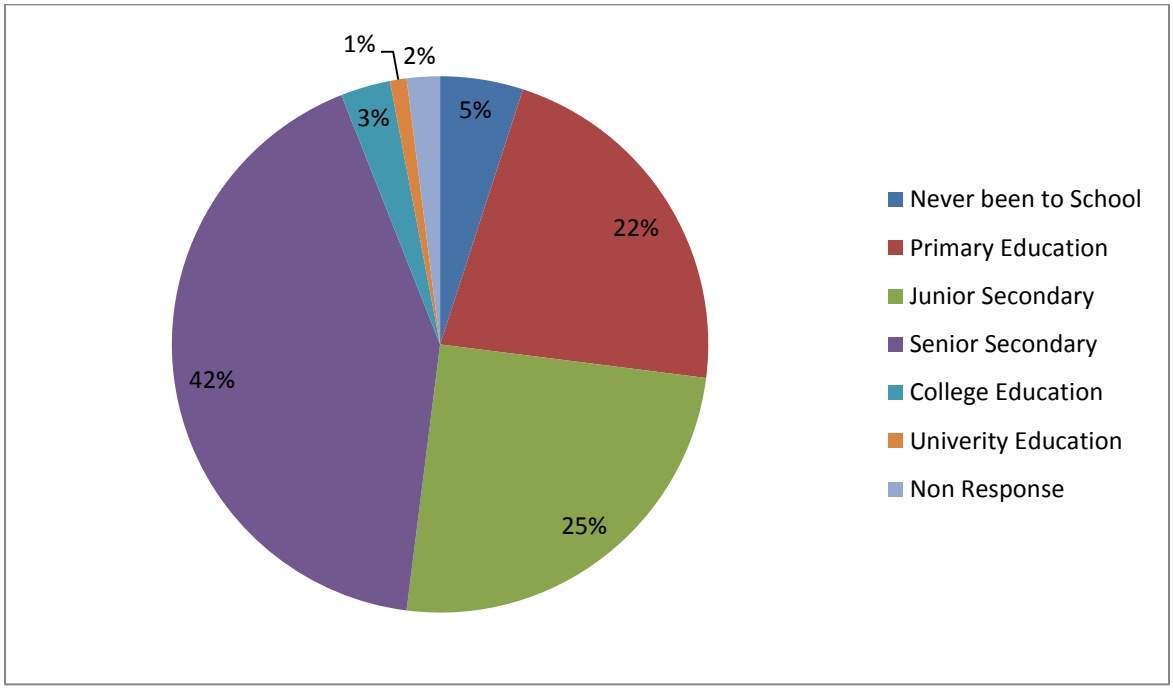


Figure2.2. Distribution of respondents by education

Source: (Primary Data)

High poverty levels are the main cause of young people's inability to further their studies beyond high school. Households only earn a limited income they can barely survive on. While primary education is free basic and senior secondary is not free. With many households earning something to barely live by prospects for furthering their studies are quiet blurry.

2.4 Availability of health facilities

Zambia's long-term socio-economic development plan through the Vision 2030, has prioritized health, and is committed to the attainment of 'equity of access to cost effective quality health services, as close to the family as possible'. The government of

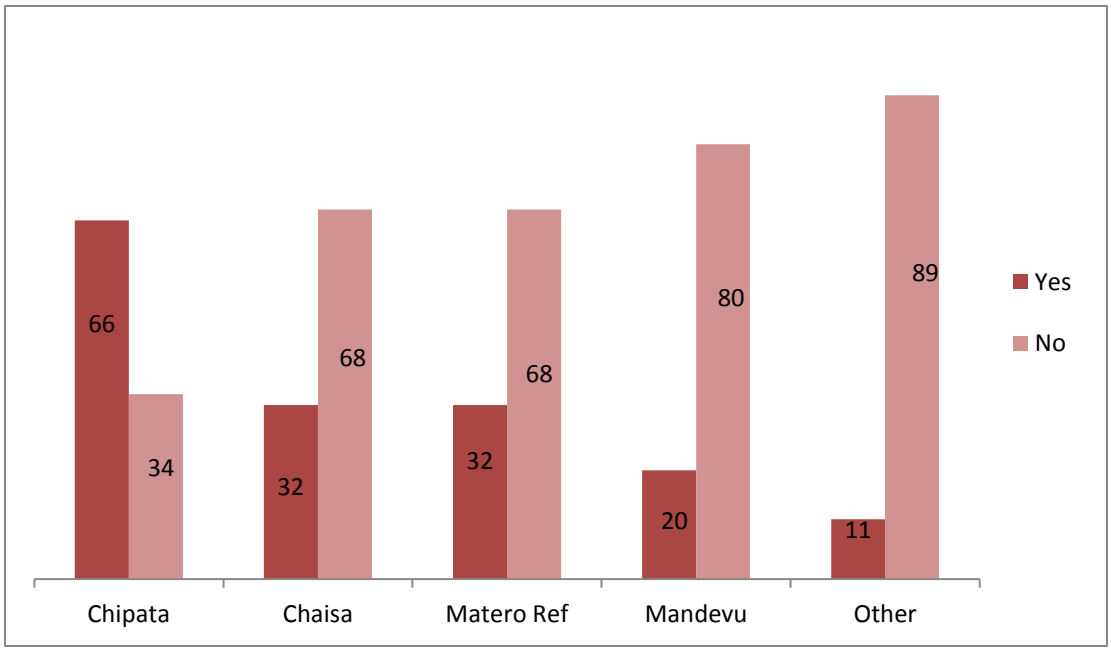
the Republic of Zambia is committed to improving the quality of life for all Zambians. Over the past years, significant efforts and resources have been invested in strengthening health infrastructure. However, the quest to bring healthcare as close to the family as possible has been very challenging as this is the case in Mandevu.

Zambia operates a pyramid classification structure of health care provision. Tertiary or specialist care is provided in Level 3 hospitals, provincial level care is provided in Level 2 hospitals, district – level care is provided in Level 1 hospital and community level care is provided through health posts and Health centers. The provision of basic health facilities in lower health facilities for example health posts and health centers, covering a limited geographical area, supported by the first, second and third level referral hospitals, through established referral system. Lusaka system lacks such a pyramid based referral structure and in most instances, patients that are supposed to be attended to at a level one hospital are directly referred to level three hospitals, thereby compromising the quantum of care.

With a population of over two million people in Lusaka, the only tertiary hospitals are University Teaching Hospital and Levy Mwanawasa Second Level Hospital. One of the major challenges in the delivery of quality health care in Lusaka and Mandevu in particular has been the inadequacy of primary and secondary health facilities.

The main goal of the Ministry of Health is to make health facilities available, as close to the household as possible is the main goal of the National Health Policy. This is vital, as it will allow users to access healthcare within the shortest possible time. Mandevu residential area has a Pediatric clinic called Mandevu Clinic. This is a clinic that only caters for children ranging from the ages of zero to fourteen. The study found that the pediatric clinic has proved to be inadequate as it only carters for children. Other age groups have to seek medical attention from nearby clinics such as Chipata First Level Hospital in Chipata Compound, Chaisa Clinic in Chaisa Compound and Matero Reference in Matero Township.

Users were asked which clinic they go to and Figure 2.3 below shows the responses of the residents of Mandevu. According to Figure 2.3, the study found that the main clinics that serve Mandevu were; Chipata First Level Hospital, Mandevu Pediatric clinic, Chaisa and Matero Reference First Level Hospital locally known as Chingwere clinic.



Health Centers which people in Mandevu go to

Source: (Primary data)

According to Figure 2.3, 66 out of 100 respondents said they go to Chipata First level Hospital. 32 out of 100 said they go to Chaisa and 32 out of 100 said they go to Matero Ref, only 20 out of 100 said they go to the Pediatric clinic. And just 11 said they go to other clinics. Other clinics included clinics like Chainama, University Teaching Hospital, Kabwata Clinic among others though these were the minority.

From Figure 2.3 it is clear that most people go to Chipata First level Hospital. Chipata can therefore be taken to be the main health facility serving Mandevu as it is very close to Mandevu residential area. The study found that different people held different views with regard to the health facility closest to them. The main factors were mostly familiarity and which part of Mandevu one resides.

According to Table 2.1 below, 44 out of 100 respondents considered Chipata to be the closest health facility in Mandevu compound. 14 considered Chaisa to be close and 18 considered Matero Ref to be close. Distance to the closest health facility seemed to be highly dependent on which part of Mandevu the respondent resides.

Table 2.1 Respondents views on the closest Health Facility

Health Facility	No. of Respondents
1. Chipata First Level Hospital	44
2. Chaisa Health Centre	14
3. Matero Reference	18
4. Mandevu Pediatric Clinic	17
5. Chipata and Matero Reference health facilities	3
6. Chipata and Mandevu health facilities	1
7. Chipata and Chaisa Health Facilities	1
8. Emmasdale Army Clinic	1
9. No response	1
TOTAL	**100**

Source: (Primary Data)

The study therefore, found that the main health facilities serving mandevu are Chipata First Level Hospital, Matero Reference, Chaisa health Centre and Mandevu Pediatric Clinic. A closer examination of these clinics will now be taken.

Mandevu Pediatric Clinic

Mandevu's only clinic is a pediatric clinic for children between the ages of 0 to 14 years. Initially there was a health centre in Mandevu previously and it was demolished and a new structure was erected in 2010. However, the clinic was only in operation in 2013. It has an establishment of sixty staff including non-medical staff. However, currently there

is only twenty five staffs in total of which 10 are medical staff and 15 are non-medical staff.

The clinic only serves children 0 to 14 years. It has several departments, which include VCT, Out Patient- OPD, TB, Family Planning, Early Childhood Development (ECD), laboratory, Physiotherapy, Children's clinic (Under-Five).

Chipata First Level Hospital

Chipata was turned into a first level Hospital in 2014. It is located in Chipata Compound right next to Mandevu Compound. After being upgraded into a first level hospital it was equipped with modern equipment as an attempt to improve service delivery to the people (HOT877, 2014). As of fourth quarter 2015 chipata had a total work force of hundred and seventy of which 111 were professionals and 59 were non-professionals.

Chipata has several departments which include; Voluntary Counseling and Testing (VCT), Maternity, Laboratory, Out-Patient (OPD), Dental, Ante-retro Therapy (ART) and In-patient department. Inpatient department only deals with medical cases and not surgical cases. Inpatient department has four cubicles which include; male, stabilization center, pediatric and female cubicle. The First Level Hospital also has a Malnutrition Centre, and Operating Theatre Department, though this only deals with minor surgeries and patients are sent home as there is no surgical ward. Other departments include TB, Voluntary Medical Male Circumcision (VMMC) and Maternal and Child health services (MCH). Under MCH the services provided include: Family Planning, Postnatal, anti-natal, Child health and Elimination of Mother to child Transmission (EMCT). Chipata First Level Hospital also provides environmental services.

The First Level Hospital also continues to be a practical site for all schools; government and private. Students studying different courses come for attachments as doctors, nurses, midwives, psycho social councilors, dentists, other fields include laboratory. Psycho social councilors also conduct their training and practicals from the site. Students come from various institutions such as University of Zambia, NRDC, Evelyn Hone College, and Chainama among others.

Chipata Health Centre has a catchment of Chaisa, Mandevu, Marrapodi, Ng'ombe, Kabanana, Garden, Mazyopa, ZaniMuone and Six Miles and it includes a maternity and admission wing (Zambia Daily Mail, 2015).

Chaisa Health Centre

Furthermore, Mandevu is also served by Chaisa Health Centre in Chaisa Compound. It was established in 2010. The Clinic has staff levels below the required amount. For instance the establishment provides for a total of fifteen enrolled nurses but the centre only has eight.

Chaisa Health Centre has several departments such as maternity, Out-Patient, In-Patient, Male Circumcision, TB, Ante-Retro Therapy (ART), Scanning, Environmental, Nutrition Services, and Adolescent Health Services. The clinic does not do deliveries or admissions as there is no in-patient ward.

Matero Reference First Level Hospital

Matero Reference is a First Level Hospital located in Matero Residential Area. It was established in 1969. The Hospital has a total of 111 professional health staff and 78 support staff. However, this is not sufficient as the establishment is over 200. The 2015 catchment population was 129, 113 and 2016 catchment population is 137 642 users.

Matero Reference First Level Hospital has several departments such as Out-Patients, In-patient, Dental, X-ray, Voluntary Counseling and Testing (VCT), Maternity, Laboratory, Physiotherapy, Youth Friendly Corner, Mother and Child Health, environmental, Nutrition Department, Laundry, Kitchen, Labour Ward, Theatre, Pharmacy, Cervical Cancer Screening and Security.

Construction works are in progress at Matero Reference as it will be turned in to a District Hospital in order to improve healthcare access to residents of Lusaka while reducing congestion at the University Teaching Hospital (UTH) and reviving its function as the top referral and educational Hospital. In this project Matero Reference Health Centre will receive new facilities for out-patient, casualty/administration building,

laboratory, maternity building, adult and pediatric wards and other related facilities. The Japan International Cooperation (JICA) Zambia office through a Grant Agreement had provided grants of up to 19.08 billion Japanese Yen to fund the "the Upgrading Lusaka Health Centres to District Hospitals" with the Zambian Government on 17th July, 2013 (JICA, 2013). The other health centre under upgrade is Chilenje Health Centre.

2.4 Conclusion

It has been found that Mandevu Compound is an unplanned settlement within Lusaka City. The residents are generally poor and engage in intermittent wage employment and are self-employed. The number of semi-skilled and unskilled is also high. Women and young men trade in various things to earn a living while others are involved in skills such as carpentry, metal fabrication among others. Housing units are mostly small with the majority living in self-help unplanned settlements. The main mode of transport is public transport. Waste management and sanitation is levels are poor and it is common to find uncollected garbage. The main Health centers that serve Mandevu include: Mandevu Pediatric Clinic, Chipata First Level Hospital, Chaisa health Centre and Matero Reference First Level Hospital. Most residents consider Chipata to be the closest to the area.

CHAPTER THREE
FACTORS AFFECTING HEALTH PROVIDERS IN THE DELIVERY OF QUALITY HEALTH SERVICES

3.1 Introduction

This chapter will focus on the factors that affect service providers in the delivery of quality health services in public health facilities. It will look at the availability of staff in public health facilities and its role in the provision of quality health services. The chapter will also look at the role of motivation in the ability of health personnel to provide quality services, and how inadequate infrastructure affects the work of health professionals. The chapter will also focus on the limitations arising from the problem of inadequate finances, shortage of medical and surgical supplies, equipment and other logistics. Furthermore, attention will be drawn to the role of high population of users on the facility's ability to provide quality services.

3.2 Availability of Health Staff

The study found that the levels of health professionals at the health facilities serving Mandevu residence were inadequate to carter for the people coming to the facilities. The critical shortage of health staff is a major obstacle in attaining quality health care. With an ever increasing population, the numbers of health workers are inadequate to provide services at an optimal level. The study found that from the forty seven health staff that were interviewed from the four health facilities, twenty seven considered the staff at their various health facilities to be insufficient to adequately meet the needs of the users. Thirteen considered the staff to be fairly sufficient and seven said the staff levels were sufficient enough to meet the needs of the users. These results show that more than fifty per cent of the health staff considered the staff levels to be insufficient.

The health facilities serving Mandevu residential area have staff levels below the establishment stipulated by the Ministry of Health. This means that they are operating with a shortfall and this negatively affects provision of quality health care. According to the In-Charge of Mandevu Paeditric Clinic in an interview on 20th June, 2016, the clinic has an establishment of 60 staff but currently there are only 25 staff, of which 10 are

medical staff and 15 are non-medical staff. The available staff accounts for only 41.6% of the approved establishment. Therefore, the available staff are far below the required number of staff. In spite of this critical shortage, the facility still manages to run. The extent of the problem is mitigated by the fact that the facility is underutilised. However, irrespective of the fact that the facility is underutilized, the facility can run more optimally with the approved establishment.

The study found that shortage of staff was also prevalent at Chipata First Level Hospital. According to an Interview with the In-charge on 16th November 2016, the current numbers are far below what is required. The First Level Hospital is supposed to have two hundred (200) nurses but it only has eighty four (84). According to the establishment there are supposed to be ten (10) stationed doctors but there are only five (5). Clinical officers are supposed to be eighteen but the facility only has seven (7). In addition, there are supposed to be thirty maids but there are only thirteen (13). These shortages are a clear indication that the facility is understaffed. The high population of users that come to the facility every day exacerbates the problem of staff shortages. This is because users interviewed stated that the hospital is usually congested. The In-Charge at Chipata clearly stated that this short fall has a direct effect on the hospital's ability to provide good and timely services to users.

Matero Reference First Level Hospital has also been operating with staff levels below the stipulated establishment. The hospital has a total workforce of one hundred and eighty nine workers, of which one hundred and one are professional staff and seventy eight are non-professional staff. However, these staff levels are not sufficient, as they are below the required establishment, which is over 200. (In-Charge of Matero Reference First level Hospital, 10th August 2016).

The study found that Chaisa Health Centre also has staff levels below the stipulated establishment. According to an interview with the In-Charge (16th November, 2016), the facility has staff levels below the required amount. The establishment provides for a total of fifteen enrolled nurses but then it only has eight on station. It is supposed to have a stationed doctor but it only has a visiting doctor who comes only on Tuesdays and

Fridays. This negatively affects the operation of the facility, as patients who need to see the doctor have to wait until he visits the clinic. The health centre is supposed to have three enrolled midwives but only has one on the ground and it is supposed to have three registered midwives, but only has two at the centre. Furthermore, there are supposed to be six clerks but there are only three at the centre. Pharmacy technicians are supposed to be two but the centre only has one. Maids are only three but these are also supplemented by other positions. Environmental staff are two which is according to the requirement of the establishment. This is the same case with nutrition where there is one person according to the required specification. Laboratory technicians, on the other hand, are supposed to be two but there is only one. Laboratory attendants are supposed to be two as well but there is only one. Security staff are supposed to be three but the clinic currently has no security staff. However, this position is being supplemented by other positions such as maids. Security role is played by people that are being paid as house cleaners (In-Charge, Chaisa 16th November, 2016).

The study established that these shortages affect the quality of services offered. Furthermore, it also puts pressure on the available staff and this means they work more to make up for the shortage. It also means that people spend more time in the queue because they only have a limited number to attend to them. Sometimes nurses end up assisting in screening of patients which is the duty of the clinical officers.

The staff that go on study leave exacerbate the shortage of staff at these facilities. Sometimes, this tends to create a false impression that the staff are at the station when in fact, they are not at the station. As a result, at first glance the facility may appear to be adequately staffed but in actual sense the people are not physically there to do the work. To curb artificial shortages, the facility recruits volunteers to ease the burden and cushion the facility. (Mandevu Paediatric Clinic by the In-charge in an interview on 20th June, 2016).

The problem of staff shortages is not just in terms of adequate numbers but also in terms of skilled personnel. This has led to a situation where nurses help in the screening of patients, a job they are not trained to do which is supposed to be done by a clinical

officer. For instance, staff at Chaisa mentioned that sometimes, nurses tend to take up almost every duty, even that which they are not trained for. An example, screening of patients, which is supposed to be done by the clinical officers, is sometimes done by the nurses. Furthermore, at Chaisa clinic the doctor comes twice a week and that is not sufficient according to the In-Charge. Chipata also reported of lacking staff with certain essential skills. For example, there is no eye specialist at the Hospital and this stifles quality service provision. The hospital also has shortage in terms of physicians and other specialists, for example dental specialists. Lack of specialists at the facility stifles quality in the sense that a case which is supposed to be handled by a specialist is handled by a general Practioner. The execution of duties will not be the same (Chipata First Level Hospital, Medical Superintendent, 31st May, 2017).

Shortage of staff leads to increased work load for the available staff. For example, at Chipata First Level Hospital there are only seven clinical officers while the approved establishment is eighteen. This means that there is a shortfall of eleven clinical officers. On a typical day, the number of patients is too large to be attended by the available clinicians. For example, Out-patient Department reports about 400 new cases daily. Therefore, the nurses are forced to help in screening and in the end neglecting their own duties. Shortages of health staff leads to high workload. In the words of the In-Charge:

> "Work load affects quality if you have 100 or 400 patients to be attended to by one person of course it affects quality. If a clinical officer is with a patient and takes more than twenty minutes, patients get upset and insult the clinical officer. Ideally screening takes about 30 minutes plus to do proper physical examination and history. However, due to large numbers waiting in line, the clinical officer is in a hurry to meet the demand and of course this affects quality."
> (In Charge of Chipata First Level Hospital, 12th July, 2016).

The two main problems concerning the human resource situation are the critical shortages of health workers, leading to abnormal staff to patient ratios, and the inequitable distribution of the available health workers, leading to imbalances. According to the National Health Policy (2012) the current establishment is inadequate to meet

health workforce needs. The Ministry of Health (MoH) the 2011-2015 National Health Strategic Plan (NHSP), aimed at reducing the disease burden and accelerating the attainment of the Millennium Development Goals and it is also particularly aimed at addressing human resource crises in the health sector. According to the Zambia Demographic Health Survey 2013-14, the priority key objectives of the 2011-2015 National Health Strategic Plan was to; reduce the population/doctor ratio from 17,589 to 10,000 by 2015 and also reduce the population/nurse ratio from 1,864 to 700 by 2015.

The shortages in human resource are perpetuated by factors such as low retention and motivation of existing health workers which leads to low productivity; inadequate funding for recruitment of additional health workers and low outputs of health workers at health training institutions. The country is unable to retain all the medical students trained using public resources such as bursary. This scholarship is non-refundable and there are no mechanisms of recovery of these public funds from the medical graduates making it easier for them to immigrate. Inability to train large numbers of health workers has also been a major contributing factor to low staff levels. Zambia has limited training facilities for doctors. University of Zambia is the biggest and there also other up-coming private universities. However, the intake for these universities is also low due to the high cost of university education. As a result, the current output of doctors cannot meet the demand.

Zambia also faces the problem of brain drain a situation where nurses and doctors migrate over-seas to seek improved career opportunities. Most health workers that have left the country have done so due to economic reasons. They desire better working conditions, higher wages and better life, to make more money and support their families and also just experience life in a more developed country. To achieve quality health care provision it is vital that there are workable numbers between health staff and users. Too many people being attended to by too few staff stifle quality and might lead to slow moving services. Furthermore, in some instances even though the required number of doctors is there, this number is not able to meet the needs of the ever increasing population, hence, the need to recruit more staff. Therefore, shortage of health personnel is exacerbated by an ever increasing population of users in these facilities. The health

system also lacks a proper directory in terms of staffing numbers. Slow Human Resources processes are therefore another contributing factor.

In an interview with a key informant from the District Medical office on 11th May, 2016, it was alluded to the fact that the staff- Patient ratio is quite high in government clinics and hospitals. As a result, the health workers are over worked and this leads to exhaustion and burnout. The human resource shortage in public health facilities in Zambia is a serious one. A projection of enrolment needs up to 2018 concluded that even by training more qualified staff, Zambia would still face shortages if no other efficiency measures were taken.

Bbaala's (2007) study on '*The impact of attrition of healthcare professionals on Zambia's health care delivery system: the case of University Teaching Hospital"* also highlights some effects of low staff, though he focuses primarily on attrition. Attrition can affect the provision of quality health services due to issues such as inadequate time spent with patients due to work overload, closure of certain units of the health facility due to shortage of staff and increased use of inappropriate health professionals, among others.

According to the World Health Organisation (Zambian Analyst, 2015) the ideal doctor-patient ratio is 1 doctor per 5,000 patients but Zambia has one of the most abnormal doctor-patient ratio which now stands at 1 doctor per 12,000 patients. This is an indication that there is a shortage of health staff in the country. The staff shortages at the health facilities in this study is a clear indication of the country-wide problem. Currently Zambia has 1000 doctors and a shortage of 3000 more.

3.3 Health Staff motivation and Satisfaction

In addition to non-availability of staff the research established that staff motivation and job satisfaction were a key factor in the provision of quality healthcare. The way health workers felt about their jobs greatly affected how they executed their duties. Motivation can be in different ways. Several factors were discovered that tend to influence health

workers' motivation and ultimately job satisfaction. These include: pay, working conditions and institutional support.

Health staff expressed dissatisfaction with the pay, as they considered it to be very little compared to the amount of work they do. According to the In-Charge at chipata;

"Workers are not well motivated. The pay compared to the work that we do is nothing"
In-Charge Chipata First Level Hospital- 12th July, 2016)

Pay is a key factor in motivating workers. According to the In-Charge at Mandevu:

"Motivation is in various ways, for others it is just encouragement. For me I am better motivated by a higher pay and not just kind words"
(In-Charge Mandevu Clinic- 20th June,2016).

Health staff generally indicated that the pay they receive was unsatisfactory and way below the work that they do. The low pay was established to contribute to low motivation and low job satisfaction. To establish whether health staff perceived their pay to be low, forty seven health staff where asked to assess whether nurses' were paid according to the work that they do. This is illustrated in Figure 3.1 below.

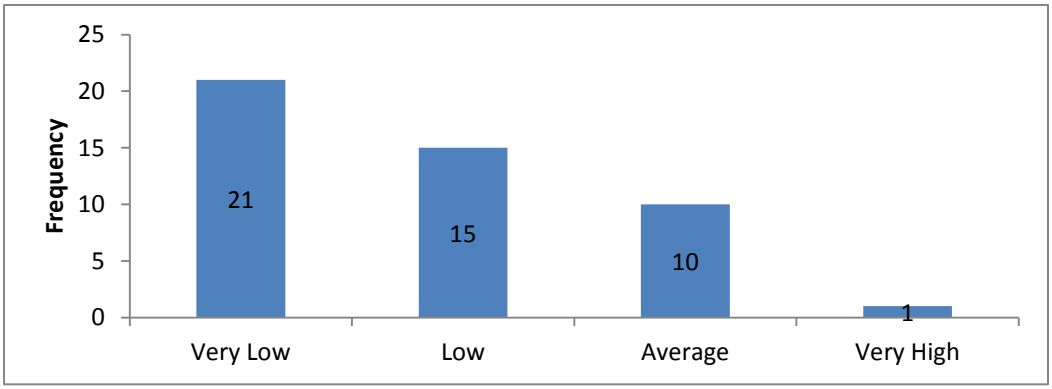


Figure 3.1: Health staff perception of the nurses' pay compared to the work they do from main clinics serving Mandevu

Source: Primary data

According to Figure 3.1, twenty one out of forty seven nurses considered their pay to be very low, fifteen rated it as low and ten said it was average and one said it was very high compared to the work that they do. Health workers, therefore, expressed desire for a higher pay as they consider themselves to be doing a lot of work. The study established that the majority (77%) of the staff interviewed considered their pay to be low compared to the work that they do.

In an interview with nurses on 30th January, 2019, the study established that the average net pays of nurses in government ranges from K5000 to K6000. However, nurses with higher qualifications and those with supervisory positions have their pay ranging from about K7000 to K10,000. The nurses in the private sector get slightly higher however, the pay mainly depends on the type of Private Clinic. For instance, a nurse interviewed revealed that a registered nurse from a private Hospitals gets a net pay of as high as K15,000.

Besides pay another factor that was revealed to affect motivation was the working conditions. Working conditions are important for motivating health workers to be productive and to meet quality standards. According to Chipata First Level In-charge, as indicated on page forty, Health workers attended to large numbers of patients, leading to exhaustion. They have too much workload and this leads to stress and burn out. With an ever increasing population, health workers have to attend to more people than is normal. The worker patient ratio was found to be way above what is appropriate. The ratio of patients to clinicians was high, sometimes leading to a situation of 50, 70 or 100 patients to one clinician.

Another factor that can affect motivation was the institutional support that the facility provides. In other words, institutional support refers to the necessary tools that are needed for health workers to perform their duties. Health workers desire to work in a clean and well maintained health facility. It is imperative that all necessary tools and other medical aids are available for work to be done efficiently and effectively. Medical Superintendent of Chipata (31st May, 2017) First Level Hospital indicated the fact that the institutional support is strong. The facility does have the necessary tools to carry out

their work. For example, the theatre was said to be well stocked and capable of carrying out big operations.

Poor management of human resource is a key contributing factor to issues of leave, accommodation and communication not being handled properly. One participant alluded to the fact that nurses' unions don't respond to the expectations of the health workers and this was demotivating. Communication between unions and staff was said to be poor. This tends to affect motivation and job satisfaction.

Motivation is in various ways and different people are motivated by different things. Money, of course, is a major motivating factor but not all the time. Zambia public health sector also responds to performance based award (Human Resource for Health, 2013). Staff motivation improves substantially with even small gestures of support and encouragement from district supervisors. For example, non-financial rewards are just as motivating. Staff felt motivated just by knowing that their efforts are appreciated. Performance based award helps to guide staff in their work, provides direction for supervisory visits and assists in monitoring health facility and district performance. Besides income, it is also vital that the monthly income comes regularly.

Kaseje (2006) echoes that poor motivation is a contributing factor to the human resources challenges in the health sector, including brain drain, conflict of interest, corruption and misuse of resources among others. Motivation entails willingness to expend energy to achieve a goal or reward. This study is supported by findings by Alhassan R.K et al (2013) who looked at the association between health-worker motivation and healthcare quality efforts in Ghana. The studies conducted in Ghana Overall revealed that staff motivation appeared low, although workers in private facilities perceived better working conditions than workers in public facilities. Significant positive associations were found between staff satisfaction levels with working conditions and the clinic's effort towards quality improvement and patient safety.

The study established that Training and development in short courses has been greatly expanded and it is a major source of motivation. The study established that the Ministry

of health has made tremendous progress in motivating heath personnel through capacity building. This is done by sending health workers to short training programmes and workshops to build capacity. Health workers greatly applaud the ministry for investing in capacity building. Health workers regularly attend training programmes through workshops and that greatly enhances capacity (In Charge Chipata First Level Hospital, 12th July, 2016).

3.4 Financial Resources

Availability of financial resources was found to be a key determinant of quality as this helps to purchase both medical and non-medical supplies and ensures the smooth running of the institution. The research established that inadequate funding was a major factor that hinders delivery of quality health services by facilities. All the four health facilities pointed out funding as a major hindering factor.

The study found that funding in some facilities was not only inadequate to meet the facility, needs but also irregular. The facilities are supposed to receive a monthly grant. However, this money does not come consistently and it is way below the requirements of the facility. As a result, the health facilities tend to run with very limited resources. According to the In-Charge at Matero Reference:

> "Funding is both irregular and erratic. The Health Facility is supposed to receive a monthly grant to ensure smooth running of services. However, sometimes it does not come regularly. This is August but the last impress was in April"
> (In-Charge of Matero Reference First Level Hospital-10th August, 2016)

Chaisa Health Centre also showed concern on inadequate funding being a factor in the provision of quality healthcare. For 2016, the clinic received a monthly impress of K5300, which according to the Matron In-charge is far below what the facility requires to run smoothly. This money is then split into three main categories namely; community allocation, clinical and outreach allocation. For community K1060 is allocated, outreach programmes are allocated K1272, while clinical is allocated K2968. Community funding

is meant for Community Action Plan such as the Neighbourhood Health Communities (NHCs), TB treatment supporters. Clinical allocation is used to buy laboratory equipment such as glasses, thermometers, mouth sticks, urine sticks, stationary, cleaning materials, infection prevention material and everything to do with management of the facility is under clinical. The outreach allocation is used for outreach programmes in MCH such as Growth Monitoring Programme (GMP), nutrition, outreach programmes in TB department and environmental department.

Furthermore, in an interview with the In- charge of Chaisa health Centre (16th November, 2016), she alluded to the fact that the impress was irregular. She said, "For 2016 we have only received impress from January to July and this is November". The funding is way below what the clinic needs to run effectively. The funding is also erratic, for example, the imprest for July was only received in November.

The problem of inadequate funding was also reported at Chipata First Level Hospital. According to the In-charge of Chipata First Level Hospital (17th November, 2016), it was found that the money allocated to the facility was inadequate. The facility receives a monthly imprest of K10,070. This money was said to be below what the facility requires to run smoothly. It was suggested that the monthly imprest should be raised as high as K100,000 as this figure might meet many of the needs at the hospital. The money that the facility receives on a monthly basis is used for maintenance, purchase of stationary, cleaning materials, surgical supplies, buying food for patients, among others. However, compared to the other facilities the monthly grant was very regular.

Health facilities also raise extra cash by running tuckshops and/canteens within the centres.

"Despite the shortages, we are managing to provide services with minimum resources and funds. We fundraise through business ventures. We sell drinks within the facility."

(In-Charge at Matero Reference- 10th August, 2016).

At Chaisa, the facility makes extra cash through the money paid to them by people running the scanning machine on private basis. The people running the scan have a contract with the District Medical office and as a result a percentage comes back to the facility. The other way money is raised is through student nurses who come to do training at the facility. Their various institutions pay the district and a percentage is given to the health centre, however, even this money is very minimal.

The study found that limited health sector funding affects quality, as it affects implementation and execution of planned projects. Clinics plan for their activities and have budgets of how the facility will run. However, this is hindered by lack of adequate funding. As a result, a facility can have very good plans and programs but implementation becomes a problem because there are no resources to carry out those plans. Because of insufficient funds, Health facilities are unable to achieve all the programs aligned to maintain smooth running of the clinic. These concerns were raised both at Mandevu and Chipata Health Facilities.

Replacement and maintenance of physical infrastructure is also hindered by lack of finances. For example: painting of the clinic, replacement of essential cables, florescent tubes, among others, purchase of laboratory reagents that have run out or replacement of essential equipment. Doing all these things that appear seemingly easy repairs is often a problem due to lack of finances. As a result, the clinic continues operating with a lot of things not working optimally.

The majority of the health staff interviewed from the four clinics considered the financial resources allocated to their facilities to be insufficient. They indicated that the money was far below what the facility needed to operate effectively.

According to Figure 3.2 below, forty seven health staff were interviewed from the four clinics and out of these fifteen (15) considered the financial resources allocated to their various clinics to be very insufficient to meet the needs of the facility and sixteen out of forty seven considered them to be insufficient, while 13 considered them to be fairly

sufficient. One respondent out of forty seven (1) considered the financial resources to be sufficient and also one considered the resources to be very sufficient.

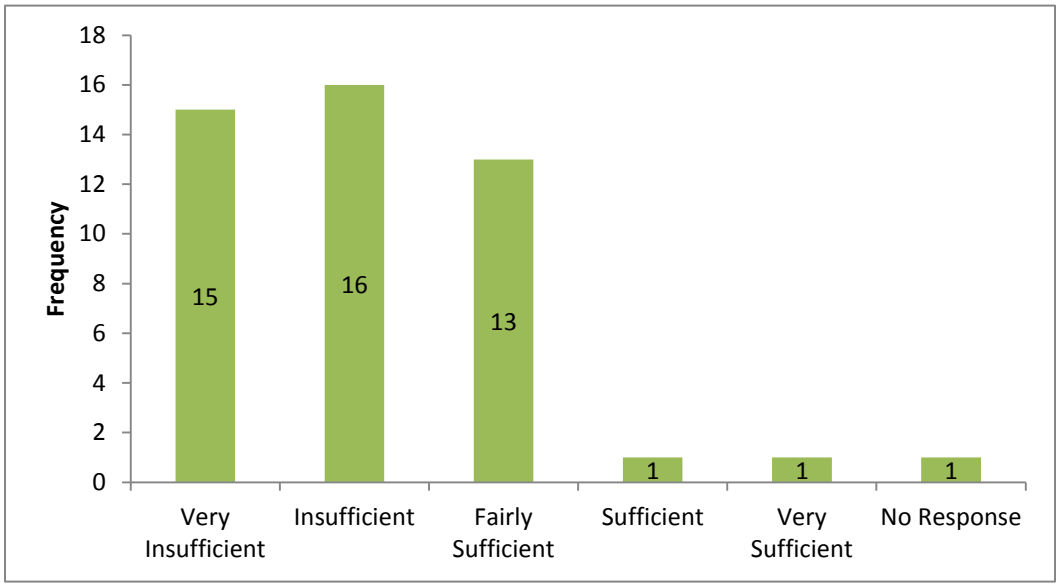


Figure 3.2; The health staffs' perception on the adequacy of financial resources allocated to their various clinics.

Source: (Primary data)

According to the Figure 3.2 above, about seventy per cent (70%) of health professionals interviewed expressed dissatisfaction with the budgetary allocation to their facility. Health professionals expressed concern that the grant received from the government is insufficient to carter for the facility's daily needs and this does not come regularly. This makes execution of their duties very difficult. Health personnel lack essential equipment to properly conduct their services. Sometimes health personnel run out of gloves, essential vaccines and even laboratory equipment breakdown. Poor funding has had a toll on the ability of health personnel to provide consistent and quality services (In – Charge Matero Reference First Level Hospital, 10th August, 2016).

The District Medical Office also echoes the problem of funding at health facilities. A key informant from the DMO stated that the problem of funding is beyond the scope of the health facilities and also beyond the scope of the District Medical office but one that needs to be attended to at National Level (key Informant for District Medical Officer,

11th May, 2016). The overall level of funding allocated to health is not sufficient to tackle the many health challenges facing the country. Donors provide nearly half (42%) of all health funding in Zambia. Other sources of funding are: households (27%), government (25%), employers (5%) and others (1%) (Republic of Zambia, 2006). In spite of the various challenges, the national government has been trying its level best to provide essential drugs and expand infrastructure.

The main sources of health care financing in Zambia are, government budget appropriations, earmarked donor funding through the national treasury, health sector basket under the SWAPs and donor support to specific projects and activities. Furthermore, the current financial allocation to public facilities is far below the minimum required for the delivery of an optimum package of care despite significant increases in the flow of funds to the health sector (National Health Policy, 2012). The grant that the government gives is not enough to carter for the facilities' daily needs. This affects the day to day operations of the health facilities.

Funding from cooperating partners comes with its own shortcomings. It is usually tailored for specific programmes of spending such as HIV/AIDS, TB or Malaria. This direct finding such as this can undermine healthcare provision if not carefully integrated with the local health care strategy. It is therefore vital that cooperating partners align their support with national health sector priorities (ACCA, 2013).

3.5 Infrastructure

In addition to the financing problem, the research also established that inadequate infrastructure was a major hindrance to the provision of quality healthcare. The increased catchment population evidenced by congestion and long queues puts increased pressure on the existing infrastructure. The existing infrastructure is not only inadequate but also lacked constant maintenance and renovations.

The problem of inadequate infrastructure was reported at all four health centres studied. This was identified as a major problem at Chipata First Level Hospital. Since the facility was upgraded to a First Level Hospital, there had not been significant expansion in terms of infrastructure. The facility was turned into a First Level Hospital; however, this did

not come with adequate expansion in infrastracture. For example, there is currently no surgical ward. As a result, patients with surgical cases are mixed with those with medical cases (In-Charge, 16th November, 2016) Shortage of infrastructure has put a lot of pressure on the existing structure. During a Focused Discussion held on 10th May, 2016, it emerged that the labour ward was small in terms of space. The users also referred to the wards as smelly and dirty. The mortuary was also another infrastructure that needed attention at the hospital.

The study also found that the infrastructure at Chipata First Level Hospital did not match its status as a First Level Hospital. For example, there is no infrastructure to house a physiotherapy department, which is a requirement at a First Level Hospital. The limited infrastructure at Chipata First Level Hospital has led to a situation where the hospital is unable to provide certain key services. The hospital also has inadequate waiting space for patients to sit as they wait to be attended to. This results in people standing. Chipata also has a shortage of toilets. For example, there are only two toilets, one for male, and another for female. This is not enough, considering the number of people that visit the health facility. Furthermore, the water tank at the facility is too small to meet the demands of the facility. However, water was said not to be a major problem. The facility also has an incinerator for garbage disposal.

Upon the upgrading of Chipata Clinic to a First Level Hospital, a theatre was built but a Post-Operative Ward was not. This has resulted in the mixing of patients with medical and surgical cases. This compromises quality in the sense that surgical patients are supposed to be isolated and kept in sceptic ward, free of bacteria and infections. However, the hospital is still obliged to carry out operations and provide the service regardless of the conditions (Medical Superintendent, Chipata First Level Hospital, 31st May, 2017).

Chaisa Health Centre also reported infrastructure to be a major factor in the provision of quality healthcare. This problem is worsened by an ever increasing population and thus puts pressure on the existing infrastructure. Chaisa Health Centre has no maternity ward, admissions or inpatient ward and the mortuary. However, women are delivered in MCH

(Mother and child Health department). MCH deals with postnatal care and under five services to children. Deliveries are only done to assist in emergency cases. When mothers come to deliver and are fully dilated they cannot be turned away, even if the health centre does not have the necessary facility. Concern was raised that even if Chaisa is just a health centre, it still needs to expand its infrastructure and that the building of a maternity ward was a necessity (Matron In-Charge, 16th November, 2016)

In the words of the Matron In-charge:

> "A labour ward is supposed to be there at the health centre when it expanded because we receive women and do deliveries. In Lusaka, when you look at Baulenu, it has a labour ward, Kamwala has a labour ward and these are not First level Hospitals. The fact that people still come to deliver at the centre shows that there is need for a labour ward. George Clinic has a labour ward, even Mutendere has a labour ward and it is not even a first level hospital."
> (In- Charge Chaisa Health- 16th November 2016).

Lack of adequate infrastructure has meant that certain services which are supposed to be provided are not provided at all or provided under difficult circumstances. For example, Chaisa Clinic does not have a labour ward. This creates problems when a woman comes to the centre fully dilated and in labour. Chaisa does not have an incinerator for disposal of garbage. The funding partner, Aids Health Foundation (AHF) has partnered with the facility to collect refuse.

Chaisa does not have adequate bed space for observing patients. Lack of adequate bed space has resulted in a situation where male and female patients are put in the same room for observation. Chaisa also has inadequate room for counselling users and this stifles confidentiality between the counsellor and the one being counselled. Health staff expressed that confidentiality between the user and the care giver is vital in the provision of quality healthcare. Chaisa also lacks a staff room. The staff considered it to be vital for the health staff to relax and exchange vital information and ideas.

Mandevu Pediatric Clinic also experienced a similar problem. According to the Matron In-Charge at Mandevu Pediatric, inadequate working space was also a major source of concern and this has resulted in people sharing offices. She observed that:

> "Some officers do not have working space, while others are squeezed into someone else's office. Due to the limited working space sometimes there is no privacy between the service provider and the patient. As a result, patients express themselves even with on-lookers around."
> (Matron In-Charge of Mandevu Pediatrics Clinic, 20th June, 2016)

Mandevu Paediatric clinic also lacks infrastructure to house key departments such as laboratory department. The clinic only carries out Malaria tests. Absence of laboratory facilities hinders quality service provision as users are often referred to Chipata First Level Hospital for Laboratory services. This results in a situation where people stop coming to the Paediatric Clinic at all and go straight to Chipata Hospital. In the words of the Matron In-charge:

> "Mandevu Clinic has no laboratory facilities but only does Malaria tests. So users would rather go to Chipata First Level Hospital instead of being referred there so as to get all the services under one roof." (Mandevu Paediatric Clinic In-Charge- 20th June, 2016).

Health workers also expressed concern with inadequate infrastructure faced by the various facilities. According to Figure 3.3 below, 51% of the health staff indicated that the infrastructure was inadequate to carter for the needs of the patients it receives. And only about 30% said it was fairly adequate.

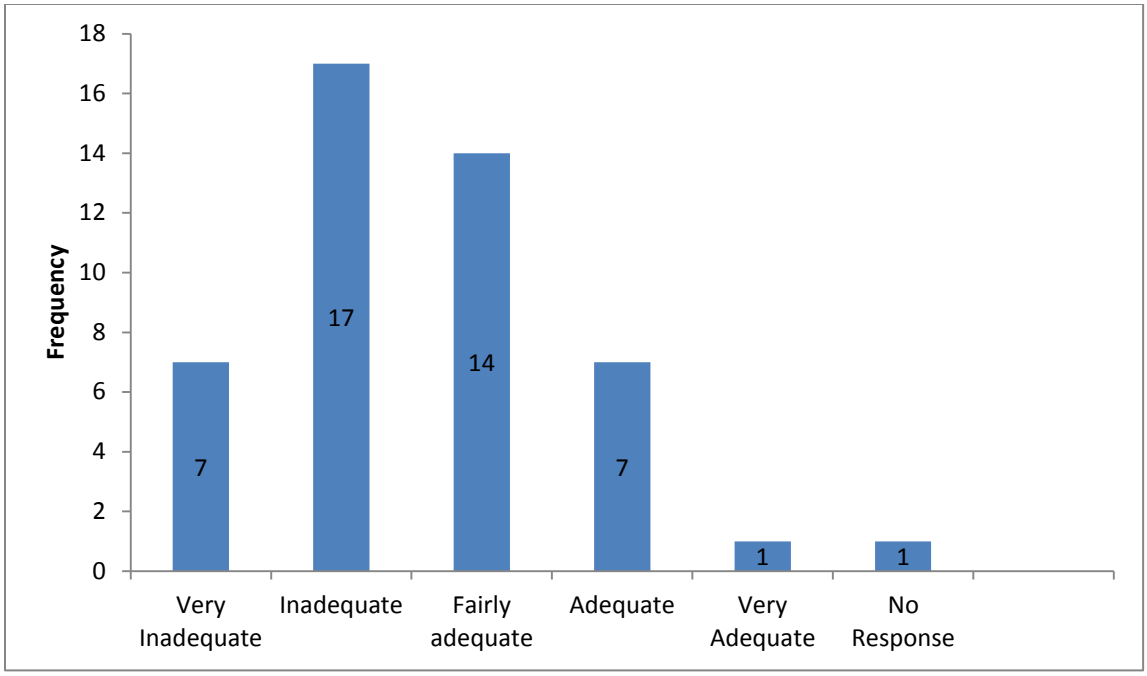


Figure 3.3 Health Staff perception on whether the health facility they worked for was big enough to carter for the needs of the patients it receives

Source: Primary data

Health workers from four different health facilities were asked if the clinic they worked for was big enough to carter for the needs of the patients they received. Out of forty seven, seven said the clinic they served was very inadequate, seventeen said it was inadequate, fourteen reported that it was fairly adequate while seven reported it to be adequate and only one said it was very adequate. Health workers expressed concern on the inadequate working space in the various facilities. Waiting space for users, as they wait to be attended to, was also another area of concern.

The findings of this study are also in line with Shikabi's (2013) in his study titled "*factors hindering primary health care delivery in Chibombo district".* The study concluded that inadequate infrastructure among other things were a hindrance to primary healthcare delivery.

In an interview with a key informant from Lusaka District Medical Office (11th May, 2016), it was noted that infrastructure in government hospitals and clinics is quite poor. The health staff do not work in an ideal environment and the conditions are not

conducive. As a result, it is very difficult to give the patient the highest quality of care. The problem of infrastructure development is beyond the District medical Office but one to be dealt with at the National Level. The key informant from The District Medical Office applauded the efforts that the government continues to make efforts everywhere to improve the health status of Zambians by providing drugs and building new structures. This is seen from the upgrade of clinics to hospitals which have mostly been pioneered by donors such as the Japanese government.

Significant efforts and resources have been invested in strengthening health infrastructure in Zambia. The Capital Investment Plan (CIP) was developed with inputs from the districts and provincial medical offices. This aimed at significantly improving the availability, distribution and state of essential infrastructure and medical equipment, so as to improve equity of access and quality of health services. Significant efforts have also been directed towards renovation of the existing health infrastructure and expansion of health training institutions. These efforts are also being supplemented with the private sector initiatives, which have led to the renovation and construction of several private health facilities (National Health Policy, 2012). Infrastructure affects quality. It is therefore, vital that the infrastructure is expanded to meet the ever increasing demand for healthcare. Adequate and equitable distribution of health infrastructure across the country is a vital factor in providing quality health care.

3.6 Availability of Medical and Surgical supplies, Equipment and other logistics

Availability and access to essential vaccines, drugs and other medical supplies is a critical factor in ensuring efficient and effective delivery of health services to the local community. The study established that shortage of medical supplies was a major hindering factor in providing quality health care. Availability of medicines in government clinics was found to be a problem. The study established that sometimes medicines were in short supply and users were given prescriptions to purchase drugs. Users indicated that mostly public health facilities tend to give certain common types of drugs such as Panadol, Oral Rehydration Salt and Piriton. Seventy five (75%) of health staff at Chipata expressed concern that sometimes the facility is not adequately stocked with essential medicines.

According to Figure 3.4 below, 1 participant out of 16 indicated that the pharmacy was never constantly/adequately stocked, 12 out of 16 said that sometimes the pharmacy was constantly/adequately stocked, while 3 reported that it was usually constantly/adequately stocked and none said it was always constantly/adequately stocked. Asked whether it was common to find there are no medicines at the pharmacy, 13 out of 16 participants said sometimes there were no medicines and only 2 said it was not common to find there were no medicines at the pharmacy.

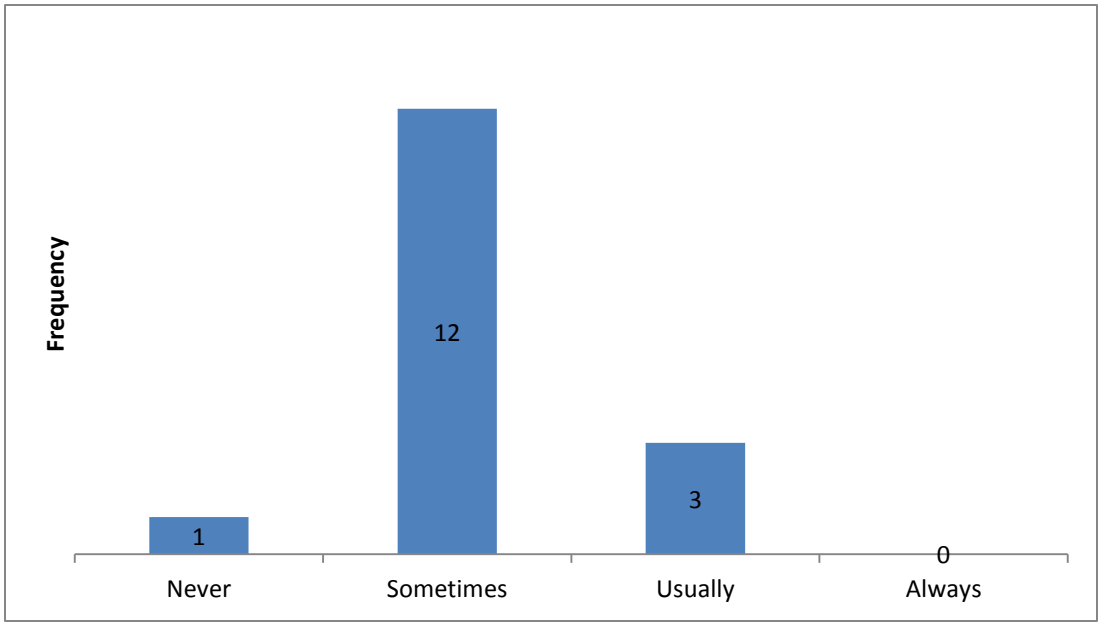


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Figure 3.4, The perception of health staff on whether the pharmacy at the Chipata First level Hospital is constantly/adequately stocked.

Source: (Primary data)

Sixty six (66%) of health staff interviewed from the four clinics indicated that sometimes it is common to find there are no medicines at the pharmacy.

According to Figure 3.5 below, thirty one out of the forty seven health staff interviewed from the various clinics that serve Mandevu said sometimes there are no medicines at the pharmacy. This accounts for to sixty six per cent of the total number interviewed.

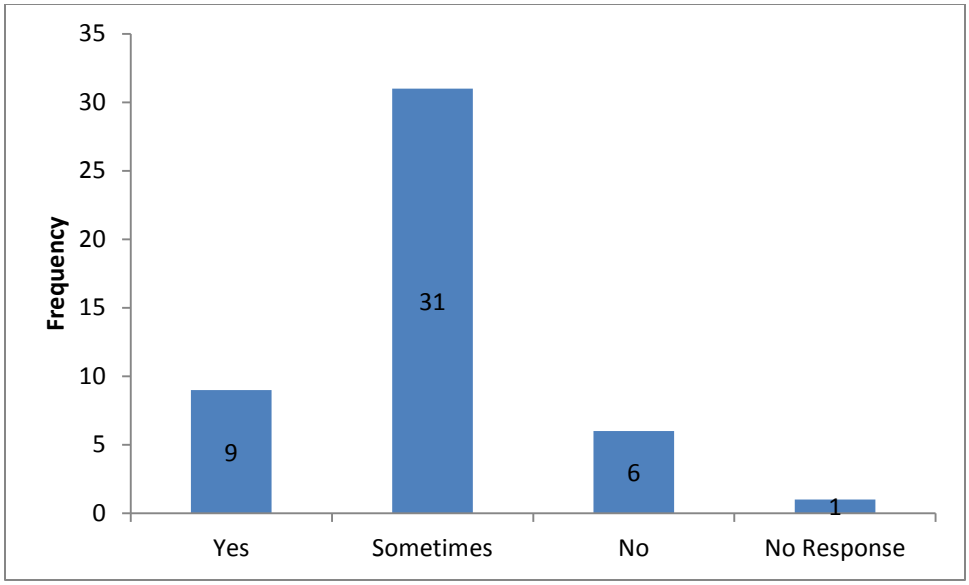


Figure 3.5 Health staff response when asked whether it was common to find there are no medicines at the pharmacy.

Source: (Primary data)

Lack of medicines at the pharmacy usually affects the scope of care provided by the health facility. Patients may receive the right diagnosis and a prescription of the drug they need is given to them. However, when they go to the facility's pharmacy that particular drug might not be available and they need to purchase it from a private drug store. This is where the challenge begins, as some of them cannot afford these drugs. When collecting the users' background information on social economic status, it was established that a lot of households in Mandevu are occupied by the poor that survive on a very limited income. Users also expressed disatisfaction with the shortage of mdicines at certain clinics. They expressed that in most cases when they fall sick the most common medicine given by the pharmacy was Panado, Piriton and Oral Rehydration Salts (ORS).

In the case of Mandevu, the In-Charge alluded to the fact that in cases where the clinic has no medicines users stop coming completely for some time. This is a major problem as it also undermines utilisation of the facility. When users visit the facility and discover there are no medicines, they stop coming completely, leaving the facility deserted until they heard that the pharmacy had been restocked. Local people viewed the amount of medicines as a measuring rode for quality. Therefore, the more medicines they received the more satisfied they were with the facility.

In addition to medicines, the study also established public facilities also experienced shortage of other medical and surgical supplies and other logistics. Modern diagnostic equipment to make work easier and faster was in short supply. For example, Chaisa reported that the clinic did not own an X-ray machine and the one available is privately owned. The health centre also lacks supplies such as oxygen. When patients need oxygen, the clinic is unable to give them so this is a challenge. At Chipata First level Hospital equipment such as X-Ray is privately owned and not owned by the facility, this was a challenge because some people might not afford the charge for such services. The X-ray machine was run by a private entity within the facility. At Chipata scanning costs K40 which, according to the in-charge, was affordable. However, assistance is often given to the elderly and those who cannot afford. Chaisa also expressed concern on the lack of an X-ray machine at the centre. It is also run privately at a charge of K60.

Power-cuts were another major factor that hindered provision of quality healthcare at the health facilities. A participant from Chipata First Level Hospital pointed out that power cuts were a major challenge within the centre, especially at night. It is vital that with the current power situation that Zambia and in particular Lusaka is facing that health facilities have alternative power sources in case of power cuts.

The Matron In-charge at Chaisa Clinic stated that the centre had no stationed ambulance to transfer critically ill patients immediately to the University Teaching Hospital (UTH). In the case of emergency, Chaisa had to call Chipata to provide an ambulance, in the event that the ambulance was in use, they will have to wait. Alternatively, Chaisa might contact the command post and then they would have to be the ones to contact Chipata. This crippled efficiency and effectiveness at the centre and ultimately affects quality. The clinic also lacks essentials such oxygen.

The Matron In-charge of Matero Reference indicated that there was frequent break down of various machines and laboratory equipment. The machines are old and in short supply which greatly affects quality and poses a great challenge in the smooth running of the health facility. Erratic supply of laboratory reagents was also another area of concern faced at the facility. Health facilities suffer from a critical shortage of equipment and the

current equipment in use was also poorly maintained. Health Staff at Mandevu Pediatric Clinic indicated the problem of water as a source of concern that affects the smooth running of the facility. Poor water supply greatly affects the ability of the facility to maintain a clean and safe environment for users.

The medical Stores Limited are responsible for storing and distributing drugs. The procurement and supplies system has been re-organised with improvements in the staffing and skills levels in the Ministry of health. However, major challenges are still being experienced such as lack of a decentralised Medical stores system, inadequate funding and the weak interface between the procurement system at MoH and the Medical Stores Limited (MSL) who are responsible for storing and distributing drugs and medical supplies.

It is the responsibility of Medical Stores Limited to distribute drugs and related products. Its tracks travel annually to hundred and ten depots around the country. From there the drugs are distributed locally by road, ox or plane. Sixty per cent of stock received by medical stores is provided by donors (ACCA, 2013).

The findings of this study are also in line with Shikabi's (2013) on *factors hindering primary health care delivery in Chibombo district.* The study concluded that some of these factors included; inadequate infrastructure, low medical supplies, lack of equipment, low budgetary allocations, and also the physical and economic barriers faced by users

3.7 High Catchment Area

The problem of staff shortages is exacerbated by the high catchment population. This was most experienced at Chipata First Level Hospital, Matero Reference and Chaisa Health Centres and least experienced at Mandevu Pediatric Clinic. As a result, the clinics tend to be overcrowded. Large numbers affect quality. The matron In-charge of Chipata First Level Hospital stated that because health personnel want to attend to everyone, they end up spending less time with a patient. For example, screening a patient takes about 30 minutes normally but the health personnel will spend less time with the patient to accommodate other patients. According to the Matron In-Charge:

"One midwife palpates a lot of mothers. Due to long queues mothers usually stay from morning to afternoon at the health facility. Palpating takes time, as we give them health education for their birth preparedness. The first time they do antenatal we have to do the PMPCT. Counsel them, test them and those that are infected can even start taking the ARVs"
(In-Charge of Chipata First Level Hospital- 12th July,2016).

According to Figure 3.6 below, 92% of households that had been to Chipata First Level hospital considered it to be overcrowded, 5% said it was fairly overcrowded, while only 3% said it was not overcrowded. The above statistics indicate that the majority of users (92%) consider the health facility to be over crowded. The study established that almost all the users of Chipata (92%) considered the facility to be overcrowded.

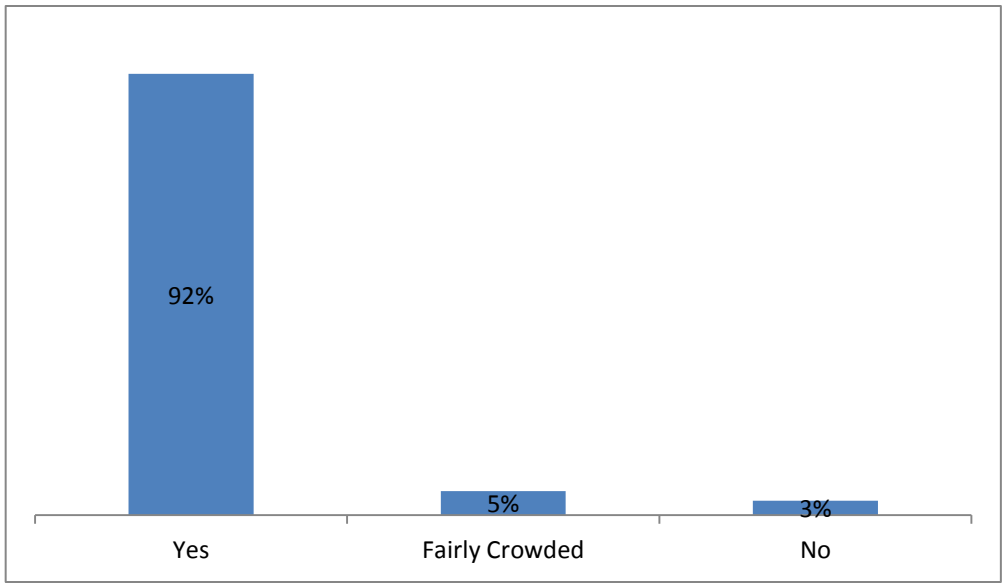


Figure 3.6: Households response to whether they thought Chipata Hospital was overcrowded

Source: (Primary data)

High population of users affects the quality of care in the sense that the health workers sometimes become exhausted with each additional patient they attend to. In an interview with the Medical Superintendent from Chipata First Level Hospital (31st May, 2017), it

was established that OPD receives about 600 to 700 people walking in per day. In addition to that, there are only two or three clinicians and two doctors. When the number of people walking in is divided by the number of clinicians already the number that each is supposed to attend to is quite high. The human element of exhaustion comes in and most likely the first patients might get a better service before the clinician is tired. On the other hand, any delay in the screening results in complaints from people waiting in the queues to be attended to. Ideally, strict examination takes time as one is supposed to examine the patient from the head to the toes.

The population of Zambia and Lusaka in particular has experienced growth. The 2010 census reported a population of 13.1 million and a population growth rate of 3 per cent per annum…. The population density in Zambia increased from 8 people per square kilometre in 1980 to 17 in 2010. Average density by province in 2010 ranged from a high of 100 people per square kilometre in Lusaka to a low of six people per square kilometre in North Wester. In addition to being the most densely populated provinces, Lusaka and Copper belt are also the most urbanised (CS0,2015 page 2). This increase in population has had a direct effect on provision of quality health care. Particularly the patient nurse ratios have also increased.

Chipata First Level Hospital has a catchment of Chaisa, Mandevu, Marrapodi, Ng'ombe, Kabanana, Garden, Mazyopa, ZaniMuone and Six Miles and it includes a maternity and admission wing. However, due to staff shortages and other financial constraints it is unable to provide high quality healthcare. For the year 2015, the total catchment population at Chipata First Level Hospital was 148, 009 users and has increased in 2016 to 153, 279 users. In 2015 monthly population above 15 years was 5,970 and has further increased further to 6,182 users on a monthly basis (Chipata First Level Hospital, 2016). Because health facilities are dealing with large numbers, this tends to put a pressure on infrastructure.

3.8 Conclusion

The study has revealed that there are several factors that affect the provision of quality health care by healthcare providers. These include; availability of staff, population of users, infrastructure, financial resources, medical and surgical supplies, equipment and

other logistics and staff motivation. These are key health building blocks needed for quality health care to be achieved. However, these building blocks are inadequate in public health facilities for them to function optimally. The available health staff are inadequate to carter for the needs of users and some of these tend to be poorly motivated in terms of pay, other conditions of service and institutional support. The health infrastructure is also inadequate to meet the ever increasing demand for health care and this also lacks constant maintaining and renovations. The financial muscle of health facilities is weak and this leads to shortages of essential medicines, vaccines, medical and surgical supplies as well as other logistics.

CHAPTER FOUR
FACTORS AFFECTING USERS IN ACCESSING QUALITY HEALTH SERVICES

4.1 Introduction

This chapter will explore the factors that affect the potential client's ability to obtain services. The chapter will examine the role that congestion at the facility plays in the user's ability to access quality health services. It will also look at how attitudes of health personnel affect users. Furthermore, the chapter will also look at whether economic or physical barriers affect access of health services by users. It will go on to look at how lack of sufficient satisfaction affects accessibility of quality health services. To conclude, other factors such as information and patient's social demographic factors and their role in the ability of users to access quality health care will be explored.

4.2. Congestion at the facilities

Congestion is caused by several factors highlighted in chapter 2 such as inadequate infrastructure; shortage of staff among others. As indicated in the introduction congestion at the health facility is one of the factors that affect users in accessing quality healthcare as it leads to long queues and subsequent delays. The amount of time someone spends at the clinic was found to be an important factor affecting provision of quality healthcare. The study found that overcrowding at health facilities is a major hindering factor to accessing quality health care. Overcrowding means longer queues and longer waiting time at the health facility. Sometimes people would shun coming to the facility due to the long queues and the amount of time they spent at the facility. This was experienced most at Chipata First Level hospital and Matero Reference First Level Hospital and it was least experienced at Mandevu Paediatric Clinic.

The majority of respondents indicated that people would go to Chipata clinic as early as 06:00 hours in the morning and come back late in the afternoon for instance 16 or 17 hours. Users stated that the long queues at the clinics have cost people their lives, as some die while waiting in the queues. One woman that was interviewed in Mandevu on 10th May 2016, indicated her child had died in the queue while waiting to be attended to

at Chipata First Level Hospital. The majority of users during the Focused Group Discussion held on 10th May, 2016 expressed their dissatisfaction with the amount of time they had to spend at the clinic. If one wanted to avoid spending many hours at the facility then it was best they to the clinic early in the morning for example, as early as 06:00 hours.

Users of Chipata First Level Hospital expressed concern on the amount of time they spent at the facility of which most described to be too long. As shown in Figure 4.1 37 per cent of respondents spent between zero (0) to four (4) hours at the hospital, 52 per cent of the respondents spent between five (5) to nine (9) hours while 11 per cent of the respondents spent between 10 to 14 hours at the facility. Among the respondents interviewed, the majority said they spent an average of eight hours at Chipata First Level Hospital. Users expressed that it was better to go to the clinic as early as possible, if one wanted to be attended to quickly sometimes as early as 05:00 hours or 6: 00 hours.

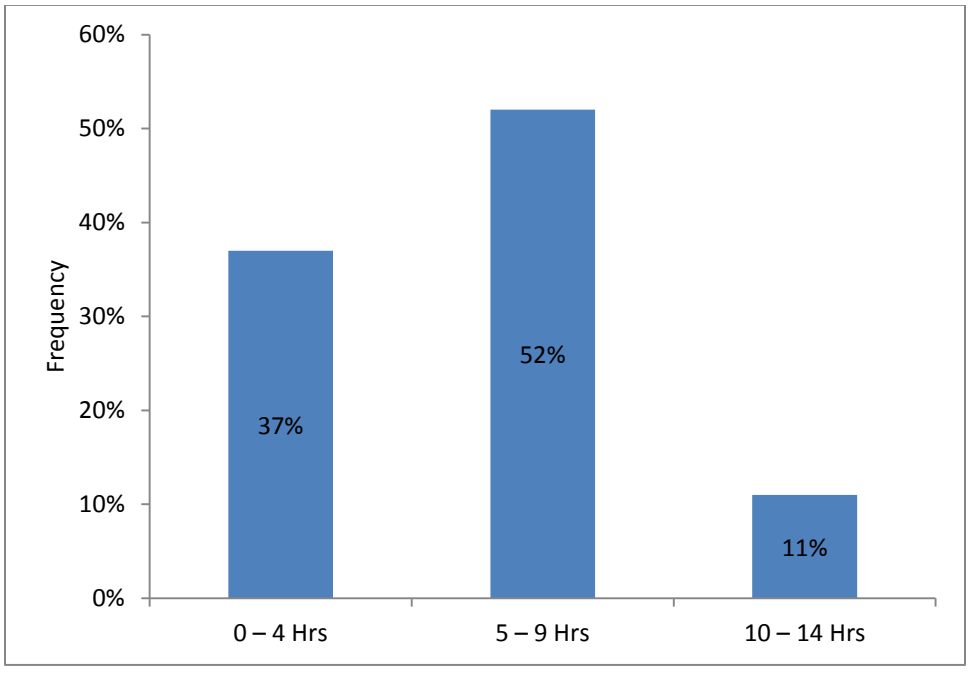


Figure 4.1 Number of Hours spent at Chipata first Level Hospital by Users

Source: Primary data

Long waiting hours is one of the most important factors that affect accessibility of health care by users. *"There are long queues and long waiting hours. There are a lot of people*

and it is overcrowded" (10th May, 2016). This was recorded by one of the male users of Chipata First Level Hospital. In a focused Group Discussion held on 10th May, 2016 women expressed that even though Chipata is closer to Mandevu, users would rather go to Matero Reference First Level Hospital, unlike Chipata. This was because the service was quicker and the labour ward was better in terms of the environment. Some women preferred to go for ante natal at Matero Reference. The majority of respondents (71%) said the time they spent at Chipata First Level Hospital was too long.

Some users, however, did allude to the fact that Chaisa Health Centre and Matero Reference also experienced long queues, being a major factor hindering accessibility though to a lesser extent compared to Chipata. Some respondents also complained having few doctors at Matero Reference as a result people wait in queues for an extended period of time. At Mandevu Paediatric clinic this was not a major problem, as it only caters for children below the age of 14. Some respondents regarded Chaisa to be more efficient compared to Chipata and Matero.

The long waiting time is caused by several factors such as high population of users and shortage of staff. However, some health facilities have put in place measures to ensure that the time spent at the facility is greatly reduced. In an interview with the Matron In-charge at Chaisa clinic on 16th November, 2016, she alluded to the fact that, to reduce on waiting time health workers report as early as possible and attend to people. This has ensured that all the people that come in the morning will not be found at the facility after lunch. Users did express satisfaction with the waiting time at Chaisa Health Centre. Even if users had to wait in the queue to be attended to the time spent at chaise was relatively shorter than Chipata First Level Hospital. Another measure put in place at Chaisa Health Centre to avoid people waiting for a long time was to tell them to return the following day for their laboratory results. And she went on to say that for their facility long waiting time is not a problem. The matron In-charge at Chipata alluded to the fact that waiting time was still a major problem at the facility. However, to curb this, the pharmacy works over lunch so that as many people as possible are attended to.

The inequitable distribution of health facilities within the country results in congestion in the existing facilities, especially in high density areas like Mandevu and Chipata townships. At the district level, the government has classified districts in A to D zones, C & D zones being the districts suffering from the poorest level of investment in health infrastructure. Users in these zones are believed to face additional barriers in accessing health facilities due to poorer health mapping, allocation of health staff, equipment, maintenance level, road conditions, etc. (African Health Observatory, 2010-2014).

There is a relationship between waiting-time and users level of satisfaction. The longer users wait, the more dissatisfied they are with the quality of service.

Figure 4.2 below, shows users perception on waiting time. Most respondents (71%) expressed dissatisfaction with the waiting time experienced at the health facility. The majority of the users regarded the waiting-time to be too long. 7% expressed satisfaction and regarded the waiting time to be just fine.

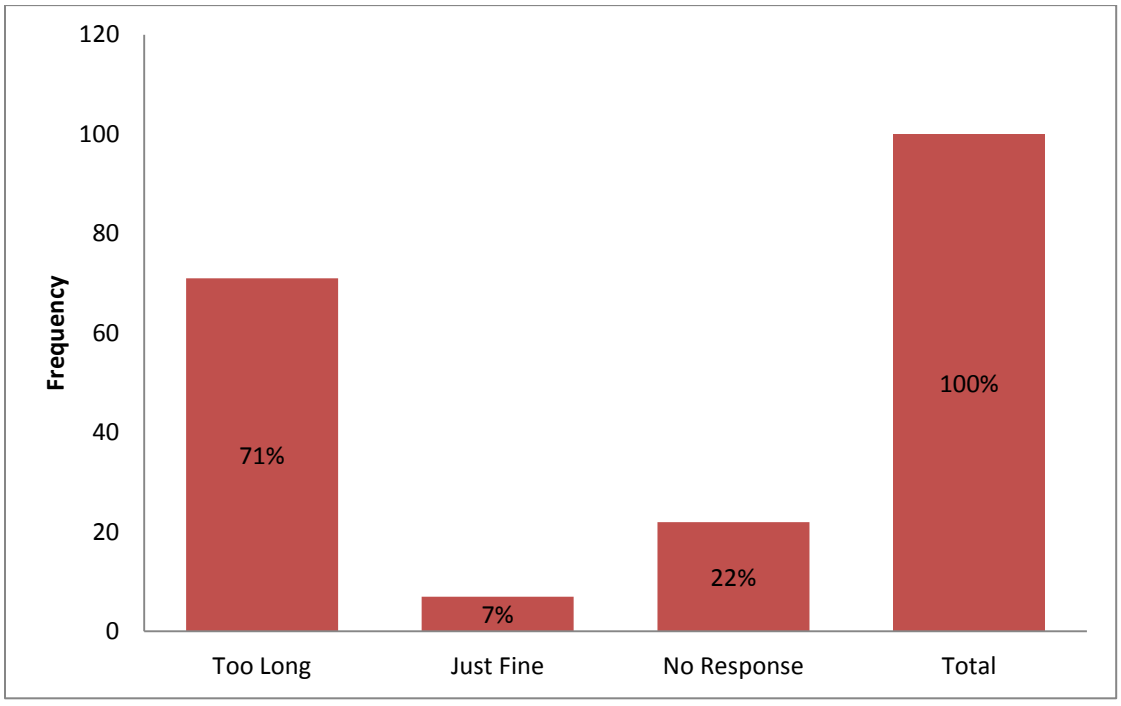


Figure 4.2 Users Satisfaction with Waiting Time at Chipata First Level Hospital
Source: Primary data

The findings at Chipata First Level Hospital can be corroborated by several studies, which documented the relationship between waiting for service and overall satisfaction. In a study conducted in Botswana, most users (63.9) were dissatisfied with the time spent at the facility. This is also supported by the findings of a study conducted in Egypt, where waiting time contributed to 47% of patients' dissatisfaction in an assessment of quality of care. Waiting time is a source of dissatisfaction for patients and remains a problem to the quality of care and services in clinics. According to a study conducted in Kuwait, people who have poor access to medical care had a higher rate of hospitalisation for common medical conditions (Bamidele AR, MBBS, MPH, 2010).

Congestion at the facilities is to a large extent as a result of large catchment areas of the health facilities which are inadequately staffed, poorly equipped with inadequate infrastructure as highlighted in chapter three.

4.3 Attitudes of Health Personnel

The study found that attitudes of health personnel affected the quality of interaction between the user and service providers. Negative attitudes of health personnel often instigate fear in the patients to express themselves. The study found that attitudes of certain health personnel can be a potential factor that can affect accessing quality healthcare. Sometimes healthcare providers were said to be rude, lacking courtesy when talking to users. A potential cause of poor negative attitudes by health personnel would be low motivation levels. As indicated in chapter three health facilities are lowly staffed and workers had low morale.

The views of the users on the attitudes of the staff were somewhat supported by the health workers themselves. For example, according to Matron In-Charge of Mandevu Pediatrics Clinic on the attitude of health staff:

"It can be a problem in certain cases. To a lesser extent it can be a barrier to accessing healthcare. We can't all be the same. Some may fear to come"

"Attitudes affect accessibility. Some people will shun away because they already have a conception that the health personnel are rude." (In-charge Mandevu Paediatric Clinic, 20th June, 2016)

In the words of the Matron In-Charge of Chipata First Level Hospital:
"One day someone can wake up and that day they do not feel motivated. And on that day they do not treat patients with courtesy and respect. But we have done our best. Maybe 80% of the time the staffs treat patients with courtesy and respect." (In-charge Chipata First Level Hospital, 12th July, 2016)

Although the attitude of health workers is a key factor in accessing health care, attitudes are quite difficult to measure. This is because different users had different experiences with health workers. For example, in a focused Group Discussion held on 10th May, 2016, users described certain health professional as rude, uncaring, unconcerned and negligent lacking courtesy and respect. One resident said that sometimes the nurses pretend like they have not seen you and just go about their business (Focused Group Discussion, 10th May, 2016).

Attitudes of health personnel may be a barrier to users accessing quality healthcare because users may feel disrespected and opt to go to a health facility that is further away, leaving the one close by. A resident of Mandevu in an interviewed on 10th June, 2016 indicated that some doctors and nurses seem unconcerned and slow. The resident went on to state that they have witnessed incidences when users become inpatient and demand to be attended to promptly and due to that arguments would erupt with patients and sometimes even physical force would be used.

The study established that different users had different experiences with health personnel. According to Figure 4.3 the study established that 48% of users felt that doctors treated them with courtesy and respect of which out of these 48, 32 indicted that they were always treated with courtesy and respect and 16 indicated that they were usually treated with courtesy and respect. Thirsty eight per cent indicated that sometimes doctors treated

them with courtesy and respect. Fourteen respondents indicated that doctors never treated them with courtesy and respect.

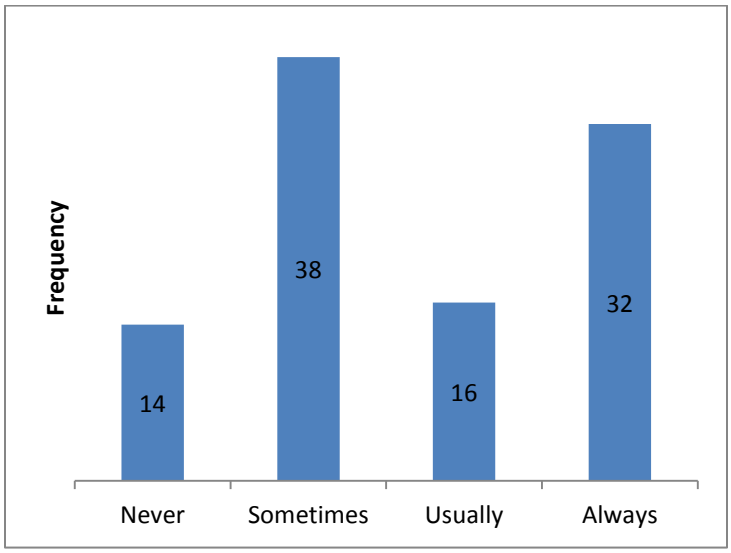


Figure 4.3 Perception of users on whether doctors treated them with courtesy and respect at the nearest health centre

Source: (Primary data)

According to Figure 4.4 below, the study established that thirty per cent (30%) of users indicated that nurses always treated them with courtesy and respect. Sixteen (16%) per cent indicated that nurses usually treated them with courtesy and respect while thirty seven (37) indicated nurses sometimes treated them with courtesy and respect. Seventeen out of hundred (100) respondents indicated that nurses never treated them with courtesy and respect.

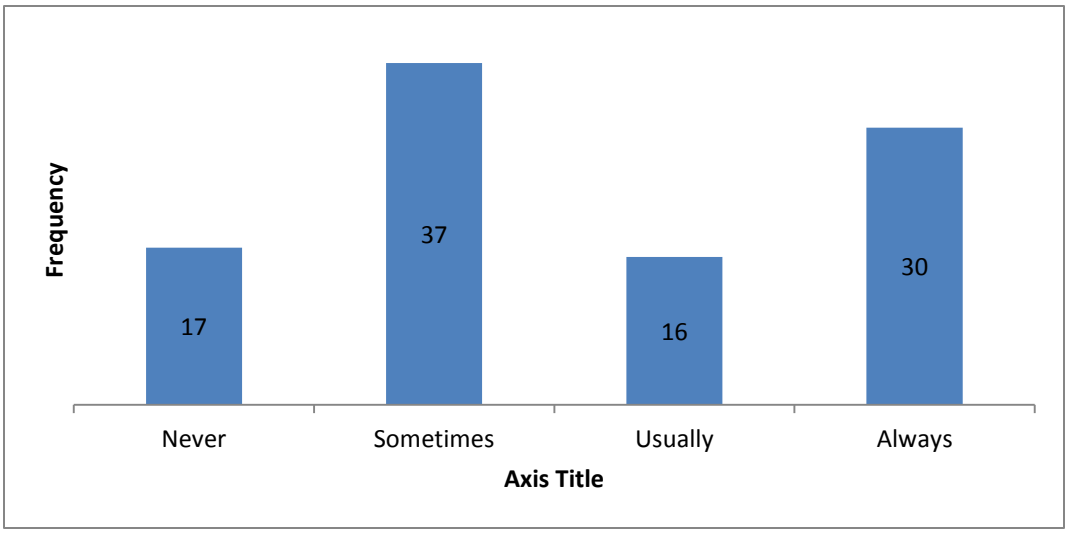


Figure 4.4 Perception of users on whether nurses treated them with courtesy and respect at the nearest health centre

Source: Primary data

For Chipata, Chaisa and Matero Reference participants in the Focused Group Discussion held on 10th May, 2016 stated that nurses spent their time loitering, and chatting, making it appear as though there was a shortage. At Chipata hospital the health staff were reported to be rude, especially in the labour ward. Nurses were also reported to be lazy and unconcerned. As a result, even though Chipata is closer, users preferred to attend Antenatal at Matero reference First Level hospital because they viewed the nurses there to be more caring. Respondents applauded Matero Reference that it was ideal for expectant mothers in terms of quality. Good relations between users and service providers are key for quality to be achieved, as this builds trust and confidentiality between the two. One respondent said that new entries were more kind and helpful.

According to the Focused Group Discussion held on 10th May, 2016, respondents perceived the staff at Chipata First Level Hospital to be negligent. Users complained that diagnostic tests were not always done. It was also noted that temperature and BP tests are not always taken when one visits Chipata. Stigma and discrimination, especially when it came to HIV/AIDS was another problem that hindered accessibility. Users expressed concern that sometimes health staff were prejudiced and sent them for VCT when they

came to the centre. The users felt disrespected and undervalued and opted that it was better not to go to the clinic at all.

4.4. Economic Factors

The study found that economic factors were also a factor in accessing health services by the local people. Economic factors mainly target on issues of affordability. This can be in form of the cost and price of services and the household's resources and willingness to pay. Although health care in government clinics in Zambia is free, considering the removal of user fees and patients are only pay a minimal amount of K2 for the record book. However, expenses are often incurred when patients have to buy the prescribed drugs from a private drug store when the hospital pharmacy has run out. Additionally, there are other costs that come up in the treatment process such as ultra sound or scan services.

According to Figure 4.5 below, users expressed that healthcare was free and they were not expected to pay anything at the health facility. The study found that most of the users (91%) indicated that they did not pay anything to access health care at the facility closest to them. 7% said they had to pay something to access certain services at the public health facility closest to them and only 2% did not respond.

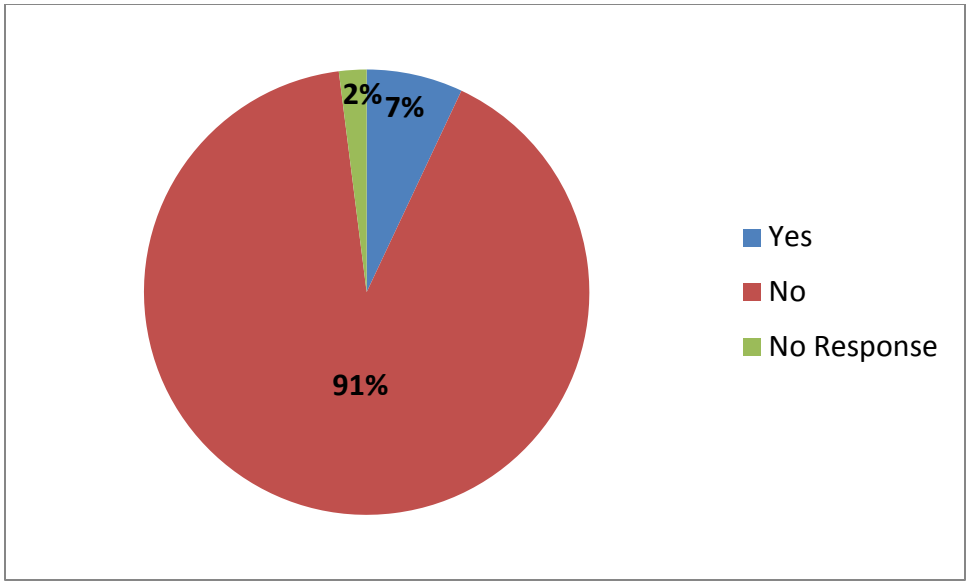


Figure 4.5 Users response as to whether they paid anything to access healthcare at the facility closest to them.

Source: (Primary data)

In 2006, the user fees removal policy was implemented in rural and peri-urban areas and this was rolled out to all Primary Health Care services across the country. This meant that users could now access healthcare from public health facilities for free. While the removal of user fees has resulted in improved utilisation of health services but on the other hand this removal has taken away an important source of flexible financing for public for health centres.

In spite of this observation, the study established that economic factors affect accessibility as some users cannot afford prescribed drugs and certain services that attract a separate fee. Shortage of drugs, vaccines and other surgical supplies is a problem in Public Health facilities. As a result, in many instances medicines are prescribed for the patient to buy. However, patients sometimes cannot afford to buy these medicines. Users expressed concern that in some instances government clinic ran out of drugs and patients were only given prescriptions to purchase drugs from a private drug store. Users complained that government clinics usually give out Paracetamol which is a pain killer.

The study established that certain amenities at the public facilities are privately owned and therefore, attract a separate fee for example X-ray and Ultra sound. At some facilities these machines were there but constantly break down. For example, a member of staff at Chipata First level Hospital expressed that even though the hospital is government owned, there is no X-ray machine, as a result a private entity provides X-ray services at extra cost. Some users are unable to afford the charge. It is important to note that in desperate situations the facility does offer assistance to those who can't afford or the elderly.

Other services that attract charges also include; payments required to obtain medical forms, Road Transport and Safety agency (RATSA) forms, Police Medical Report or Medical record book. Whether such fees hindered accessibility was quiet subjective, as different people have different incomes. However, a key point raised was that most people in the community are unemployed and have low incomes. The area is generally marred by high poverty levels.

At Chaisa Health centre it was revealed that some people could not afford services such as Laboratory and Radiography services, as they were privately owned. This affects service quality because even when diagnosis of the right illness is done, if the user cannot afford to get an X-ray, the work of the doctor or clinical officer becomes very difficult.

The study established that the patients' financial status may affect their ability to access quality healthcare services. Sometimes the patient cannot afford the costs associated with his or her treatment and decides to cancel the treatment. In a situation where the patient does not follow the doctor's orders due to financial problems, the treatment will not be effective. Mandevu residential area is a high density area where most people are unemployed and have a low income and hence, some fail to pay for services such a scan and X-ray.

The findings are similar to those found in Mazabuka in a study titled "District Factors Perceived by Caretakers as Barriers to Health Care for Under-Five Children in Mazabuka District, Zambia" conducted by H. Halwindi (2013). Financial constraints also posed

considerable barriers to accessing needed health care for the children, including issues related to user fees, penalty fees, and high cost of prescription medicines.

The findings are similar to a study titled "Factors influencing healthcare service quality" done in Iran (Mosadeghrad,2014) were the financial status of users affect quality of care. Doctors reported that sometimes they prescribed drugs to patients and those patients would return to the facility several weeks later in the same condition because they could not afford the prescribed drugs.

Living Conditions Monitoring Surveys and Participatory Poverty Assessments undertaken so far, suggest that poverty is widespread in Zambia. The poor seem to be concentrated in the high density settlements, which do not have adequate essential public services and therefore provide the least expensive housing that the poorest perhaps find affordable (Urban Slums Report: The Case of Lusaka). The country is experiencing high levels of unemployment and weak socio-economic status of the population, which have implications on the health status of the population. Income inequity among the population has remained high, with the Gini Coefficient at 0.57 in 2004 (a drop from 0.66 in 1998), (National Health Strategic Plan, 2011-2015).

4.5. Insufficient satisfaction in the Quality of Healthcare

The research established that due to poor service delivery in some facilities, people lacked sufficient satisfaction in certain health facilities; hence some users were reluctant to access services. Shortage of drugs and vaccines sometimes discouraged people to come to the clinic. In some cases, people had to buy medicines when the pharmacy had none. As a result, some users decided to buy medicines directly from a private drugstore without going to the clinic. Poor staff attitudes and congestion which led to subsequent delays at health facilities was a source of dissatisfaction. Lack of confidence in the quality of care sometimes led to a situation where people by passed the closest facility because they thought they could get a better service.

According to Figure 4.6 below, 37 out of hundred respondents indicated that they by-passed the nearby clinic and went to a further one because they felt they could get a better service. 62% said they went to the closest clinic to acquire the required service and only 1% did not respond.

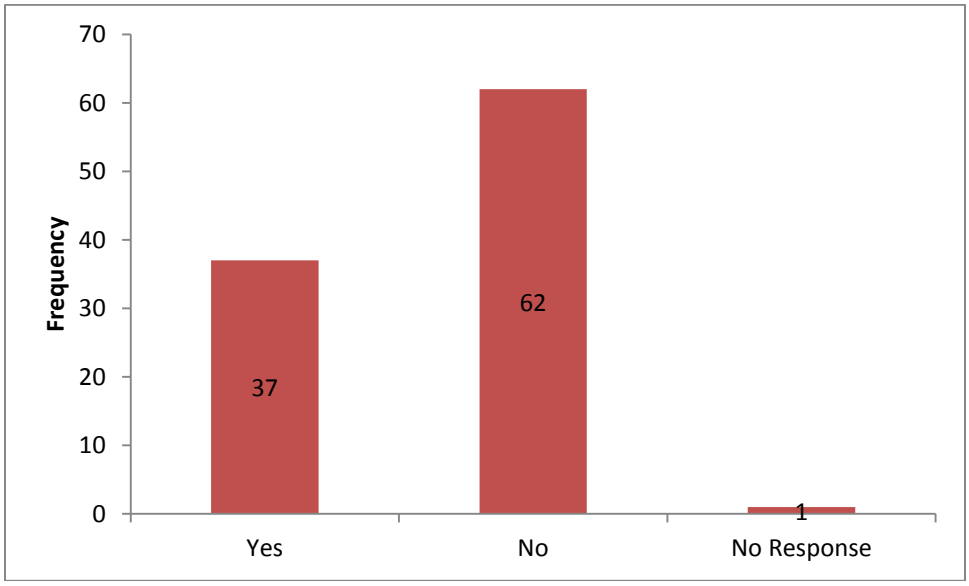


Figure 4.6. Do you ever go to an alternative Clinic besides the closest one because you think you could get a better service?
Source: Primary Data

Lack of sufficient satisfaction in the quality of care was also caused by perceived attitudes of staff. Users expressed concern that sometimes service providers were rude and uncaring. In most cases healthcare providers lacked courtesy, respect and were often rude to users. Their attitudes were sometimes poor. Poor quality can also be evidenced in the rate at which they did their work. In a Focus Group Discussion held on 10th May, 2016 users expressed concern that sometimes health workers were negligent and unconcerned.

Users also lacked confidence in the quality of health care as they felt the facility sometimes did not do a proper diagnosis before prescribing drugs. There is ample evidence confirming that access to quality health care is a major problem. Where health care is available, the quality is often severely deficient, leaving its effectiveness well short of potential efficacy. This poor quality is a hindering factor to access quality health care. This is a potential cause of high mortality rates. As long as such quality deficiencies persist, the estimates of avoidable deaths will persist (O'Donnell, 2007).

The level of confidence in the service provider was also reflected by the level of satisfaction with certain health facilities that was experienced by the users. Quality healthcare is subjective, complex and multi – dimensional. Health care quality is associated with patient satisfaction. Therefore, quality healthcare must meet the patient's needs and at the same time satisfy the service providers (Mosadeghrad, 2013). In spite of the many challenges public health facilities face in providing quality care, it is important to measure the level of satisfaction with services provided. Satisfaction was measured using variables such as: Number of health Staff, infrastructure, availability of medicines and waiting time.

The general view was that health personnel are different and sometimes people had different experiences at the various facilities. The study established that people were not fully satisfied. In subsequent explanations people mentioned that they did not expect much from a government clinic. However, the most dissatisfaction came from lack of medication, waiting time and attitudes of health personnel. Users expressed satisfaction with the speed at which certain facilities worked and the help they received at the facilities. Users also expressed satisfaction with the high level of professionalism exhibited by some health personnel.

The study found that of the four clinics sampled, users were most dissatisfied with the quality of services at Chipata First Level Hospital. In a Focused Group Discussion held on 10th May, 2016 users expressed dissatisfaction with waiting time, negligence, lack of drugs, rudeness of staff, shortage of medicines, environment, bad toilets, and inadequate infrastructure among others. However, the general feeling was that new entrants were more helpful and kind.

Patients expressed dissatisfaction with lack of proper diagnosis before prescribing medication. For example, it was alluded that sometimes they don't take BP or temperature before prescribing medication. Other users expressed dissatisfaction with the poor attitudes of health personnel. A lot of dissatisfaction was expressed on the lack of prescribed medicines at the health facility. This resulted in a situation where users had to look for money and buy the medicine from a private drug store.

According to 4.7, the study established that only 76 out of 100 reported to have been to Chipata First Level Hospital and out of those who have been to Chipata, 11% said they were very satisfied, 45 reported to be fairly satisfied. 13 said their experience was unsatisfactory and 28 reported their experience to be very unsatisfactory.

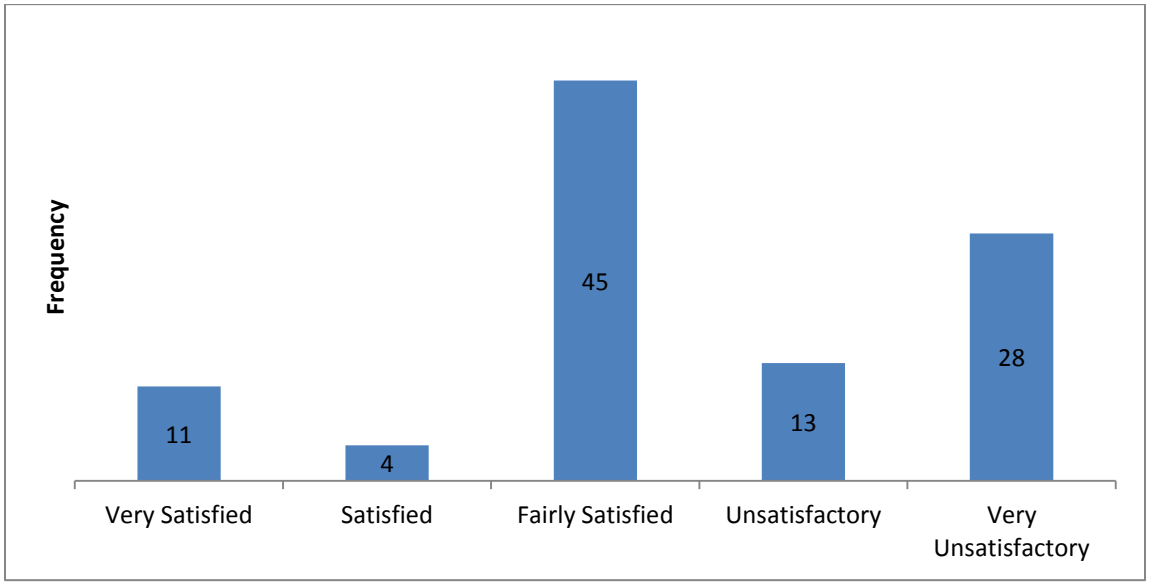
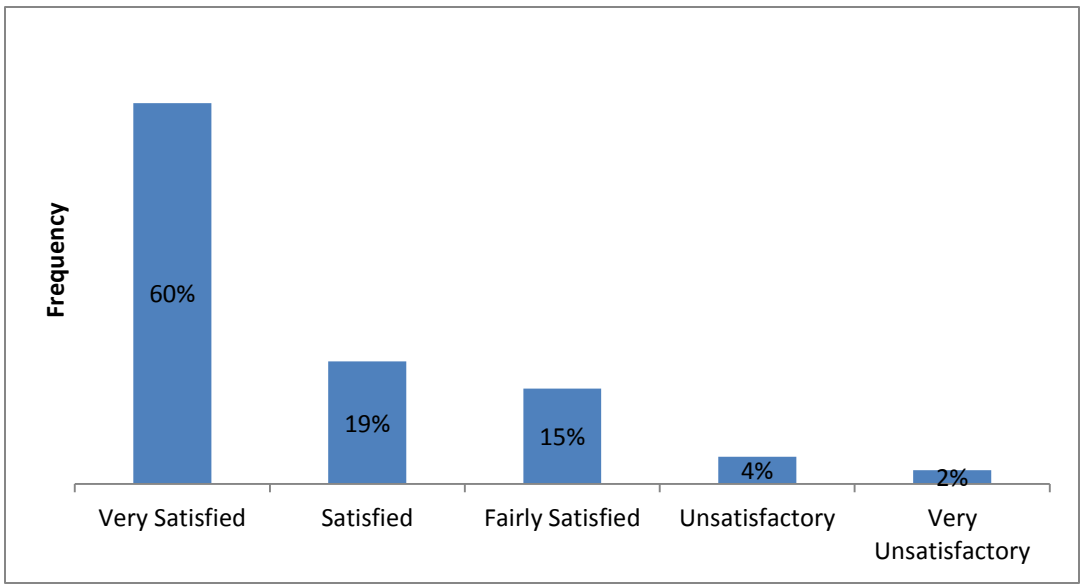


Figure 4.7 Users levels of Satisfaction with quality service delivery at Chipata First Level Hospital

Source: Primary Data

According Figure 4.8, the study established that only 47 out of 100 reported having been to Chaisa out of those who have been to Chaisa, 60% said they were very satisfied. Users expressed the most satisfaction with short waiting time. User expressed satisfaction with the fact that they did not have to wait for many hours to receive a service. This is consistent with the statement by the in-charge who alluded to the fact that the facility has put in measures to ensure that patients who come in the morning should not be found after lunch.



Source: Primary data

Figure 4.8 Users levels of satisfaction with the quality of service delivery at Chaisa health Centre

According to Figure 4.9 below, 53 out of the 100 respondents reported having been to Matero Reference First Level Hospital. And out of those who have been to Matero Reference, 40 per cent said they were very satisfied with the quality of health services. Users expressed satisfaction with good quality services and quicker services in-spite of large numbers. It is important to note that when it comes to satisfaction each user had a different experience. While others expressed satisfaction with quick services and rated the hospital as the best, some expressed dissatisfaction with lack of doctors, long waiting time, lack of courtesy by staff, corruption and lack of transparency when attending to patients.

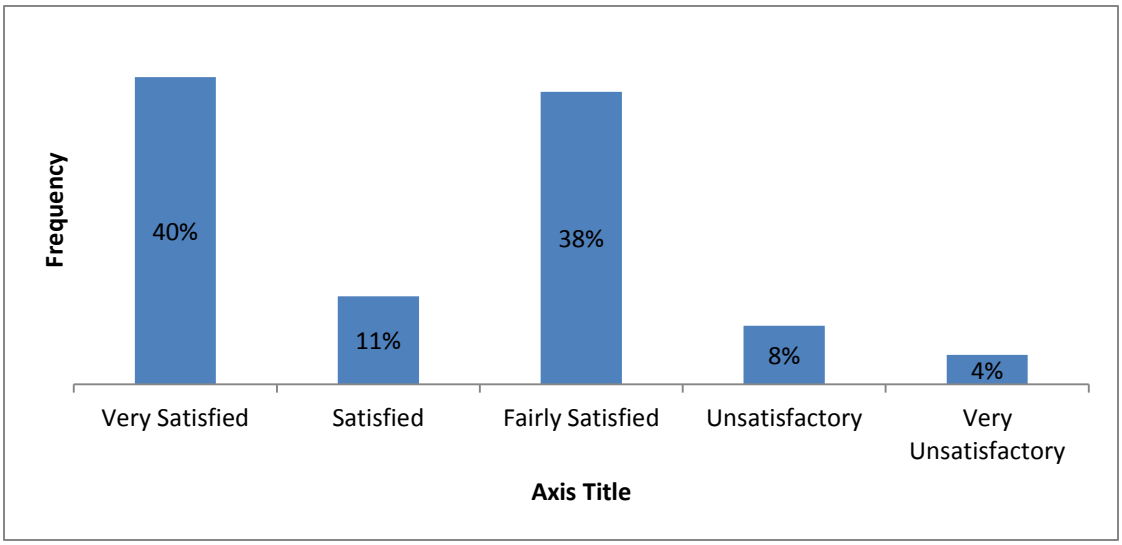


Figure 4.9 ***Users levels of satisfaction with the quality of service delivery at Matero Refernce First Level Hospital***

Source: Primary Data

The research revealed that satisfaction at Mandevu Paediatric clinic was low but relatively better compared to the other health facilities. Waiting time was shorter compared to the other clinics. Medicines were given though sometimes the clinic had no medicines. In times when medicines were not available at the clinic users abandoned the facility and stopped coming completely. Utilization would only resume after the facility was stocked with medicines again. Poor attitude of a few health personnel was raised as a source of dissatisfaction.

The study found that Chipata, Chaisa and Matero Reference were more than 100 per cent utilised if not over utilised. The long queues, overcrowded hall ways were evidence that people came to these clinics.

Mandevu Paediatric Clinic, however, was found to be under-utilised. The matron reported that only a small fraction of the people in Mandevu came to the clinic or even know about the clinic. She therefore, reported that the clinic was only 50 per cent utilised. Sensitizations were made on a regular basis but these have not proved to be very effective. One contributing factor to the underutilization of Mandevu was found to be the limitation in terms of services provided. For instance, there are no laboratory services. Therefore, users did not want to be referred to Chipata if tests needed to be carried so

they just went straight to Chipata. Table 2.1 in chapter one shows clearly shows the extent of utilization of various health facilities in Mandevu

4.6. Other factors affecting Access

In addition to the above factors affecting access, there were also other factors that were identified that are relatively minor as no much detailed information was made available. Other factors affecting access included lack of full information, distance, social demographic factors of users and corruption.

The study found that lack of full information on services provided at the health facilities also hindered accessibility by the local people. In an interview with the In-charge from Chipata first Level hospital it was revealed that people had a certain amount of information but not full information. However, health centres do sensitizations through Neighbourhood Health communities (NHC). For example, at Chipata First Level Hospital, health professionals go out in the field once a month to carry out sensitizations through various ways such as drama. Each department sends a representative in the community to talk about what they do. Whether these sensitization campaigns have been successful or not is another issue. Having enough information about the services a health facility provides is important, as it greatly affects accessibility.

The In-charge of Chipata said;

"The information is there on the services we provide. Although some of them may not have full information. We invited people from the community; we even had drama about the services being offered. Information is a factor to a lesser extent." (12th July, 2016).

However, the In-charge at Mandevu clinic, in an interview, did allude to the fact that a lot of people in Mandevu did not know that a paediatric clinic existed in the area.

"Information we are giving them. But you go outside and ask them that do you know there is a children's clinic? Do you know we give

immunisation? They say we don't know. Sensitizations is done using drama, mega phones etc"(20th June, 2016).

Generally, the health facilities provide information in various ways so as to sensitize the people. However, this has been effective with some facilities and quite ineffective with others like Mandevu Peadiatic Clinic where some people living in the area are not aware that a children's clinic exists. Information was found to be a factor in accessing quality healthcare only to a lesser extent, as facilities make efforts to conduct sensitization campaigns through the Neighbourhood Health Communities (NCH) and other strategies.

It was not definite to ascertain as to whether distance was a factor or not in terms of people accessing healthcare. As observed in Chapter 2 figure 2.1 people held different views on which facility they considered to be close to their home. This was mainly based on which part of Mandevu one lives and the health facility they were familiar with. It was also revealed that because of distance, transport is a key factor, especially in emergency cases. For example, pregnant women sometimes deliver at home because they cannot afford to book a cab. This has led to a lot of home deliveries. It is due to this background that the health facility gives the expectant mothers Birth Preparedness so they can start saving money to aid logistics during delivery. Due to the distance users need transport money to get to the facility.

On the contrary, some health personnel did not consider distance as a major problem. They alluded to the fact that even if Mandevu had no adult clinic, the surrounding clinics were close enough.

"It is not a problem because these are distances which people can walk. It is not like the villages were people walk many kilometres" (Chipata In-Charge, 12th July, 2016).

Socio-demographic factors influence the interaction between a provider and the patient and consequently the quality of services. The study found that low education levels of users were a major problem in providing quality healthcare. A health professional stated

"Most people are not educated and this is a great challenge when it comes to providing quality health care". Due to the low education levels among users, explaining certain things becomes a major challenge. Another health personnel stated that "Most households are headed by young parents who cannot decide for themselves". Due to these factors, certain basic information concerning health and wellness was difficult to communicate.

This was also found to be true based in the Demographic Health survey. The use of antenatal care services from a skilled provider is strongly related to mother's level of education. Women with more than a secondary education are more likely to receive antenatal care from a skilled provider (99 percent) than women with no education (91 Per cent). Similarly, women in the highest wealth quintile (99 per cent) are more likely than women in the lowest wealth quintile (92 per cent) to receive care from a skilled provider.

The study revealed that patients had a misconception on the quantity of drugs they received at the health facility. To them quality means receiving a lot of drugs at the clinic. So if they are given few drugs or none at all they are dissatisfied even though their illness does not require a lot of drugs. One key informant stated that "quality according to the local people is medicines, if they are given a lot of medicines that is the threshold for quality".

The research established that users felt that corruption was another key factor that hinders accessibility of health services. Users expressed concern that sometimes transparency was seen to be lacking in the attendance of patients. Sometimes money was slipped in the record book so as to be given first priority. Female user interviewed on 10th June, 2016 reported that sometimes if they don't want to waste a lot of time at the clinic they simply slip some money in the record book and their name will be called earlier, skipping other people on the queue. They attested to the fact that corruption does take place at the facility.

4.7. Conclusion

Although there are various factors that may hinder users in accessing quality healthcare, the study identified the following; congestion at health facilities, economic factors,

attitudes of personnel, lack of confidence in the quality of healthcare, among others. Quality healthcare does not only involve the service provider's ability to produce good services but also meeting the patient's needs. Users in Mandevu were affected by the congestion at the clinic which results in long queues and subsequent delays. Attitudes of health personnel also play a role in users' accessibility. The way patients are treated may determine whether they will come back to the facility or not. Economic and physical barriers also affect accessibility. Through the Vision 2030, the government has prioritised health, and is committed to the attainment of 'equity of access to cost effective quality health services, as close to the family as possible'. The facility must enable users to access timely and efficient services. Accessibility is therefore a key factor in quality service provision.

CHAPTER FIVE

CONCLUSIONS AND RECOMENDATIONS

5.1 Introduction

The chapter presents the conclusions and recommendations arising from the study. The chapter begins with conclusions drawn from the analysis of the findings. The chapter ends by discussing policy recommendations and recommendation on areas for future research.

5.2 Conclusions

The study established that several factors affected the provision of quality health services in Mandevu residential area. These factors included both service provider related factors and user related factors. The study established that the factors that affect service providers in delivering quality health care included; the availability of staff, high population of users, inadequate infrastructure, level of staff satisfaction and motivation and availability and access to essential vaccines, drugs and other medical supplies. Furthermore, the factors that affect users in accessing quality health care included: congestion at the facility, economic factors, lack of sufficient satisfaction in the quality of care among others. These factors have been explored further below;

The study established that availability of quality staff was a major factor that affected provision of quality health care. Health staff numbers were below the required establishment to operate optimally. Furthermore, The Study established that Health staff job satisfaction is very important in delivering high quality medical services to patients. Job satisfaction includes issues such as pay and working conditions. Generally, workers were well motivated in terms of capacity development, as there have various training opportunities like short workshops. However, they were poorly motivated in terms of pay and high patient population leading to exhaustion.

Inadequate infrastructure was a major hindrance to the provision of quality healthcare. The increased catchment population poses great challenges on infrastructure. As a result, some staff lacked working space, patients lacked adequate waiting rooms and wards. The infrastructure was not only inadequate but also poorly maintained. With an ever-

increasing population, the available infrastructure was inadequate to provide optimum quality services.

Furthermore, the study concluded that availability of financial resources was a key determinant of quality, as this helps to purchase both medical and non-medical supplies and ensures the smooth running of the institution. Inadequate funding was found to be a major factor that hinders delivery of quality health services by facilities. All the four health facilities pointed out funding as a major hindering factor.

The study established that availability and access to essential vaccines, drugs and other medical supplies are a critical factor in ensuring efficient and effective delivery of health services to the local community. The study revealed that shortage of medical supplies was a major hindering factor in providing quality health care. Sometimes the pharmacies lacked essential medicines and users have to be given prescriptions to purchase drugs from private drug stores.

The study established that another factor that affected quality at the clinics serving Mandevu Residential Area was high population of users receiving care from the facilities. This led to a situation where the clinic is over- crowded. As a result, health staff spend less time with a patient so as to carter for more people. The situation also resulted in longer waiting time by users at the facility. However, this problem did not apply to Mandevu Paediatric Clinic as it was found to be under- utilised but applied to Chipata First Level Hospital, Matero Reference and Chaisa health centre.

There are several factors that affect accessibility of quality health by users. These include: congestion at the facility, economic factors, lack of sufficient satisfaction with the quality of care of healthcare and other factors included; distance, information the patient's social and demographic factors.

The study established that congestion at the facility which led to subsequent delays affected accessibility of quality health care by users. Users sometimes decided not to go to the facility even when they required medical attention because they avoided waiting

for a long time. Sometimes users could be at the facility for as long as 8 hours. Long waiting can result in a situation where people get critically ill while waiting and even die.

Economic factors also affected accessibility of quality healthcare by users. Certain services such X-rays and Ultra sound accompanied a charge that some people could not afford. Furthermore, the facilities lacked the prescribed drugs as a result users needed to purchase the drugs from a private drug store. Sometimes people cannot afford those medicines. Sometimes users could not afford to transport a patient to the nearest health facility, this resulted in mothers for example delivering at home.

The other factor that affected access by users was the general lack of sufficient satisfaction in the quality of services. Sometimes users avoided going to the clinic because the services were poor from previous experiences. This involves a combination of different factors such as bad environment, slow moving services, uncaring and rude personnel among others.

The study established that other factors that affect accessibility included; users' social-demographic factors, lack of information and distance among others. The study established that the Social-demographic factors of users were also a factor affecting accessibility. Most of the users are young mothers with low education levels. Sometimes this affected the quality of interaction between them and the service provider. Furthermore, users have a mind-set that they should always receive a lot of medication when they visit the facility, in instances where maybe just one or no medication is prescribed for them that is poor quality service.

The study established that distance was another factor that affected accessibility of health services by users but only to a lesser extent. Some residents preferred to go to Chaisa and Matero Reference even if Chipata was closer so as to get timely treatment.

Lack of information was another factor that affected access of quality health care. Users had partial information on services provided. Sometimes sensitization was done in the

community and still people did not have full information about the services provided by the facility.

The study established that 'Quality Healthcare' is subjective, complex and multi – dimensional. Health care quality is associated with patient satisfaction. And users expressed different levels of satisfaction for a different clinic.

Users expressed some dissatisfaction with Chipata First Level Hospital in terms of waiting time, negligence, lack of drugs, rudeness of staff, shortage of medicines, dirty environment, bad toilets, and inadequate infrastructure, among others. Users some dissatisfaction with Chaisa and Matero Reference. Users showed satisfaction with Matero Reference and Chaisa health centre with regard to shorter waiting time compared to Chipata.

The Study concluded that Chipata First Level Hospital, Chaise Health Centre and Matero Reference were 100% utilised, if not over utilised. Mandevu Paediatric Clinic was found to be under-utilised. Utilization was measured by the large numbers of people visiting the facility to seek medical attention.

In a nutshell, based on the findings contained in the document, it can safely be concluded that in spite of the tremendous efforts by the service providers and the government, quality of healthcare in public health facilities is quite poor. A lot still remains to be done, if quality healthcare in public health facilities is to be attained. Several factors affect delivery of quality healthcare such as human resources, finances, number of staff, availability of infrastructure, client population and availability of medicines, among others.

5.3 Recommendations

5.3.1 Policy Recommendations

Quality healthcare is an asset and ill health a liability to any country. It is, therefore, imperative that high quality services are provided which must not only satisfy the service

providers but also meet the needs of the users. Mandevu, being a high density residential area with only a Paediatric clinic, the study made the following recommendations:

1. *Expansion in existing infrastructure*

   The study recommends that existing infrastructure in the various health facilities be expanded to carter for the ever-growing population

2. *Construction of health facility in Mandevu*

   A health facility be constructed in Mandevu Residential area so as to complement the already existing Paediatric Clinic and decongest Chipata First Level Hospital.

3. *Increase in human resources for health*

   More health workers be trained and those already trained are put on pay roll so as to reduce the current staff shortages and further reduce the patient to worker ratio. This will further reduce the workload health workers currently have. High work load leads to burnout and exhaustion and this greatly affects quality health provision. If more staff are deployed and infrastructure is expanded this will greatly reduce the waiting time spent at health facilities. Furthermore, working conditions of health staff be improved. Pay is an important motivator and therefore needs to be improved.

4. *Increased finances*

   That the financial muscle of the health system is strengthened. More resources must be directed towards health care to ensure smooth running of health facilities. Furthermore, the study recommends that healthcare financing must not only be sufficient but regular and consistent. This will ensure smooth operation of the facilities.This will also ensure that health facilities are constantly and adequately stocked with essential vaccines, drugs and other medical and non-medical supplies and other logistics. Medical supplies will ensure quality healthcare and higher user satisfaction.

5. *Improved equipment*

   That government, through the Ministry of Health, purchases modern equipment for health facilities. This will reduce on breakdown of laboratory equipment and other essential equipment on a regular basis. And a special team must be put up to ensure maintenance and repairing and educate on proper usage. The study recommends that every health facility has a standby ambulance in case of emergencies. Critically ill patients usually have challenges to be ferried to a higher hospital as they cannot afford

transportation. A standby generator should also be purchased at every health facility in the case of power cuts especially at night.

6. That to improve accessibility of health services by users, certain measures should be put in place:
   6.1 Educate health workers to treat users with courtesy and respect. This will ensure that health staff are politer. People will be free at the facilities and build better relationships with the health workers.
   6.2 Recruit more health workers so that there are enough staff attending to patients and this will reduce the waiting time at the health facility.
   6.3 Expand infrastructure in order reduce the catchment population of existing facilities. This will further reduce over-crowding in clinics. Furthermore, with more health facilities users will walk shorter distances to the closest health facilities
   6.4 Scale up sensitization campaigns so that more people are educated on the services offered by the health facilities and the kind of help they can get from the health facility.
   6.5 Make health care as free as possible. Ensure that all government facilities have necessary equipment to provide essential services. Certain services at clinics are provided by private entities hence, accompanied by a higher charge.
   6.6 Improve the general quality of health services so that people do no shun public health facilities due to poor quality services.

7. To improve the levels of satisfaction among users, the study recommends that health facilities find a way to get feedback from the users. A tool that can be used is the suggestion boxes. Users can drop their views on the quality of services they are receiving. This will allow health workers to know what they need to work on so as to improve the experience of users. If these are already in existence users must be encouraged to use them. Users expressed dissatisfaction with long waiting time, lack of medicines, poor attitudes of health personnel among others.

5.3.2 Recommendations on Areas for Future Research

This study has looked at the factors affecting delivery of quality healthcare in public health facilities: the case of Mandevu residential area. It has provided a pool of information on what affects health providers in providing quality health care to serve high density populations. Several factors have been identified using various instruments such as questionnaires and face to face interactions such as interviews. Future research can further develop such insights and weigh their relevance to other contexts. The following can be potential areas for future research:

1. The study identified staff shortage as a key factor affecting provision of quality healthcare therefore, areas for future research on Human Resource Planning in the provision of public health care to curb shortages of staff may be considered.
2. Another potential area of future research would be measurement of the levels of satisfaction with various services of clients coming to the health facility using a relevant criterion.

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Zambia Daily Mail 12 April, 2015

APPENDICES

APPENDIX 1: HOUSEHOLD QUESTIONAIRE

UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND POST GRADUATE STUDIES
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

RESEARCH TOPIC:

FACTORS AFFECTING DELIVERY OF QUALITY HEALTH SERVICES IN ZAMBIA: THE CASE OF MANDEVU RESIDENTIAL AREA.

Dear Respondents,

My name is Towela Kaonga. I am a Post Graduate student at the University of Zambia and this research is a requirement in the fulfilment in the Masters in Public Administration (MPA) programme. The main objective of this study is to investigate that factors that affect delivery of quality health services in Mandevu residential area.

You have been selected as a respondent for this study. Kindly spare a few minutes to respond to this questionnaire. Be assured that your responses shall be treated with strict confidentiality as this research is purely academic and will be used to write the dissertation. Honest and sincere answers will be highly appreciated.

Instructions: Tick in the circle against your appropriate response or write in the blank space

Questionnaire number…….

SECTION A: BACKGROUND INFORMATION

Q1. What is your sex?

1.	Male	[ ]
2.	Female	[ ]

Q2. How old are you?.....

Q3. What is your marital status?

1.	Single	[ ]
2.	Married	[ ]
3.	Divorced	[ ]
4.	Widowed	[ ]

Q4. What is your level of education?

1.	Never been to school	[ ]
2.	Primary Education	[ ]
3.	Junior Secondary	[ ]
4.	Senior Secondary	[ ]
5.	College Education	[ ]
6.	University Education	

Q5. Are you employed?

1.	Yes	[ ]
2.	No	[ ]

If yes, proceed to question 6, if No proceed to question 8.

Q6. Which sector?

1.	Formal sector	[ ]
2.	Informal sector (Self-employed)	[ ]

Q7. What is your monthly income?

1.	Below 2000	[ ]
2.	Between 2000 and 4000	[ ]
3.	Between 4000 and 5000	[ ]
4.	Above 5000	[ ]

SECTION B: factors hindering accessibility of health services

Q8. Which health centres do you usually go to?

		YES	NO
1.	Chipata Clinic	[ ]	[ ]
2.	Chaisa Clinic	[ ]	[ ]
3.	Matero Reference	[ ]	[ ]
4.	Mandevu Pediatric Clinic	[ ]	[ ]
5.	Other	[ ]	[ ]

Q9. Which health facility is closest to you?.....

Q10. Which Are there any charges people have to pay to access certain services at public health facilities

1.	Yes	[ ]
2.	No	[ ]

If yes to Q10. If No then skip to Q13

Q11. What kind of charges?.....

Q12. Can you regard the charges too expensive?

a. Yes [ ]
b. No [ ]

Q13. Do doctors treat you with courtesy and respect at the health facility closest to you?

1. Never [ ]

2. Sometimes [ ]

3. Usually [ ]

4. Always [ ]

Q14. Do nurses treat you with courtesy and respect?

1. Never [ ]

2. Sometimes [ ]

3. Usually [ ]

4. Always [ ]

SECTION C: USER SATISFACTION

Chipata clinic

Doctors and Nurses

Q15. Are you satisfied with the number of Doctors at Chipata Hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

Q16. Are you satisfied with the number of nurses at Chipata Hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

Waiting Time

Q17. How long is the waiting to access all the health services one requires at the health centre?

1. Too long [ ]
2. Just fine [ ]

Q18. How much time do people spend at the clinic on average?

……

Infrastructure

Q19. Is Chipata Hospital big enough to carter for the needs of the people it serves?

1. Yes [ ]
2. Fairly enough [ ]
3. No [ ]

Q20. Are you satisfied with the number of wards at Chipata First Level Hospital Hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

Q21. Do you think Chipata Hospital is overcrowded?

1. Yes [ ]
2. No [ ]

Pharmacy

Q22. Are you satisfied with the pharmacy at Chipata Hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

Q23. Is it common to find there is no medicines at the pharmacy?

1. Yes [ ]
2. No [ ]

Reception and Registry

Q24. What is your opinion on the keeping of patient's records?

a. Excellent [ ]
b. Very Good [ ]
c. Good [ ]
d. Average [ ]
e. Poor [ ]
f. Very Poor [ ]

Modern Technology and Equipment

Q25. Are u satisfied with the equipment used to carry out the necessary diagnostic tests at chipata hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

Quality of Health Services

Q26. Are you satisfied with the quality of services provided by Chipata Hospital?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

CHAISA CLINIC

Q27. Are you satisfied with the quality of services provided by Chaisa clinic?

1. Very Satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]
6.

Q28. Rate your level of satisfaction with the following at Chaisa clinic?

		Very Satisfactory	Satisfactory	Fairly satisfactory	Unsatisfactory	Very Unsatisfactory
1	No. of Doctors					
2	No of Nurses					
3	Infrastr					

7. .Ve ucture						
r 4 Pharma y cy						
[5 Waiting time						

Matero Reference

Q29. What is your level of satisfaction with the quality of services at Matero Reference?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]

Q30 Rate your level of satisfaction with the following at Matero Reference?

Q 3 1 .		Very Satisfactory	Satisfact ory	Fairly satisfactory	Unsatisfactor y	Very Unsatisfa ctory
W 1 h	No. of Doctors					
a 2 t	No of Nurses					
i 3 s .	Infrastr ucture					
4	Pharma cy					
y 5 o u r	Waiting time					

Q31 What is your level of satisfaction with government clinics in general in terms of service delivery?

1. Very satisfied [ ]
2. Satisfied [ ]
3. Fairly Satisfied [ ]
4. Unsatisfactory [ ]
5. Very Unsatisfactory [ ]

SECTION C: UTILIZATION OF HEALTH SERVICES

Q32. Do you ever go to an alternative clinic besides the closest one because you think you would get a better service

1. Yes [ ]
2. No [ ]

Q33. Is the alternative clinic Government or private?

1. Government [ ]
2. Private [ ]
3. Both [ ]

Q34. What is the name of the clinic or hospital?.....

Q35. Do you sometimes buy your own medicines because you are avoiding waiting in long queues at the hospital?

1. Never [ ]
2. Sometimes [ ]
3. Usually [ ]
4. Always [ ]

Q36. What other challenges do you have with the clinics that serve Mandevu?.....
.....
.....

THANK YOU FOR YOUR COOPERATION

APPENDIX II: HEALTH STAFF QUESTIONAIRE

UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND POST GRADUATE STUDIES
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

RESEARCH TOPIC:

FACTORS AFFECTING DELIVERY OF QUALITY HEALTH SERVICES IN ZAMBIA: THE CASE OF MANDEVU RESIDENTIAL AREA.

Dear Respondents,

My name is Towela Kaonga. I am a post graduate student at the University of Zambia and this research is a requirement in the fulfilment in the Masters in Public Administration (MPA) programme. The main objective of this study is to investigate that factors that affect delivery of quality health services in Mandevu residential Area.

You have been selected as a respondent for this study. Kindly spare a few minutes to respond to this questionnaire. Be assured that your responses shall be treated with strict confidentiality as this research is purely academic and will be used to write the dissertation. Honest and sincere answers will be highly appreciated.

Instructions: Tick in the circle against your appropriate response or write in the blank space

Questionnaire number…….

SECTION A: BACKGROUND INFORMATION

Q1. What is your sex?

1. Male [ ]
2. Female [ ]

Q2. What is your age?.....

Q3. What is your position at the hospital?.....

Q4. What are your qualifications?.....

SECTION B: PROBLEMS FACED BY SERVICE PROVIDERS IN PROVIDING QUALITY SERVICES

Employee capacity

Q5. Are there sufficient numbers of doctors at your clinic to carter for the needs of the patients?

1. Very Insufficient [ ]
2. Insufficient [ ]
3. Fairly Sufficient [ ]
4. Sufficient [ ]
5. Very Sufficient [ ]

Q6. Are there sufficient numbers of nurses at your clinic to carter for the neds of the patients?

1. Very Insufficient [ ]
2. Insufficient [ ]
3. Fairly Sufficient [ ]
4. Sufficient [ ]
5. Very Sufficient [ ]

Q7. Are there enough support staff at for example cleaners?

1. Yes [ ]
2. No [ ]

Q8. How would you rate the pay of doctors at your clinic according to the work they do?

1. Very Low [ ]
2. Low [ ]
3. Average [ ]
4. High [ ]
5. Very High [ ]

Q9. How would you rate the pay of nurses at your clinic according to the work they do?

1. Very Low [ ]
2. Low [ ]
3. Average [ ]
4. High [ ]
5. Very High [ ]

Q10. How would you rate the management and administration of Human Resources in the health system in Zambia?

1. Very effective [ ]
2. Effective [ ]
3. Fair [ ]
4. Ineffective [ ]
5. Very Ineffective [ ]

Infrastructure

Q11. Is the clinic big enough to carter for the needs of patients it receives?

1. Very inadequate [ ]
2. Inadequate [ ]
3. Fairly adequate [ ]
4. Adequate [ ]
5. Very Adequate [ ]

Q12. Are their sufficient number of wards at the clinic?

1. Very inadequate [ ]
2. Inadequate [ ]
3. Fairly adequate [ ]
4. Adequate [ ]
5. Very Adequate [ ]

Q13. Do you think the clinic is overcrowded?

3. Yes
4. Fairly crowded [ ]
5. No [ ]

Pharmacy/Medical Supply

Q14. Is the pharmacy at the clinic constantly adequately stocked?

1.	Never	[	]
2.	Sometimes	[	]
3.	Usually	[	]
4.	Always	[	]

Q15. Is it common to find there are no medicines at the pharmacy?

3.	Yes	[	]
4.	Sometimes	[	]
5.	No	[	]

Reception and Registry

Q16. How would you rate the reception of patients at the clinic?

g.	Excellent	[	]
h.	Very Good	[	]
i.	Good	[	]
j.	Average	[	]
k.	Poor	[	]
l.	Very Poor	[	]

Q17. What is your opinion on the keeping of patient's records?

1.	Excellent	[	]
2.	Very Good	[	]
3.	Good	[	]
4.	Average	[	]
5.	Poor	[	]
6.	Very Poor	[	]

Modern Technology and Equipment

Q18. Does the clinic have the necessary modern diagnostic equipment to provide quality health services?

1.	Yes	[	]
2.	No	[	]

Healthcare Financing

Q19. Are the financial resources allocated to the clinic adequate enough to carter for the needs of the institution?

1.	Very insufficient	[ ]
2.	insufficient	[ ]
3.	Fairly Sufficient	[ ]
4.	Sufficient	[ ]
5.	Very Sufficient	[ ]

Leadership and Governance

Q20. How would you rate the management and administration of health system in Zambia?

1.	Very effective	[ ]
2.	Effective	[ ]
3.	Fair	[ ]
4.	Ineffective	[ ]
5.	Very Ineffective	[ ]

Q21. What some of the major problems that the clinic faces in providing quality healthcare that u have not already highlighted?.....

……..

…….

……

ACCESSIBILITY OF HEALTH SERVICES

Q22. Are people required to pay a certain charge for certain health services

1.	Yes	[ ]
2.	No	[ ]

Q23. What services are these?.....

Q24. How would you rate these fee?

1.	Very high	[ ]
2.	High	[ ]
3.	Moderate	[ ]
4.	Low	[ ]
5.	Very Low	[ ]

Q25. Do you think lack of money affects access of quality healthcare by people in the community?

1. Yes [ ]
2. No [ ]

Q26. If your answer to question 25 is Yes, please give reasons for your answer?

……..

Q27. Do you think users of your health facility have sufficient information about the services you provide?

1. Very high [ ]
2. High [ ]
3. Moderate [ ]
4. Low [ ]
5. Very Low [ ]

Q28. How would you rate the attitudes doctors and nurses and patients have towards patients (For example do they treat them with courtesy and respect)?

1. Excellent [ ]
2. Very Good [ ]
3. Good [ ]
4. Average [ ]
5. Low [ ]
6. Very Low [ ]

Service Delivery

Q29. How would you rate the services provided by the clinic?

1. Excellent [ ]
2. Very Good [ ]
3. Good [ ]
4. Fairly Good [ ]
5. Poor [ ]
6. Very Poor [ ]

Q30. What factors do you think impede people from accessing quality health care in Mandevu?.....

……..

THANK YOU FOR YOUR COOPERATION

APPENDIX III: INTERVIEW GUIDE - HEALTH FACILITY IN-CHARGE

UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND POST GRADUATE STUDIES
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

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Dear Respondents,

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You have been selected as a respondent for this study. Kindly spare a few minutes to respond to this Interview. Be assured that your responses shall be treated with strict confidentiality as this research is purely academic and will be used to write the dissertation. Honest and sincere answers will be highly appreciated.

INTERVIEW GUIDE: HEALTH FACILITY IN-CHARGE

1. What is your position?.....

2. How many medical staff does your clinic have?.....

3. What services does your clinic provide?

……
……

4. what challenges does your clinic face in providing quality health care?.....
.....
.....
.....
infrastructure, funding, Medical supply, motivation in terms of pay)

5. what is your view on the levels of motivation among health personnel?.....

6. Do you think that affects quality of service provision?.....

7. What Challenges do you think your users face when it comes to accessing quality health services?.....
.....
(Information, distance, attitudes of health personnel, economic barriers)

8. What is the level of utilisation of your health facility?.....

APPENDIX IV

INTERVIEW GUIDE :INTERVIEW GUIDE-KEY INFORMANT

UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH AND POST GRADUATE STUDIES
MASTER OF PUBLIC ADMINISTRATION PROGRAMME

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You have been selected as a respondent for this study. Kindly spare a few minutes to respond to this interview. Be assured that your responses shall be treated with strict confidentiality as this research is purely academic and will be used to write the dissertation. Honest and sincere answers will be highly appreciated.

INTERVIEW GUIDE: KEY INORMANT

1. What are some of the problems faced by public health facilities in high density areas in providing quality health care?

2. What is the role of the government in providing quality healthcare?

3. Are you familiar with the administration and management of public health facilities?

4. How does the administration and management of Public Health facilities affect the provision of quality healthcare?

5. Do the conditions of services of the health staff affect the provision of quality healthcare?

6. How can these be improved?

7. Are health staffs properly motivated?

8. How can the government improve the institutional support to improve the health sector in Zambia? (Healthcare Financing, Political will…..)

Any documents that you can avail to me to enhance my study