AN EVALUATION OF THE RESTRUCTURING OF THE MINISTRY OF HEALTH: A CASE STUDY OF KABWE DISTRICT (2006-2011)

BY

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A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL FULFILMENT OF THE REQUIREMENT OF THE DEGREE OF MASTER OF PUBLIC ADMINISTRATION

LUSAKA

2015

DECLARATION

I, Stella Sibeso Mulima, 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.

Signature: _____

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CERTIFICATION OF APPROVAL

This dissertation of Stella Sibeso Mulima has been approved as partial fulfilment of the requirement for the award of the Degree of Master of Public Administration by the University of Zambia.

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ABSTRACT

The provision of quality health services has always been a cornerstone of the Zambian health care system. In this vain, the Government of the Republic of Zambia (GRZ) made a policy decision to restructure the Ministry of Health(MOH) in 2006.This dissertation discusses whether the 2006 restructuring of the Ministry of Health(MOH) has led to improved service delivery with particular focus on Kabwe District from 2006-2011.

The general objective of the study was to evaluate the 2006 restructuring of the MOH in Kabwe district. The specific objectives of the study were; To assess the quality of health services provided by the MOH after the 2006 restructuring, To assess the extent to which the community participates in decision making concerning health service provision at the local level; To establish the constraints faced by health providers in the provision of health services and To identify the challenges faced by the service users in accessing health services.

The research design used was a case study**.** Both qualitative and quantitative techniques were used. The researcher used both primary and secondary data. Primary data was collected from key informants through interviews using interview guides and from members of the public and health workers by using a questionnaire with open and closed ended questions. Secondary data was collected through document reviews. The study used a sample size of 190 respondents comprising of 70 health workers, 94 service users and 26 key informants.

The two provincial hospitals and one rural health centre were selected purposively, the other four health facilities from which the sample of health workers was drawn was selected by using systematic random sampling.The proportional method was used to select respondents from the rural and urban health facilities. The service users were selected randomly from among those accessing the health facilities as out- patients.

The study found out that the 2006 restructuring of the MOH has led to an improvement in the quality of health service delivery in terms of drug availability, nursing care and the positive perception of both service users and health workers on the quality of services offered. However, other indicators of quality of care still do not fare well such as shortage of health personnel and long waiting time. The study also revealed that community participation in decision making is minimal in nearly all health centers and non existent in hospitals. Challenges faced by service users included long waiting time, accessibility to health facilities and poor attitude of health workers in some instances whilst health workers main constraints were; low staffing levels, lack of transport, inadequate medical equipment and infrastructure.

The researcher recommends that: Hospitals form advisory committees so as to enhance community participation and improve service delivery.Facilities to research further on the root causes of long waiting time so as to improve service delivery. Government to invest in: infrastructure, equipment, transport and deploy more health workers to the facilities.

To George Mulima, my late Father, who has been an inspiration in my life.

ACKNOWLEDGEMENTS

I am deeply indebted to my supervisor, Dr. L. C. W. Kaela, for his untiring guidance to ensure that this dissertation is completed. My gratitude also goes to my work colleague, Mr Kennedy Mwape, for his invaluable assistance in data collection.

My thanks also go to my family, for their moral and financial support.

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LIST OF ABBREVIATIONS AND ACRONYMS

CBOH	Central Board of Health
DHIS	District Health Information System
DHMT	District Health Management Teams
DMO	District Medical Office
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HRMO	Human Resource Management Officer
HMIS	Health Management Information System
KMC	Kabwe Municipal Council
LHP	Lunsemfwa Hydro Power
MOH	Ministry of Health
NHA	National Health Act
NGO	Non Governmental Organisation
PMO	Provincial Medical Office
PRSP	Public Service Reform Programme.
RTI	Respiratory Tract Infection
TB	Tuberculosis
UTH	University Teaching Hospital
USAID	United States Agency for International Development
WHO	World Health Organization
ZESCO	Zambia Electricity Supply Corporation
ZCCM-IH	Zambia Consolidated Copper Mines-Investment Holding

CHAPTER ONE

INTRODUCTION

1.1Background

The provision of quality health services has been the bedrock of successive governments in Zambia. However, owing to the economic downturn in the second republic, the state of quality health care was compromised. The change of government in 1991 saw the country embarking on a number of policies to improve public sector performance. Among the programmes which were initiated were the Public Sector Reform programs. (PSRP). According to GRZ (2001) The PRSP had three cardinal objectives, namely:

I. To improve the Government capacity to formulate, analyze and implement national policies and perform its appropriate functions.
II. To effectively manage public expenditure to meet fiscal stabilization objectives.
III. To make the public service more efficient and responsive to the needs of the country's population.

The Government of the Republic of Zambia (GRZ), therefore, initiated the PRSP to make the public sector more viable and hence offer quality services. However, the successful implementation of the programme required a strategic implementation plan and critical path for all the implementation processes and programmes.

In order to make the Ministry of Health (MOH) more responsive, efficient and offer quality services, a similar, but separate program, was initiated referred to as health sector reforms. The health reforms were introduced during the period 1991 to 1998.The main elements of these reforms were decentralization of key management responsibilities to distribute financial and health resources. According to MOH (2006), the underlying principle of these reforms was decentralization of health service delivery through the delegation of key responsibilities from the centre to the district and hospital levels. Decentralization also aimed at shifting resources from

the centre to operational levels where healthcare was conducted. The importance of community participation in the management of health services and the need for a well-motivated and remunerated work force was equally emphasized.

In the process of implementing the reforms, the Central Board of Health (CBoH) and Health Management Boards were created, as executing agencies of the Ministry in 1995. During this period, MOH retained the functions of policy making, strategic planning, resource mobilisation and monitoring of the sector. "The CBOH took on the operational functions of the Ministry which then assumed the responsibility for general policy, regulation and norm setting." Bossert et.al (2003:358)

Owing to this division of responsibilities, the organization of service delivery in the Ministry of Health was tiered into five levels. The national level was managed by the CBOH with the guidance of policies formulated by MOH. Referral hospitals, for instance, University Teaching Hospital (UTH) were also included at this level. On the other hand, the district level comprised, District Board of Health and District Health Management Teams. The community participated through Health Care Advisory Committees. Thus, the clinics and health centers reported to both the District Health Management teams and District Health Boards respectively. District Hospitals were managed by Hospital Management Teams and hence reported dually to the District Management Teams and also directly to CBOH.

However, despite the reforms having been implemented successfully and Zambia being viewed as a mirror of decentralization in Africa, the CBOH was abolished in 2006, owing to a number of factors.

The Ministry of Health was not willing to give up the health workers to the CBOH for fear of staff shortages country wide. The WHO (2005) purports that, "The Ministry of Health feared losing workers if they did not find the terms of the linkage favorable-a major cause of concern in a country with significant Human Resource for Health shortages".

The duplication of responsibilities was also another impeding factor. This was because the CBOH and the MOH could both recruit and discharge workers, thereby leading to a dual status

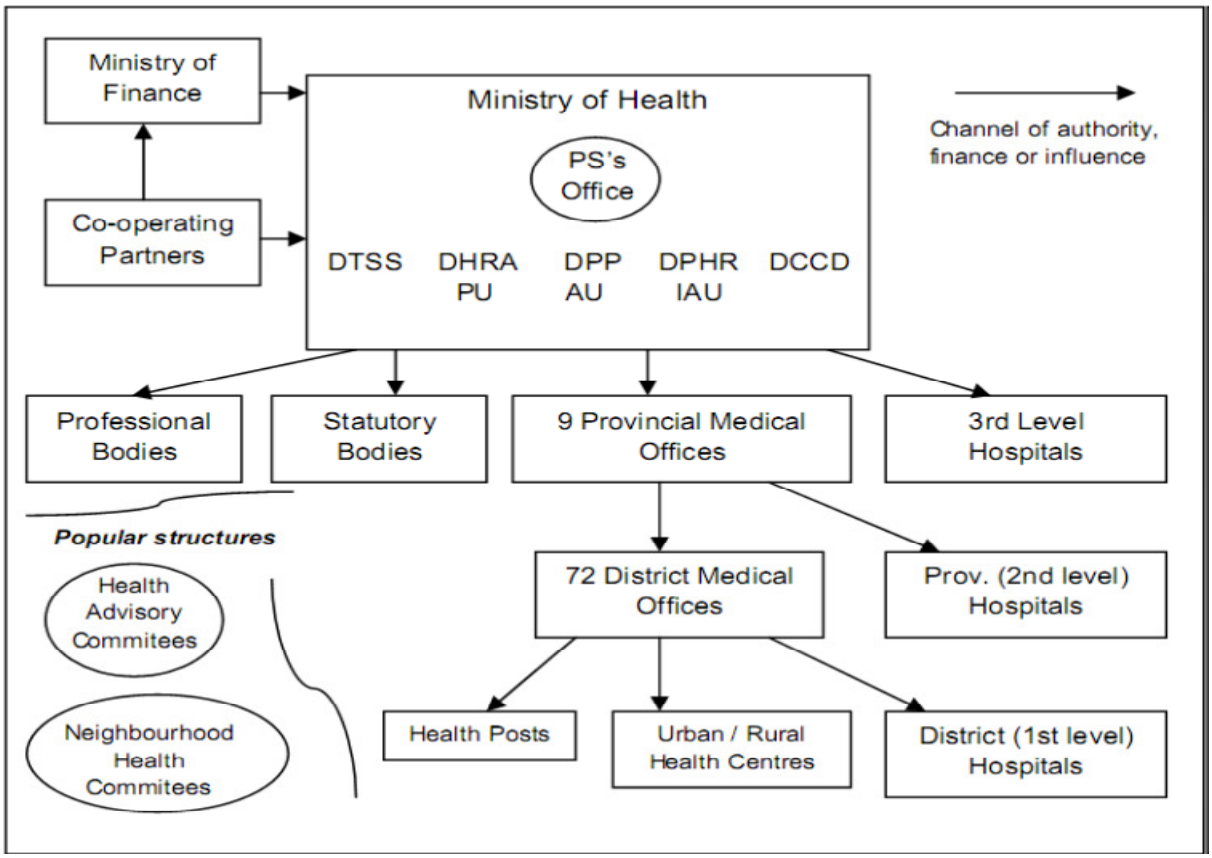
of responsibilities and high expenditure. According to the MOH (2006), The Ministry was faced with significant challenges, which included duplication of functions between MOH-HQ and CBoH, failure to implement de-linkage of staff from Public Service to the Health Boards, and an overall bloated and costly central level structure.

The MOH (2006) further states "… the Government made a policy decision to restructure the health sector by repealing the National Health Services Act cap 315 of 1995 to facilitate the merger of the MOH-HQ and CBoH functions at the center and dissolution of the hospital and district management boards, and the introduction of a new organizational structure for the health sector in order to bring the much needed improvements to service delivery".

The objectives of the restructuring were in line with public service reform programme (PSRP) embarked on earlier by Government in 1991. According to the 2006 strategic plan for the Ministry of Health, where the restructuring process was based, the major objective of restructuring was to ensure efficient and effective organization and management of health service delivery at all levels, providing clearly defined roles, responsibilities and appropriate authority to contribute to the improved delivery of cost effective and quality health services.MOH (2006).

The new structure aimed at having an equitable distribution of skilled health workers across the country to facilitate the efficient delivery of health services to the people of Zambia, as close to the family as possible. The organizational structure was redefined as shown in figure 1.1. Job descriptions and specifications for all positions in the new structure were developed. An internal recruitment and person-to-post matching exercise to fill, appoint and place people in the posts in the approved structure was equally initiated and is still in progress. Training on the performance management package was equally rolled out so as to manage a decentralized performance management system. The Ministry of Health was also expected to devolve primary health care activities to the local authorities in line with the decentralization policy.

Figure 1.1 Organisation Structure of MOH after 2006 restructuring.



Source: MOH (2006)

In order to ensure continued community participation in the management of health services, advisory committees were reintroduced. According to Campbell and Caffery (2009) Advisory Committees were created to replace the boards and public accountability of health institutions at the local level. However, for the community to be involved in health issues or activities, they require knowledge or an understanding of the activities that they are expected to participate in.T

The current Zambian health system is organized in a referral flow system similar to the overall administrative system in the country. Health service delivery is through several health posts, health centers, district hospitals, provincial hospitals and Tertiary hospitals such as UTH. The link between the head quarters and the lower levels of health care is facilitated by the Provincial Medical Office.

1.2 Statement of the problem

The restructuring of the Ministry of Health was carried out in conformity with the Public Service Reform Programme (PSRP) which aims at creating a cost-effective and efficient Public Service capable of delivering quality service to the Public. However, since the restructuring programme was initiated, the quality of health service delivery in the Ministry of health has continued to be a major concern by the majority of stakeholders. As MOH (2010) says," the main objective for the health sector was to "ensure equity of access to cost-effective, quality health services, as close to the family as possible"… However, even though significant progress was reported, service delivery also continued to experience major constraints and challenges, which negatively affected performance". It is against this backdrop, that this study sought to evaluate the 2006 restructuring of the Ministry of Health and in so doing find out whether it had achieved its objectives in Kabwe District.

1.3 Objectives of the study

1.3.1 Main objective of the study

The main objective of the study was to evaluate the 2006 structural changes in the Ministry of Health on service delivery.

1.3.2 Specific objectives

The specific objectives of the study were;

1. To assess the quality of health services by MOH after the 2006 restructuring.

2. To assess the extent to which the community participates in decision making concerning health service provision at the local level.

3. To establish the constraints faced by health workers in the provision of health services.

4. To identify the challenges faced by the service users in accessing health services

1.4 Significance of the study.

The study will be useful to researchers, planners and policy makers in the Ministry of Health. It shall also provide insights in the development of strategies that would improve the performance of health personnel in the sector. It will also provide relevant literature on the subject.

1.5 Scope of the study

The study was restricted to Kabwe district only. Kabwe district is centrally located in central province of Zambia, with a population of diverse background. Hence, the extent to which the findings may be generalized is limited.

1.6 Limitations of the study

- Some key respondents were not willing to be interviewed and demanded to be paid.
- Only two respondents from MOH were available.

This, therefore, could have affected some of the outcomes.

1.7 Conceptual Framework

Health Sector Reforms are seen collectively as a policy action in policy analysis. Walt (1994) defines policy as, "a set of interrelated decisions taken by political actors or groups of actors concerning social goals and the means of achieving them". Anderson (1975) defines policy as "a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of social concern". By policy analysis one seeks to find out how policies are made, who the actors are, and whether a policy has achieved its objectives, and should be maintained or replaced. Thus, in general terms, health sector reforms can be defined as policy creation or change that affects health care delivery in a given setting.

The conceptual framework which guided this study was based on the assumption that the restructuring of the Ministry of Health was implemented within the policy framework of the Ministry of health of which strategies included recruitment and placement, Decentralization, Financing, Performance management, regulation and community participation as shown in Figure1.2. A proper combination of all these elements must, therefore, work together to maximize quality health service delivery. For instance, if the rightful people are recruited and

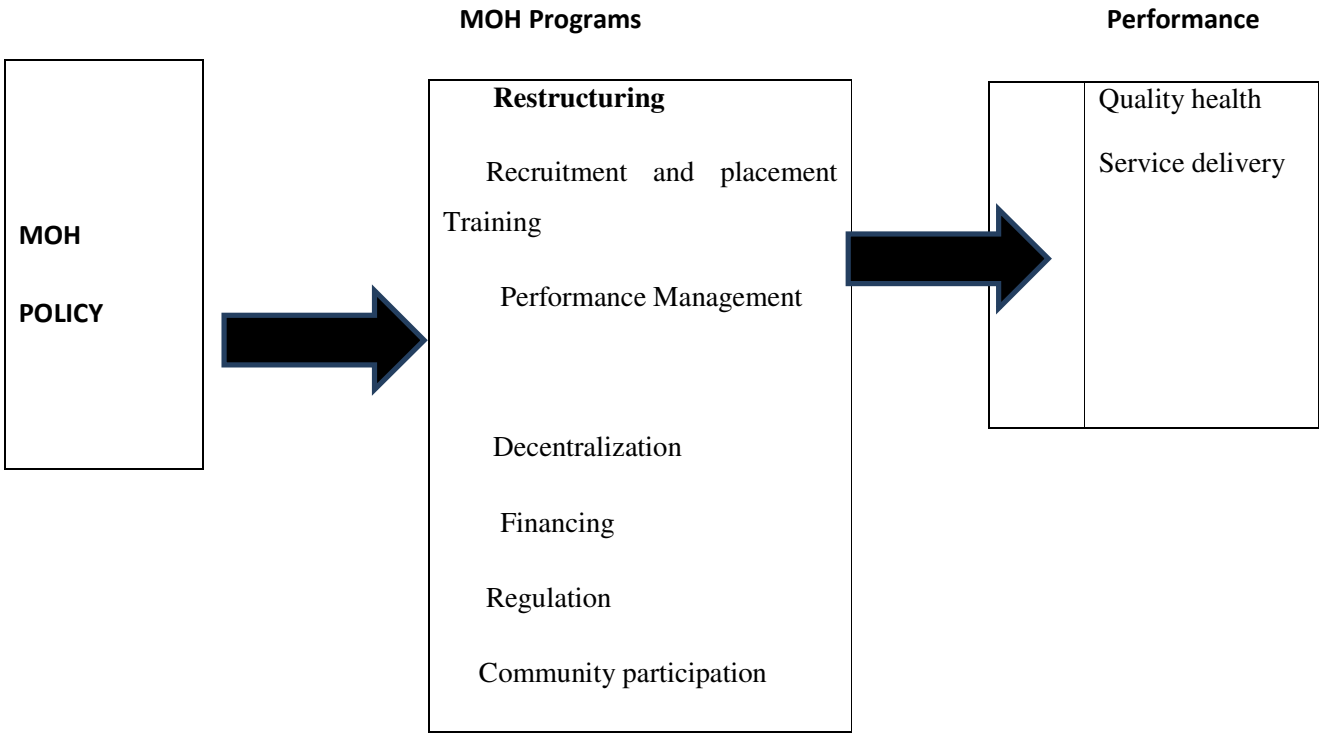
placed in the right positions, then quality service delivery should be expected. Therefore, the successful implementation of these functions would enable a health system achieve its objectives and therefore, respond to the community's demands. The probable outcome would hence lead to desired outcomes which among other things include quality health service delivery.

Quality health care is multi dimensional and can be defined from different perspectives. According to Roemer and Montoya (1988), Quality health care consists of the proper performance according to standards of interventions that are known to be safe, affordable and acceptable to the society in question and that have the ability to produce an impact on mortality, morbidity, disability and nutrition.

Thus in relation to the Zambian policy, quality of health care would include affordability, accessibility, acceptability, effectiveness and equity among many others. The institute of medicine (2006) further defines quality of health care as "the degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

In relation to this study, the government initiated management and organizational changes in the health sector so as to correct the poor service delivery in the health sector. The achievement of the objectives of the restructuring process would hence include incorporating the strategies of the restructuring program thereby providing quality health service delivery as shown in figure 2.
However, in order to assess the effectiveness of the program therefore, the aspect of challenges faced by both service users and providers need to be put into consideration. WHO (2000) defines effectiveness both from a provider and client perspective saying "this implies that users receive effective, safe and timely assistance; from a client perspective, quality refers to care received under appropriate physical and ethical conditions. Hence, the challenges faced by both service users and service providers would assist in determining whether the strategies employed in the MOH policy of restructuring are yielding desired results.

Figure 1.2: Conceptual Framework-Restructuring for Improved Service Delivery.



Source: Author 2013

As shown in figure 2, in order for the restructuring programme to achieve the desired results of improved service delivery, there is need for proper implementation of all the restructuring strategies as explained below;

1.7.1 Financing There is need to have a proper financing system in place for any health system to function effectively. Health financing refers to the methods used to mobilize the resources that support basic health programs, provide access to basic health services and configure health service delivery systems. Schieber and Akiko (1997).

WHO (2007) further adds that health infrastructure, medicines and health technology are dependent on finances and hence vital in the provision of comprehensive and quality health services. Hence, a good performance of a health system is dependent on access to essential medicines and supplies. Availability of medicines among many others has been cited as the most

cardinal element of quality health by care consumers and the absence of medicines is a determinant factor in the underuse of government health services. According to the MOH (2006) "the quality, efficiency and effectiveness of health service delivery are, to a large extent, determined by the availability of appropriate staff, infrastructure and equipment, essential drugs and medical supplies".

Therefore, health financing is a key factor of the health systems performance in terms of efficiency, equity and quality. Various health sector reform programs are involved in strengthening health financing systems by mobilizing resources, advocating how resources should be allocated and configuring health service delivery.

1.7.2 Regulation refers to the use of coercive efforts by the state to alter the behavior of actors in the health system, including providers, organizations and patients. This equally applies to those who provide, finance health care, produce inputs like pharmaceuticals and those who educate health professionals .According to Laffont and Tirole (1993), "regulation is often more effective when appropriate incentives and efforts to influence individual behavior complement regulatory initiatives". For instance regulations aimed at improving the quality of health services can, if successful, lead to improved health outcomes and increased public satisfaction. In the health sector, therefore, governments use regulations to establish the obligations and responsibilities of service users and health providers to ensure service delivery is offered at the optimal level.

1.7.3 Recruitment and Placement: The human resource function is cardinal if any health system is to achieve its objectives effectively. This is because, depending on the environment, human resources have the potential to either carry out their duties effectively or not. As Adam and Hirschfeld (1998) noted, people working in health services are not exclusively instruments for delivering necessary health care, but are strategic actors who can modify the governments' projects, such as trying to impede budget cuts, which they present as a strategy to protect the quality of services, or blocking a more equal deployment of resources, which becomes an obstacle to achieving a more equitable access to care".

This assertion is also supported by Price (2000:26) who contends that, "deployment, equitable distribution and utilization of appropriate staff to match the organizations strategies remain

important aspects of human resources". Hence, a well distributed, deployed and utilized health worker will lead to an achievement of desired objectives, thereby improving service delivery.

The recruitment process and procedures require coordination across many different government agencies and between different levels within the organisation. For instance, in Zambia the process involves communication through many different channels within the MOH, negotiating annual Personal Emolument (PE) budgets with the Ministry of Finance, verifying vacancies and once the MOH receives Treasury and Public Service Management Division (PSMD) authority to recruit, the MOH can advertise to fill the funded and approved positions. The advertised positions are matched to specific vacancies or locations. PSMD is responsible for maintaining the establishment for each line ministry. The MOH decides how the allocation will be made and decides the skills mix and cadres of health workers to be recruited. Job descriptions are then developed for all the positions in the new structure and approved by PSMD.

1.7.4 Performance Management: The WHO (2006) defines performance as, "a combination of staff being available, competent, productive and responsive"**.** Therefore in order to have desired results in the health sector there is need to put in place effective performance management systems. This is because poor performance of health workers might lead to inappropriate care which would hence contribute to reduced health outcomes**.** Franco et.al assets that health sector reforms need to address the performance of health workers due to its labour intensive nature.
According to Martinez (2001) Performance management consists of the following activities: job descriptions, supervision, performance appraisals, continuous education, rewards and career development. Thus, in this vain, if fully implemented, managers would be able to track the performance of their staff and hence attend to performance gaps.
Kolehmainen and Aitken, (2004) further add that Managers must be able to assess the quality and productivity of their staff; they must be able to supervise and motivate their staff, ensure appropriate tools and resources, and identify performance gaps and address these.
Special attention equally needs to be paid to training, as it might be a solution to addressing performance gaps.

1.7.5 Decentralization: Decentralization involves the transfer of responsibilities from a central government to lower levels of government or autonomous or semi-autonomous organizations (Rondinelli et al. 1983). In this instance, health reformers recommend decentralization largely to increase health sector performance. There are basically there types of decentralization: deconcentration, devolution and delegation.

Bossert and Bowser (2000) further adds that the major objectives of decentralization in relation to the health sector are: increase service delivery effectiveness through adaptation to local conditions and targeting to local needs, improve efficiency of resource utilization by incorporating local preferences into determination of service mix and expenditures. Increase cost-consciousness and efficiency of service production through closer links between resource allocation and utilization, increase health worker motivation through local supervision and involvement of service users in oversight, performance assessment, improve accountability, transparency, and legitimacy by embedding health service delivery in local administrative systems, increase citizen participation in health service delivery by creating systems and procedures for involvement in planning, allocation, oversight, and evaluation, increase equity of service delivery by enabling marginalized and poor groups to access health care providers and to influence decisions on service mix and expenditures.
Thus decentralization, if properly adhered to, enhances participation and, therefore, might be a recipe for improved health service delivery.

1.7.6 Community Participation: The sustainability of health reforms is usually associated with community participation. Community participation in health, therefore, is a process where people express their right to be active in the development of appropriate health services. According to Bulushi and West (2005), Community participation is defined as "encouraging and helping public, private and community sectors take part in the identification and analysis of local health problems, decision making process and preparation of the health plans of action facilitated by MOH".Community participation can be viewed both as an input in the process of health production, by providing a mechanism for information and needs to be channeled to health officials, and as a mechanism to hold those same health officials accountable for performance. This, therefore, entails that involving the community in health service provision will lead to

accountability in decision making, use of scarce resources efficiently and development of mechanisms for proper feedback. However, the extent of community participation depends upon the existence of institutions and mechanisms that give citizens a voice in the decision-making process.

In relation to this study, the government restructured the health sector so as to correct the poor service delivery in the health sector. The achievement of the objectives of the restructuring process would, hence, include incorporating all the elements mentioned in the conceptual framework.

This study, therefore, was based on the premise that the policy reforms in the health sector were aimed at improving service delivery at all levels of health care and as close to the family as possible. As Bossert (1998) noted, we often expect health reforms to produce improvements in equity, efficiency, quality and financial soundness of health systems.

1.8 Literature Review

1.8.1 Introduction

This section reviews literature on related studies to the topic under investigation. There is quite a substantial number of studies done related to the topic. However, the literature did not provide all the knowledge that society needed to fill the existing gap, hence necessitating the need for the research. The literature reviewed looked at how health reforms were embarked on in Africa and other parts of the world, including lessons learnt from each of the cases.

According to WHO (2007) a health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health improving activities.

Basically, any health system should aim at offering quality health services which include taking the community on board. However, if the above objectives of health reforms are to be attained and improve health service delivery, there is need to have in place adequate financial and human resources, a well-functioning health information system, sufficient infrastructure and medical

supplies among many others. WHO (2007:3) asserts that, "to achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organized".

Cassels (1995) in his paper "Health Sector Reforms: key issues in less developed countries" discussed the need for less developed countries to analyze carefully the political, economic and constitutional reforms so as to assess the potential and need for health reforms. His paper also analyzed the institutional or structural changes needed to adequately deal with the problems of the health sector. His work also provided insights to this study in that he provided guidance on how reforms should be defined in relation to existing policies, institutions, structures and systems and also how to deal with issues of efficiency, access, cost containment and responsiveness to community demands.

1.8.2 Health Reforms in Africa

Kiriga et.al (2009) carried out a research on monitoring and evaluation of health sector reforms in the WHO East African region. Their study focused on a comprehensive analytical framework for assessing Health Sector Reforms and demonstrated the use of the analysis framework using cost recovery mechanisms, as a case study in the WHO region. Their study showed that monitoring and evaluation of health sector reforms are necessary for assessing the achievements of objectives and in so doing provide necessary feedback. As health sector reforms do not take place in a vacuum, analysis of the context and design should, therefore, provide clear and detailed descriptions of key issues driving the reform, who are the main actors and what their mandates are. Indicators of the aspect assessed should include equity, quality efficiency and sustainability. In relation to this study, Kiriga's work provided a lot of guidance as it provided the criteria to consider when evaluating health reforms.

A study was carried out by Bossert and Berman (2000) on how health sector reforms performed in developing countries such as China, Chile, Columbia and Zambia. Their study research concentrated on the effective implementation of health reforms and what made some countries not to implement the reforms to the expected levels. They found out that equity problems were

significant in all the countries and that Health sector reforms required several conditions that are difficult to achieve such as, major political opportunity for change, sound leadership and stability in government. In addition to the afore said, it was found out that reformers did not focus on the outcomes such as, the improvements in health, equity, financial protection and patients' satisfaction that reform program are supposed to accomplish. This study, however, is different but cardinal to this one, as it did not focus on improvements in service delivery and community participation. Furthermore, the study was conducted when Zambia had just initiated the decentralization reforms.

A study on the health reforms and the quality of Health care in Zambia was also conducted by Macwan'gi et.al (1999). Their study focused on the implementation process of the health reforms and their impact on the quality of care. Their study revealed that studies on quality of health care need to take into account the various aspects of care, type of facility and different settings within which the health facilities are situated. Perceptions on quality of care also differed between the urban and rural populace. Among the challenges noted included; lack of sufficient drugs at health centers, long waiting time for patients to be attended and poor communication between health providers and clients. Accessibility to the health centers was also another challenge and community participation was also limited in that they were not involved in the planning and delivery of basic health care. Macwa'ngi et al's study looked at health reforms in terms of quality of service and users satisfaction and explains the challenges faced by service users, hence making it quite similar to this study. However, it was conducted at the time when the central board of health was still operational.

A study on the impact of health reforms was also conducted by Moomba (2006).Her master's thesis focused on access to health services and facilities in Lusaka and Kafue districts. One of the objectives in the study on community participation was equally used in this study to measure the extent of community participation in decision making of health service delivery. Moomba's study was relevant to this work in that, it was possible to compare how community participation was integrated before the implementation of the 2006 health reforms.

Chongo and Milimo carried out a study commissioned by the Ministry of Health systems research unit and the health reforms implementation team (HRIT). The focus of the study was on the decentralization aspect of the reforms with emphasis on the structural changes of the public

health system in Zambia and how the various organs of the new structure function in terms of their responsibilities and linkages that exist between them. This study was cardinal to this study as it looked at the nature and historical context of health reforms and elaborates the roles played by the different organs of the health system. However, the study was conducted at the time when health reforms were in their infancy in Zambia and did not focus on the quality of service delivered.

Seshamani et.al (2002) in their book *Zambia's Health Reforms: Selected Papers 1995-2000* covered a wide range of aspects of health reforms. The factors covered in this book include topics on National health Accounts, Health seeking behavior, Health care providers and Health care financing. The papers were extremely important to this study, as they provided insights into the major elements and the implementation process of the health reforms, despite their focus being at the time when the Central Board of Health was still operational.

The various studies done in Zambia have not really focused on aspect of improvement in health service delivery as a result of the 2006 restructuring of the Ministry of health. Furthermore, the role of the community in decision making has not been fully exhausted and there is still a knowledge gap as most studies did not encompass the community as players in the health service delivery chain. In addition, there is insufficient information on the challenges faced by both service users and providers. This, hence, justified the carrying out of this study.

South Africa, just like Zambia, also initiated a number of reforms to address identified crisis in the health sector and henceforth improve service delivery. In a recent paper, Schaag et.al (2011) looked at reforms holistically. They discussed the South African health reforms in the context of appropriateness, potential synergies, sequencing, potential gaps and risks. They revealed that, from the delivery point of view, the reforms appeared to be disjointed, lacking cohesion and operating as a collection of vertical policy spots without consistent or uniform direction. In addition, the challenges to access included distance to facilities, deficiencies in stewardship, leadership and management of different aspects of the health system and inadequate recognition of health human resources. The quality improvements put in place were seen as positive and responding to the needs of the service users. The study provided a lot of insights to this probe.

However, it is quite different in that the reforms were analyzed in the context of linkages between available health policies and the methodology which was used was that of document reviews and interviews with key informers to illicit information. Apart from that, the study was conducted at the national level and hence did not trickle down to facility level.

Martineau and Buchanan (2000) carried a comparative study in Zambia, Russia and the United Kingdom on the Human resources and the success of Health sector Reform. They found out that Health sector reforms usually neglected human resources, a key factor in the successful development of any reform and that, restructuring always has insinuations for the numbers and types of staff. From all the three countries the common challenge was lack of capacity to ensure that human resources is comprehensive and integrated with service delivery and strategies to develop human resources as important components of health reforms. They concluded that for reform to be successful, human resource should be regarded as a critical success factor and capacity building to support human resource changes should be put in place. As the overlying assumption for restructuring the health sector aims at enhancing performance, the study is very cardinal to studies concerned with the analysis of health sector reforms in that lessons can be drawn on how to incorporate and motivate the workforce. However, their study only focused on reforms in the context of human resources and did not put other stakeholders such as service users into consideration.

Kenya is yet another country where successive health reforms have been initiated so as to fulfill the fundamental right of provision of good health to its citizens. The goal of the health sector reforms was to promote and improve the health status of all Kenyans through restructuring of the health sector and hence make all health services effective, accessible and affordable. Osaya and Rifkin (2003) conducted a research on the Health Sector Reforms in Kenya with emphasis on district level planning. Their study revealed that the 1994 health reforms of Kenya emphasized outcomes, instead of processes and hence have not achieved the government's goal of improving health and ensuring equity for the citizens of the country. In addition to the afore said, it was also found that, poor management and lack of stewardship of resources, lack of adequate infrastructure was responsible for the health crisis in the country. Whilst the health policy sought to promote and improve the health status of all citizens, the neo liberal approach, and market orientation of the health system have made the path to making good health for all a myth. As a

result, the policy formulation and implementation were found to be wide apart, as the increasing health disparities among the poor. They contend that restructuring should not only be a question of better management but more importantly adequate resources to ensure quality and continuity of service provision under new management structures. This research, however, did not emphasize on service delivery at facility level as a result of restructuring, nor did it consider community participation in the provision of health services. Furthermore, the population of the study was confined to key informers only.

Jeppson and Okuonzi (2000) equally carried out a study on vertical or holistic decentralization of the health sector with experiences drawn from Zambia and Uganda. They argued that Health Sector Reforms and decentralization are instruments to improve health services but should not be regarded as ultimate objectives in service delivery. They further contend that the reforms were likely to be sustainable in Uganda than in Zambia. This is because the reforms in Uganda were rooted in wider political and administrative structures of the government. Nevertheless the reforms in Zambia at the time were seen to be effective innovations that could enhance management of health services, even though the linkage between the reforms and development objectives were not feasible. In addition, it was noted that both countries had applied a push, rather than a pull, system of services which was more favorable to the health professionals than the service users. They revealed that health sector improvement is expected in the form of increased utilization of health services, better access to health services, more coverage of the population with basic services and better quality of health care. However, the implementation of the reforms at the time did not bring improvement in people's quality of life during the period under review. Access to basic health had also declined especially in Zambia where both aspects of quality were declining. Thus, Jeppson and Okuonzi's study analyzed the impact of reforms in light of efficiency. Therefore, a lot of insights were drawn from the study, as the focus was similar to this study. Though resourceful, the study was conducted at the time when Zambia had embarked on the first phase of the restructuring process. In addition the methodology used was a desk research and the population only consisted of key informants.

Ghana introduced health sector reforms in the 1980s because of worsening economic conditions and the inability to sustain recurrent government expenditure to provide free health care to its population. The health sector reforms were part of broader structural adjustment programmes

under the guidance of The World Bank and the International Monetary Fund. These macroeconomic policies, embedded in neoliberal ideology, aimed mainly at reducing government spending to address budgetary deficits, introducing cost recovery mechanisms through user fees and liberalizing health services to allow private sector involvement.

The reforms had a profound impact on the financing and organization of the health sector. The liberalization of the health sector led to a rapid increase in the number of private health providers, many of them informal and unregistered. In general, these health sector reforms undermined the potential for cross-subsidies in the overall health system and resulted in increased inequalities in access and utilization of health services. By the end of the 1990s, public resources for the health sector had declined sharply and health system funding relied heavily on cost recovery policies and voluntary health insurance. Following the re-introduction of user fees, the utilization of health services decreased significantly in Ghana, particularly among people of low incomes. As well as the decline in utilization, user fees were also associated with delays in seeking treatment and increased reliance on self-medication.

Willis and Khan (2009) conducted a study on the nature and impact of health reforms in Latin America and Africa. The context of the study was on the impact of the reforms on health providers, service users and community participation. Their research revealed that there were notable similarities in the reform policies and processes in the two continents. Community participation in health service decisions was effective through the set up of consultative mechanisms where community members were able to participate in the development of health initiatives. For instance, in Senegal, community involvement was found to be centered on health committees which were given authority to gather and use resources to improve the quality of health care in facilities. obstacles in the implementation of reforms included: opposition by health personnel, lack of qualified personnel to implement reform, inadequate financial resources and the inability of management committees to ensure efficient management of health centers. However, the reforms in the two continents were not fully conducted within a discourse of promoting equity and participation which is a prerequisite for nearly all health reforms in developing countries. In assessing the impacts of health sector reforms, a variety of elements therefore need to be considered such as how reforms have influenced provider and user behavior,

patterns of service provision and whether these have improved services by extending health coverage and raising quality. This study provided a gap to this research in that it was a desk research and did not focus on the impact of the reforms on service delivery. However, it provided useful insights on how health reforms impact on both service users and health providers.

Health reforms were introduced in Argentina during the 1990s. However, in 2001 the country was plunged into economic and political turmoil and hence putting a heavy strain on the health sector reforms. These were applied at the same time as wider neo liberal and social reforms. The health system in Argentina comprises the public sector, social insurance funds and private health care. Elements considered in the health sector reforms included: decentralization, separation of provision and financing, more reliance on market forces and reform of social insurance funds. In order to have smooth implementation of the reforms, the Government of Argentina, therefore, introduced competition into the health insurance sector, whilst cutting employer contributions to social insurance and insisting a minimum package of services.

Lloyd Sherlock (2005) carried out a study on the impact of Health reforms in Argentina. His analysis was that the reforms were fairly superficial, increasing the overall fragmentation and complexity of the health sector whilst failing to improve regulation or accountability. The research further suggests that assumptions about market mechanisms did not put issues of regulation into consideration but viewed the health sector in terms of separate components and overlooked cross cutting problems. Countries like Zambia, can learn a lot of positive lessons from this study, by introducing health insurance for all citizens.

Health Sector reforms have also been carried out in Newfoundland. Jelesenski et.al (2003) carried out a research on the impact of restructuring on acute care hospitals in Newfoundland and Labrador. The study evaluated the impact during and after restructuring in areas such as level of acuity, appropriateness of hospital stay and efficiency of acute care, bed use human resource, health care provider perceptions, quality of care and patient satisfaction. The study basically focused on reforms in the light of organizational changes to ensure technical efficiency through improvements in productivity and quality. The study highlighted that accessibility of acute and

long term care beds were a challenge, health workers were demotivated, whilst integration of administrative and support functions did not match with the level of clinical integration. Jelinski et.al 'study gives an indication that Health Sector Reforms can lead to high levels of costs and higher human resource expectations which can lead to demotivation of staff.

Bulushi and West (2005) carried out a study on health reforms and community involvement in Oman. Their study revealed that the MOH in Oman instigated several initiatives to involve communities in health service provision with the objective of enabling people to: have increased control over their health, improve their health and to ensure cost-effectiveness of health services. The study established that decentralization of planning, management and budgeting within Oman's health system was one of the most important factors in achieving community involvement in health. They assert that for future sustainability, communities should share responsibility in decision making in health initiatives and programs concerning their health. Involving the people in making decisions encourages them to take greater responsibility for their own health promotion and health care. They further assert that a sense of ownership is felt and it leads to more commitment and acceptance to the health services and programs through MOH. Their study further highlighted the need to educate the public and give the effective information in health education if community participation is to be effective and limit participation.

A lot of insights were drawn from this study, as Oman seems to have made remarkable achievement in engaging the community in decision making. They have shown that community involvement and participation is vital to sustain health systems' reforms.

1.8.3 Conclusion

The literature review shows that studies done on Health Reforms are quite substantial. However, few concentrated on structural reforms in terms of service delivery and community participation in decision making but on accessibility, equity and sustainability. In addition, there is insufficient information on the challenges faced by both service users and providers This, therefore, justifies the carrying out of further research on the 2006 restructuring of MOH in Kabwe district.

1.8.4 Lessons learnt

A critic of the reviewed cases shows that the result of Health Sector Reforms follows a similar pattern, whether in high or low-income countries. Initially, there is usually a strong enthusiasm about Health Sector Reforms in all countries. But the positive attitude is typically not matched with the actual results of the reforms. In addition, the health sector reforms seem to have solved management problems but without improving the health sector objectives and in the process created new problems. The ultimate benchmarks to assess the results of the Health Sector Reforms should be the health sector objectives of: equity, efficiency, quality and financial protection.

In relation to community participation in decision making, the available literature has shown that community participation is still multi-faceted and hence more still needs to be done in order to enhance it.

1.9 Methodology

1.9.1 Research Design

The research design which was employed in this study was a case study**.** Both qualitative and quantitative techniques were used. The researcher used both primary and secondary data. Primary data was collected from key informants through interviews using interview schedules and from members of the public and health workers by using a questionnaire with open and closed ended questions. Secondary data was collected through document reviews.

1.9.2 Sample Size

The study used a sample size of 190 respondents. This comprised seventy (70) health workers, ninety four (94) service users and twenty six (26) key informants, as shown in table 1.1

Table 1.1: List of key informants

Institution	Number
Ministry of Health	2
General Nursing council	1
Health professional council of Zambia	1
Provincial Medical office	2
District Medical Office	2
Facility Administrators	7
Health Advisory Committee Members	10
Resident Medicals Association	1
Total	26

The seventy (70) health workers were distributed as follows: forty four (44) nurses, fifteen(15) Clinical officers and eleven(11) Doctors. The list of facilities maintained at the PMO was used as a sampling frame for the health facilities.

1.9.3 Sampling procedure

There are thirty two (32) public health facilities in Kabwe. This includes the two second level hospitals: Kabwe General Hospital (KGH) the provincial hospital, and Kabwe Mine hospital (KMH), Twenty (20) urban health centers, 1 rural health center and six (6) health posts.

The proportional method was used to select respondents from the rural and urban health facilities. Proportional sampling is a method of sampling in which the investigator divides a finite population into subpopulations and then applies random sampling techniques to each subpopulation.

The two provincial hospitals and one rural health center were selected purposively, the other four health facilities from which the sample of health workers was drawn was selected by using systematic random sampling. This method involves arranging the target population to the required standard and then selecting every nth element at regular intervals. The total distribution of health workers was: 44 nurses, 11doctors and 15 clinical officers as shown in table 1. 2.

Table 1. 2. Distributional Framework for Health workers

Cadre	Total
Doctors	11
Nurses	44
Clinical officers	15
Total	70

The doctors at the DMO were selected purposively, whilst other health workers were selected from health facilities using systematic random sampling. The establishment registers for the health facilities were used as sampling frames. The process of selecting the sample involved the following: staff registers from the facilities were acquired beforehand; three numbered lists of Doctors, Clinical Officers and nurses were developed from the staff establishment. Those who were on leave or not working in the station were removed from the list. The ones available were numbered and the nth number was picked and selected for the sample. The list of facilities maintained at the PMO was used as a sampling frame for selecting the facilities.

The service users were selected randomly from among those accessing the health facilities as out- patients. These were distributed as follows: 16 for each hospital and 12 for each of the selected heath centers making a total of 94.

1.9.4 Demographic characteristics of respondents

The demographic characteristics of respondents for this study which include health users and health workers are shown by age, sex and marital status in Table 1.3 and 1.4 respectively.

The majority of the health worker respondents were female (50) of which 39 were married, 6 single, 4 widowed and 1 divorced. The total number of Males under this category was 20 of which 19 were married and one was single.

Table 1. 3: Demographic characteristics of health workers by sex, age and marital status

Age (Years)	**Male**					**Female**				
Range	No.	Single	married	Divorced	widowed	No.	Single	married	Divorced	widowed
20-24	0					1	1			
25-29	1	1				19	2	17		
30-34	10		10			9	1	8		
35-39	5		5			14	2	9		3
40-44	1		1			1				1
45-49	2		2			3		3		
50-54	1		1			2		1	1	
55-59	0					1		1		
60+	0					0				
Total	20					50				

Source: Field Data

As shown in Table 1.4, more than half of the service users (65) were female of which a larger proportion were married (39), 18 single, 3 Divorced and 5 Widowed. The male respondents were 29 of which, 24 were married while 5 were single.

Table 1. 4: Demographic characteristics of health users by sex, age and marital status

Age (Years)	**Male**					**Female**				
Range	No	Single	married	Divorced	widowed	No	Single	married	Divorced	widowed
20-24	3	2	1			15	5	10		
25-29	4	2	2			10	4	6		
30-34	6		6			9	2	6		1
35-39	7		7			19	7	10	2	
40-44	4		4			6		3	1	2
45-49	3		3			3		2		1
50-54	2	1	1			1		1		
55-59	0					1				1
60+	0					1		1		
Total	29					65				

Source: Field data

1.9.5 Methods for Data Collection

Primary data was collected from respondents during field research, while secondary data was collected through document reviews. The researcher used open and closed ended questionnaires to illicit responses from the health workers and service users. Data from key informants was collected using in -depth interview guides. Secondary data was collected through document reviews. The documents that were consulted included: Bless and Achola, (1983). Fundamentals of Social Research Methods. Lusaka. Cassels. A (1995): Health Sector Reform: Key Issues in Less Developed Countries, Journal of International Development. Ministry of Health (2006.): National health strategic plan 2006–2010: Towards attainment of the Millennium Development Goals and National Health Priorities. Government of the Republic of Zambia, Lusaka, Zambia. Ministry of Health (2006): Restructuring Report for the Ministry of Health, Lusaka, Zambia. World Health Organization (2000): Health Systems: Improving performance. The World Health Report 2000. Geneva.

1.9.6 Data Analysis

Statistical data was analyzed using Statistical Package for Social Sciences (SPSS) and presented as percentages, tables, and graphs. Descriptive data was analyzed through the thematic approach where it was categorized, tabulated and arranged under themes and sub-themes.

1.10 Chapter Outline

Chapter one consists of the introduction of the dissertation. Chapter two discusses the context of restructuring the Ministry of Health in Kabwe district. It also discusses the demographic and economic factors of the district. Chapter three discusses the quality of health service delivery after the 2006 restructuring of MOH. Chapter four discusses the extent to which the community participates in decision making concerning health service provision at the local level. Chapter five highlights the constraints faced by health workers and challenges faced by service users. Chapter six discusses the conclusions of the study. It also gives recommendations on how health service delivery can be improved in the district.

CHAPTER TWO

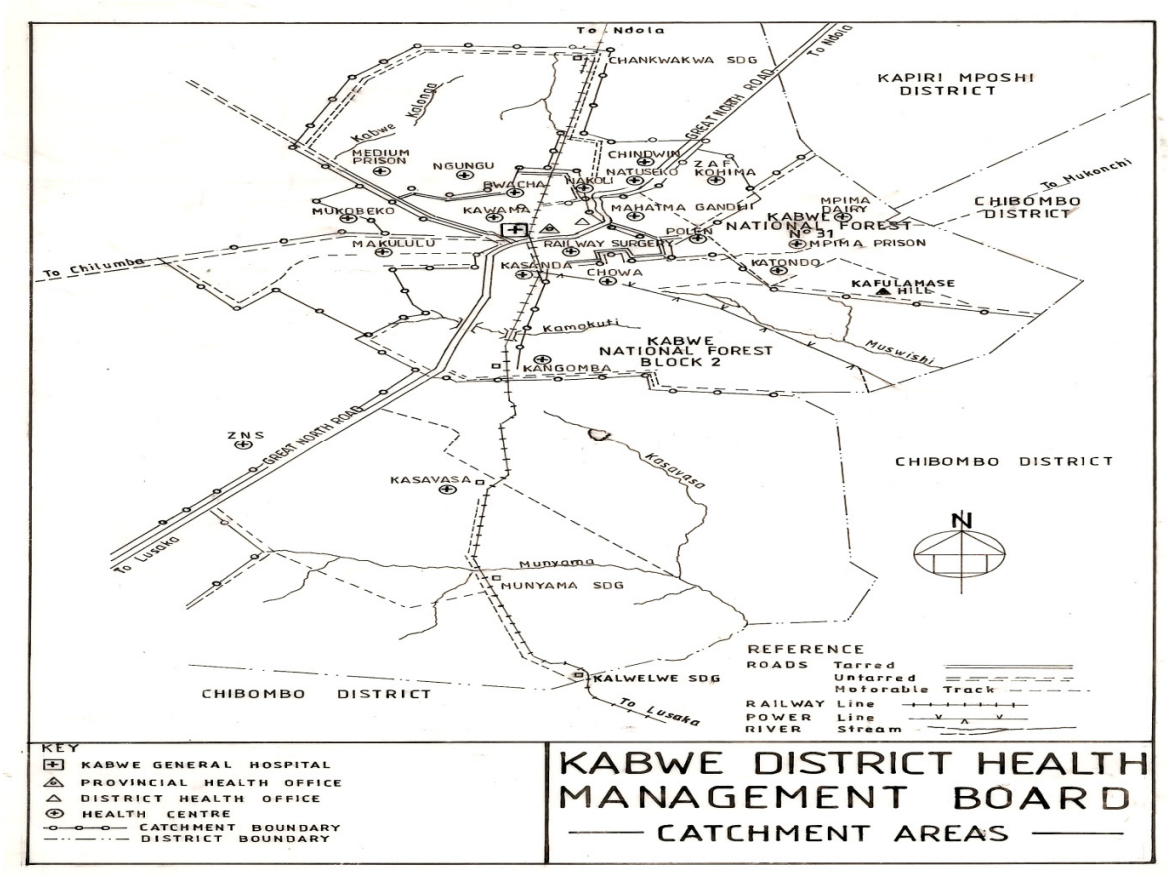
SOCIO-ECONOMIC PROFILE OF KABWE DISTRICT

2.1 Introduction

This chapter sets out to discuss the restructuring of the Ministry of health in relation to Kabwe District and also gives a profile of Kabwe. The chapter discusses the socio- economic profile of Kabwe highlighting the population and literacy levels, economic activities among many others.

2.2 Profile of Kabwe District

Map 2. 1: Kabwe District and surrounding areas.



Source: KDMO

Kabwe district which is 1,530 sq. km is the provincial capital of Central Province of Zambia. Geographically it is in the Centre of Zambia. It lies about 139KM north of Lusaka, the capital of Zambia, on the main national trunk road (the Great North Road) linking Lusaka to the Copperbelt Province. It is located on latitude 14o 27' South and longitude 28o 27' East. Central Province has ten (10) districts namely, Chibombo, Kabwe, Kapiri, Mkushi, Mumbwa, Itezhi Itezhi, Serenje chisamba Ngabwe,chitambo and Luano. The total population of Central Province is estimated at 1,267,803, of which 202,360 (15.5%) accounts for Kabwe district. 51.2% of the projected population are female and 48.8% are male. The average growth rate for the district was 1.4% being the least of all districts in central province. Kabwe is the most densely populated district in the province with a population density of 128.7 persons per square kilometer. The district has fourteen Peri-urban areas or unplanned settlements. These mainly occupy intervening spaces left underdeveloped because of being unsuitable for development, such as poorly drained areas. The population growth follows two patterns; Through densification and extension and Internal migration from high cost and medium cost residential areas towards low cost and Peri-urban areas. The number of households is estimated to 47,796. (CSO 2010)

Kabwe District has two (2) constituencies namely Bwacha and Kabwe Central.Makululu compound the biggest unplanned settlement in Zambia and central Africa as a whole is found in Kabwe. Other high densely populated areas include Katondo,Nakoli,Bwacha,Ngungu and Chimanimani compounds.

The town was formerly known as the broken Hill and was founded when the Broken Hill lead and zinc deposits were discovered in 1902.The famous skull Broken Hillman from which the town later derived its name was also discovered in the area in 1921.

Table: 2.1 Summary of Statistical Information of Kabwe District, Zambia.

No	Parameter/Variable	Aspect
1.	Population	**202,360**
2.	Political Wards	**27**
3.	Constituencies	**2**
4	Total number of households	**39,862**

Source CSO (2010)

2.2.1 Language and ethnicity

According to the (CSO Analytic report 2012) Bemba is the widely used language of communication spoken by 33.5% in Zambia. To this effect, Kabwe District is no exception as the high proportion of the population use Bemba as a medium of communication. Other languages in the district include;Tonga,Lenje,Ila,Kaonde,Chewa,Lozi,Nsenga,Mambwe,Ngoni and Lamba. However, lala is the largest ethnic group followed by Tonga and Bemba.

2.2.2 Tourism

Kabwe District has a well undeveloped tourist potential which is advantaged by its central location and close proximity to Lusaka, such as Lukanga Swamps, 50 km west, with a wildlife area (currently a Game Management Area) on the other side of the Kafue River, 120 km from Kabwe. Other tourists' attractions include, Mulungushi Dam, Chifunkunya Hills, Lunsemfwa Wonder Gorge, and the Luangwa Rift Valley. The valleys are very scenic wilderness with good wildlife potential. .(Mankapi 2001)

Other historical sites include Big Tree National Monument: a fig tree with a 50 m wide canopy on the east side of Broadway, which served as a meeting place on many occasions during the early years of the town's history. Bwacha House National Monument: Number E1376 Musuku Road, Bwacha Township, where on 8 March 1958 Kenneth Kaunda was elected President of the Zambian African National Congress and the Mulungushi Rock of Authority.

In 1921 a human fossil (a skull) called Broken Hill Man or Rhodesian man (classified as Homo Rhodesiensis or Homo Heidelbergensis) was found in the town.

2.2.3 Education

Educational opportunities in Kabwe are diverse. Government, mission and private schools exist in Kabwe District. The district, through the Ministry of Education, is striving to achieve Universal Primary Education by 2015 as stated in the millennium goals. The district has made progress towards achieving Universal Primary Education by implementing education reforms aimed at revamping the educational sector. One such reform is the Free Basic Education Policy

(FBE) which was introduced in 2002.The district has 107 learning institutions as shown in Table 2.2.

Table 2.2: Number of schools by category, Kabwe District, Zambia.

No	Category of school	Number of schools
1	Government Primary schools	37
2	Community schools	28
3	Private schools	21
4	Secondary schools	12
5	Grant aided secondary schools	3
6	Private colleges	2
7	Skills center	1
8	College of education	1
9	Trades Centre	1
	Total	**107**

Source: Zambia Annual school census. (2012)

Kabwe district also boasts of two public Universities: Mulungushi University and Nkrumah University. The National Fire Fighting Services Training School is also found in Kabwe. It is hoped that with the increase in both secondary and tertiary institutions, the literacy levels for the district shall improve in the near future.

As of 2012 the District had a total of 65,558 pupils, 2,572 teachers and 1,098 number of classrooms broken down as shown in Table 2.3.

Table 2.3: Number of Pupil/Teacher and Classes by category of School, Kabwe District, Zambia.

No	Category of school	Number of pupils		Number of teachers		Number of classrooms
		Boys	Girls	Male	Female	
1	Primary	19,997	20,548	481	946	474
2	Community	4,701	4,699	114	125	134
3	Private	1,542	1365	84	57	159
4	Secondary School	6,265	6461	346	432	231
TOTALS		**32,485**	**33,073**	**1,025**	**1,560**	**1,098**
Grand Total		**65,558**		**2,572**		**1,098**

Source: Zambia Annual School Census (2012)

2.2.3.1 Examination performance

The District Scoped the third position in 2012 for grade 7 at National level and first position at provincial level as shown in table 2.4. (Zambia Annual school census,2012)

Table 2.4: Examination performance - 2012 Kabwe District, Zambia.

Grade	Pass rate2010	Pass Rate 2011	Pass Rate 2012
7	**100%**	**100%**	**100%**
9	**69%**	**56%**	**48%**
12	**69%**	**67%**	**71%**

Source: Zambia Annual school census. (2012)

2.2.4 Formal and Informal Business

The closure of the Kabwe Division of Zambian Consolidated Copper Mine (ZCCM) in 1996 and the Zambia China Mulungushi Textiles in 2007 resulting in retrenchments led to high levels of unemployment and social dislocation in the district. This was made worse by massive retrenchments in Zambia Railways Limited which was then the fore runner to Railway Systems of Zambia (RSZ). As a result, the town has been characterized as the 'Ghost Town'. The environmental damage in the after math of the closure of the mines was the main factor of Kabwe being labeled as the most highly lead polluted town in the world.(Mankapi 2001) To this effect, ZCCM-IH with funding from the World Bank embarked on an environmental program 'Keep Kabwe Green' and Decontamination Project. However, a number of new industries have been established; such as Fine Steel, Zalco, Chiman Manufacturing Ltd and Ferro-Alloy and Super Deal.

A small section of the population in the district is in formal employment, while the majority is in the informal sector. A survey by GKN Consult (2000) shows that in Kabwe, with the exception of the Peri-urban areas, wage employment is the most important source of income of urban areas for male household members. 46.4% of all adult male household members are employed (a steady job) whilst in Peri-urban areas it is at 26.2%.. (KMC strategic Plan 2011)

In the formal sector, the major employers are the public service and parastatals like Zambia Electricity Supply Corporation (ZESCO), and private companies like Railway Systems of Zambia (RSZ), Sable ZINC, Shoprite Checkers, Zambeef, Kabwe Industrial Fabrics, National Breweries, Lunsemfwa Hydro Power (LHP) Zambia State Insurance (ZSIC) and various banks, as well as various commercial and retail outlets. With the current economic boom the country is experiencing, it is hoped that Kabwe will attract some more investors.

2.2.5 Agriculture

Following the closure of mining and manufacturing companies that were operating in the district, agriculture has become part of the main economic activity in Kabwe. Historically, small scale agriculture has dominated the agriculture sector in terms of production levels, especially for maize production. Agricultural activities in the district are more concentrated at subsistence

level. However, this is compensated by the town's close proximity to major farming towns such as Mkushi,Kapiri Mposhi and Serenje.

2.2.6 Water Supply Management

Production of water in Kabwe generally is a challenge. A number of water points in form of boreholes are being done in a bid to improve access to clean and safe water across the district. In addition there is also dam construction and rehabilitation in the whole district. The status of water supply in Kabwe district is as given in Table 2.5.

Table 2.5: Percentage of Water supply within the township, Kabwe district, Zambia.

No.	Type of Connection	Number of connections	Expected population	% served
1	House/ Yard Connection	8537	51222	21%
2	Communal Taps	22	11000	5%
3	Public Taps	126	22680	10%
4	Hand Pumps	*	2700	1%
5	Hand Dug Wells	*	104699	44%
6	Kiosks	30	45000	19%
	Total	**8715**	**237301**	**100%**

Source: Lukanga Water and Sewerage Co. Ltd 2010

The majority of the population (44%) depends on hand dug wells for their water supply. It should be noted that hand dug wells are also used by the population which also uses taps. This is to reduce the cost of water bills from Lukanga Water and Sewage Company, the major water utility company in the district.

2.2.7 Central Government

At Provincial level, there is a Provincial Minister responsible for political affairs. Administratively, the Province is headed by the Permanent Secretary, who is the most Senior Civil Servant in the Province while District Commissioners are in charge of the districts. With a total of six districts, Central Province has six (6) District Commissioners.

2.2.7.1 Local Government – Local Authorities, Constituencies and Wards

Kabwe district, the Provincial Administrative Capita of central province, is the only district with a Municipal Council headed by the Town Clerk. The other districts are headed by Council Secretaries as chief executives

2.2.8 Transport and Communication

The District has a good railway and road network system. The Lusaka –Copperbelt (TAZARA) railway line passes through the town and it also lies on the Great North Road. The districts' central location is good for inter-regional trade, commerce and industry.
The transport infrastructure sector in the district includes the Rural Roads Unit; the Road Development Agency and the Railway Systems of Zambia.

2.2.9 Waste Management

Lack of proper waste management and sanitation is a problem for many inhabitants of Kabwe. Comprehensive volumes of waste have been accumulated in the streets and burning of waste is common in open spaces and creates a lot of inconvenience for the inhabitants.

The contracting and execution of waste management is organized, monitored and controlled by a Waste Management Unit (WMU) which is within the public health unit in the KMC organization. (KMC strategic Plan 2011)

Legislation with respect to waste management includes the Local Government Act of 1991, Public Health Act of 1930, Mines and Minerals Act of 1995, National Health Services Act of 1996, and Ionizing Radiation Act of 1975 in Zambia.

The Waste Management Regulations Statutory Instrument No. 71 of 1993 controls the transportation of waste and management of waste disposal sites. Under these regulations any persons transporting waste or operating waste disposal sites including Local Authorities in Kabwe are required to obtain licenses and adhere to standards and conditions stipulated by ECZ.

2.2.9.1 Kabwe Municipal Council Waste Management By-Laws

In addressing policy issues in waste management, Kabwe Municipal Council has enacted Municipal Solid Waste Management By-laws. This By-law applies to the management of municipal solid waste generated in, imported into or transferred through the municipality of Kabwe and other waste which is managed together with or in the same facility as the municipal solid waste.

These By-laws binds all waste producers, waste managers, collectors, transporters and recyclers residing or conducting business in the town of Kabwe. It also has provisions for the municipal council for the purpose of performing its functions under these by-laws, engage waste managers for waste management Zones.

The By-laws empower the council to appoint waste managers to help in the management of solid waste. The waste managers are expected to operate in accordance with a license to transport waste issued by the Environmental Council of Zambia. However, the performance of these waste managers is yet to be assessed.

The types of solid waste generated include:

- Domestic waste which is generated as a result of daily activities in homes. This Waste comprises of paper, bottles, plastics and organic waste.
- Commercial waste which is generated from commercial activities and other related Premises and Industrial waste which is generated from industries such as KIFCO and
- Hazardous waste which is waste generated from mining operations and health Care facilities.

Most of the waste is disposed of indiscriminately in pits, open areas and by burning. Consequently, this has contributed to a number of problems such as blocking of storm drains, resulting into floods and the stagnant water, which become breeding grounds for mosquitoes.

Flooding in some areas such as Chowa has been attributed to refuse that had blocked the drains and eventually the main canal. (KMC strategic Plan 2011)

2.2.9.2 Solid Waste Dump Site

Kabwe has one authorized refuse dump site located about 7 Km from the CBD near Mukobeko Township. The Dump Site is in deplorable state and without proper infrastructure, equipment or management. However, there are no management interventions at the site as evidenced from uncontrolled dumping of waste, no warning signs and absence of signage and security. All the waste generated from industries and residential areas is disposed off by the owners.

2.3 Implementation of Health Reforms in Kabwe.

Before the 2006 restructuring, the organization of health service delivery in Kabwe was tiered into five levels. The national level was managed by the CBOH with the guidance of policies formulated by the Ministry of Health. On the other hand, the District level comprised of District Board of Health and District Health Management teams. The community participated through health care Advisory committees. The hospitals had health boards whilst the health centers community had neighborhood committees and all were functional. (Mudenda et.al 2008) Thus, the clinics and Health centers reported to both the District Health Management teams and District Health boards respectively. There was also only one second level hospital. This is because Kabwe General and Kabwe Mine Hospital operated as one hospital though with two different establishments but one overall head (Medical Superintendent).As there was no district hospital the hospital boards negotiated with the District board on how much of their grant the District should allocate to the Hospitals providing for the purchase of beds. The negotiations were limited within 20-40 percent of the board's operating grant.

However, after the 2006 restructuring, the organisation of the MOH was changed and the hospitals (Kabwe General and Kabwe Mine Hospitals) were also split into separate entities and operated independently. The establishment was redefined and Staff with rightful qualifications were recruited and placed into the rightful positions. Those without the rightful qualifications, but acting in positions which they did not qualify for, were equally relegated or put into rightful positions. This therefore, demotivated those who were in the boards as the emoluments they

enjoyed in the boards were no longer available. Therefore, there was a loss of qualified and experienced staff because of unattractive government salaries and conditions. In addition, some of the technocrats resisted the dissolution of boards fearing that they would not be reabsorbed into the new structures of the ministry or the civil service. The community Advisory committees were equally dissolved and new people were appointed so as to enhance community participation.

2.3.1 Provincial Medical Offices

The Provincial Medical office was referred to as the Provincial Medical Board before the restructuring was initiated. The Provincial Medical Offices are located in Kabwe as Kabwe is the provincial headquarters of Central province.

The Provincial Medical Office (PMO) in the service delivery chain performs the role of Coordination, Monitoring, Technical supportive supervision, Quality Assurance and Performance Management. The (PMO) is, therefore, the link between the centre and lower structures (districts, private sector, NGOs and other service providers).

The Provincial Medical Office headed by a provincial Medical Officer, is supposed to provide technical backstopping services in order to ensure that set standards, guidelines and protocols articulated at the Centre are adhered to. This is usually done through monitoring and evaluation for purposes of reporting on the provincial situation at the centre and providing feedback to the centre on areas affecting service delivery that might require strategic policy interventions. The Provincial Medical Office therefore provides performance assessment, technical support, quality assurance and monitoring and evaluating the management and delivery of health services by lower levels in the core areas of public health, clinical care, human resources management, planning and development and the management and implementation of health support systems.

The Provincial Medical Office comprises the following Units:-

Public Health Unit, Clinical Care Unit, Planning and Health Systems, Human Resource, Accounts, Audits, Procurement and Administration and Logistics as elaborated below.

2.3.2 Public Health Unit

The Unit is responsible for coordinating and ensuring the efficient and effective service delivery in the areas of:-Maternal and Child Health, Environmental Health and Sanitation,Communicable Diseases Control,Health Promotion and Education,Non-Communicable Diseases,Nutrition; and Epidemiological surveillance in the province to facilitate the collection, collation and analysis of medical and health data/statistics for onward submission to the Centre.(MOH 2006)

The unit is responsible for managing and overseeing efficient and effective service delivery with respect to Clinical Care and diagnostic services in the province through policy interpretation, technical backstopping and supervision to service delivery Units.

The Clinical Care Unit is headed by a Clinical Care expert who supervises the unit in the provision of technical support, guidance and backstopping in the area of clinical care and its associated components.

2.3.3 Planning Department

The unit is headed by a Principal Planner who coordinates planning and budgeting and build capacities at lower levels to plan and budget as well as develop and implement planning budgeting systems and financial management systems.

2.3.4 Human Resource Department

The unit is headed by a Senior Human Resource Management Officer who oversees and supervises human resource functions in the areas of staffing levels and human resource profiles in order to facilitate the design and implementation of appropriate interventions.

2.3.5 Accounts, Internal Audit, Procurement and Administration and Logistics Unit

These Units perform their individual support functions that facilitate the day to day management and running of the offices.

2.3.6 District Medical Office

The district is the focal point of service delivery where the service delivery units consist of, health Posts, health centres and 1st Level Hospitals and Neighborhood Health Committees. Prior to the restructuring, the District Medical Office was referred to as the District Management Office. It is at these points that activities relating to the providing of Preventive and Curative services in health are being implemented. It is headed by a District Medical Officer.(MOH 2006)

At district level, the functions relating to efficient and effective health service delivery include:

- Supervision of 1st Level Hospitals, rural health centres and health posts as they provide curative, preventive and promotive interventions in line with set standards and guidelines. This would be for purposes of effective policy implementation.
- Coordinating the preparation of action plans, progress reports, budgets and annual reports;
- Dissemination of guidelines, and general coordination at district level
- Needs Assessment and performance assessment of services provision in issues relating to public health, clinical care, human resource and health systems;
- Programme management; and
- Human resource planning, management and development (staffing and establishment, training and advisory functions on human resource needs in the district and its Constituents.

The District Medical Office is basically made up of the following Units:-

Public Health, Clinical Care, Planning and Health systems, Human Resources, Support Units such as Procurement, Accounts and Administration and Logistics.

2.3.7 Health Service Delivery Units

Kabwe District has 29 urban health centers, one rural health center, 6 health posts and 2 second level hospitals. In terms of referral cases, the Zambian health system requires that a case starts from a health center then referred to the district hospital and from there to a second level hospital

or provincial hospital and finally to the tertiary hospitals such as UTH. However, Kabwe District is an exception in that it has no district hospital but two second level hospitals. (MOH 2012)

Table 2.6: List of Health Facilities According to Levels, Kabwe District, Zambia.

Type/Level	**GRZ**	**Mission**	**Private**	**Total**
Hospitals(2ND Level)	2	**-**		2
Urban Health Centers	20	**-**	3	23
Rural Health center	1	-	-	1
Health Posts	6			6
Total	29	-	3	**32**

Source: MOH (2012).

Below is a brief description of the type of level of health care in Kabwe District.

- **Health Posts:** As shown in Table 2.6, there are six health posts in Kabwe. These basically are Intended to cater for populations of 500 households (3,500 people) in the rural areas and 1,000 households (7,000 people) in the urban areas, or to be established within 5-km. radius for sparsely populated areas.

- **Health Centers:** These facilities include urban health centers (UHC) which are intended to serve a catchment population of 30,000 to 50,000 people, and rural health centers (RHC) which service a catchment area of 29-km. radius or population of 10,000

- **2nd Level Hospitals:** There are two second level hospitals in Kabwe. i.e. Kabwe General and Kabwe Mine Hospital. Kabwe General Hospital is the provincial hospital for central province whilst Kabwe Mine is purely a second level hospital. General hospitals at provincial level and are intended to cater to a catchment area of 200,000 to 800,000

people, with services in internal medicine, general surgery, pediatrics, obstetrics and gynecology, dental, psychiatry and intensive care services. These hospitals are also intended to act as referral facilities for the 1st level institutions, including the provision of technical back-up and training functions.(Mudenda et.al 2008)

Each district is supposed to have a District Hospital but Kabwe is an exception in that it has two second level hospitals. Thus in terms of referrals the district purchases bed spaces from Kabwe General Hospital though it is not sustainable.

The community is supposed to play a major role through the Hospital Advisory Committees and Neighborhood Health Committees.

2.3.8 Top ten causes of Mortality (All Ages)

RTI Pneumonia, Cardio Vascular and TB were the major top ten causes of mortality for all ages in the District during the period 2009 to 2011. However, the number of cases have reduced compared to the past two years owing to interventions put across by the MOH. Table 2.7 shows a summary of the top ten causes of mortality in Kabwe district in the last three years.

Table 2.7: Top 10 Causes of Mortality (All ages)

No	2011		2010		2009	
	Disease	**Number dead**	**Disease**	**Number of death**	**Disease**	**Number of death**
		Total		**Total**		**Total**
1	RTI Pneumonia	65	TB	206	RTI Pneumonia	170
2	Cardio Vascular	58	RTI Pneumonia	148	Anaemia	106
3	TB	46	meningitis	125	Severe Malnutrition	93
4	Diarrhoea non bloody	30	Diarrhoea non bloody	122	meningitis	93
5	Trauma	27	Non Pnemonia	101	Cardial Vascular	69
6	Crtpotococcal meningitis	24	Severe Malnutrition	88	Diarrhoea non bloody	47
7	Anaemia	22	Malaria	87	Trauma	43
8	Severe Malnutrition	22	Anaemia	81	Malaria	36
9	Digestive System Non Infectious	14	Cardial Vascular	79	Pnemocystic Carinin Pnemonia	25
10	Neoplasm	11	Digestive System Non Infectious	56	Karposis Sarcoma	10

Source: HMIS (KDMO)

CHAPTER THREE

ASSESSMENT OF QUALITY OF HEALTH SERVICES AFTER THE 2006 RESTRUCTURING OF MOH.

3.1 Introduction

The vision of the Ministry of health is to provide Zambians with equity of access to cost effective, quality health care, as close to the family as possible. Therefore, the quality of care was considered as a litmus test of the 2006 restructuring of the Ministry of Health. Quality of care was studied with regard to the following aspects: waiting time, accessibility of the facility, quality of nursing care and availability of drugs.

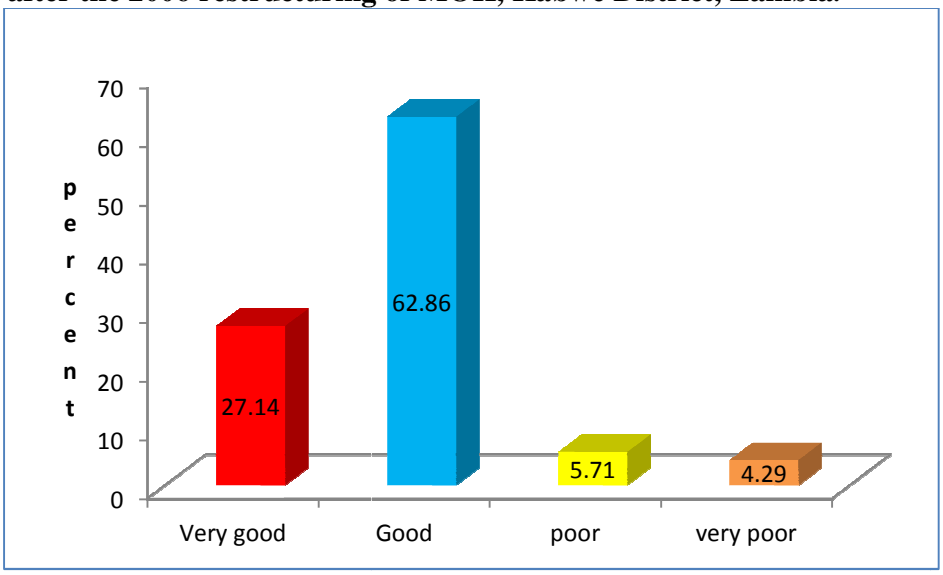
This chapter, therefore, presents the quality of health services in Kabwe district as a result of the 2006 restructuring of the Ministry of Health.

3.2 Assessment of Quality of Health Care

The provision of quality health services has always been a cornerstone of the Zambian health care system. Quality of care was measured using elements such as drug supplies, availability of equipment, and quality of nursing care among many others.

Health worker respondents were initially asked to rate the quality of health service delivery after the 2006 restructuring programme. The study revealed that 44 (63%) of the 70 health workers were of the view that the quality was good, 19 (27%) said it was very good, 4 (6%) of were of the view that the service was poor and only 3 (4%) said the health service was very poor as shown Figure 3.1.

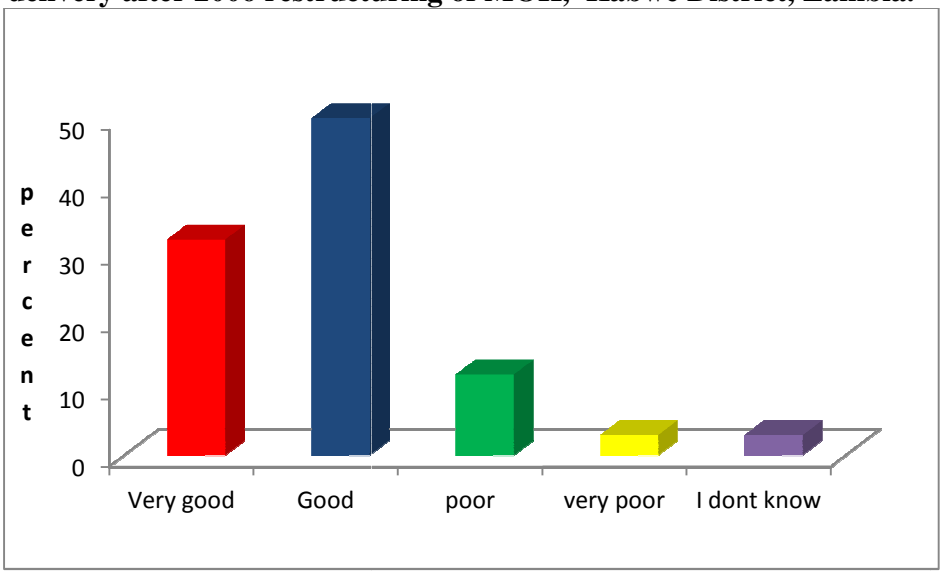
Figure 3.1: Health worker responses on the quality of service delivery after the 2006 restructuring of MOH, Kabwe District, Zambia.



Source: Field data.

Service users were equally asked a similar question on how they rated the quality of service after the 2006 restructuring of the MOH. Among the 94 respondents interviewed, 47 (50%), said it was good, while 11 (12%) and 3 (3%) said it was poor and very poor respectively. Hence a conclusion that service users are of the view that service delivery has improved could be drawn.

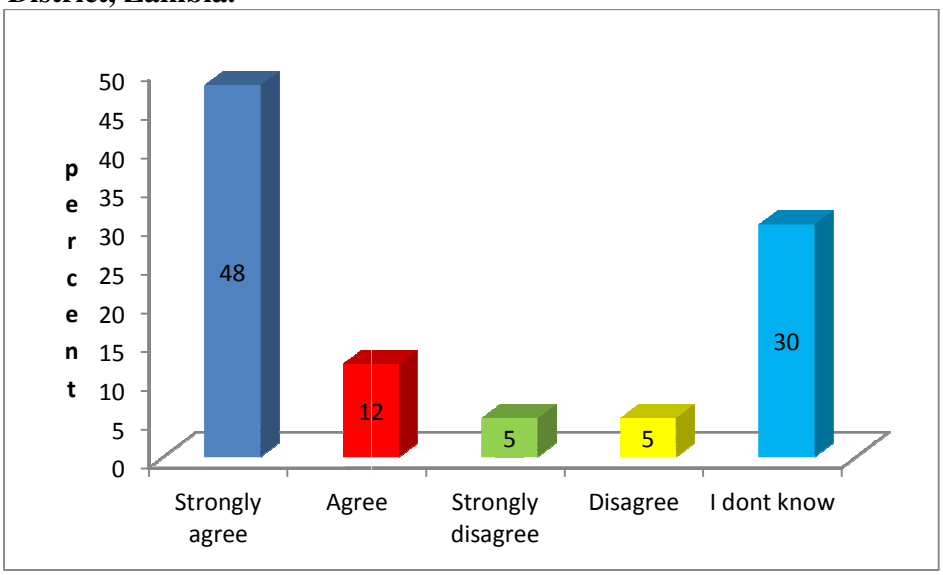
Figure 3.2: Responses by service users on the quality of health service delivery after 2006 restructuring of MOH, Kabwe District, Zambia.



Source: field data.

Service users were equally asked whether private health facilities provided better services compared to public health facilities. It was found out that 45 (47.9%) of the 94 respondents strongly agreed with the assertion, 11 (11.7%) agreed, 5 (5.3%) strongly disagreed and 28 (29.8%) preferred not to give their views as shown in Figure 3.3.

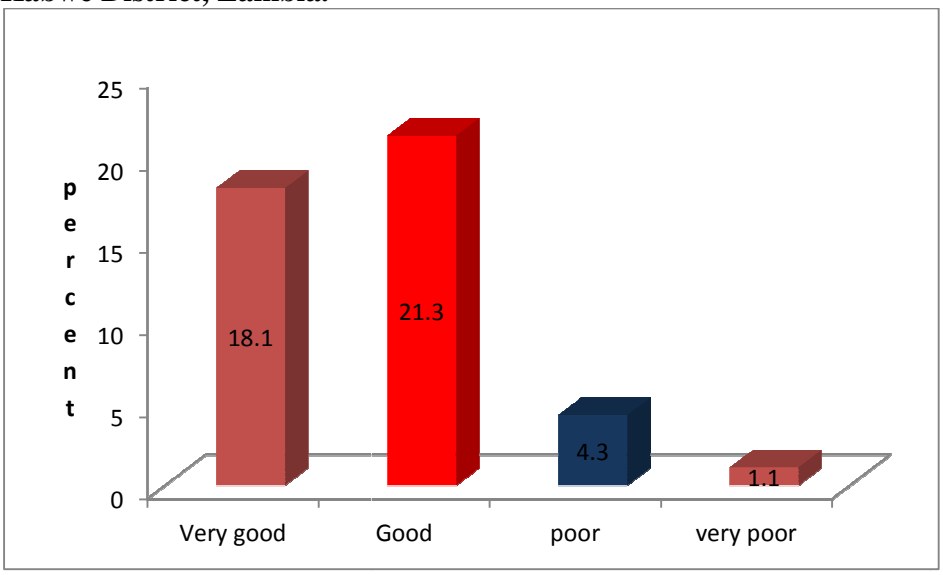
Figure 3.3: Responses by service users whether private health facilities offer better services than public health facilities. Kabwe District, Zambia.



Source: field data.

Apart from that, service user respondents who had once been admitted before in the health facility were asked on the quality of nursing care. Among the 94 respondents interviewed, 51 said that they had never been admitted whilst 43 indicated that they had once been admitted. Among the 43 admitted, 18 % revealed that the nursing care was very good, 21% said it was good, 4.3% said it was poor whilst 1% said it was very bad. This, therefore, indicates that according to the service users, the levels of nursing care are of high standard. Figure 3.4 shows the perception of service users on the quality of nursing care in Kabwe district.

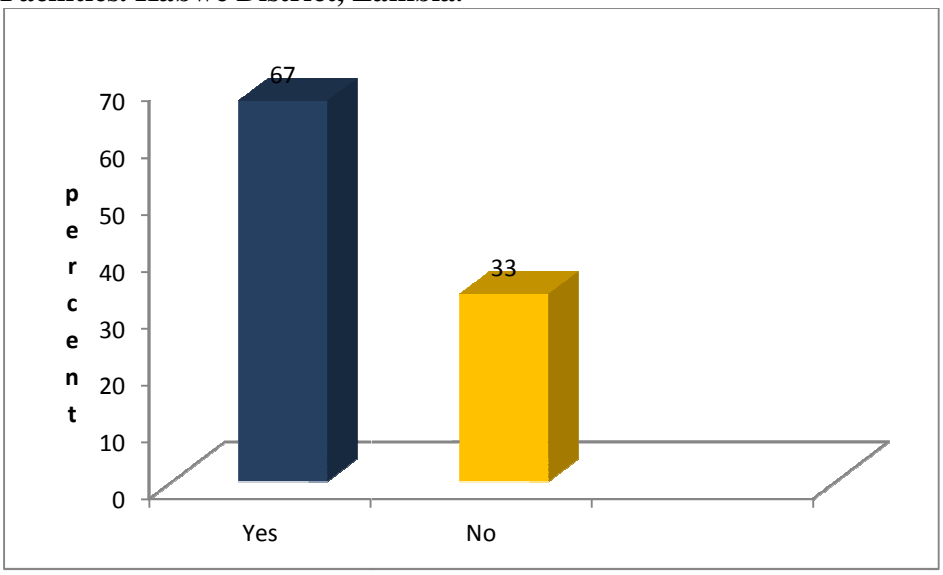
Figure 3.4: Admitted service user responses on quality of nursing care. Kabwe District, Zambia.



Source: field data.

To ascertain the drug availability in health facilities, health worker respondents were asked if their facilities had adequate supplies of drugs. The majority, 47 (67%), noted that the facilities had adequate stocks of drugs, whilst 23 (33%) indicted that they did not have adequate drug supplies as shown in Figure 3.5.

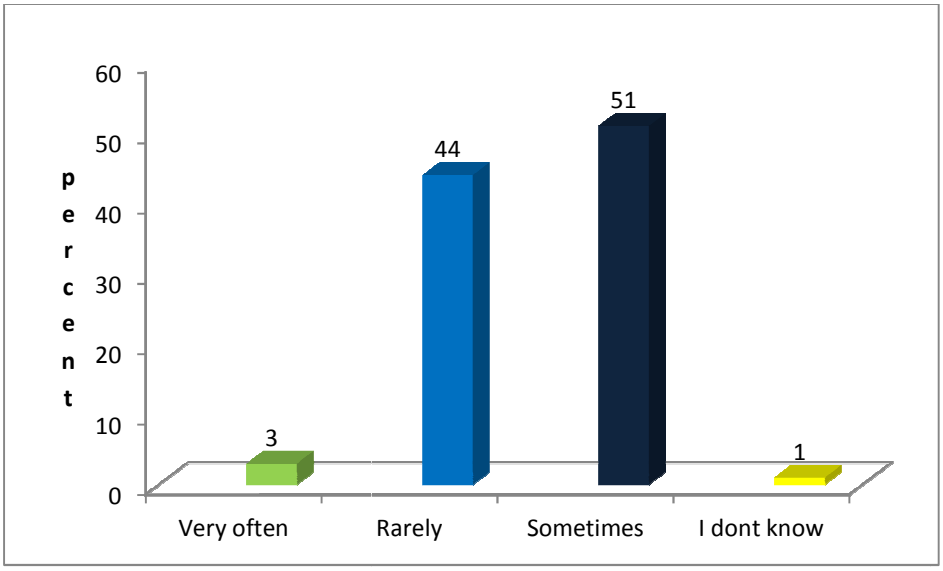
Figure 3.5: Health worker responses on availability of drugs in health Facilities. Kabwe District, Zambia.



Source: field data.

Furthermore, health worker respondents were asked how often their facilities experienced the drug stock outs. More than half of the respondents 36 (51%) indicated that they sometimes experience shortages. About 31 (44%) said they rarely experienced shortages, while a small proportion 2 (3%) said that they often experienced shortages. Figure 3.6 shows the responses of health workers on the frequency of drug shortages in the surveyed facilities.

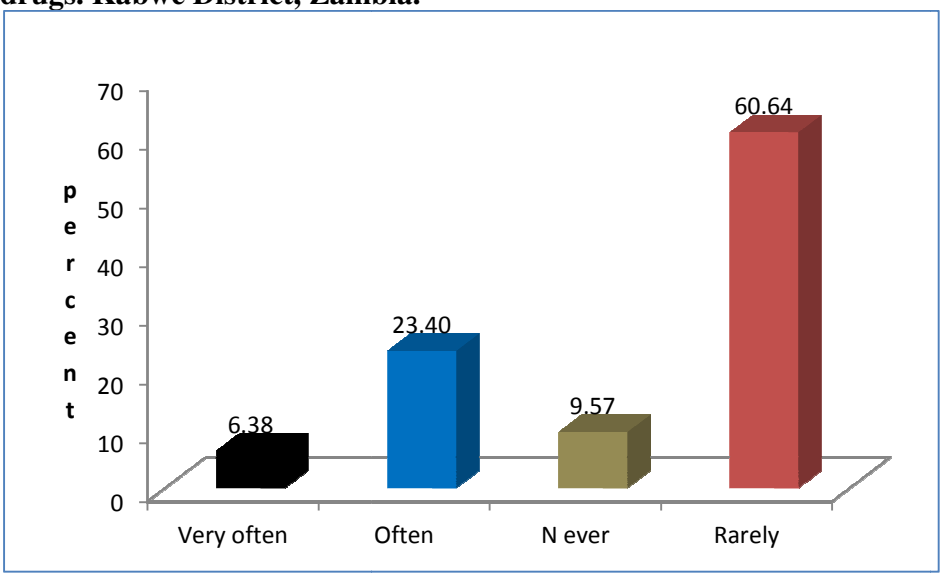
Figure 3.6: Health worker responses on drug stock outs, Kabwe District, Zambia.



Source: field data.

In addition, Service users were also asked how often they were asked to buy drugs at the health facility they usually go to. 57 (61%) of the respondents said rarely, 22 (23%) said often,6 (6.4) said very often while 6 (6.3 %) said very often as shown in Figure 3.7.

Figure 3.7: Service user responses on how often they are asked to buy drugs. Kabwe District, Zambia.



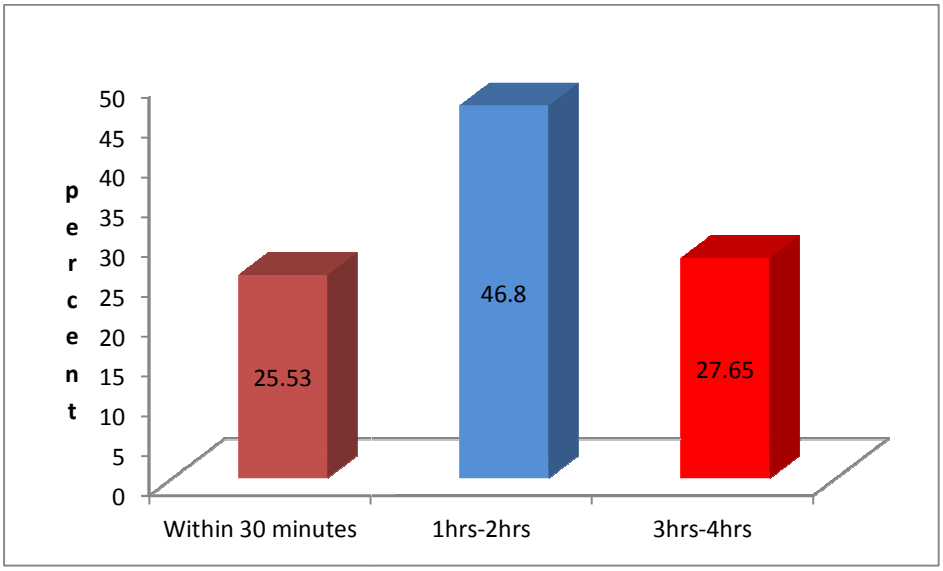
Source: Field data.

A conclusion can, therefore, be made that drugs in health facilities in Kabwe District are readily available. However, key informants from all the surveyed health facilities revealed that Medical Stores Limited usually does not supply the requested drugs in totality and in time. Hence, they have to procure the shortfall using funds allocated for other programs.

3.3.1 Waiting time

Service users were asked how long they had to wait before they are attended to at the health facility they usually go to. Less than half,44 (46.8%) of the respondents revealed that they had to wait for 1-2 to hours, 26 (28%) had to wait for 3 to 4 hours whilst 26% said they were attended to within 30 minutes as shown in Figure 3.8.

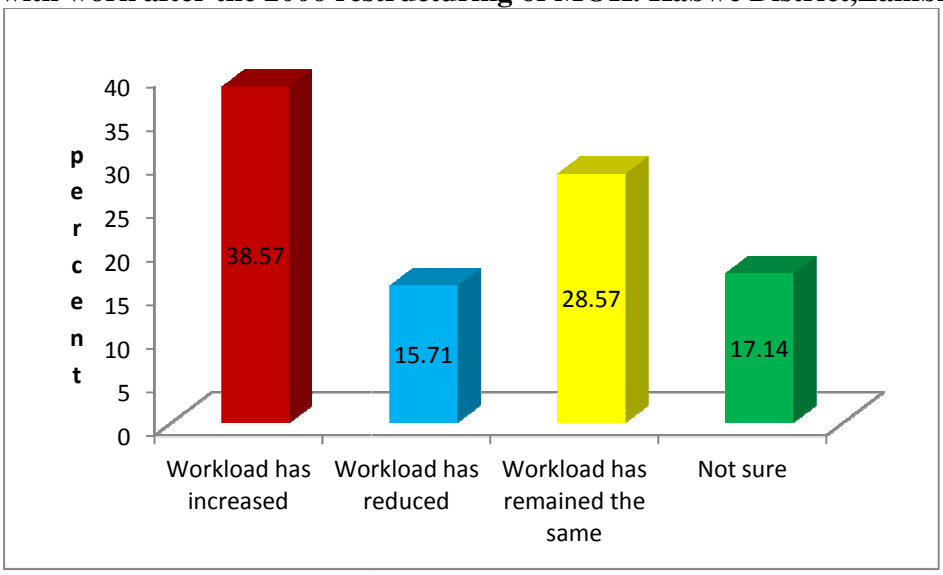
Figure 3.8: service user responses on waiting time. Kabwe district, Zambia.



Source: field data.

In order to understand the magnitude of waiting time in relation to quality of care, health worker respondents were asked to assess their workload after the 2006 restructuring. The majority, (38.57%) reported that they were overwhelmed with work as shown in Figure 3.9.

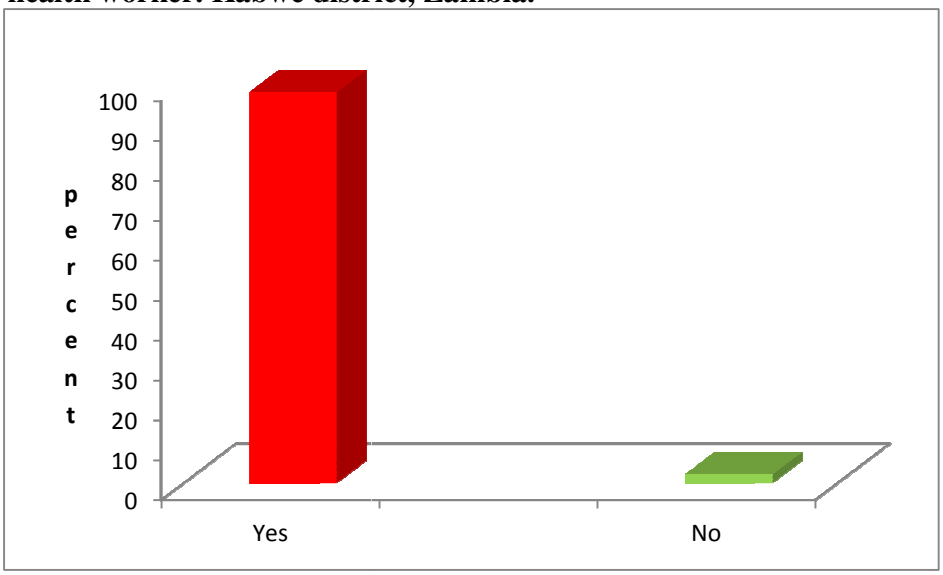
Figure 3.9: Responses by Health Workers on whether they are overwhelmed with work after the 2006 restructuring of MOH. Kabwe District,Zambia.



Source: field data.

Furthermore, service users were asked if each time they visited their nearest health facility they were attended to by a qualified health worker. Most of the respondents, 92 (98%) said that they were attended to by qualified health personnel as shown in Figure 3.10**.** Hence, this shows that despite being overwhelmed with work, health workers attend to their patients accordingly.

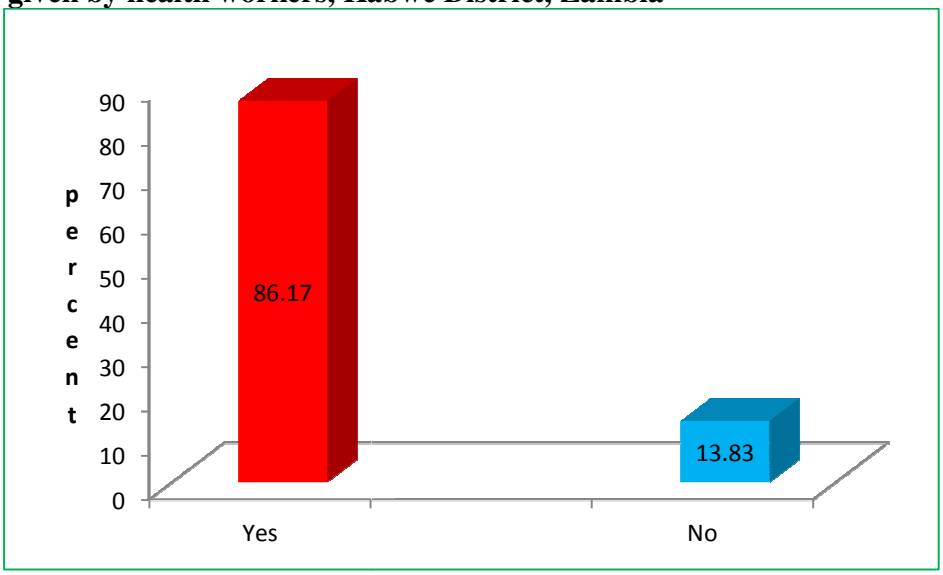
Figure 3.10: Service user responses on whether attended to by qualified health worker. Kabwe district, Zambia.



Source: field data

As a follow up question, Service user respondents were asked whether they were satisfied with the explanation given to them by health workers concerning their ailment. The research revealed that the majority 81 (86.2 %) were satisfied with the explanation and 13 (13.8%) were not satisfied as shown in Figure 3.11.

Figure 3.11: Service user responses on whether satisfied with explanation given by health workers, Kabwe District, Zambia



Source: Field data

Service users were asked to rate which activities were provided adequately at the health facility they usually go to. Whether health workers were friendly and whether the attitude of the health workers was good had the least scores of 42 and 40 respectively. The aspect of patients having privacy during treatment had the highest score of 62, followed by health worker revealing the name of the illness which had the score of 52 as shown in Table 3.1. Thus, one can infer from these findings that the attitude of health workers is found not to be favorable and hence needs to improve.

Table 3.1. Service users responses on various aspects of quality.Kabwe district, Zambia.

Aspects of Quality	Score	percentage
Health worker revealed name of illness	58	20
Health workers friendly to patients.	42	14
Patient is given time to explain illness	45	15
Patient can ask questions	50	17
Attitude of health worker was good.	40	14
Patient had privacy during consultation/treatment	62	21

Source: field data.

Interviews with the key informants at MOH revealed that in line with its vision, deliver highest of all quality in health care, the Ministry had set up quality improvement initiatives in all health facilities in Zambia. Thus, health facilities were expected to form quality improvement committees where the main focus is on working on identified challenges within the health facility.

It was further indicated that the restructuring also led to the creation of a Directorate of Technical Support Services to effectively coordinate the programmes and performance of the PMO, DMO and Statutory Bodies affiliated to the MOH and in so doing manage the performance of the health sector. Furthermore, a new directorate of Mobile Health Services was created and launched in April 2011. It has seven vehicles with specialized units. The unit provides health care equivalent to 1St Level health facility. (Interviews with directorate technical support services MOH.15.03.2013)

Ironically, interviews with the provincial key informants and facility heads revealed that the performance of the health institutions was monitored through Performance Assessment conducted quarterly by the MOH, DMOs and Hospitals. These service and quality control audits are basically intended to measure the extent to which minimum standards in provision of health care are maintained. That is the facilities are supposed to hold their own performance assessment using standardized performance assessment tools provided by the MOH. Thereafter, the PMO will go and assess the facilities using the same performance tool. If any gaps are found, discussions on how to improve performance are held. Technical support on the identified gaps will then be given at a later date. However, concerns were raised by health facility heads that at times, they are not given feedback and at times the officers doing the performance audits did not

have the necessary technical know-how. (Interview with principal planner, PMO Kabwe.6.03.2013)

3.3 Discussion of Findings.

The main objective of this chapter was to assess the quality of services provided by MOH after the 2006 restructuring. Quality was measured using availability of drugs, waiting time, quality of nursing care and waiting time.

It has been established that, both service users and health workers are of the view that the quality of health care has improved since the restructuring program was initiated. However, service users are still of the view that private facilities provide better services compared to public facilities indicating that despite the noted improvement, a lot still needs to be done. However, it must be borne in mind that, private health facilities are not free and there focus is on profit making, hence, would want to provide the best service so as to increase its clientele and in the process earn more profit.

In order to find out whether quality nursing care was being provided, service users who had once been admitted before in all health facilities surveyed were asked to rate the quality of nursing care. Results show that the majority were satisfied with the care they received proving that the quality of care has improved. In this instance, Psychological and emotional states of the user also need to be considered. When people are sick, they are easily irritable and may not appreciate the efforts of those assisting or caring for them. Therefore, for the service users to indicate that the nursing care was of acceptable standard clearly shows that the quality of health care has improved. Thus, an assumption can be made that, there is a noticeable improvement in health service delivery in Kabwe district.

It has also been shown that, waiting time is another challenge faced in all the health facilities surveyed. In order to be attended to, service users spend a lot of time on the queue as evidenced from the findings where the majority had to spend 1-2 hours on the queue. For instance, at Makululu health center, there was only one clinical officer who worked at the facility. As a

result, service users queued up as early as 05.00 hrs so as to be attended to faster. In this instance, waiting time was used as a yardstick to find out the efficiency of the restructuring program. Different reasons as to why service users wait long before they are attended to can be deduced. In rural areas shortage of staff may be a leading factor, while high population in relation to available health resources may be a major factor leading to long waiting time in urban areas.

However, when facility managers from the surveyed facilities were asked the major cause of the long waiting time, the major response given was lower staffing levels and the number and type of investigations one required. However, though staffing levels may be one of the leading causes, management of health workers is another area of concern. For instance, during the time of data collection, the sampling frame collected from the PMO showed that the required staff were available in all the health facilities which were to be surveyed. A visit to these facilities, however, revealed that, most of the health workers, especially doctors, were not available as some were said to be on study leave whilst others were on unpaid leave in search of greener pastures. Internal transfers also make it difficult to determine the actual numbers of doctors at facilities, a situation which needs to be urgently corrected and properly documented.

In this vain, attrition levels for health workers, especially doctors is one area of concern which needs urgent attention in Zambia. For instance as of 2010, they were 911 doctors towards an establishment of 2,300. The establishment, therefore, needed a further 1,389 doctors. for it to be filled. However, with the attrition rates estimated at 10% of qualified health workers, the high doctor patient ratio will need urgent prioritization. (MoH 2012) Therefore, there is need to make the working conditions and remuneration packages for health workers favourable so as to retain these essential workers. The enrollment rates of doctors in universities should also be increased to mitigate future shortages.

Furthermore, the staffing pattern as reflected in these established posts need to be carefully reviewed before recruitment is done. This is all the more important because MOH facilities are far more labor-intensive than either mission or private facilities, despite the high shortage of health workers. Alternatively, MOH should set explicit criteria on positions that urgently need to be filled. Failing to do so, would result in a high number of administrative positions which are easier to fill whilst essential health workers may continue to be in short supply. (MOH 2006).

This, hence, shows that lower staffing levels compromise the quality of health care as health workers are overwhelmed with work.

The research has also established that service users rate the attitude of health workers unfavorably. In general, some of the health workers in health centers were described as friendly and caring. However, they were instances where respondents were skeptical in giving their views for fear of being victimized despite being assured that their responses were in confidence. This therefore, indicates that the attitude of health workers is an area which needs further probing.
In cases where the health workers' attitudes appeared to be negative, especially from the respondents in hospitals, it can largely be attributed as an expression of frustration as a result of the poor working environment marked by shortage of workers and lack of medical requirements. This is evidenced by the high understaffing levels for professional staff such as doctors. At Makululu, health center for instance, the service users were receptive of the attitude of health workers despite waiting for a long time on the queue as they empathised with the only clinical officer, who they said, had to work long working hours alone to cater for the growing population.

The situation is further compounded by health workers feeling that the government is not doing enough to motivate them especially where remuneration is concerned. Salaries were reported to be too low, and the accompanying conditions of service were not corresponding with the amount of work they were doing. It hence, would seem reasonable that, where trained health workers are not available, districts should be provided with the authority and allocated with adequate resources to facilitate task shifting in order to provide the necessary services. It would also be of help if orientation processes that provide newly hired health workers with basic understanding of context (including pay and incentives), expectations and procedures of the facility and district to which they are posted were intensified. It, thus, can be deduced that, there is a correlation between low staffing levels and attitude of health workers. This, therefore, shows that more still needs to be done on the aspect of health worker attitude towards their patients and work in totality.

The research also established that drugs were readily available in all facilities surveyed. When service user respondents were asked whether they were asked to buy their own drugs, the majority 57 (61%) indicated that they were rarely asked to do so while 22(23.4%) said they were

often asked to buy their own drugs. This hence, shows that, despite some of the service users being asked to buy their own drugs sometimes, the percentages are minimal thereby indicating that levels of health care have improved as drugs are readily available. However, despite the availability, it can clearly be seen that some services are not being offered in totality owing to adjustments in the budgets as outlined by the facility administrators. This is because, despite government having a huge budget on drugs which are procured and delivered through Medical Stores Limited (MSL), what is delivered is usually not to the expectations of the health facilities and is mostly delayed. As a result, health facilities end up procuring the shortfall in order to continue giving quality services. However, the shortage experienced can also be attributed to poor drug inventory management by the health facilities, over prescribing by the service providers and pilfering by some of the staff. The latter needs further investigations more so, since MOH was riddled with embezzlement of funds in 2009 where donor aid was suspended as a result. Nevertheless, facility administrators praised the 2006 restructuring as they were now able to control their own resources and budget accordingly and in so doing improve the conditions of their health facilities. It can hence, be deduced that, there is enough political will to provide quality health care on the part of health providers as they understand that availability of drugs is regarded as quality health care by the community in general.

In summary, as shown by the data, it can hence be deduced that that quality of health care has improved despite the aspect of long waiting time and poor attitude of health workers towards service users being rated unfavorably in all the health facilities surveyed.

CHAPTER FOUR

COMMUNITY PARTICIPATION IN DECISION MAKING IN THE PROVISION OF HEALTH SERVICES

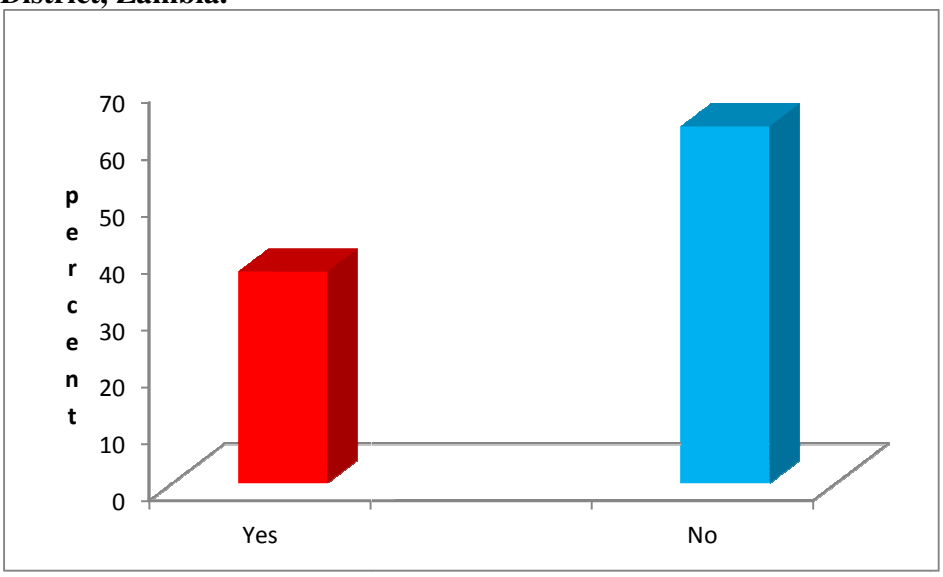
4.1 Introduction

This chapter presents and discusses to what extent the community is involved in decision making concerning health service provision at the local level in Kabwe District. According to MOH (2006) Involvement of community in health service delivery was one of the core reasons for the restructuring of the health sector. Therefore, in order to assess the levels of community participation and involvement in decision making, service users, health workers and key informants were asked on the numerous aspects of community participation.

4.2 Awareness of Existence of Neighborhood Health /Hospital Advisory Committees

Service user respondents were asked whether they were aware of the existence of Neighborhood Health committees and Hospital Advisory Committees at the nearest health facility where they usually go to. It was revealed that only 35 (37.2%) of the service user respondents were aware, while the majority, 59 (62.8%), were not aware, as indicated in Figure 4.1.

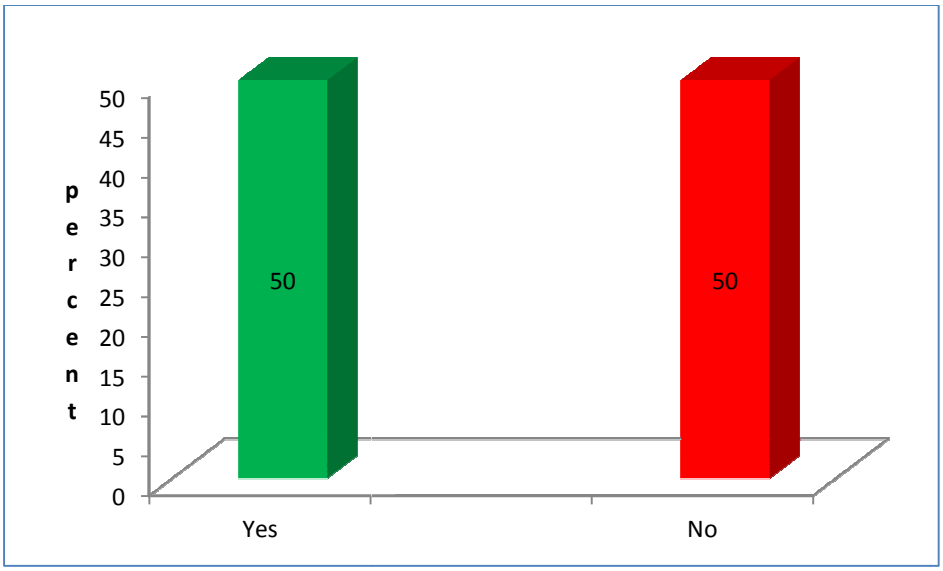
Figure 4.1: Service user responses on awareness of existence of Neighbourhood Health/Hospital Advisory Committees, Kabwe District, Zambia.



Source: Field data

Health worker respondents were equally asked whether they were aware of the existence of Hospital/Neighborhood Advisory Committee at the health facility where they worked from. Among the seventy (70) health workers interviewed only half 35 (50%) knew about the Advisory Committees at their facilities.

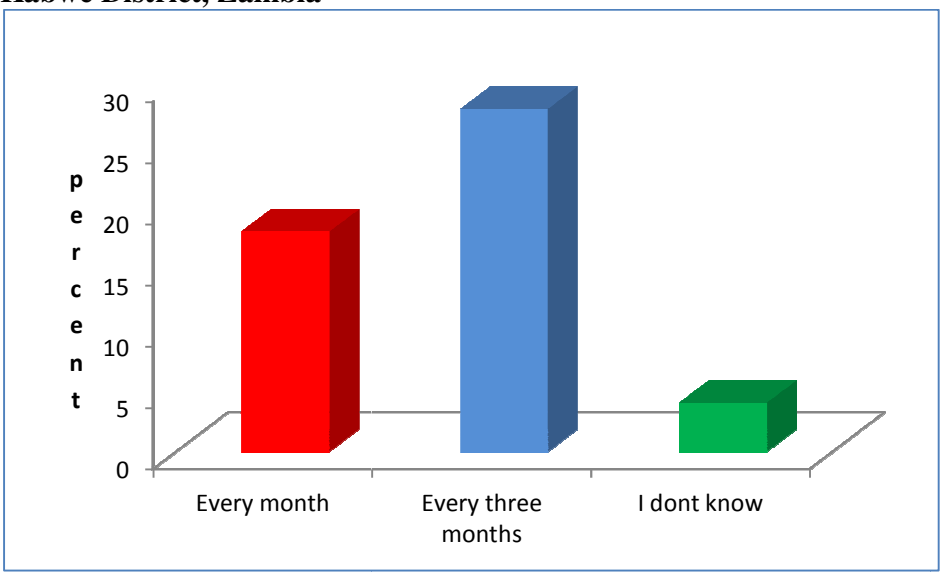
Figure 4.2: Health worker responses on awareness of existence of Neighbourhood Health/Hospital Advisory Committees, Kabwe District, Zambia.



Source: field data

Health worker respondents who said they were aware of the existence Neighbourhood Health/Hospital Advisory Committees were further asked how often the committees held their meetings. The research revealed that of the 35 who said they were aware, 18% said every month, 28% said every three months and 3% were non responsive as shown in Figure 4.3.

Figure 4.3: Health worker responses on how often Neighbourhood Health/Hospital Advisory Committees hold their meetings, Kabwe District, Zambia



Source: Field data

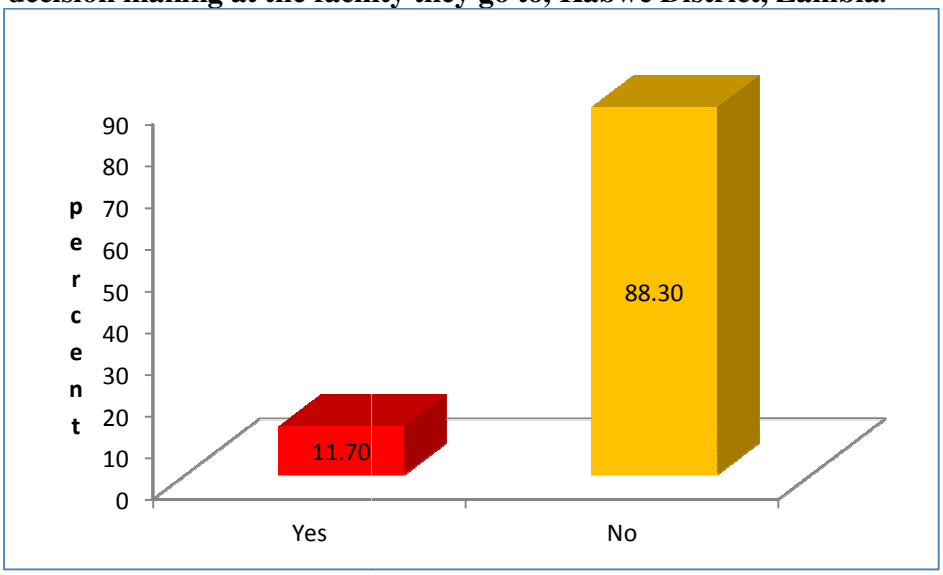
When health facility heads were interviewed it was revealed that the hospitals (Kabwe General and Kabwe Mine) did not have any Hospital Advisory Committees in place, whilst in all health centers Neighborhood Health Committees were available and functional. Key informants from the hospitals further revealed that they were not clear on the terms of reference for Hospital Advisory Committees, as they did not have guidelines from the MOH on how they are supposed to operate and therefore could not pay sitting allowances.

Members of the Neighborhood Health Committees, when interviewed, revealed that they held meetings with the management of the health centers quarterly and that some facilities pay K30.00 per sitting whilst other facilities did not pay any allowances. They further added that the agenda of these meetings was mostly centered on health campaigns.

4.3 Community participation in decision making

Service user respondents were asked whether they participated in any way in the decision making process at the nearest health facility they usually go to. The results showed that the majority, 88.3% did not participate in decision making while only 11.7% said they participated as shown in Figure 4.4. The activities which those who said participated included HIV committee meetings and Immunization Programs.

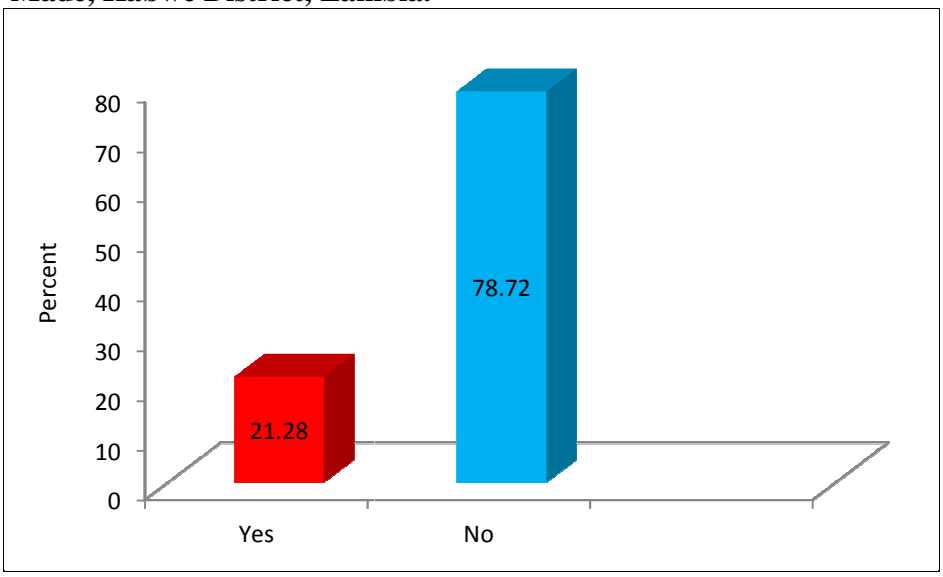
Figure 4.4: Responses by service users on community participation in decision making at the facility they go to, Kabwe District, Zambia.



Source: field data

In addition, service user respondents were asked whether the Neighborhood/Hospital Advisory Committees gave them feedback on decisions or projects undertaken at the health facility they usually go to. It was found out that more than half of the respondents (78%) did not receive any feedback while 21% of the respondents said they received feedback. Figure 4.5 shows service user responses on whether Neighborhood/Hospital Advisory Committees gave feedback on decisions made.

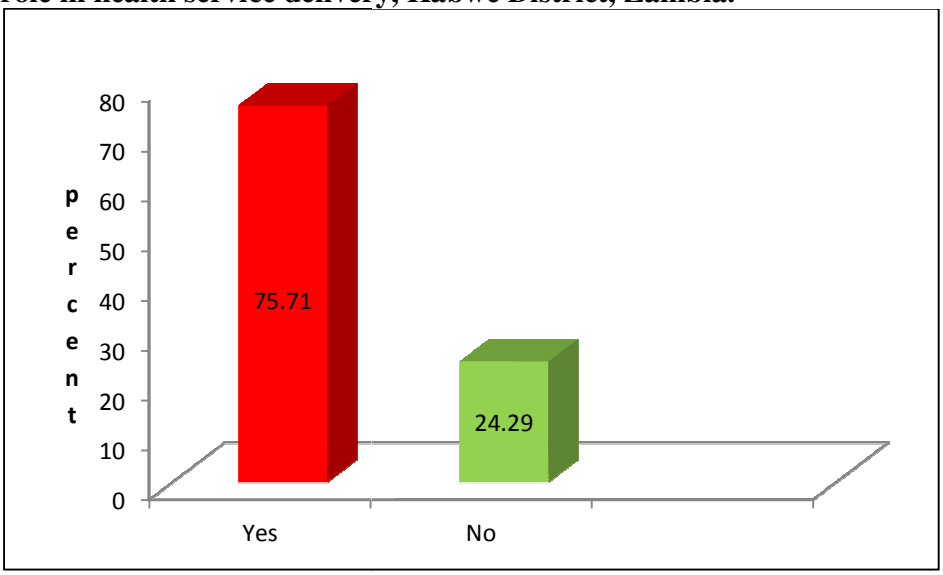
Figure 4.5: service user's responses on whether Neighbourhood Health/Hospital Advisory Committees gave feedback on decisions Made, Kabwe District, Zambia.



Source: field data.

Health workers were further asked whether the community can play a role in health service delivery. It was established that the majority of the health worker respondents (75%) agreed whilst 24% disagreed as indicated in Figure 4.6**.**

Figure 4.6: Health worker responses on whether community can play a role in health service delivery, Kabwe District, Zambia.



Health workers were further asked to select which activities they thought members of the community could participate in to improve health service delivery. It was found that raising community awareness was the most preferred choice as it had the highest frequency of 70. This was followed by contributing labour and assisting with transport which had frequencies of 60 and 51 respectively. Assist when called by providers had a score of 25 whilst making monetary contributions had a score of 15.Planning and budgeting was deemed the least important activity as it had the least score of 3. Table 4.1 shows activities that health workers would want the community to participate in so as to improve health delivery.

Table 4.1: Health worker responses on what activities the community should participate in to improve health service delivery, Kabwe, District, Zambia.

S/No	Activity	Score
1	Raising community awareness	70
2	Contribute labour	60
3	Assisting with transport	51
4	Assist when called upon by providers	25
5	Making monetary contribution	15
6	Planning and budgeting	3

Source: Field data

4.4 Discussion of Findings

The main essence of this chapter was to assess the extent to which the community participates in decision making concerning health service provision at the local level.

The study has established that the majority of service users are not aware of the existence of Neighborhood Health /Hospital Advisory committees. The same was noticed with health worker respondents where only half (35) of the 70 respondents were aware of the existence of Neighborhood/Hospital Advisory committees in their facilities. The fact that both health workers and service users are ignorant of the need and existence of community Neighborhood Health /Hospital Advisory committees shows that community participation in decision making is just a myth and might not be realized in the near future. This further indicates that, sensitization was

not adequately done and relevant information on health reforms was not fully disseminated. In addition, some of the interviewed health workers regarded the subject of community participation as a role specifically meant for facility administrators. The fact that, health workers equally did not know when the committees held their meetings clearly indicates a lack of interest and ignorance over the subject. From this scenario, one would argue that, if the majority of both respondents (service users and health workers) are ignorant of the need to have Neighborhood Health /Hospital Advisory Committees in place, then the aspect of considering community members as stakeholders in health service provision will not be realized in the near future. Despite the health reforms emphasizing the importance of communities not just as users but as active participants in the delivery of health care, a sense of alienation still pervades the community and prevents them from attaining higher forms of participation in the delivery of health care.

It has also been shown that the hospitals do not have Hospital Advisory Committees in place. The fact that hospitals are still waiting for terms of reference from the center indicates that Hospital Advisory Committees will not be formed in the near future. Since health centers have committees, one would argue whether the terms of reference they are using are different from the hospital ones. When hospital facility administrators where asked this question, their response still premised on responses from the center. It must be pointed out that, MOH headquarters is not outside the country and there are usually interactions between institutions and MOH. From this scenario, it can hence be deduced that, hospitals do not have the political will to include community participation in the running of their facilities. This is exacerbated by the community's ignorance on the role they are supposed to play in health service delivery. This is basically because, if the community members fully understood their roles and responsibilities, they would have demanded for participation through the relevant authorities. This failure by the hospitals to honor its obligations makes the relationship between the community and health facilities as a routine activity that has no policy consequences when in actual fact, the opposite is true.

On the aspect of community participation in decision making, results have shown that levels of community participation in decision making are very low and hence not fulfilling one of the aims of the restructuring of the MOH. The research has shown of the 94 respondents, the majority, 83 (88.3%) did not participate in decision making while only, 11 (11.7%) participated. This hence

shows that, despite the Neighborhood health committees being present in health centers they do not fulfill their task as a link between the community and health service providers, as decision making is solely in the hands of health workers.

As earlier revealed, the aspect that might have hindered community participation in decision making is ignorance on the part of the service users. This is basically because, the majority of service users clearly do not understand the concept of community participation. In addition, the composition of members in the committee also needs to be put into consideration. According to the terms and references for the Neighborhood Health /Hospital Advisory committees, membership to the committee should comprise people with background in: Human Resource, Financial, Public Relations, Medical and Nursing professionals and influential community members. However, if membership is selected without following the laid down criteria, there is an element of having people in the committee who do not understand the role they are supposed to play. Despite some of the key informants from the Neighborhood health committees indicating that they at times, gave feed back to the community through general meetings and having a poor response from the community, a conclusion can be made that, the levels of community participation in decision making are very low. Furthermore, members of the community are not fully aware of their roles and responsibilities.

Generally, in the minds of the majority of health workers and service users, community participation means provision of labour hence, involvement in decision making by the community is clearly non-existent. The concept of community participation is clearly not understood by the community. There is a need to raise the community's knowledge about the various forms of community involvement and to increase their sense of ownership. Strategies to increase community awareness about various forms of community participation and their involvement in health service delivery should be prioritized by relevant authorities.

The above can be tallied with the responses by health workers, where they were asked to state which activities the community should participate in to improve health service delivery. Raising community awareness had the highest score whilst planning and budgeting which was considered as a major aspect of community participation in decision making had the least score.

The range of responses therefore, shows that health workers do not perceive service users worthy of being partners in decision making but as an extended arm of health service provision. It is worth mentioning, however, that the majority of health workers are of the view that the community can play a role in health service delivery.

In a nutshell, the findings have shown that out that community participation in decision making is minimal in Kabwe District. It has also been revealed that the hospitals do not have Hospital Advisory Committees in place. Furthermore, both health workers and service users were ignorant of the need for the existence of the Advisory committees in health facilities, hence not conversant with the roles they were supposed to play.

CHAPTER FIVE

CONSTRAINTS FACED BY HEALTH WORKERS AND SERVICE USERS

5.1 Introduction

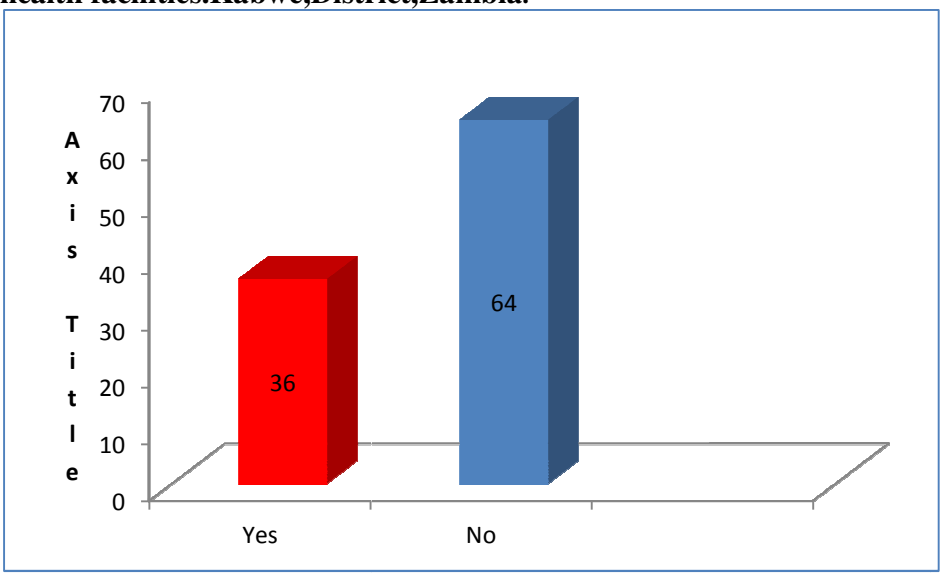
This chapter presents and discusses the challenges faced by health workers and service users in the provision health service delivery in Kabwe District**.** In doing this, the chapter analyses how effective the 2006 health reforms have been, through information collected from health workers, service beneficiaries and informed respondents in relation to the interview guides and questionnaires that guided the study.

5.2 Constraints faced by health workers

5.2.1 Availability of Equipment

Health worker respondents were asked if they had adequate equipment for carrying out their work effectively. The majority of the respondents 45 (64%) revealed that they did not have adequate equipment to work with within their facilities, whilst 25 (36%) said they had the necessary equipment as indicated in Figure 5.1.

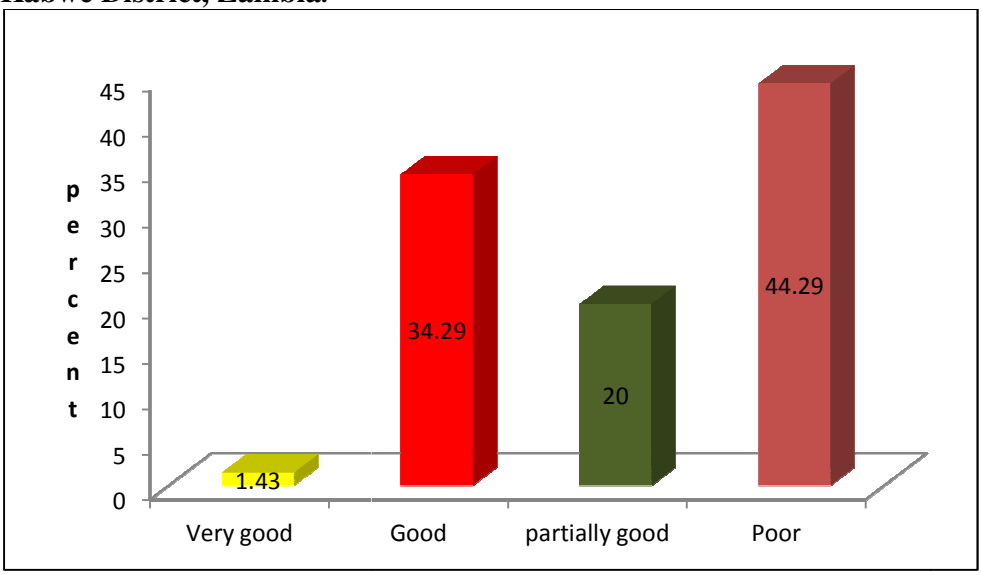
Figure 5.1: Health worker responses on availability of equipment in health facilities.Kabwe,District,Zambia.



Source: field data

Health worker respondents were further asked to state the condition of the available equipment. 31(44.29%) of the respondents said that the equipment was in poor condition, 14 (20%) said that it was in partially good condition whilst 24 (34.3 %) and1 (1.4%) said it was good and very good respectively as shown in figure 5.2.

Figure 5.2: Health worker responses on condition of available equipment, Kabwe District, Zambia.



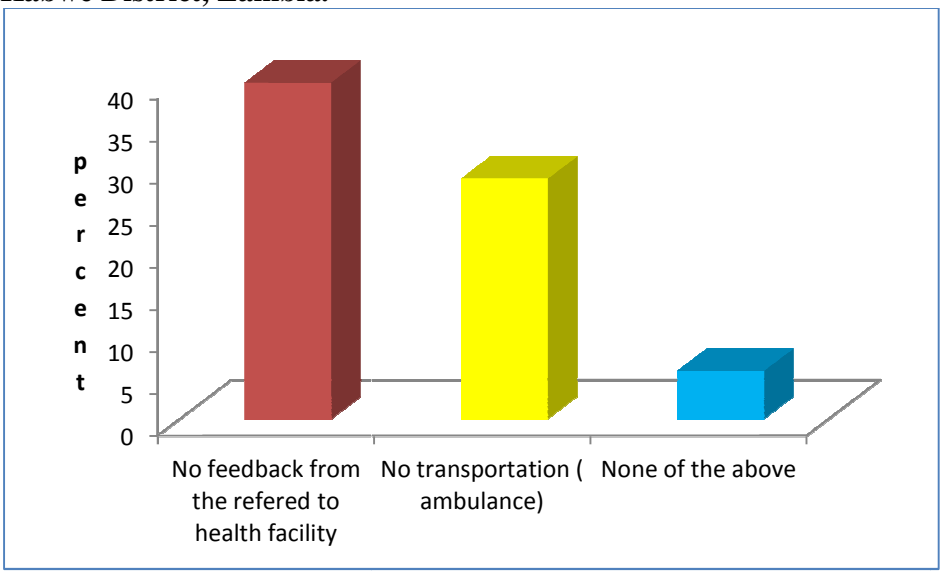
Source: field data.

5.2.2 Transport

It was found that inadequate transport was a major problem in nearly all the facilities. For instance, interviews with facility heads revealed that the hospitals did not have ambulances and hence faced challenges in referring patients whilst the District Medical Office had only one ambulance thereby making operations and referrals difficult.

Health workers, when asked what challenges they faced in the referral of patients, 28 (40%) of the respondents indicated that they did not have feedback from the facility where the patient was referred to whilst 20 (29%) revealed that they faced transport challenges. 4 (6%) said N/A while 18 (26%) were non responsive. This, hence, shows that the major setbacks faced in referrals are lack of feedback and transport. However, lack of feedback is a more managerial issue and can easily be resolved through improved communication between referring facilities, whilst transport borders on availability of finances.

Figure 5.3: Challenges faced by heath workers in referring patients, Kabwe District, Zambia.



Source: Field data

However, Interviews with key informants at the MOH revealed that the Government was in the process of procuring ambulances for all health facilities in Zambia to mitigate the transport problem. He also hinted that Infrastructure development was being done in phases and will soon incorporate all facilities in Kabwe district.

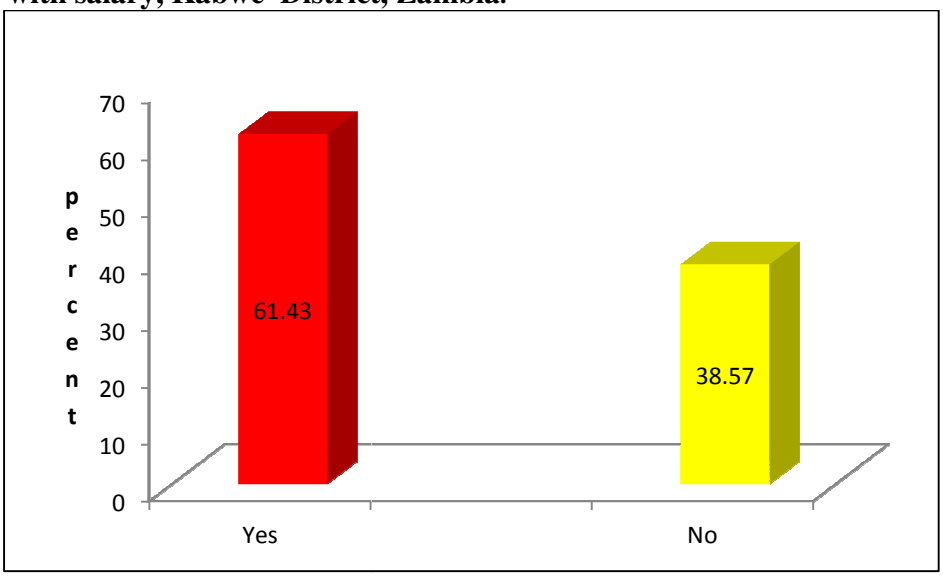
5.2.3 Motivation strategies

In order to ascertain the levels of motivation in relation to performance, health worker respondents were asked how they were retained or motivated. No responses were given to the question. However, when interviewed, key informants from the PMO and MOH indicated that strategies such as: the retention schemes, uniform maintenance, commuted overtime, night duty allowance and improved salaries were measures put in by government to motivate and retain health workers and hence ease their challenges. The most direct strategies undertaken to motivate health workers have been undertaken by individual managers.

As a follow up question health worker respondents were asked whether they were satisfied with the salary given to them. It was found that 61.43% of the respondents said they were satisfied

while 38.57% indicated that they were not satisfied. Figure 5.4 shows the views of health workers on whether they were satisfied with their renumeration.

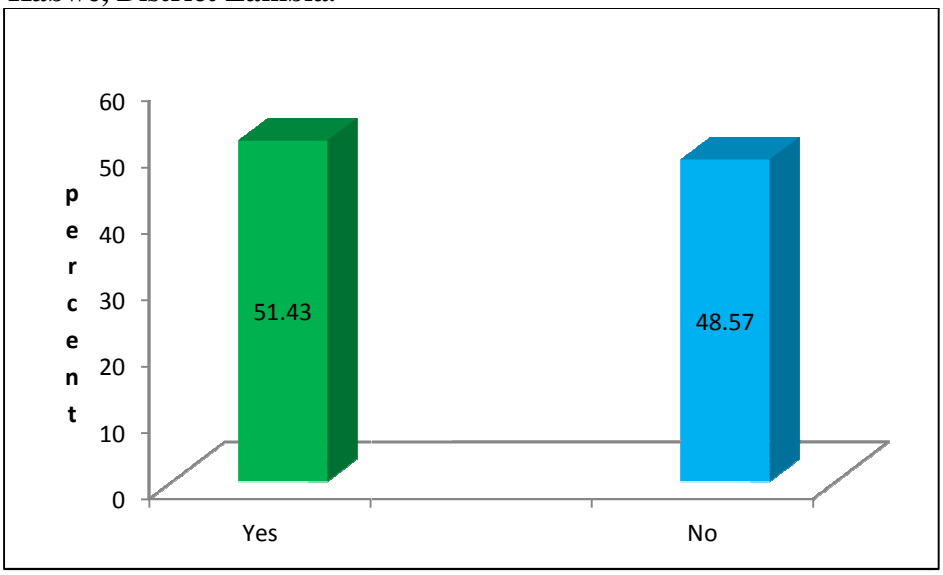
Figure 5.4: Health worker responses on whether they were satisfied with salary, Kabwe District, Zambia.



Source: field data.

Health workers were asked if they engaged in other income generating activities to supplement their income 36 (51.43%) of the respondents gave a positive affirmative while 34 (48.57%) said they did not engage in any other income generating activities as indicated in figure 5.5.

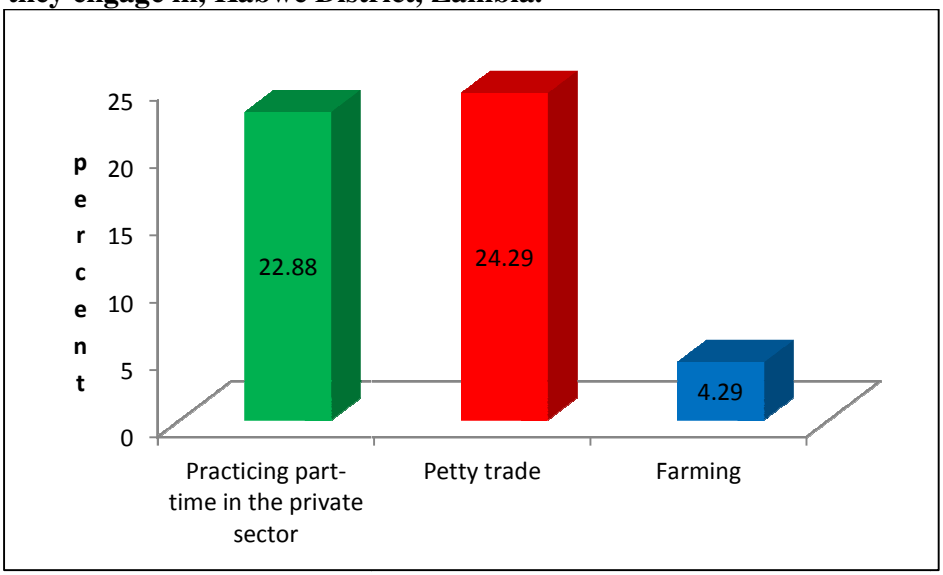
Figure 5.5: Health worker responses on other income generating activities. Kabwe, District Zambia.



Source: field data

Among 36 health worker respondents who said that they engaged in other economic activities, 23% revealed that they practiced part time in the private sector, 24% said that they engaged in petty trade while only 4% said they practiced farming as shown in figure 5.6.

Figure 5.6: Health worker s responses on other income generating activities they engage in, Kabwe District, Zambia.



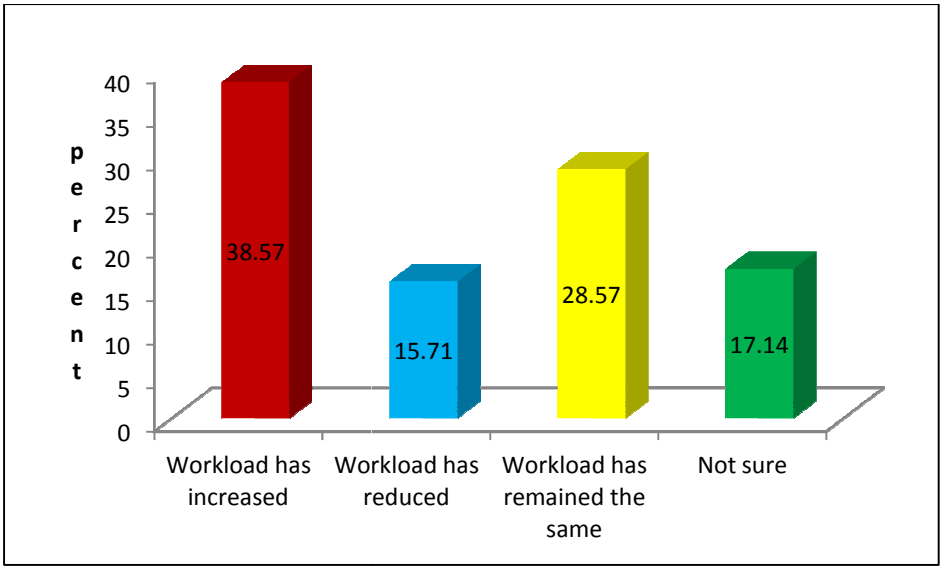
Source: field data

5.2.4 Shortage of staff

Low staffing levels was also one of the areas bemoaned by facility heads and other key informants. An interview with provincial human resource management officer revealed that the district had a total number of 32 doctors, 51 clinical officers and 457 nurses. However, the majority of these staff, especially medical doctors, were not actually available; others were said to be on study leave whilst others were working elsewhere but being maintained on the establishments. In addition, the HRMOs from the hospitals further revealed that the establishments still had medical staff vacant positions, with the doctors being in the majority, hence the recruitment exercise was on going.

As earlier indicated, the majority of health worker respondents indicated that they were overwhelmed with work as shown in figure 5.7. This can hence be attributed as the cause of long waiting time.

Figure 5.7: Health worker responses on workload. Kabwe District, Zambia.



Source: field data

5.2.5 Building infrastructure and patient Amenities

Another challenge cited by Facility Mangers was inadequate infrastructure and patient amenities. They contend that health facilities are in generally good physical state, although many of them are quite old. For instance interviews with the facility head for Kasavasa health center revealed that the health facility had only one ward, hence service users had to share regardless of their sex. It was further revealed that the health facility had no laboratory infrastructure, hence the services had to be outsourced from town which was quite costly on the part of service users.

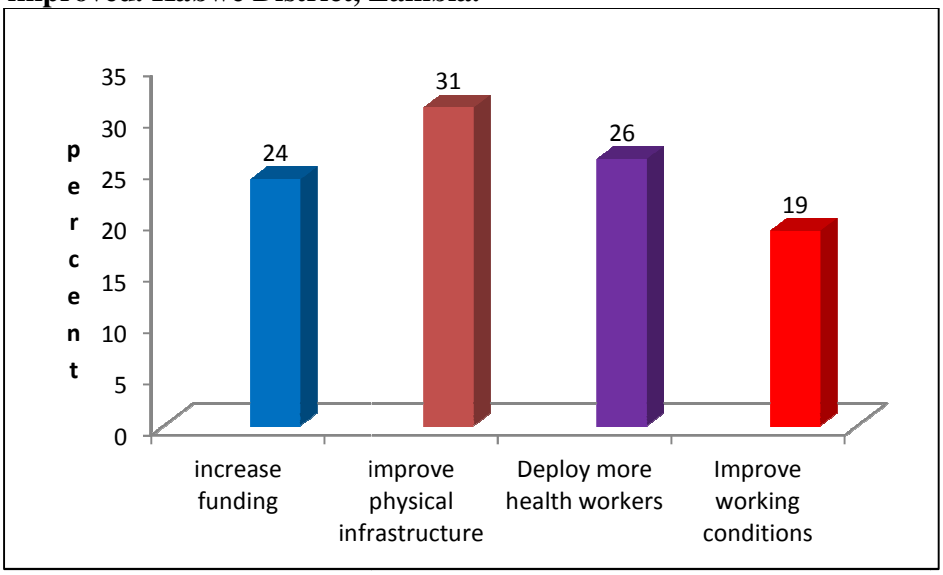
Key respondents from the PMO revealed that the restructuring programme, however, also brought with it expanded establishments, hence the need to expand the existing infrastructure. They also added that patient amenities such as mother's shelters were also lacking in most of the facilities but were on the plan of action and would be worked on in due course.

5.2.6 Financing

Another challenge cited by all facility heads was inadequate funding. It was revealed that the funding was not enough to carry out most of the facility operations. Therefore, it was difficult for them to provide a better service when the funding was inadequate and usually disseminated late.

The four main themes that, according to the responses of the 70 health workers would improve service delivery included: improving physical infrastructure (31%), deploy more health workers (26%), increase funding (24%) and improve working conditions (19%) as shown in Figure 5.8.

Figure 5.8: Health worker responses on how service delivery should be improved. Kabwe District, Zambia.



Source: field data.

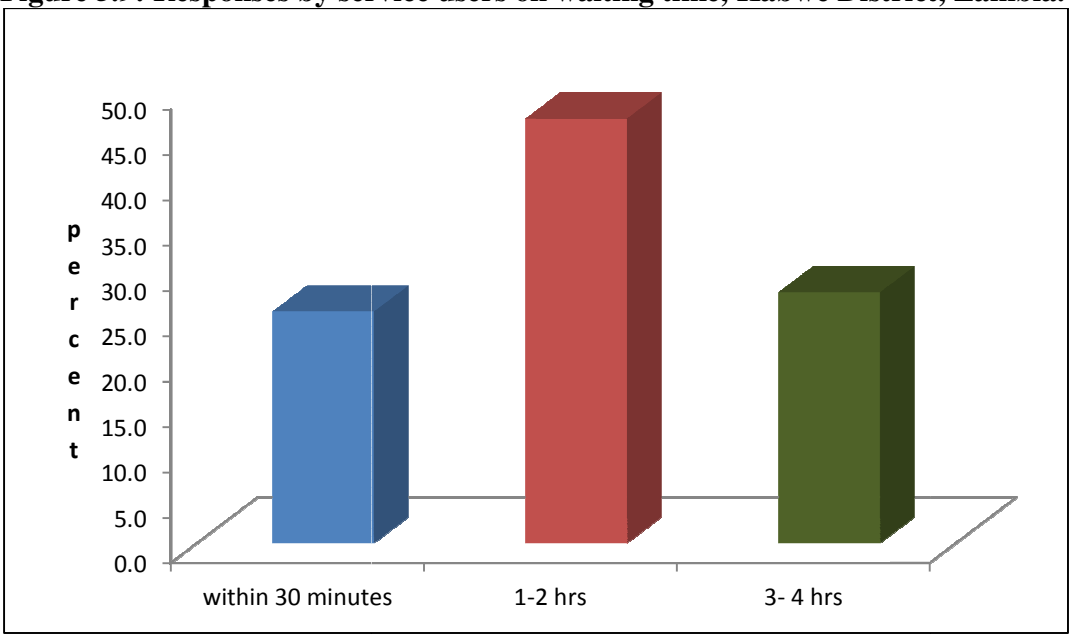
5.3 Challenges faced by service users in accessing health services

This section of this chapter sets out to discuss the challenges faced by service users in accessing health services in Kabwe district.

5.3.1 Waiting time

Waiting time was used to measure both the quality of service and challenges faced by health users. The study established that long waiting time was the most challenge faced by service users as indicated from the responses where it was found that only 24(26%) of the respondents were attended to within 30 minutes, as shown in figure 5.9. However, Key informants attributed the long waiting time to shortage of staff.

Figure 5.9: Responses by service users on waiting time, Kabwe District, Zambia.

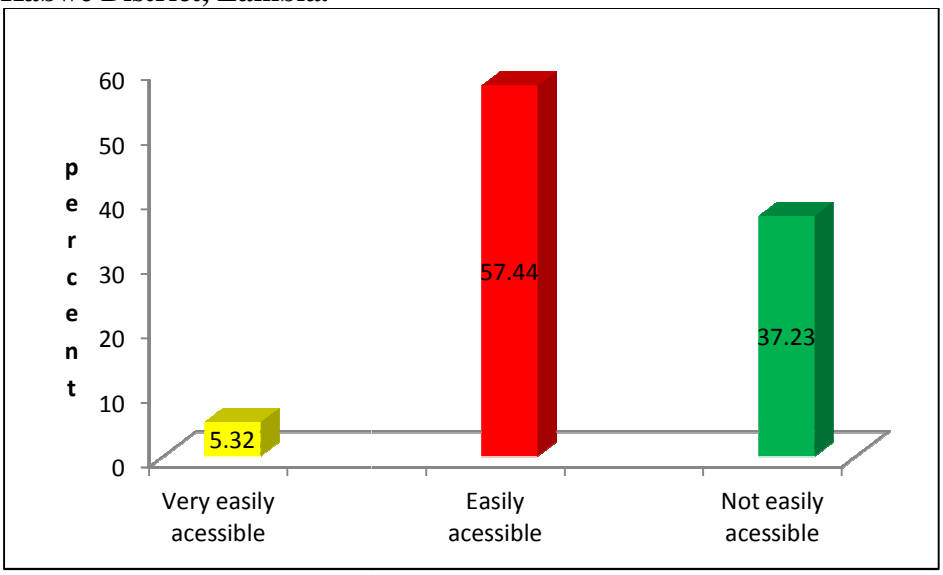


Source: Field data

5.3.2 Accessibility to health facilities

Service user respondents were asked how easily accessible were the health facilities where they usually go to. The study established that 54 (57.4 %) of the respondents indicated that the facilities were easily accessible, 5 (5.3%) said that they were very easily accessible and 35 (37.2%) said that they were not easily accessible as shown in Figure 5.10.

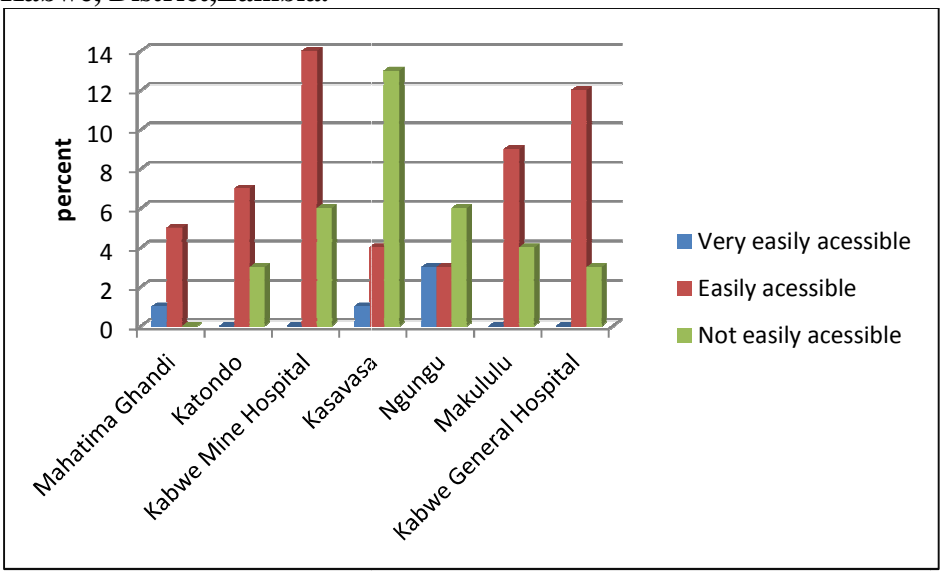
Figure 5.10: Service user responses on accessibility of health facilities. Kabwe District, Zambia.



Source: field data

However, the study revealed that the majority of the service user respondents who said that the health facilities were not easily accessible were those found in the rural area of Kasavasa (13) as shown in Figure 5.11.This was followed by Kabwe Mine Hospital and Ngungu Urban Health Center each with a score of 6. Kabwe Mine Hospital, though located in an urban set up was cited as being inaccessible. This could be attributed to the health facility not having public bus routes. On the other hand, Ngungu despite being an urban health center, is located further away from the central business district and is the only health facility in Bwacha township hence not easily accessible to service users from nearby farms.

Figure 5.11: Service user responses on accessibility by type of facility. Kabwe, District,Zambia.



Service users were asked an open ended question on how service delivery should be improved. Improving staffing levels so as to reduce the long waiting time had the highest score of 60, followed by improving infrastructure which had a score of 30. The outstanding example was cited at Kasavasa where service users were made to share one ward regardless of the gender. The maternity wing was also cited as being too close to the ward and hence did not provide privacy. Construction of more health centers to improve accessibility had a score of 20. Provision of services such as laboratory and X-ray facilities in health centers had the least frequency of 10.

Table 5.1: Service user responses on what should be done to improve health service Delivery, Kabwe District, Zambia.

S/No	Activity	Score
1	Improve staffing levels	60
2	Improve infrastructure.	30
3	Build more health centers	20
4	Provide laboratory and x-ray services in health centers	10

Source: Field data

5.4 Discussion of Findings

This chapter focused on the constraints and challenges faced by both health workers and users. The study has established that health workers face a number of constraints in carrying out their duties.

Most of the health workers, 45 out of the 70, indicated that they did not have adequate equipment. Thus, from the above scenario, one can infer that health workers are not able to carry out full examinations on their patients because of lack of necessary equipment especially in instances where Laboratory and Radiology examinations are not done. This, therefore, indicates that health workers are working under strenuous conditions and hence the quality of health care given is compromised. As the quality, efficiency and effectiveness of health service delivery are determined and dependent on the availability of appropriate medical equipment, it is further desirable that it is available and functional at all times. So far, what is clear is that, services are not being offered to optimum levels because of the above stated challenges. As facilities have been given autonomy, what is required is sufficient funding so as to procure the needed equipment and provide the desired health services.

The findings also revealed that, transport is another major handicap cited by health workers. Serious transport challenges exist in all health facilities surveyed. For instance, Kabwe Mine hospital had just one vehicle to use both for administrative and referral purposes whilst the health centers equally had just one Ambulance for referral purposes. In this scenario, it can be deduced that, it is quite difficult for facilities to carry out their daily activities as a result of transport challenges. Interviews with facility administrators further revealed that, procuring of vehicles is beyond their threshold and as a result, they are solely dependent on the MOH to come to their aid. As the sector is faced with financial constraints, this is one challenge which will take time to be addressed. However, there is need for it to be prioritized before lives are lost. From this scenario, a conclusion can be made that, service delivery is hampered by transport challenges and if no urgent action is taken, more lives might be lost as a result of late referrals.

The study has also shown that, health facilities face challenges of not receiving feed back when they refer patients. This scenario, therefore suggests that there is no adequate communication between facilities and treatment of patients is continued without verifying from the referring

institution or informing them how they commenced the treatment. Therefore, a conclusion can be made that, health facilities have not fully utilized the laid down procedures in the referral process and hence the need for them to be reviewed if the system is to become effective.

As has been shown, despite government putting in measures such as retention schemes, on call allowances for doctors, uniform allowance, night duty allowance and improved salaries among many others, some of the health workers are still of the view that nothing tangible has been done to motivate or retain them. As earlier outlined, the study has established only 43 out of the 70 health worker respondents were satisfied with their salaries. This finding, however, is contrary to the focus and views of MOH where schemes like the Zambian Health Workers Retention Scheme (ZHWRS) where introduced to attract and retain core health workers in the underserved rural and remote areas. Selected cadres of health workers are receiving a monthly retention allowance for the duration of the contract, as well as other non-monetary incentives so as to address the distribution of health workers equally. However, there is still need to re -visit the motivation strategies so as to have an effective and highly motivated workforce.

When Health workers were asked if they engaged in other income generating activities to supplement their income 36 (51.4%) agreed while 34 (49%) said they did not engage in any other income generating activities. Among the 36 health worker respondents who said that they engaged in other economic activities, 23% revealed that they practiced part time in the private sector, 24% said that they engaged in petty trade while only 4% said they practiced farming.

From these finding, inferences might be drawn that, despite health workers indicating that they are overwhelmed with work as earlier reported, what is surprising is that they are still engaged in private practice. This, therefore, suggests that, long waiting time in health facilities can either be due to inefficiency on the part of the staff as they might be tired from the private practice hence fail to carry out their duties diligently or the lower staffing levels of health workers. It therefore, can be deduced that, low salaries can lead to increased absence from work in order to earn extra income and ultimately lead to poor service delivery.

The research has also shown that Low staffing levels is another major constraint faced by health facilities. Health facilities are faced with staff shortages not because of lack of consistencies in

the establishment register but probably due to attrition and absenteeism. For instance, there were cases where health workers especially doctors, would appear on the establishment but be working from another station. In addition, some of the health workers were never at the station or would come late and getting hold of them so as to interview them was quite a challenge. The attrition can further be attributed to health workers search for greener pastures and a lack of adequate incentives. It must be pointed out, however, that finances are not the only mode of motivation as specified by motivation theorists. It therefore, can be deduced that, the critical shortage of health workers is a major obstacle to the provision of quality health care and hampers Zambia's attainment of the 2015 Millennium Development Goals(MDGs).The Government of the Republic of Zambia, therefore, needs to urgently consider training more health workers and increase funding to the sector.

It has also been revealed that, health facilities have challenges of infrastructure. Ironically, improving physical infrastructure was the first theme cited by health workers to improve service delivery. Inadequate infrastructure such as limited number of wards, lack of a cooking area for patients and mothers' waiting area were the two most common shortcomings of the surveyed facilities.

For instance, Interviews with the facility head for Kasavasa health center revealed that the facility had only one ward hence service users had to share regardless of their sex. It was further revealed that, the health facility had no laboratory infrastructure as a result, the services had to be outsourced from town. However, as earlier discussed key informants from the MOH revealed that the GRZ had set aside infrastructure development funds and the implementation would begin in due course. The state of limited infrastructure is one area which needs to be looked into urgently, as the mixing of both males and females in one ward infringes on peoples rights. The situation would have been different if it was in an urban area as people are more aware of their rights and have more options. It would also be of help to the service users, if the facility administrators would be more innovative and find alternative measures instead of waiting for the Government to act. Requesting the private sector to assist could also be another alternative.

The study has also shown that service users face challenges of long waiting time. However, facility managers indicated that at times the long queues were inevitable as patients cases were

different and was dependent on the type of investigation being done. They further added that, the problem was coupled with lower staffing levels. However, as earlier pointed out, the majority of health workers are engaged in private practice which can lead to them being overworked and inevitably affect their work. This is because, having more than one job makes one not to have adequate time to rest, hence, ones' work might suffer because of divided loyalty. Furthermore, over population in some of the urban areas leads to overcrowding of the urban health centers. Hence, this scenario coupled with shortage of health workers can be attributed as the major causes of long waiting time. This, therefore, shows that waiting time in health facilities still remains a major challenge as the average waiting time exceeds an hour in all facilities surveyed.

The study has also revealed that health facilities in Kabwe are easily accessible especially in urban health facilities. However, the majority of responses who said facilities were not easily accessible were those found in the rural area of Kasavasa. This might be attributed to Kasavasa, being the only rural health center in Kabwe district hence lagging behind in development. The major obstacle to accessibility of health centers was transport as respondents had to walk Kilometers to access the health facility. It must be pointed out, however, that none of the respondents indicated that the health facilities are not accessible. Nevertheless, Kabwe District, being the provincial capital of central province should not be having aspects of service users not being able to access health services. The fact that some of the respondents had to cycle kilometers to access health services is quite unacceptable in this age and era.

In summary, the study has clearly shown that health workers face major constraints which include inadequate equipment, Infrastructure, transport, staff shortages and limited finances. The major challenge faced by service users on the other hand is the long waiting time. Accessibility to health facilities was also a challenge faced primarily by respondents from the rural setup of Kasavasa. Improvement in staff numbering and physical infrastructure have been cited by both health workers and service users as major aspects which need to be considered if service delivery is to improve.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter contains conclusions and recommendations of the study. The main objective of the study was to find out whether health service delivery had improved after the 2006 restructuring of the MOH in Kabwe District. Since the restructuring programme was initiated, the quality of health service delivery in the Ministry of health has continued to be a major concern by the majority of stakeholders. Hence, this study, sought to establish whether the 2006 restructuring program had resulted into improvement of health service delivery in Kabwe District.

6.2 Conclusions

6.2.1 Quality of health care.

The key findings in relation to quality of health care were:

Both service users and health workers are of the view that the quality of service delivery in Kabwe district had improved as a result of the 2006 restructuring program. However, service users still regard the services being offered by private health facilities as better compared to public health facilities. The quality of nursing care was also rated highly by service users who had once been admitted before in the facilities surveyed.

Drugs were readily available in all facilities surveyed as a limited number of service users were given prescriptions to buy their own drugs. This was also proved by the fact that health facilities rarely had drug stock outs. However, the findings also show that they were instances where health facilities had to procure drugs using their grants as Medical Stores Limited would in most instances, deliver the drugs late and not to the ordering level of the health facilities.

The attitude of health workers was rated as poor by the majority of service users. However, positive responses were given to services such as health workers revealing the name of the illness and having privacy during treatment.

Service users face the challenge of long waiting time in all health facilities surveyed. According to the findings from the study, service user respondents had to spend more than an hour on the queue before being attended to thereby compromising the quality of services.

From the findings presented, it hence can be concluded that quality of health care has improved despite the aspect of long waiting time and poor attitude of health workers towards service users being rated unfavorably. As most of the health workers reported being overwhelmed with work, a conclusion may be made that long waiting time is as a result of lower staffing levels. However, this still needs to be proved by further research.

Since the availability of drugs is one of the most important criterion by which people judge the quality of health services, a conclusion can therefore, be made that the restructuring of the MOH has led to an improvement in the quality of health service delivery.

6.2.2 Community participation in decision making.

The study revealed that the majority of service users are ignorant of the existence of Neighborhood Health /Hospital Advisory committees in the health facilities. Furthermore, the two second level hospitals did not have Hospital Advisory committees in place.

The findings also revealed that community participation was mostly restricted to health dissemination programmes such as HIV and immunization Programmes. It was also established that no feedback is given to the community on the decisions made by the neighborhood health committees nor the management of the health facilities indicating that the community is ignorant of projects undertaken by the health facilities.

Hence, from this scenario, a deduction can be made that community participation in decision making in health facilities in Kabwe district is minimal.

In conclusion, while the health reforms underscore the importance of community participation not just as users but as active participants, the data has shown that community participation in decision making is minimal in Kabwe District. Furthermore, the majority of the service users were ignorant of the existence of the Advisory committees, hence not conversant with the roles they were supposed to play. It was also revealed that, the majority of health workers were equally unaware of the importance and role of community participation, as evidenced from the absence of these committees in hospitals. The levels of participation were mostly limited to dissemination of health programs. In addition, communities regard major contribution in terms of labour inputs rather than participation in decision making. This, therefore, proves that communities'non-involvement in decision making is as a result of insufficient orientation on levels of participation at their local health facilities and not following the laid down criteria on who to include in the committees by relevant health authorities. Therefore, it may be inferred that, due to ignorance on the part of community members and lack of political will by health workers, the extent of community participation in decision making concerning health service provision at the local level is minimal. Hence, there is no effective link between health workers and the community in Kabwe district.

6.2.3 Constraints faced by health workers.

The study has established that health workers face a number of constraints as they carry out their duties. These included; inadequate medical equipment, infrastructure and transport among many others. Lack of transport was cited as one of the major constraints which affected service delivery in all the facilities surveyed. This is because without transport, it is difficult to refer patients to higher levels of care and to carry out the day to day activities of the facility.

It was also found out that facilities do not receive feedback when they refer patients. This, therefore, suggests that communication between facilities is minimal and patient care might be compromised as there is no effective communication on the continuity of care by health workers.

The study has also shown that despite Government funding, facilities still regard financing as another major challenge.

The study also established that low staffing levels compounded by high attrition rates has affected health service delivery. All the health facilities surveyed in the study indicated low staffing levels as a constraint which they faced. It therefore, can be deduced that, long waiting time is as a result of health facilities not having enough medical staff.

The study has also established that health workers do not regard strategies set up by Government which include rural hardship allowance, uniform maintenance, and commuted overtime, night duty allowance as motivation and retention strategies. In this vain, the majority of health workers engage in other income generating activities which include practicing in the private health facilities among many others. This scenario is inconsistent with the views of health workers where they indicated that they were overwhelmed with work due to low staffing levels and yet engage in private practice. Therefore, this scenario might lead to conclusions that health workers do not carry out their duties efficiently hence the long waiting time, as their focus might be on private practice where they get an extra income. This is evidenced by service users indicating that private health facilities provide better services than public health facilities.

The findings have also revealed that health workers regard improving physical infrastructure and recruiting more health workers as the most appropriate solution to improve health service delivery.

It therefore, can be concluded that, health workers face a number of constraints in the provision of health services of which low staffing levels, lack of transport, inadequate medical equipment and infrastructure stand out. In this vain, the majority of health workers engage in other income generating activities which include practicing in the private health facilities among many others. This scenario is inconsistent with the views of health workers as they indicated that they were overwhelmed with work due to low staffing levels and yet engage in private practice. Therefore, this scenario might lead to conclusions that health workers do not carry out their duties efficiently hence the long waiting time, as their focus might be on private practice where they get an extra income. This is evidenced by service users indicating that private health facilities provide better services than public health facilities.

6.2.4 Challenges faced by service users

The study has established that the major challenge faced by service users is long waiting time which was attributed to lower staffing levels.

Accessibility to health facilities was also cited as a challenge by the majority of service users from the rural health center set up. However, it must be pointed out that, the majority of service users are of the view that health facilities in Kabwe are easily accessible. Therefore, this shows that service users'challenges and health workers constraints are interrelated. For instance, shortage of staff will lead to the health worker being over whelmed and the service users to have a long waiting time

The main conclusion of the study, therefore, is that the quality of health service delivery in Kabwe District has improved since the 2006 restructuring of the MOH was initiated. Nevertheless, provision is still hampered by constraints which include; lower staffing levels, inadequate equipment, infrastructure and transport among many others. Service users face major challenges of long waiting time and accessibility for those in rural areas. Community participation in decision making is minimal in health centers and non-existent in hospitals.

6.3. Recommendations

To improve health service delivery in Kabwe District, the study makes the following recommendations

1. The Government through MOH should increase the staffing levels of health personnel in all the facilities. This can be easily realised by direct recruitment and replacement of staff on available vacant positions of each establishment. This may inevitably help in reducing the waiting time.

2. There must be a deliberate policy to orient old and new health workers on the strategies that have been put in place to motivate and retain them within the MOH. This will assist the workers to fully understand what is expected of them.

3. Government through MOH should put in place measures aimed at effectively monitoring the performance of health workers. That is health workers should fully account for their man hours, and institutionalising the Performance Management Package (PMP) is a better option. In this way it will be possible to find out whether health workers are putting in as much effort in their work as they do in the private sector.

4. Government to prioritise infrastructural development in the health facilities.

5. Government to procure ambulances and the required equipment for all the hospitals and health centers. The available equipment should be routinely serviced and maintained to increase their life span.

6. Health facilities to research further on the root causes of long waiting time so as to improve service delivery.

7. Where trained health workers are not available, districts and hospitals should be given authority and resources to facilitate for task shifting.

8. Hospitals to form Hospital Advisory Committees so as to enhance community participation.

9. The community to be oriented on the terms of reference of the Neighborhood Health /Hospital Advisory Committees. This will make the community beware of their role in the provision of health services.

10. Government and facility heads to put in mechanisms to continue encouraging health workers on the importance of positive attitude towards patients.

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APPENDICES

APPENDIX A

INTERVIEW GUIDE FOR KEY INFORMANTS

DATE…….

OFFICIAL POSITION OF RESPONDENT/OFFICIAL……

1. How do you rate the services provided by health workers after the 2006 restructuring of the Ministry of Health?

2. What is your opinion on the health services provided by private health institutions?

3. In your view have all the positions been filled by qualified people?

4. In your opinion how easily accessible are the health facilities?

5. How do you rate the attitude of health workers towards patients?

6. What is your opinion on the quality of nursing care for admitted patients?

7. What is your comment on the availability of drugs in health facilities?

8. What is your view on the availability of equipment?

9. Are there any fees charged for the health services?

10. What is your opinion on the health care referral system?

11. How is the performance of health facilities/health workers assessed?

12. What mechanisms have been put in place to maintain, retain and motivate health workers?

13. How is information disseminated from the higher to the lower levels?

14. In your view has the decentralization policy been fully implemented?

15. Which stakeholders do you involve in planning?

16. How functional are the Hospital Advisory Committees/Neighborhood Health Committees?

17. What challenges do you face in health service delivery?

18. What do you think should be done to enhance health service delivery?

APPENDIX B

QUESTIONNAIRE FOR SERVICE USERS

Identification number……..

Date of Interview……./…./…..(Month/Day/Year)

Introduction

My name is Mulima Sibeso Stella. I am an MPA student at the University of Zambia carrying out a research on the Impact of the restructuring of the Ministry of health on service delivery: The case of Kabwe District (2006-2011).In trying to find out whether service delivery has improved as result of the reform program you are kindly requested to answer the questions in the questionnaire. Please note that the responses you will give will be confidential. The information may help the Ministry of Health (MOH) plan and see how best they can provide quality health services to the Zambian people.

Instructions

I. Do not write anything on the questionnaire that might lead to your identity being revealed.

II. For each question a list of responses is given except where otherwise stated, put X against your answer.

PERSONAL DATA

For Official use

1. Sex

1. Male [ ]

2 Female [ ] [ ]

2. Marital status

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

[ ]

3. Age

1. 20 – 24 [ ]
2. 25 – 29 [ ]
3. 30 – 34 [ ]
4. 35 – 49 [ ]
5. 50 – 54 [ ]
6. 55 – 59 [ ]
7. 60 and above [ ] [ ]

4. Employment status

1. Employed [ ]
2. Unemployed [ ]
3. Self-employed [ ]
4. Others specify**... [ ]** **[ ]**

5. Monthly income

1. Below K500, 000.00 [ ]
2 .Between K1, 000, 000 .00-K2, 000,000.00 [ ]
3 .Between K3, 000, 000 .00-K4, 000,000.00 [ ]
4. Between K5000, 000.00 – K6000, 000.00 [ ]
5. Above K7, 000,000.00 [ ]

Assessment of effectiveness of the restructuring program

6. How do you rate the quality of service given to you by health workers at the nearest public health facility you usually go to now compared to five years ago?

1. Very Good. [ ]
2. Good [ ]
3. Poor [ ]
4. Very poor [ ]
5. I don't know [ ] [ ]

7. Health services provided in private health facilities are better than those provided by the nearest public health facility you usually go to?.

1. Strongly agree [ ]
2. Agree [ ]
3. Strong disagree [ ]
4. Disagree [ ]
5. I don't know [ ]

[ ]

8.How long do you usually wait before you are attended to when you visit your nearest health facility?

1. Within 30 min [ ]
2. 1hr-2hrs [ ]
3. 3hrs-4hrs [ ]
4. I don't know [ ]

[ ]

9. Each time you visit your nearest health facility are you attended to by a qualified health worker?

1.Yes [ ]
2.No. [ ] [ ]

10.If No to 9,who attends to you ?please specify.

……..
…….. [ ]

10. When you are attended to at your nearest health facility does the explanation given to you by the health workers meet your expectations?

1. Yes [ ]
2. No [ ]

[ ]

11. From the list below tick the services which are provided adequately at your nearest health facility.

1. Health workers reveal name of illness [ ]
2. Health workers are friendly to patients [ ]
3. Patient is given time to explain illness [ ]
4. Patient can ask questions [ ]
5. Attitude of Health Workers was good.
6. Patient had privacy during consultation/treatment [ ]
7.None of the above [ ]

Challenges faced in accessing the service

12. How easily accessible is the nearest health facility where you usually go?

1. Very easily accessible [ ]
2. Easily accessible. [ ]
3. Not easily accessible [ ]
4. I don't Know [ ]

[ ]

13. Have you ever been admitted to this health facility?

1. Yes [ ]
2. No [ ] [ ]

14. If the answer to 12 is Yes. How would you rate the quality of nursing care?

1. Very good [ ]
2. Good [ ]
3. Fair. [ ]
4. Very poor [ ]
5. Poor [ ] [ ]

15. When you were admitted did you …

1. Share the bed with someone [ ]
2. Sleep on the floor because the facility was full [ ]
3. Refered to other facilities because the facility was full. [ ]
4. was comfortable, everything was as expected. [ ]
5. N/A

[ ]

16. How often are you given prescriptions to buy drugs after being attended to at the health facility you usually go to?

1. Very often [ ]
2. Often [ ]
3. Never [ ]
4. Rarely [ ] [ ]

17. Do you pay any fees for you to be attended to at the nearest health facility you usually go to?

1. Yes [ ]
2. No [ ]

[ ]

18.If yes to 16, are the fees charged affordable?

1.Yes [ ]
2.No [ ]

Extent of Community participation

19. Do you participate in any way in the decision making process of the nearest health facility you usually go to?

1. Yes [ ]
2. No. [ ] [ ]

20. If Yes to **19**, give at least two activities in which you participate in at the nearest health facility you usually go to.

……..

……..

21. Are you aware of the existence of the neighborhood committees/Advisory health committee for your nearest health facility you usually go to?

1 .Yes [ ]
2. No [ ] [ ]

22. If yes to **21**, have you ever been consulted on any projects to be undertaken by the Neighborhood health committee/ Hospital Advisory committee?

1. Yes [ ]
2. No [ ]

23. Does the Neighborhood health committee/ Hospital Advisory committee give you feedback on the decisions they make with the management of the nearest health facility where you usually go to?

1. Yes [ ]
2. No [ ]

24. In your view what should be done to improve the quality of health Service delivery at your local health facility you usually go to?

……..

……..

THANK YOU VERY MUCH FOR YOUR KIND CO-OPERATION

APPENDIX C

QUESTIONNAIRE FOR HEALTH WORKERS

Identification Number ---------

Date of interview----------/-----/----- (Month/Day/Year

Introduction

My name is Mulima Sibeso Stella. I am an MPA student at the University of Zambia carrying out research on the Impact of the restructuring of the Ministry of health on service delivery: The case of Kabwe District (2006-2011). The questionnaire targets service providers and you have been randomly selected to participate in the study Please note that the responses you will give will be confidential. The information may help the Ministry of Health (MOH) plan and see how best they can provide quality health services to the Zambian people.

Instructions

I. Do not write anything on the questionnaire that might lead to your identity being revealed.

II. For each question a list of responses is given except where otherwise stated, put X against your answer.

Personal Data

6. Sex**<u>for official use</u>**

1. Male [ ]

2. Female [ ] [ ]

7. Age

1.20 – 24 [ ]

2.25 – 29 [ ]

3.30 – 34 [ ]

4.35 – 49 [ ]

5.50 – 54 [ ]

6.55 – 59 [ ]

7.60 and above [ ] [ ]

8. Marital status

5. Single
6. Married
7. Divorced
8. Widowed

[ ]

3.Level of Education

1.College certificate [ ]

2.University Degree [ ]

3.Postgraduate Degree [ ]

4. Other…Please specify… [ ]

4. Monthly income

1 .Between KR2000.00 – KR3000.00 [ ]

2.Between KR4000.00 – KR5000.00 [ ]

3. Between KR5000.00 – KR6000.00 [ ]

4 .Above KR7000.00 [ ]

E. Others…Please specify… [ ]

5.How long have you served in the Ministry of Health?

1. 1-3Years. [ ]
2. 4-6years. [ ]
3. 6-8 years. [ ]
4. 8-10 years. [ ]
5. Above 10 years. [ ] [ ]

Assessment of effectiveness of the restructuring program

6. How do you rate the quality of service offered by MOH after the 2006 restructuring.

1. Very good [ ]
2. Good [ ]
3. Poor [ ]
4. Very poor [ ] [ ]

7. In your opinion has restructuring improved the delivery of health services?

1. Strongly Agree [ ]
2. Agree. [ ]
3.Partially Agree. [ ]
4. Disagree. [ ] [ ]

8.In your view has the restructuring of the Ministry of Health put the right people in the right positions?

1.No. [ ]
2.Yes. [ ] [ ]

9.Are you satisfied with your salary/income?

1. Yes [ ]
2. No [ ] [ ]

10.Do you engage in other income generating activities to sustain your livelihood?

1. No [ ]

2. Yes [ ]

…….

[ ]

11. If 'Yes'. From the list below which one do you mostly engage in to enhance your income.

1. Practicing part- time in the private sector. [ ]

2. Petty trade [ ]

3. Farming [ ]

4. Moonlighting [ ] [ ]

5.Any other…please specify…….

12. From the list below, what in your view would be the best option to improve health service delivery at your facility?(tick one)

1. Increase funding [ ]

2. Improving physical infrastructure. [ ]

3. Deploying more health workers to the facility [ ]

4. Improving working conditions for health workers. [ ]

5 Any other please specify

13. Is your performance measured by using APAS at least once a year?

A.Yes [ ]

B.No. [ ] [ ]

14. If No to 13, how is your performance measured. Please specify….

……

15. Considering the 2006restructuring program how do you assess your workload

after restructuring?

1.Workload has increased. [ ]

2.Workload has reduced. [ ]

3.Workload has remained the same. [ ]

5.Not sure. [ ] [ ]

16. Do you have significant equipment needed to do your job effectively?

1. Yes [ ]

2. No [ ] [ ]

17. What kind of condition is the available equipment?

1. Very Good. [ ]

2.Good. [ ]

3.Partially Good [ ]

4.Poor. [ ]

5.Very Poor. [ ] [ ]

18. Are treatment protocols readily available?

1. Yes [ ]

2. No [ ]

19. Is the bed capacity adequate to cater for all the patients you admit?

1. Yes [ ]

2. No. [ ] [ ]

20. In case the bed capacity is fully filled where do you admit the excess

patients?

1. Refer them to other facilities. [ ]

2. Let them sleep on the floor. [ ]

3.Share the bed space. [ ]

4.Anyother specify**…** [ ]

21.Is the facility where you work supplied with adequate drugs to cater for all patients?

A. Yes [ ]

B. No [ ] [ ]

22. How often do you experience drug stock outs?

1. Very often [ ]

2. Rarely [ ]

3. Sometimes [ ]

4. I don't know [ ] [ ]

23. Are there stipulated guidelines for referrals?

1. Yes [ ]

2. No. [ ]

24. If yes to 23, what challenges do you face from the list below in referring patients from one facility to the other?

1. No feedback from the referred to health facility? [ ]

2 .No Transportation (Ambulance) [ ]

3N/A [ ]

4. Any other Please specify**…** [ ]

25. Do you attend any workshops to enhance your performance?

1. Yes [ ]

2. No. [ ] [ ]

26. If Yes to 25, how often do you attend these said workshops

1. Never [ ]

2. Once in a month [ ]

3.1-2 times every three months [ ]

4.3 times in six months [ ] [ ]

E. Once a year. [ ]

27. In your view has the attendance of these workshops enhanced your performance?

1. Yes [ ]

2. No [ ]

28. Mention at least two mechanisms that have been put in place to motivate and retain you.

……

……..

29. Do you participate in the Annual Planning?

1.Yes [ ]

2. No. [ ] [ ]

30. What part do you play in the budgeting process?

……

31. How do you rate the flow of information from the top management?

to subordinates at your facility? .

1 .Very good [ ]

2. Good. [ ]

3. Very poor. [ ]

4. Poor [ ]

5. I can't say [ ]

[ ]

Community participation

32. Is there a Hospital Advisory committee/Neighborhood health

committee at the facility you work from?

1. Yes [ ]
2. No. [ ] [ ]

33. If Yes to 32, how often does the Hospital Advisory committee/Neighborhood health

committee hold its meetings?

1. Every month [ ]

2. Every three months. [ ]

3. Every six months. [ ]

4. I don't know. [ ]

5.N/A [ ]

[ ]

34. Do you think the community plays a significant role in service provision?

1.Yes [ ]

2.No [ ]

[ ]

35. From the list below tick against the contribution that you think the community can contribute to enhance health Service delivery at your facility.

1 Contribute Labour [ ]
2 Assisting with transport [ ]
3 Assists when called upon by providers [ ]
4. Raising community awareness [ ]
5. Making Monetary contributions [ ]
6. Planning and budgeting [ ]
7. Any other… Please specify**…** [ ]

36.What challenges do you face in health service delivery.....

37. What do you propose needs to be done to improve health service delivery

at the facility you work from?

…….

…….

…….

THANK YOU VERY MUCH FOR YOUR KIND CO-OPERATION