HEALTH REFORMS ANDTHE QUALITY OF HEALTH CARE IN ZAMBIA

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ABBREVIATIONS

ANC	- Ante-natal Clinic
DHMT	- District Health Management Team
DK	- Don't Know
GDP	- Gross Domestic Product
HC	- Health Centre
HHR	- Household Respondent
HR	- Health Reforms
K	- *Kwacha* (Zimbabwean currency; K1,250 was $1.00 at the time of the research)
MOH	- Ministry of Health
MSWCD	- Ministry of Social Welfare and Community Development
N	-.Number
NHC	- Neighbourhood Health Committee
PHC	- Primary Health Care
UHC	- Urban Health Centre
UTH	- University Teaching Hospital
STD -	Sexually Transmitted Disease

PREFACE

In 1994, the World Bank published its report *Better health in Africa*, which outlined policies to improve the quality of Primary Health Care by increasing participation of local populations and to ensure its financial sustainability. The latter was to be realised by the principle of cost-sharing. The report was the logical sequel to the World Bank's previous report (*World Development Report 1993: Investing in Health*) in which it had sketched the economic implications of improved health conditions. That report emphasised that development is not possible without a healthy population; health, in other words, is an economic asset. In the same year, 1994, the Zambian government launched its Health Reforms which aimed at a revitalisation of Primary Health Care by introducing cost-sharing as a key principle of community participation and sustainability .

Two years later, researchers from the Zambian Institute for African Studies (later to be renamed as the Institute of Economic and Social Research) and the University of Amsterdam, the Netherlands, met and designed a research plan to study the achievements of Health Reforms in Zambia. The Danish Ministry of Foreign Affairs accepted the proposal and financed its execution. The first phase of the research was conducted between April and July 1995, the second between June 1996 and February 1997.

Much has been written about the Zambian Health Reforms (e.g. Cassels & Janovsky 1996, Koot 1997, Chabot 1998), but little of this is based on systematic field research. The views of the two main parties which are affected by the reforms, health workers and local communities, are rarely taken into account. This study focuses on *their* views and *their* experiences with the Health Reforms.

A parallel study on the revitalisation of Primary Health Care in Uganda, financed by DANIDA, was carried out by a team of researchers from Makerere University, Kampala, Uganda, and the Royal Tropical Institute in Amsterdam, the Netherlands. A brief comparison between the main conclusions of the Ugandan report (Munene 1997) and the Zambian research is presented in the conclusions of this study. A large number of people contributed to the realisation of this research. First of all we are grateful to the Danish Ministry of Foreign Affairs for its generous and patient funding of this study. Secondly, we would like to thank all respondents and key informants, both health workers and consumers of health services, for their enthusiastic co-operation. We hope that this study will contribute to a gradual improvement of health conditions in their community.

We would further like to express our gratitude to the following institutions which facilitated the work in Zambia: the Central Board of Health (CBOH); the District Health Management Teams of Lusaka Urban, Kaoma, Senanga, and Mwinilunga. Individual people who were contracted to carry various assignments

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In the Netherlands the following colleagues contributed to the planning and management of the research project: Pieter Streefland, Cor Jonker, AnneLoes van Staa and Teresa Klerkx. Preeti Kirbat helped in the production of this report.
This publication is based on two earlier reports (Macwan'gi et al. 1996, 1998) and a publication in *Health Policy and Planning* (Van der Geest et al. 2000).

The study report is available to the Ministry of Health, to NGOs and community based organisations involved in the promotion of health in Zambia. Copies are also being sent to all institutions which participated in the research. We invite them to study its conclusions and recommendations and determine how these can feed into reform implementation and/or modification, in consultation with local health staff and community representatives.

Lusaka/Amsterdam, May 1999

ABSTRACT

The general objective of this Primary Health Care Research Project was to study the factors which inhibit or facilitate Health Reforms in both rural and urban Zambia and, on the basis of this knowledge, to contribute to the improvement of basic health care. The study examined the implementation process of the Health Reforms and assessed their impact on the quality of care. To achieve this broad objective, the research was divided into two phases, an exploratory and an evaluation phase.

During the exploratory phase qualitative data was collected with the aim of generating research hypotheses and developing research instruments for the evaluation phase. Three supplementary research methods were used: (i) Focus Group Discussions (FGDs) with users and potential users of health services, (ii) in-depth interviews with health workers and community leaders; and (iii) observations of patient-provider interactions and general health centre conditions. The exploratory research was carried out in two districts, one rural (Senanga, Western Province) and one urban (Lusaka). In each district two health centres were selected, one offering integrated services and the other having a non-integrated service model.

The evaluative phase was planned to test the hypotheses generated in the first phase and to quantify some of the key findings observed in the exploratory research. The specific objectives for the evaluative phase were to: (i) assess health providers' and users' awareness of the Health Reforms; (ii) study health providers' and users' views and practices with regard to cost-sharing; (iii) explore the extent to which rural and urban communities are involved in the planning and delivery of health services; (iv) examine providers' knowledge and views with regard to decentralisation of decision making; (v) study users' and providers' views about the quality of care at basic health facilities after the introduction of cost-sharing (with special regard to patient-health worker interaction, availability of drugs, physical conditions at the centre, accessibility of services, competence of the staff and the effects of the treatment) and (vi) determine trends in the utilisation of health services against the background of cost-sharing.The study was conducted in three provinces of Zambia: Lusaka, North Western Province and Western Province. Multiple complementary research methods were used: (i) a household cross-sectional survey; (ii) informal/in-depth interviews with health providers; (iii) exit interviews with patients who had just received medical treatment from selected health centres and (iv) review of records for the period 1990 - 1996. The sample consisted of a total of 1515 households drawn from rural and urban areas, 98 providers were interviewed through a self-administered questionnaire and 381 patients took part in exit-interviews.

1. The study shows that most of the health workers are aware of the Health Reforms and their aims. According to them the main aim of the Health Reforms is to improve the quality of care and health services and to enhance the general health status of the community. Various sources of information on Health Reforms are reported, the major ones being seminars/workshops, Health Reforms reports, and DHMTs. Health providers from rural areas rely more on health information reports, while those in urban areas depend more on DHMTs.

2. The study found differences between household respondents' and providers' perceptions of cost-sharing. Community members complained that they are not able to pay for health care. Inability to pay for health care is linked to high levels of poverty prevailing in the country. Most providers, on the contrary, held the view that the community can afford to pay for health care.

   No conclusive evidence could be established about the preferred mode of paying for health care (user fees or prepayment) since the respondents in the rural districts were not familiar with the concept of prepayment. In the urban sample, however, both providers and community respondents showed an overwhelming preference for prepayment.

   In-kind payments are uncommon in rural districts and non existent in urban areas. The economic adversity and consequent financial constraints notwithstanding, people are willing to pay for health care, if they are assured of obtaining a tangible form of health care, particularly high quality drugs.

3. The study observed that the respondents do not consider cost-sharing a form of community participation. Only physical contributions especially in the form of labour is considered to be community participation. A related finding is that most of the household respondents did not know how they, as individuals, could help improve the quality of service at their local health centres.

4. The process of decentralisation is still in its initial stage. Most health workers are not involved in planning and decisions about how user fees money should be utilised. About two thirds of providers do not get a bonus from user fees and most of them do not know the reason. However, most health workers reported that they are supervised in accounting by their respective DHMTs.

5. Results of this study indicate that studies on quality of care need to take into account the various aspects of care, type of health facility and different settings within which health facilities are located. The study underscores that perceived quality of care varies by type of health facility. The highest quality is accorded to church-related hospitals, followed by government hospitals and government health centres. The study also notes major rural - urban differences in perceptions about quality of care.

Whereas in general, the findings of the study show a positive appreciation of the quality of care provided, household respondents from rural areas are more likely to report that the general standard of health services is good while urban respondents are more critical of services being offered at various health facilities.

While a general picture may show a fairly positive picture, a critical examination of specific areas of care reveals some causes for concern. One critical area is the lack of sufficient drugs at health centres. For example, during the exit interviews, one quarter of respondents who were prescribed medicines did not get all their medicines on the day of the interview. Other indicators of quality of care which do not fare well are waiting time and communication between clients and health providers. Waiting time is generally reported to be long at all study sites and most of the household respondents report that health workers do not usually tell patients what illness they have nor do patients get the opportunity to ask questions about their problem.

Access to health facilities, especially in rural areas is reported to be limited. Many health centres are far from where patients live, transport to health centres is difficult and often there are no health staff to attend to patients, especially in rural areas. More than one third of the respondents complain that hospitals in the rural areas and health centres in general are not accessible at night.

Health workers' knowledge is rated well but this knowledge is not translated into practice. For example, about two thirds of respondents in the exit interviews reported that they, or the patients they brought to the health centre, were not examined. Data on treatment and perceived treatment outcome shows a rather negative picture: about half and a third of the respondents in the household survey report that they usually do not receive the treatment they expect and do not get better after the treatment.

6. Finally, people hold the view that cost-sharing has a negative impact on the utilisation of health services. This is supported by the observed decline in the numbers of people going to health institutions after the introduction of cost-sharing. However, the introduction of fees does not seem to have had a sustained negative impact on utilisation; a year later the utilisation of health services began to grow again.

   A reason for concern is the weaknesses of the Social Welfare Scheme. The present period of economic adversity is leading some people to forego health care because they cannot afford the fees while they are not aware of the Scheme which is supposed to assist those who are in serious economic problems.

In conclusion, cost-sharing, which is the 'heart' of Zambia's Health Reforms, may prove successful as a new form of community participation and democratisation, provided it is applied in a humane way and the promise of good quality health care is kept.For the users of health services, in rural as well as in urban areas, good quality means first of all more and better drugs. The question is whether health policy makers in the country are willing and able to meet this popular demand.

PART I

BACKGROUND, METHODS AND CONTEXT

CHAPTER 1

INTRODUCTION

This report covers the exploratory and evaluative phases of a primary health care (PHC) research project in Zambia. The general objective of the project was to contribute to the revitalisation of basic health care in both rural and urban Zambia. Specifically, the project examined the implementation process of the Health Reforms and assessed their impact on the quality of care. The project aimed at understanding community factors that inhibit and/or facilitate the functioning of basic health services through both qualitative and quantitative research methods.

1.1 Background

Vast inequities in health and health care were prevalent in Zambia at the time of the country's independence. To reduce these inequities, massive investment had to be effected in the health sector, resulting in an expansion of health facilities. For instance, the number of government hospitals increased from 19 in 1964 to 42 by 1990 (CSO 1992: 42). Even more spectacular were the improvements in the number of government run rural health centres which increased from 187 by 1964 to 661 by 1990 (CSO 1992: 42). Since the rural areas had the worst health conditions due to lack of opportunities, the government made special efforts to improve those through the adoption of PHC.

In 1972 about one-fourth of the total population did not have access to any modern health facility within 15 km; in some worse-off provinces, largely rural ones, the proportion was one third (ILO 1981: 104). There were and still are disparities in the allocation of government health funds between urban and rural areas which are both cause and effect of the imbalances in the availability of facilities.

The improvements scored by the government shortly after independence, notwithstanding, the health system was criticised for being too curative-oriented. To improve on this aspect, the government adopted Primary Health Care, concentrating on the rural dwellers, while little attention was given to the urban population (cf., Limbambala et al. 1994).

In addition to the achievements scored in terms of development of the infrastructure, health indicators also improved. These improvements, which were mainly attributed to government funded initiatives, were made possible because of a buoyant economy in the immediate post-independence period.

The fortunes of a good economy were, however short-lived, with a fall in the country's chief export (copper) prices and a rise in oil prices. These factors precipitated

an economic contraction which was compounded by internal mismanagement. "For long, the country has been characterised by a state-dominated economy which was marked by enormous waste of resources as its main features; low or negative rates of GDP growth; high unemployment and underemployment; rising inflation; high levels of poverty and inequality in the distribution of income and wealth and a considerable part of the social service infrastructure in a state of disrepair" (Seshamani et al. 1993: 1). Since the provision of health services was largely contingent on continued resource-inflows from the government, the poor economy meant that health conditions deteriorated. The infant mortality rate, for example, rose again to 107 by 1992 (World Bank 1994b). Since the 1970s the central government budget allocation to the Ministry of Health has been less than 10% of the total budget. Financing of the health system became highly dependent on donors with the result that sustainability arose as a critical issue (cf. Soeters 1997).

Other health indices worsened as well. Under-five mortality rates rose again, the percentage of the population with access to safe water and sanitation declined and the immunisation coverage also took a downward turn. In addition to these negative trends, a rise in malnutrition levels was noted. Loss of real income (in terms of both declining employment opportunities and effects of inflation and government policy on real wage levels, rather than inadequate food stocks at the national level perse) explain why households became food insecure (Saasa & Kawanga 1994: 26).

To stop the downward spiral the new government, which came to power in 1991, set out a package of measures to bring new life into PHC. These 'Health Reforms' were very much influenced by the spirit of the day: Structural Adjustment, which was being 'sold' to policy makers by the World Bank or donor community and by policy-makers to health workers and their clients as an exercise in making health care more sustainable (cf. Chabot et al. 1995, World Bank 1994a). The Bamako Initiative of 1987 was the concretisation of this new policy by which African governments agreed to: put their resources squarely behind the proven elements of PHC; make more rational use of their slender health budgets and; examine creative approaches to community financing methods which hadalreadyenabled communities in a number of African nations to take chargeof local health needs.

The idea of charging communities for health services was based on the premise that people already paid high fees for private health care, provided that it was of good quality. It was assumed that if people were willing to pay for private services, they would equally be willing to pay for government services, as long as quality is assured. The Health Reforms package was adopted as a comprehensive approach to resolving the inequities inherent in health services. The health vision was stated as a commitment to "the fundamental and human principle in the

development of the health care system to provide Zambians with equity of access to a cost effective, quality health care as close to the family as possible." This meant provision of better management to attain "quality health care for the individual, the family and the community. In order to facilitate the attainment of this vision, the government has adopted the Primary Health Care strategy as the more appropriate vehicle" (MOH 1994: 28).

Taking into account the shortcomings and lessons of PHC in the 1980s, the government selected six operational principles to guide the new strategy: Self-reliance and participation of individuals, families and communities; Equity; Inter-sectoral collaboration; Decentralisation; Appropriate technology; and Emphasis on promotive and preventive health services. This project examines some of these principles.

It should be pointed out that these objectives were largely the same as those of the previous PHC attempt, but the means by which the government hoped to achieve them was new: community involvement came to include cost-sharing and more emphasis was placed on the development of basic health care in both urban and rural areas, whereas in the 1980s, PHC was a strategy designed mainly for the rural population. Furthermore, the new government claimed that the introduction of PHC in the 1980s had been haphazard (there was no implementation strategy and the funds were insufficient), whereas its Health Reforms contained a plan on how the measures were to be implemented (MOH 1994: 28). The introduction of cost-sharing was the most drastic policy measure by which the government hoped to improve both the quality and the sustainability of basic health services.

1.2 Research objective

As mentioned before, the general objective of the Primary Health Care Research Project was to contribute to the improvement of basic health care in both rural and urban Zambia through the understanding of community factors that inhibit and/or facilitate the government's Health Reforms. The study examined the implementation process of the Health Reforms and assessed their impact on the quality of care. To achieve this broad objective, the research was divided into two phases, an exploratory and an evaluation phase.

1.3 Exploratory research phase

The main objective of the first phase was to explore the conditions of basic health services after the introduction of the Health Reforms and to collect qualitative information on people's views and practices with regard to the new situation. Both users and providers of basic services in two rural and two urban health centres were interviewed. Two overall questions that were addressed were: (1) To what extent are the Health Reforms being implemented and: (2) Are the Health

Reforms contributing to an improvement of the quality of health care. The three main research tools that were used for the study were open, loosely structured interviews with health workers and key informants from the community, focus group discussions with a variety of people from the community, and direct observations in the four health centres and their surroundings.The findings of this first phase of the research have been presented in a separate report (Macwan'gi et al. 1996). The exploration led to the formulation of a number of hypotheses which were to be 'tested' in a second phase.

1.4 Hypotheses

The hypotheses were divided over six fields of interest in the study of Health Reforms. The following ones were eventually selected to serve as starting points for the quantitative ('evaluative') research phase:

Cost-sharing

- Both users and providers of basic health care are opposed to the introduction of cost-sharing in health care.
- Both providers and users prefer the insurance scheme to user fees.

Community involvement

- Members of the community do not feel 'involved' in the planning and delivery of basic health care.
- Providers are more likely to report that the community is involved in planning and delivery of health services than members of the community.
- Community members do not consider cost-sharing as a form of 'community involvement'.

Decentralisation

- Bureaucratic tape has been reduced; health workers feel more in control of their own work.
- Lack of supportive structures at district and health centres limits the decentralisation process.
- Health centre staff are not actively involved in decision-making regarding use of money collected through cost-sharing.

Quality of care

- Providers are more likely to report that cost-sharing has improved the quality of care than users.
- Users in urban areas have a higher expectation of quality of care than their rural counterparts.
- User-provider interactions are more positive (friendly and understanding) in rural areas than in urban areas.

- Availability of drugs is considered the most important element of good health care by users and to a lesser extent by providers.
- Providers are more positive about the quality of services (i.e., availability of drugs) at health centres than users.
- There is no marked difference in the availability of drugs between rural and urban areas.

Utilisation

- The introduction of cost-sharing has led to a reduction in the utilisation of basic health services.
- The low level of knowledge about the social welfare scheme among the community and the providers leads to non-utilisation of the scheme.

1.5 Evaluative research phase

Starting from these hypotheses, the quantitative research set out to investigate and quantify the main findings of the first phase and to 'test' the hypotheses. The specific objectives for this second phase were:

- To assess health providers' and users' awareness of the Health Reforms;
- To assess health providers' and users' views and practices with regard to cost-sharing;
- To examine the community's and health providers' knowledge and use of the exemption scheme;
- To explore the extent to which rural and urban communities are involved in the planning and delivery of health services;
- To examine providers' knowledge and views with regard to decentralisation of decision making;
- To study users' and providers' views about the quality of care at basic health facilities after the introduction of cost-sharing (with special regard to: patient-health worker interaction, availability of drugs, physical conditions at the centre, accessibility of services, competence of the staff, and the effects of the treatment);
- To determine trends in the utilisation of health services against the background of cost-sharing.

  The subjects presented in the chapters of this report follow the order of these objectives.

CHAPTER 2

METHODOLOGY

2.1. Exploratory phase

The exploratory phase used three supplementary qualitative research methods: (i) Focus group discussion (FGDs) with members of the general community and users of health services; (ii) In-depth informal interviews with providers and community leaders, and (iii) Observations of the physical setting of health facilities and interaction between users and providers.

2.1.1 Study sites

The exploratory research was conducted in two districts, one urban: Lusaka and one rural: Senanga in the Western Province. Selection of the districts was guided by a carefully formulated criteria. First, the study was designed to reflect both rural and urban basic health care conditions and people's perceptions about basic health care services. Second, Senanga was selected because it was one of the three districts (Mansa and Monze) which participated in the pilot study for decentralisation of financial management and is located in one of the most undeveloped rural provinces. Lusaka was selected because it is one of the most urbanized districts and has a large pool of key informants who participated in the formation of Health Reforms. Key informants provided background information which was needed to understand the research subject in detail.

2.1.2. Study population

The study population consisted of users of basic health care services, health providers and the community. The community comprised of key informants from service organisations such as churches and NGOs and potential users of basic health services. To identify participants for the study, the following selection criteria was used. Firstly, health providers and potential users of basic health services were selected purposefully to ensure that each category of health personnel available at the four health centres (Chilenje, Kabwata, Itufa and Kaanja) participated in the study and to get a wider representation of the community respectively. Secondly, a self-selective procedure involved recruiting individuals of either sex who reported to the four health centres for preventive (MCH) and curative services during the time when the Research Team was scheduled to be at the health centre and were willing to participate in a group discussion. Identification of users to participate in the study continued until when the required number for a focus group discussion was obtained. A total of 25 FGDs were conducted and 35 informal interviews with various categories of

health providers (nurses, clinical officers, medical doctors, classified daily employees, environmental health technicians, traditional birth attendants and community health workers) who were working at the health centres at the time of the study were conducted. Finally, a checklist was used for observing physical conditions and interaction between providers and users.

2.2. Evaluative phase

During the evaluative phase multiple supplementary research methods were used: (1) a household cross-sectional survey; (2) informal/in-depth interviews with health providers; (3) exit interviews with patients who had just received medical treatment from selected health centres and (iv) a review of records.

2.2. 1. Household cross-sectional survey

A total sample of 1,515 households was drawn from rural and urban areas. The sample was proportionately divided into urban and rural areas comprising 634 and 881 households respectively. This represents 42% and 58% of urban and rural population respectively and corresponds to the urban and rural population proportions as given by the 1990 Population and Housing Census. Within each household, the head of the households or any other member of that family responsible for making health decisions was interviewed using a semi-structured questionnaire. Within the selected districts, the sample was proportionately divided according to the catchment population of the selected residential areas.

Urban sub-sample

In Lusaka district, a sub-sample of 634 households was divided proportionately using the catchment populations of the health centres under study namely Chawama and Kabwata.

Rural sub-sample

The rural sample of 881 was divided between two rural provinces, Western and North Western. That is, sub-samples of 448 and 433 households were drawn from Western and North-Western Provinces, respectively. In Western Province 448 households were divided proportionately between two districts, Senanga and Kaoma using the 1996 District Population Estimates: 245 household interviews were conducted at Itufa in Senanga and 203 at Chitwa in Kaoma District. In North-Western Province only one district (Mwinilunga) was studied. The 433 households were proportionately divided between two rural health centres studied (Nyangombe and Sachibondu) using their respective catchment populations.

Table 2.1: Sample size by district

provincial/ district	*number of interviews*		
	household	*exit*	*provider*
Lusaka Province Lusaka Urban District	634	176	36
Western Province Senanga District Kaoma District	245 203	58 51	23 19
North Western Prov. Mwinilunga District	433	86	20
total (n)	*1515*	*381*	*98*

2.2.2. Informal interviews with health care providers

Ninety-eight providers were interviewed using a self-administered questionnaire. At least one member of staff in each category was interviewed at each health centre visited. In a few cases where providers such as CHWs, TBAs and CDEs could not understand certain questions they were aided in answering the questionnaires.

2.2.3. Patient exit interviews

A total sample of 381 patients was agreed upon for interviews after taking into account the feasibility of data collection. This sample was divided into urban (176) and rural (195) patients. The interviews were conducted using a structured questionnaire. The data was collected by positioning the interviewers at exits of the health facilities to faciliteit interviewing of patients as they came out of the health centres after receiving care.

2.2.4. Review of records

The study also assessed whether there had been an increase or decrease in the attendance of patients over the last five years. This was done by reviewing patient attendance data, and admission figures for populations aged under and above five years from 1991 to mid 1996 at each health centre where patient exit interviews were conducted.

2.2.5. Study sites

The study was conducted in four districts: Kaoma and Senanga in Western Province, Lusaka urban in Lusaka Province and Mwinilunga in North-Western Province. Two of these districts, Lusaka and Senanga were also covered in the

exploratory phase, while the other two, Kaoma and Mwinilunga were not. The districts previously covered in the exploratory phase were included in the evaluation phase in order to follow up issues or trends raised from the exploratory phase.

A total of 23 health centres were sampled from the four districts. An average of six health centres representing about 30% of all the health centres in each district were selected for the study. Since the staff is very less especially at rural health centres, it was necessary to include this number of health centres in the study in order to get an adequate sample.

Table 2.2: Number of providers who participated in the study, by district and health centre

district	*health centre*	*no. of providers*
Lusaka Urban	Chainda	11
	Chawama	10
	Chelstone	7
	Chilenje	.8
	Kanyama	8
Kaoma	Chitwa	6
	Kahare	2
	Kasimba	3
	Mbanyutu	3
	Namilangi	3
	Nkeyema	3
Senanga	Itufa	6
	Kaanja	1
	Litambya	6
	Sioma Catholic	6
	Mission	3
	Sitoti Mission	1
	Nangweshi	
Mwinilunga	Nyangombe	5
	Sachibondu Mission	6
	Luaba	3
	Sailunga	2
	Mukalanga	1
	Ikelenge	3
total (n)	*23*	*98*

2.2.6. Data management and analysis

Data collection and entry were done concurrently with the collection process. A separate team of data entry personnel was engaged. During this stage, the data was also cleaned and reorganised where necessary. Cross-checks between entered

data and questionnaires were often carried out. Once all the data had been collected, frequency distribution for all the variables were run to have a feel of the information. At this stage, further cleaning of data was undertaken especially where inconsistencies were observed. The frequency distributions and statistics were subsequently used in writing the report.

PART II

STUDY FINDINGS

CHAPTER 3

AWARENESS OF HEALTH REFORMS

The MOH Policy and Strategies Document categorically states that the implementation process of Health Reforms cannot succeed without community involvement (MOH 1994). 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. People cannot form attitudes towards certain objects or issues and/or adopt behaviours unless they are aware of them. To assess the general knowledge about the Health Reforms, health care providers were asked whether they knew about the Health Reforms and their aims and their sources of information about the Health Reforms.

The information presented in Table 3.1 shows that the majority (75%) of providers were aware of the Health Reforms. The study also shows that there was a higher level of knowledge among urban than rural health workers (81% and 74% respectively). Providers were further probed to determine their knowledge about the aims of the Health Reforms. The majority (59%) stated that the aim of the Reforms was to improve the quality of health care, while 15% said the aim was to improve people's health status. Among the providers from urban sites, 58% mentioned "improvement of quality of care" while 16% stated that the aim was to improve the health status of the population. The corresponding percentages for rural districts were 59% and 15% respectively. While it is acknowledged and appreciated that a high proportion of respondents were knowledgeable about the Reforms, the fact that 23% of health care providers are not aware that Health Reforms have been introduced in that very district that they are employed in, is a matter which should be of great concern to the authorities.

In addition to questions about the Reforms and their goals, providers were asked to state their source of information about the Health Reforms. The major sources of information about the Reforms were Seminars/Workshops (26%), Health Reforms Information Reports (26%), and District Health Management Teams (15%). In rural areas, Health Reforms Information Reports were the most common source of information (29%), followed by Seminars (26%), and District Health Management Teams (9%). Among the urban health workers, however, the order of importance of these sources was Seminars (25%), District Health Management Teams (23%) and Health Reform Information Reports (8%).

The high percentage of providers who reported seminars as their major source of information may point to weaknesses in communication strategies at the district level. That a very low proportion (15%) of the respondents reported the

district as their source of information suggests that it is mainly the few people who are able to attend these workshops who have access to the information.

Table 3.1: Health providers' knowledge about the Health Reforms

do you know about the health reforms ?	*urban*	*rural*	*total*
Yes	81%	74%	75%
No	19%	26%	25%
total (n)	*36*	*62*	*98*

Table 3.2: Providers' views on the aims of the Health Reforms

	urban	*rural*	*total*
Improve quality of care	48%	36%	41%
Improve health services	10%	23%	18%
Improve people's status	16%	15%	15%
Others	26%	26%	26%
total (n)	*58*	*92*	*150*

Table 3.3: Providers' sources of information about Health

	Urban	*Rural*	*Total*
Seminars/workshops	25%	26%	26%
HR information reports	8%	29%	20%
DHMT	23%	9%	15%
Others	44%	36%	37%
total (n)	*52*	*77*	*129*

Conclusion

The study shows that most of the health workers are aware of the Health Reforms and their aims, but the fact that one in every four health workers is not aware of the Health Reforms is both surprising and alarming. Three major aims of the Health Reforms that were reported are: improving the quality of care of health services and of people's general health status. Various sources of intervention on Health Reforms are reported. The major sources of information are seminars/workshops, Health Reforms reports, and DHMTs. The study shows that health providers from rural areas rely most on health information reports, while those in urban areas depend more on DHMTs. This could mean that DHMTs in urban areas do a better job in sensitising their health workers than DHMTs in rural areas.

CHAPTER 4

COST-SHARING

One of the major principles of the Zambian health sector reform process is partnership, which entails government engagement with other actors in the management and provision of health care. Key actors are the consumers of health care who, among other roles, are expected to contribute towards the cost of providing health care. This marks a major policy shift from free medical services as was the case in the previous Zambian government. However, as has been indicated in the Introductory Chapter, the provision of free medical services was sustainable only to the extent that the state treasury allowed it. A downturn in the economy, and the resultant fiscal constraints negatively affected the government's ability to provide free medical services. Shortages of drugs, poor remuneration of staff and a breakdown of health facilities became evident in the health sector.

Partly in order to resuscitate the health sector and induce a sense of partnership with consumers of health care, Health Reforms in general and cost-sharing in particular were introduced. Cost-sharing casts the community not just as consumers of health care but also as active participants in the financing and delivery of health services. Communities contribute towards the cost of health care either through cash payments (user fees and pre-payments) or in-kind payments. User fees are direct payments made each time a person seeks care from health facilities while pre-payments take the form of a health insurance scheme that allows individuals and/or families to pay in advance and obtain health care from a health facility within a predetermined time span. In-kind payments, though piloted, are only operational in the rural areas of the country. These payments predominantly comprise of agricultural produce which is given in lieu of cash payments.

4.1 Exploratory findings

Rural communities

At Itufa and Kaanja RHCs, only user fees were being implemented. As a result, the community was more aware of user fees than any other health reform. People were not in favour of user fees; they expressed strong negative views against them. An overwhelming majority said they were poor and could not afford to pay user fees. Teachers wondered why they should pay for health services when they pay government tax which should be used for the provision of social services. Other complaints from the community include that

authorities at Senanga hospital charge for the use of the mortuary and wondered "why fees should be extended to the dead."

Another concern raised was the poor quality of services provided despite the money realized through user fees. Box 4.1 contains more statements about user fees as expressed by the community. Out of the 72 people who participated in the twelve focus group discussions, only two held the view that paying for health services was a good idea since the scheme had led to an improvement in the availability of drugs at the clinics. Occasional shortages of drugs were reported and very strong recommendations were made to improve the availability of drugs. The study participants also indicated that they were not happy with the scheme because they did not know how the money raised through user fees was used.

However, the role of user fees in improving RHCs services was very clear to providers. They noted that before the introduction of user fees, lack of funds constrained improvement of RHC services. But this situation has now changed, RHCs have access to funds and can purchase cleaning materials and carry out renovations to improve the outlook of health facilities.

Urban area of Lusaka

Unlike in the rural areas, where only user fees were found to be in place, in urban areas both the prepayment scheme and user fees had been implemented. The key issue regarding the two options of health financing was that they had been implemented without consultation of both providers and the community. As a result the community by and large reacted negatively to cost sharing

Box 4.1. Community views about user fees at Itufa and Kaanja Clinics

Against user fees

A housewife at Kaanja Clinic:

"We will be dying in our villages because we are too poor to afford money to pay for the medicine, the bed and the books in which our illnesses are written."

Another housewife at Kaanja Clinic:

"These charges have resulted in more deaths because of lack of money. Instead of buying food, we are forced to use that money to pay for medication."A female farmers at Itufa:

"Sometimes, I cannot manage to pay double for myself and the child because I do not have enough money to pay at the clinic."

A male teacher at Itufa:

"People die in their homes because they believe that you have to pay each time you go to the clinic, so people just stay at home even when they are sick."

For user fees

A male farmer/fisherman at Itufa:

"The fee that I think is unfair is mortuary fees for dead bodies. Otherwise user fees are not bad because we know what this money is being used for."

A female member of Kaanja Village Health Committee:

schemes at least in the initial phase. The majority said they could not afford the charges. People contended that they were already paying through government taxes and paying for health services was tantamount to double taxation.

While the providers said they knew the differences between 'user fees' and 'pre-payment' schemes, the community did not. They said they got to know of the 'user fees' only when they reported at the health centres for treatment. They expressed dissatisfaction with this arrangement.

In addition, to lack of detailed information about how the prepayment and user fees schemes operate, providers cited that conflicting statements from the Ministry of Health senior officials on the exemption procedures affect their work. As a result they said it was difficult to give proper and satisfactory explanations to the public. They however, acknowledged lack of initiative on their part to take up the issue with the central offices and seek clarification. The community wondered why cost sharing scheme was introduced when those implementing it did not understand it. "Some health workers do not know the criteria for exempting those who cannot afford from paying user fees"

Box 4.2. Users' reactions to user fees in the urban health centres

A male participant at Chilenje health centre
"Where does one get money for the scheme? It is better to visit traditional healers instead."
A teacher complained:
"The pay of a teacher is the lowest in the country. How do we manage the escalating cost of living now that we have to pay for health services too?" We do not get enough to pay for user fees."
Young men got angry as they tried to explain their situation and one pointed out:
"I am unemployed and not even able to buy bathing soap. How does the government expect me to find money top pay for health services.?"
A male member of the Health Neighbourhood Watch Team (HNWT):
"The new Government had very convincing slogans but their actions are terrible....How do we explain this to the people in the community?"
A female member of the HNWT:
"What will my friends say when they realise that I am in the Health Neighbourhood Watch Team?"
A teacher in Lusaka:
"Does Health Reforms mean charging fees? After all there is no real improvements to the services. Medicines are still out of stock, nurses are still rude, so what are we paying for?"
Another female teacher:
"Traditional healing is the only solution to our health problems. Traditional healers are reliable and quite cheap compared to the clinic where you pay money and get no attention and drugs."

said one male participant. During the discussions about the exemptions scheme it was pointed out that some people stayed at home when ill and without money because they did not know about the social welfare scheme. Selected reactions of the providers and community are given in the two Boxes 4.2 and 4.3.

Whereas in rural areas people were unanimously opposed to user fees, in the urban area of Lusaka people said fees were welcome as long as the standards of services provided improve. A female participant at Kabwata said that "fee paying was al right so long as those who are unable to pay can be assisted by the government." An out-of school youth at Kabwata had this to say: "The scheme is al right because whenever a baby gets sick you just go to the clinic even when you do not have money to pay. The scheme is al right because without it there would be no medicines just like in the past. "People in urban areas are relatively more willing to pay than their rural counterparts on condition that measures to ensure quality of services and equity of access to health services are put in place.

4.2 Attitudes towards cost-sharing

The first phase of this project indicated that people especially those from rural areas are opposed to the introduction of cost-sharing. Rural respondents reported that they were poor and could not afford to pay the fees. Although urban residents were also opposed to the idea of paying for health facilities, they were relatively more receptive to the idea of payment, than their rural counterparts. However, urban dwellers' positive disposition towards fee paying was conditional on improved quality of care and specifically availability of drugs.

To quantify community attitudes towards cost-sharing that were observed in the first phase, respondents in the household survey were asked for their opinions on whether they thought people should pay for health services or not and why people should or should not pay. Information about providers' attitudes on the same topics was also collected by asking them parallel questions to those asked to the household respondents. In addition, providers were also asked whether the community was willing to pay for health care.

Results of this study are consistent with the findings of the first phase which showed that people objected to the idea of paying for health services. It can be observed from Table 4.01 that slightly over three quarters (77%) of the sample think that people should not pay for health services. This pattern is observed in both rural and urban areas. In contrast, Table 4.02 shows that a high proportion of providers from both rural (74%) and urban (89%) areas were of the view that people should pay for health services.

Box 4.3. Providers' reactions to user fees in the urban health centres

"Some people cannot afford the scheme and therefore turn to traditional medicine. My neighbour has a large family, but no one is working, so they have reported to traditional healers for treatment."
"When people from the community pay money, and get no drugs, they get annoyed and shout at us."
"The government should also consider that some people are poor and others rich. Poor people should pay what they can afford and not what they cannot afford."
"We are also Ministry of Health (MOH) staff, we should therefore, be given free treatment at UTH when we fall sick and not made to pay as is the case now."
"Prepayment scheme should continue but members of staff should be excluded from paying for health services and be attended to free of charge - more especially at UTH, where we are made to pay regardless of being nurses in the MOH."

Table 4.01: Household respondents' attitudes towards cost-sharing

should people pay for health services ?	*urban*	*rural*	*Total*
Yes	31%	17%	23%
No	69%	83%	77%
total (n)	*634*	*881*	*1515*

Table 4.02: Providers' attitudes towards cost-sharing

should people pay for health services ?	*urban*	*rural*	*total*
Yes	89%	74%	78%
No	11%	26%	20%
total (n)	*36*	*62*	*98*

After establishing the proportion of the respondents who were for and against the idea of charging people for health services, those who disagreed were asked why people should not be charged for health care. As could be expected, Table 4.03 shows that the major reason given by 80% of the respondents was that people were poor and, therefore, could not afford the fees. The next largest category (17%) were those who said that medical services should be provided freely. The pattern of responses in urban areas was similar to the national level, with 62% and 20% saying people were poor and medical services should be

provided freely, respectively. In the rural areas, 58%, 6% and 20% of the respondents maintained that people were poor; that it was impossible to find money when one was sick; and that medical services should be freely provided respectively.

Table 4.03: Household respondents' views on why people should not pay for health services

reasons	*urban*	*rural*	*total*
People are poor	62%	58%	80%
Medical services should be free	20%	6%	17%
It is us who built the clinic	0	3%	2%
Impossible to find money when ill	1%	20%	13%
Drugs not always available	12%	0	4%
No proper equipment	5%	1%	2%
Others	0	2%	2%
total (n)	*431*	*731*	*1162*

4.3 Ability to pay for health care

The introduction of user fees has been done in an environment of increasing economic adversity. In addition to looking at the practice of fee paying, the study also assessed the community's ability to pay for health services. It should be stated at the outset that assessing people's financial capability through a survey is fraught with difficulties. The responses obtained from the survey may not reflect peoples' 'true' ability, but just perceptions about their financial status. For example stating that one is not able to pay may also mean that they are opposed to paying for health care and that one finds it an unjust policy. Similarly, it is likely that acknowledging one's ability to pay implies acceptance of cost-sharing. Responses on ability to pay should, therefore, be treated with caution.

Nonetheless, community ability to pay for health care was assessed by asking household respondents whether they were always able to pay for health care, while providers were asked the same question for the people in their community. The responses in Table 4.04 show that only a quarter (26%) of the community sample reported that they always had enough money to meet their health needs. The majority (68%) reported that they did not always have money for health care, while 14% never had money at all. In rural areas, 15%, 67%, and 18% respondents respectively, said they always, sometimes, and never had enough money for their health care. The corresponding percentages for urban communities were 40%, 51% and 9% respectively. We are inclined to derive from this that people are indeed unhappy about the introduction of cost-sharing. On the other hand, majority of providers, both from rural (89%) and urban (78%) areas, said people in their communities are able to pay for health care services (Table 4.05). This finding clearly shows contrary perceptions between

providers and the community. Being workers at the local health facilities, the providers have better knowledge about the costs of providing services and find the fees low. In their view, the people can afford them. The large number of community respondents who expressed their inability to pay for health care, may reflect their unwillingness to pay for something they have always received freely.

Table 4.04: Community members' reported ability to pay for health services

do you always have enough money to pay for health services ?	*urban*	*rural*	*total*
Always	40%	15%	26%
Sometimes	51%	67%	68%
Never	9%	18%	14%
total (n)	*634*	*881*	*1515*

Table 4.05: Providers' views about the community's ability to pay for health services

are people in this community able to pay for health care	*urban*	*rural*	*total*
Yes	78%	89%	85%
No	22%	11%	15%
total (n)	*36*	*65*	*98*

4.4. Preferred mode of payment

To further understand cost-sharing, this study also tested the hypotheses that "both providers and users prefer the prepayment scheme to user fees". To collect data related to this hypothesis, providers and community respondents were asked whether people preferred user fees or the prepayment scheme. In addition, respondents were also asked to give reasons for their preference. The answers are extremely different for urban and rural respondents due to the fact that the prepayment scheme was an unknown phenomenon in the rural districts. The scheme was initially supposed to be introduced on a pilot basis in selected urban sites, which was later to be replicated elsewhere. Unfortunately, this had not been done at the time of the study and the scheme has remained a largely urban practice. We, therefore, take only the urban responses as 'valid'. Both providers (75%) and community members (85%) in the urban areas have an overwhelming preference for the prepayment scheme.

In an environment of high morbidity and little tradition of saving, the prepayment scheme is attractive. People can obtain medical care any time they fall sick without having to worry about having ready cash. Another reason for preferring the prepayment scheme may be that people perceive that it costs less than user fees and has more loopholes for avoiding payment. For rural dwellers in particular, the scheme would be a convenient way of paying because of the

seasonal nature of their economic activities. Rural populations mostly derive their means of livelihood from farming and it would, therefore, be easier for them to pay for health care at the time when they harvest, and then be covered for a longer period until their next harvest.

Table 4.06: Providers' preferred mode of payment for health services

preferred mode of payment	*urban*	*rural*	*total*
User fees	14%	76%	53%
Pre-payment	75%	19%	40%
No preference	5%	3%	4%
Others	6%	2%	3%
total responses (n)	*36*	*62*	*98*

Table 4.07: Community views on preferred mode of payment for health services

preferred mode of payment	*urban*	*rural*	*total*
User fees	12%	57%	38%
Pre-payments scheme	85%	41%	59%
Others	3%	2%	3%
total responses (n)	*634*	*881*	*1515*

4.5. The actual practice of paying for health care

The study also examined whether people actually pay for health care and what modes of payment they use. A large majority (77%) of household respondents agreed that people do indeed pay for health services (Table 4.09). It can be seen from this Table that there was a higher proportion (81%) of people in urban areas who said that people pay for health services than was the case in rural areas (74%). This pattern is supported by responses from providers among whom the majority (93%) agreed that people indeed pay for health services (Table 4.10).

The providers were also asked to state how people in their catchment areas paid for health services. Table 4.10, also shows that the majority (62%) said that people paid through user fees, while 38% reported that people paid through the prepayment scheme. Rural communities were reported to pay mostly in the form of user fees (92%) in comparison to the prepayment scheme (8%). However, an opposite picture is observed for the urban sites where more people (89%) reported paying through the insurance scheme than with user fees (11%) (Table 4.10). In-kind payments were more widespread in rural than urban settings. Thirty nine percent of the providers from rural and 6 percent of the urban respondents reported that people paid in kind (Table 4.10).

In order to determine whether people actually paid in-kind or cash, household respondents who had reported an illness episode in the house were asked if they had paid for the illness and whether the payment was in-kind or cash. Table 4.08 shows that most (94%) of the respondents paid cash and only a small proportion

(6%) paid in-kind. In rural areas, 9% of the respondents paid in-kind compared to 3% in urban areas.

Table 4.08 Household respondents' reported mode of payment for first illness episode

Did you pay cash or in-kind for first illness episode?	*rural*	*urban*	*total*
Cash	91%	97%	94%
In-kind	9%	3%	6%
total (n)	*259*	*256*	*515*

This study also explored whether people use in-kind contributions to pay for health care. Although in-kind payments are an appropriate method for ensuring equity in cost-sharing, the practice was not widespread in the study population. Paying for health services is almost universal now, most of the household respondent reported that people pay for health services, this mode of paying is almost universal (Table 4.09). The results further show that less than a third (27%) of the providers agreed that in-kind payments were allowed at their health centres (Table 4.10). Understandably, more (39%) providers from rural areas agreed that they allowed in-kind payments in their health centres than did their urban counterparts (6%).

Table 4.09: The practice of cost-sharing according to household respondents

Do people pay for health services ?	*urban*	*rural*	*Total*
Yes	81%	74%	77%
No	19%	26%	23%
total	*634*	*881*	*1515*

Table 4.10: Providers' views about whether and how people pay for health services

Do people pay for services?	*urban*	*rural*	*total*
Yes	97%	90%	93%
No	3%	10%	7%
How do they pay?			
User fees	11%	92%	62%
Prepayment scheme	89%	8%	38%
Can people pay in kind?			
Yes	6%	39%	27%
No	94%	61%	73%
total (n)	*36*	*62*	*98*

Table 4.11 shows that the mean levels of payments according to household respondents in the urban areas were K1,082 and K551 under the insurance scheme for first and follow-up visits respectively, while the mean charge under

user fees for first visit and follow up visit was K2,474 and K2,496 respectively. The corresponding levels for rural areas were K719, K174, K223 and K217.

In general, mean expenditure user fees are higher in urban areas. For example, Table 4.11 shows that user fees for first visit is K2,474 compared to only K233 for rural areas. A similar pattern is observed for follow up visit. Reported mean values for prepayment scheme (Table 4.12) and user fees (Table 4.13) show a similar pattern, that urban areas report higher user fees than those from rural areas. Providers' responses also confirm this pattern of higher mean expenditures among urban than rural dwellers.

Table 4.11: Mean expenditure (in *Kwacha*) on health services by mode of payment (user fees and prepayment scheme) according to household respondents

	urban	*rural*
User fees first visit	2474	223
User fees follow up visit	2496	217

Table 4.12: Mean value of prepayment scheme fees (in *Kwacha*) according to providers

Time period	*urban*	*rural*
Monthly	510	100
Quarterly	1569	--
Annually	6007	500

Table 4.13: Mean value of user fees (in *Kwacha*) according to providers

user fees	*urban*	*rural*
New visit	1536	310
Follow-up visit	1333	100

These figures show a discrepancy between the mean amounts given by providers and by household respondents. Household respondents generally reported higher amounts than providers. Either community members are spending more than the providers say they are or the household respondents overestimate the amount they spend on health care.

4.6. Exemptions from paying for health care

The current health financing policy, while attempting to encourage community contributions also acknowledges that health care is a fundamental right and, therefore, accords the privilege of not paying to those who cannot genuinely afford the fees. Categories of people who are exempted from paying include children under the age of five years, old people aged 65 years and above, people laid off from employment and people with chronic diseases such as tuberculosis and AIDS as well as those attending preventive services such as ante-natal care

and screening for STDs. To assess respondents' views and knowledge about the exemption scheme, the community and providers in the sample were asked parallel questions on whether everybody should pay and whether there were some people/groups of people who should not pay for health services.

Results presented in Table 4.14, show that most of the households respondents were of the view that some people should be exempted from paying. Seventy and 75 percent of household respondents form urban and rural areas were in favour of exemptions. Higher proportions (89 and 95 percent) of providers from urban and rural areas also favoured exemptions (Table 4.15).

Table 4.14: Community views on whether everyone should pay for health services

should everyone pay for health services?	*urban*	*rural*	*total*
Yes	30%	25%	30%
No	70%	75%	70%
total	*634*	*881*	*1515*

Table 4.15: Provider's views on whether everyone should pay for health services.

should everyone pay for health services?	*urban*	*rural*	*total*
Yes	11%	5%	7%
No	89%	95%	93%
total	*36*	*62*	*98*

In order to test the respondents' knowledge about the exemption policy, they were further asked to categorise the people who, in their view, should not pay. Consistent with current policy, the community reported that children under five years (39%), followed by the elderly (31%), pregnant mothers (13%) and people with chronic illnesses (12%) should not pay. Roughly the same pattern was observed in rural and urban areas (Table 4.16).

Table 4.16: Household respondents' knowledge on selected cost-sharing indicators

a. are there people or groups of people who should not pay?	*urban*	*rural*	*total*
Yes	89%	83%	85%
No	11%	17%	15%
total (n)	*634*	*881*	*1515*

b. if yes, who should not pay?	*urban*	*rural*	*total*
Children under five	44%	35%	39%
Pregnant women (ANC)	10%	15%	13%
Chronic patients	12%	13%	12%
STD screening	1%	1%	1%
Elderly (over 65 years)	30%	33%	31%
Others	3%	4%	3%
total (n)	*1207*	*1786*	*3013*

c. what kind of help can those who have no money get?	*urban*	*rural*	*total*
Nothing	63%	46%	53%
Exemption	5%	17%	12%
Get a loan	2%	11%	7%
Church gives money	0%	4%	2%
Social welfare scheme	6%	3%	5%
Pay later	4%	5%	5%
Don't know	19%	11%	14%
Others	1%	3%	2%
total (n)	*634*	*881*	*1515*

In order to draw parallels between communities and providers of health care, providers were asked similar questions like those posed to the household respondents. Table 4.17 shows that an overwhelming majority (93%) agreed that there are some people who are not supposed to pay. The corresponding percentage for rural and urban areas was 94 and 92 respectively. Providers who agreed that some people should be exempted from paying were further asked to indicate which categories of people should be exempted from paying. Responses to the question who should pay, show a similar pattern to that observed among household respondents. These findings tally fairly well with the official government policy about exemptions.

Table 4.17: Provider's knowledge on selected cost-sharing indicators by area

*a. are there people or groups of people who sh**ould not pay?***	*urban*	*rural*	*total*
Yes	92%	94%	93%
No	8%	6%	7%
total (n)	*36*	*62*	*98*

b. if yes, who should not pay?	*urban*	*rural*	*total*
Children under five	18%	23%	19%
Pregnant women (ANC)	13%	19%	14%
Chronic patients	18%	22%	18%
STD screening	12%	9%	9%
Elderly (over 65 years)	17%	23%	19%
Others	20%	26%	21%
total (n)	*182*	*235*	*472*

c. what kind of help can those who have no money get?	*urban*	*rural*	*total*
Will be treated free	48%	37%	41%
Refer to social welfare or church	26%	10%	17%
Pay later / Given loan	13%	37%	27%
No answer	7%	10%	9%
Others	6%	6%	6%
total (n)	*54*	*97*	*133*

4.7. The Social Welfare Scheme

In order to gauge knowledge about the Social Welfare Scheme, providers were further asked whether they had ever heard of the Social Welfare Scheme. Table 4.18 indicates that two thirds (67%) of the respondents said they had heard of the scheme. There was a higher level of knowledge in urban than in rural areas (81% and 60% respectively). Providers were further asked how the scheme functions. About two thirds (61%) of the providers said that the Social Welfare Scheme does not function at their health facilities. Those who reported that the scheme is functioning, mainly said that it supports under-five children (25%) and disabled people (10%).

This study also found that providers' general knowledge about the exemption scheme is high on certain issues, and low on others. For example, very few providers were aware that pregnant women and individuals seeking STDs screening were also exempted from paying. Of those who were aware of the scheme, the majority said the health centres received no assistance from the MSWCD. Others said the Social Welfare Department was not well co-ordinated and had a very weak link with the Ministry of Health.

Table 4.18: Provider's knowledge about the Social Welfare Scheme.

a. have you ever heard of the Social Welfare Scheme?	*urban*	*rural*	*total*
Yes	81%	60%	67%
No	19%	40%	33%
total (n)	*36*	*62*	*98*

b. does the Social Welfare Scheme function at this health facility?	*urban*	*rural*	*total*
Yes	94%	30%	39%
No	46%	70%	61%
total (n)	*36*	*62*	*98*

c. how does the Social Welfare Scheme function?	*urban*	*rural*	*total*
Pays services for disabled	12%	10%	10%
Provides clothes for under-five children	42%	20%	29%
Does not function	46%	70%	61%
total (n)	*36*	*62*	*98*

To further probe community knowledge about the Social Welfare Scheme, the community respondents were asked what they would do if they fell sick and had no money to pay for health services. Surprisingly, over half (53%) of the respondents said that there is nothing that they can do in such a situation. The next largest category (14%) did not know what they would do, while 12% said health staff at the clinic allowed people to access health care without paying for it. The range of responses for urban communities was not very different from the aggregate results. Rural areas recorded a higher proportion (17%) of respondents who said that health staff at health facilities allowed people to access services freely, than the corresponding percentage for urban dwellers (5%).

Table 4.18 shows high levels (67%) of knowledge about the Social Welfare Scheme among providers. Similar to the community, providers were also asked what they would do if an ill person who had no money turned up for health care. Table 4.17, indicates that of the whole sample of providers, only 17% stated that they would refer the patient to the Social Welfare Department. However, note that providers form urban areas (26%) are more likely to refer patients to the Social Welfare Department than their counterparts from the rural areas (10%). The majority (41%) of the providers said they would attend to the patient without asking him/her to pay, while 27% of the respondents said they would attend to the patient and ask them to pay later. There is a wide discrepancy between provider and the community levels of knowledge about the Social Welfare Scheme. Providers were more knowledgeable than the community. Health workers could, therefore, be used more effectively to disseminate information about the Social Welfare Scheme and, therefore, avert unwarranted low attendance at health facilities which could arise as a result of perceived inability to pay for services.

4.7. Conclusion

While household respondents stated that they were not able to pay for health care, providers said that people in their localities could pay. Household respondents by and large argued that the economic environment had weakened their financial position. The reported inability of the respondents to pay could also be a way of protesting over the poor quality of health services that they obtain in return for their money.

When asked what type of payment they preferred, both providers (75%) and community members (85%) in the urban areas showed an overwhelming preference for the prepayment scheme. The answers in the rural districts were not taken into consideration as the respondents were not familiar with prepayment. The prepayment scheme derives it attractiveness from the fact that it enables people to pay in advance when they have the money and obtain health care any time irrespective of their financial position at the time of illness. Moreover, as has already been said, the prepayment mode of cost-sharing seems more economical and open to manipulation.

Although it could be an appropriate way of paying, in-kind payments are not widespread. These payments would especially be ideal in the rural settings where people derive their means of livelihood from agriculture and may be better positioned to pay in kind than with cash. By the same token, prepayments schemes, while at the period of the research confined to urban areas, seem particularly appropriate for rural areas in view of the seasonality of people's income.

This study underscores that although about two thirds of the providers are aware of the Social Welfare Scheme, very few patients were refereed for such services. Low utilisation of the Social Welfare could indicate that providers do not have adequate knowledge about the scheme. It could also mean that providers are aware that the Social Welfare Scheme is not yet operational and do not want to waste their time by referring patients to a non-existent system. Even more critical, the criteria for determining who is poor or not is not easily available to health workers. The economic adversity and consequent financial constraints notwithstanding, people were willing to pay for health care, especially if they were assured of obtaining a tangible form of health care such as drugs.

CHAPTER 5

COMMUNITY PARTICIPATION

Primary Health Care has often been characterised as 'democratisation of health'. At the same time, lack of democratisation and a hidden domination from the top have repeatedly been diagnosed as the main problem of Primary Health Care (see van der Geest et al. 1990), also in Zambia (e.g., Theunisz 1989, Koenraadt 1992). Involvement of communities in the delivery of health care was, therefore, at the heart of the reforms in the health sector. In order to asses people's awareness of community participation and their involvement in actual health care activities both health workers and members of local communities were interviewed on various aspects of community participation. We shall first briefly present the findings of the exploratory research.

5.1. Exploratory findings

Rural communities

Community involvement in health activities such as planning has long history in Western Province because of the Dutch funded PHC project which has been operating in the area for almost a decade. Village Health Committees (VHCs) or Area Health Boards (AHBs) have been created in villages and committee members visit and meet with village representatives to assess community needs which are later prioritised for interventions. The research team had the privilege of attending a planning meeting between providers and Village Health Representatives at Itufa Rural Health Centre. Prior to this meeting VHRs met and consulted with people in their villages. The purpose of these meetings are to identify community felt problems, which would then be communicated and discussed by the VHC for possible interventions. Based on the reports of these meetings, an action plan would be developed.

Although the witnessed community-diagnosis meeting could be said to be an indication of community involvement in the delivery of health services, discussions with community key informants brought out some contradictions. The community denied being involved in planning activities, while providers reported that communities were involved. The apparent contradiction could mean that, the community representatives who participate in the community diagnosis and other related meetings do not reflect the interests and concerns of the wider community; and that there is no effective link between health workers and the general community.

In addition to involvement in the planning process, the community was also asked if they would be willing to participate in other activities at the health

centres. One of the issues that was put forward for discussion was whether they would be willing to contribute towards health workers' salaries. The majority were against this idea. Reasons advanced were that people were already contributing by paying taxes and in addition they were too poor. Nonetheless, they said the community could still be involved in programme planning, implementation and monitoring. This would facilitate ownership of the programme by the community and ensure its sustainability. The community is also involved in health activities through payment of user fees and contribution of labour. However, providers indicated that, people are less willing to do voluntary work. "I have never seen the community come to work voluntarily, they only work when they are given something such as maize from the programme Against Malnutrition (PAM). People are willing to work when they know that they will be paid." (Senior Dresser Kaanja Clinic).

Urban situation, Lusaka

To determine community involvement in health activities, the study assessed how and to what extent the community participates in the planning and delivery of their own health services. Discussions about this topic elicited various responses. Most significant was the fact that health workers and the community had different views. Policy makers - who are the key personnel among providers unanimously reported that the community participates in the planning and evaluation of health services. On the contrary the users and the community denied they played any role in planning and evaluation of health services.

A marked lack of community involvement in planning of health services was observed at Kabwata and Chilenje urban health centres in Lusaka. People perceived their involvement in the provision of health care through voluntary labour and materials towards activities such as construction of structures, painting or cleaning usually after being requested by health authorities. As a result, the only involvement that community members acknowledge was occasional voluntary work at the facilities. One participant at Kabwata said: "We only come to know of a health project when they want free labour". Supporting this, a female participant asked: "How can we become involved in health services, when they are planned and brought to us?" This question indicates that the people who are beneficiaries of the health services do not play an active role in planning and managing their health services. They are considered 'recipients' of services planned for them by the government.

Most of the health centre users interviewed during the research indicated that they were not partners in the provisions of health care but recipients. Their opinions were that the Government always brought health care services and projects to them. No consultations or information is made available prior to the

introduction of projects. The introduction of Health Reforms and especially the user fees' was a case cited by many as an example in which the Government just introduced a programme without providing prior information. Despite the Government attempts to involve the community as partners in the provisions of health care, the community feels they have been relegated to the position of receivers of both health services and projects. Partially because provision of information to the public which is a pre-requisite for their participation has not effectively reached the general population. This was noted at Chilenje and Kabwata, where providers indicated that the community and government are partners in the delivery of health services, yet the community denied being involved. It is also interesting to note that the most salient form of community involvement and the most widely implemented element of the Health Reforms' 'user fee' was never mentioned as community involvement. This perhaps reflects people's understanding of community participation and their own definitions of the term. Since the community feels that user fees have been imposed on them they probably do not regard it as a form of participation.

5.2. Findings from the evaluative research

One of the major findings of the first phase of this research was that the meaning of 'community participation' was not clear to the study respondents. Most respondents related community participation to physical labour done at health facilities. Community members disagreed that they were involved in the planning for health services in their areas, while providers, in contrast, claimed that local people were involved in the process. These findings guided the team in hypothesising that policy makers and health care providers were more likely to report that the community was involved in planning and delivery of health services than the community itself. It was further postulated that lack of community involvement in planning for Health Reforms leads the users to perceive cost-sharing as having been imposed upon them.

Involvement of communities in the delivery of health care is at the heart of the reforms in the health sector. In order to asses people's awareness of community participation in the study areas, household respondents were asked what their local communities and they themselves could contribute to the improvement of the local health centre.

The range of responses given to these questions shows that the respondents do not perceive themselves as active agents in the process of managing health care in their communities. Community members mainly perceive their contribution as physical participation. Table 5.1 shows that about two thirds (64%) of the respondents from rural areas believe that the community could improve health facilities by contributing physical labour (64%) while 10% and 7% stated that

the community can make financial and in-kind contributions. Urban respondents too said that the community could contribute towards improving the health facilities by supplying labour (44%), money (9%) and in-kind contributions (5%). It is worth noting that a very low proportion of respondents from both rural (3%) and urban (5%) sites mentioned participation in planning as a way of improving health facilities in their areas. None and very low proportions of rural and urban
respondents respectively also identified fees (4%) and community awareness campaigns (4%) as a way to improving health facilities.

Findings on what household respondents themselves could do to improve the quality of care tallied with those on what communities could do. Most of the respondents said they would contribute by way of providing labour. Again rural dwellers (33%) were more likely to report that they would contribute their labour than the urban residents(25%). There was a higher inclination toward contributing in kind among the rural dwellers (13%) than among urban respondents (4%). There was little sign of community planning for the improvement of health centres, in both rural and urban areas. It is worth noting the rather high proportion of respondents from both rural (32%) and urban (43%) sites who said they did not know how they could individually improve the standards at their local health facility.

Table 5.1: Types of contribution the community can make to improve their health centre

Contribution	*rural*	*Urban*
Supply labour	64%	44%
Contribute money	10%	9%
In-kind contributions	7%	5%
Discussing and planning	3%	5%
Assisting with transport	0	1%
Paying user fees	0	4%
Raising community health awareness	0	4%
Other	6%	2%
Don't know	22%	14%
total (n)	*818*	*634*

.3. Conclusion

In conclusion, while both rural and urban household respondents reported that people paid for health care, the respondents did not consider this as a form of community participation. Only physical contributions especially in the form of labour at health centres were considered to be community participation. This perception may also explain why such a low proportion of the community respondents stated that they were involved in planning activities at their local

health facilities. Another major finding of this study was the high proportion of household respondents who said that they did not know how they, as individuals could help improve the quality of service at their local health centre. This shows a feeling of powerlessness among individuals to effect change at health institutions. Although the Health Reforms underscore the importance of communities not just as consumers 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 management of health care.

Table 5.2: Types of contribution respondents themselves can make to improve their health centre

contribution	*rural*	*urban*
Supply labour	34%	25%
Contribute money	9%	7%
In-kind contributions	13%	4%
Discussing and planning	1%	2%
Assisting with transport	0	1%
Paying user fees/scheme	0	5%
Raising community health awareness	0.5%	1%
Can help whenever called by clinic	4%	5%
Do not know	33%	43%
Other	5.5%	7%
total(n)	*818*	*634*

CHAPTER 6

DECENTRALISATION

Decentralisation of essential functions is one of the major elements of Health Reforms aimed at revitalising Primary Health Care. According to the 1992 Health Reforms Policy Documents, power and management of finances will be delegated to the district and health centre level. It is envisaged that this process will create structures that facilitate active involvement of providers at peripheral health facilities and users in health matters, decision making and planning in particular. Therefore, this study examined the extent to which management of health care services has been decentralised.

6.1. Exploratory findings

Rural communities

Information from the FGDs indicated that people were generally not aware of the decentralisation of essential functions which is one of the elements of the Health Reforms. The community reported that they were not involved in decisions about management of the RHCs indicating that the decentralization process has not yet fully taken ground. Providers on the other hand, were more knowledgeable about decentralisation than the community. They noted that districts now kept part of the money raised from user fees and disbursed part of it to health centres. Providers, further indicated that in collaboration with the community, they have identified major health problems in their catchment areas and that health centres can hire casual workers with the money now at their disposal, while appointment powers for all other workers still remains at central level.

Knowledge about Health Reforms, differed among providers, with those at provincial and district levels being more aware than those at local health centres. Providers at district and provincial levels were directly involved in the execution and to some extent planning of Health Reforms. The PHC provincial co-ordinator for example, is a member of the national health Reforms Implementation Committee Team. Although some essential functions had been decentralised, the providers noted that not much had been done to empower health centres to adequately manage the added responsibilities under Health Reforms. Providers complained that they had no capacity (skills and facilities) to manage financial resources, they are not being compensated for the extra responsibilities associated with Health Reforms, and are already overstretched by their current responsibilities and that they do not have time for the new roles.

Urban situation, Lusaka

Discussions about decentralisation in Lusaka did not yield much information, because most urban workers and participants from the community knew little about this issue compared to their rural counterparts, due to lack of information from the higher authorities to both health workers and the community. The providers indicated that the process of decentralisation had not yet been fully implemented. However, some aspects of health planning and decision-making were carried out at the district level. They cited purchases for replacement of drugs that was done from the overall budget of the centres through DHMT offices. What participants considered to constitute decentralisation was the imminent creation of Health Neighbourhood Watch teams (HNWT) in their respective areas. These according to the community were likely to help in community diagnosis and strengthen management at the RHCs. Even with such interesting information, not many users understood the concept of decentralisation and its objectives.

Health workers who participated in the study reported that most decision are still taking place at central levels and that they are not effectively involved in planning and decision making. For example, health workers at health centre level and community members do not participate in decisions regarding funding for drugs or new projects. They said the current structure does not facilitate their involvement. Long bureaucratic 'red tape' was also reported as a constraint affecting management of urban health centres. This was noted in form of delays experienced when drugs run out from some health centres.

The community stated that the leadership at the health centres was not effective. This observation is consistent with the providers' reports that there was no plan to maintain the physical infrastructure or to service the equipment. The community pointed out that the persistent shortage of drugs was not being addressed adequately by the leadership of the respective health centres. Failure by health centre staff to get clarification on guidelines about the criteria for benefiting from the social welfare scheme intended to assist the poor was regarded as lack of effective leadership.

The study also found that urban health centre staff were not effectively involved in the management of funds raised through user fees. Their responsibility is mainly to collect the money from users of basic health services and send it to the district level. Health workers cannot directly use the money they collect for health centre requirements like replenishing their drug stock. The community also expressed ignorance about how the money raised was being used. The findings suggest that decentralisation still has a long way to go.

The evaluative study took this suggestion as its starting point and examined the extent to which management of health care services has been decentralised. To

assess the decentralisation process, providers were asked what they knew about decentralisation in general, about specific issues related to decentralisation and about their involvement in the decentralisation process. Results presented are not segregated by rural and urban.

6.2. Utilisation of user fees

Under the new current Health Reforms, management of finances will be delegated to the district and health centre level. Therefore, this study examined whether health workers in the study knew of how money from user fees is utilised and whether staff are involved in planning and decisions about management of user fees. Results of this study indicate that over half of health workers in the sample are aware how money contributed by the community through user fees is utilised. Table 6.1 indicates that 57% of the respondents reported that revenues from user fees are used to improve health facilities and 6% said they were spent on buying drugs and equipment. More than a quarter of them said they did not know how the revenues were used.

Table 6.1: How money from user fees is used, as reported by health providers

	number of respondents	*percentage of respondents*
Improve health centre	56	57%
Buy drugs/equipment	6	6%
Do not know	27	28%
Other	9	9%
total (n)	*98*	*100%*

6.3. Bonus

Within current Health Reforms, there is a provision that allows health workers to receive a bonus for money collected in form of user fees. This is an incentive to boost staff morale. The study examined whether staff get bonuses and, when this is not the case, reasons for not getting a bonus were solicited. Table 6.2 shows that over two thirds (68%) of health workers do not receive any bonus. Most of them (61%) do not know the reason. Reasons which *were* given for not receiving a bonus were that there is no such provision (19%) and that it is not authorised by the higher authorities (10%) (Table 6.3). The responses point to a lack of knowledge.

Table 6.2: Do health workers get a bonus?

do you get a bonus?	*number of respondents*	*percentage of respondents*
Yes	31	32%
No	67	68%
total (n)	*98*	*100%*

Table 6.3: Reasons for not getting a bonus

	number of respondents	*percentage of respondents*
No provision	13	19%
Not authorised by Government / DHMT	6	10%
Do not know	41	61%
Other	7	10%
total (n)	67	99%

To assess the actual decentralisation process, providers were asked if they had a role in planning and decision making about how money from user fees is used. Table 6.4 shows that three quarters (74%) of health workers are not involved in planning and decisions about how health funds should be utilised.

Table 6.4: Providers' responses on whether they have a say on how user fees are spent

	number of respondents	percentage of respondents
Yes	25	26%
No	73	74%
total (n)	*98*	*100%*

To further understand the decentralisation process this study also examined availability of supportive structures such as accounting facilities. Under the decentralisation system, health centre staff are expected to collect and manage money from user fees. Effective management of finances requires knowledge at least in basic accounts (book keeping) and a supportive environment such as a safe system for collecting and keeping money. To determine if current Health Reform system supports the new roles in financial management at the health centre level, providers in the study were asked if they received any training in basic book keeping and whether they are supervised in accounting.

Table 6.5 shows that two thirds of health staff reported that health workers are not trained in accounting. However, although the majority of the health staff reported that they were not trained in accounting, slightly over two thirds (69%) said that health workers do receive supervision in accounting.

Table 6.5: Providers' responses on whether they are trained and supervised in accounting

a. is the staff trained in basic accounting?	*number of respondents*	*percentage of respondents*
Yes	23	24%
No	65	66%
Do not know	10	10%
total (n)	*98*	*100%*
b. is the staff trained in basic accounting?	*number of respondents*	*percentage of respondents*
Yes	68	69%
No	22	22%
Do not know	8	9%
total (n)	*98*	*100%*

6.4. Conclusion

The process of decentralisation is still in its initial stage. Most health workers are not involved in planning and decisions about how user fees money should be utilised. About two thirds do not get a bonus and most of them do not know the reason. At the time the study the Central Board of Health had not invested much in training staff in financial management, however, most health workers reported that they are supervised in accounting procedure. Lack of accounting skills and the under-developed state of the accounting system indicate that the decentralisation process is still at a low level.

CHAPTER 7

QUALITY OF CARE

The vision of the current Zambian health reform process is to "provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible (MOH 1994). The quality of care could be considered as the acid test of the Health Reforms.

7.1. Exploratory findings

During the exploratory phase of the research 'quality of health care' was studied with regard to the following four aspects: (i) attitude of health personnel, (ii) physical conditions at the health centre, (iii) availability of drugs, and (iv) accessibility of the facility.

Rural conditions

7.1.1. Providers' attitudes and interaction with the community

The provider-user relationship was reported to be good by both providers and the community. in the Western Province. In general, the staff at both Itufa and Kaanja health centres were described as friendly and caring. The following quotes highlights the community views about the health staff. One respondent in Kaanja produced the understatement: "Health workers do not insult us." Another participant agreed: "The health staff are always concerned with our health problems, they always try by all means to do what they can to save people's lives". The same views were expressed at Itufa clinic: "They have good attitudes towards us. They welcome everyone and treat each one. The health service personnel are respectful and friendly towards us. The only problem I have noticed is that the clinic runs out of drugs." "Sometimes for serious cases, the health staff seem to really care for the sick," another person added. Teachers on the other hand, were more critical about health providers. Since they were 'fellow workers', they thought, they should be given favours. This, apparently, was not happening and as a consequence, teachers were unhappy.

In cases where the providers' attitudes appeared to be negative, the community said it was largely an expression of frustration over the poor working environment: shortage of workers and lack of medical equipment. The community felt that the two RHCs in the study were understaffed. At Itufa, it was felt that the number of workers at the clinic was inadequate for the catchment population. The clinic has a catchment population of 12,972 in excess of the recommended range of 5000 - 10000 for a large rural health centre. The situation is compounded by the Public Service restructuring program resulting in many people loosing their jobs and feeling insecure.

Further, illnesses and death of staff poses a major problem. At Kaanja, the Environmental Health Technician had been ill for a year and one nurse had died, leaving only one qualified person to manage the facility with the help of two classified Daily Employees (general workers). Providers complained about their poor conditions of service and that their morale had been reduced as a result. Salaries were reported to be too low, and the accompanying conditions of service were not commensurate with the amount of work they were doing. Some workers reported not having been confirmed in their jobs for a long time and hence continued getting lower salaries than they were supposed to. The director of the DHMT expressed his disappointment by saying " I am not happy with my conditions of service in that our salaries are very low. In other Ministries, there are benefits that people in positions like ours enjoy, but in the Ministry of Health we do not have such. All the proposals submitted to the MOH Headquarters to improve our conditions have not been attended to."

Interviews were also held with CHWs and TBAs who both reported experiencing similar poor working conditions of service. One TBA at Itufa complained about not receiving a salary and not having a bicycle. As a result, she could not effectively carry out her work in villages. She continued: "The drug kit is not enough, some drugs are not available. There is a need to improve the drug situation" She further observed that the PHC unit infrastructure was inadequate, "I do not have a table, chair and shelves." However, there was consensus among health providers that the Health Reforms had improved the situation

7.1.2. Physical conditions and infrastructure

The community observed improvements in the physical conditions and infrastructure as well as general cleanliness at RHCs. Renovations and painting of buildings were cited as signs of specific improvements. At Itufa, the community mentioned and the team observed that a new mothers shelter had been constructed, new homes for clinic staff had been built and a pit latrine erected. The Research team also observed that the clinic had undergone rehabilitation in terms of cleanliness, it had been painted and looked hospitable. All the clinic's window panes had been fixed, giving it a pleasant new look. These improvements had been made possible by the introduction of user fees and collaboration with service organisations such as the World Vision International, which had constructed the mothers shelter.

However, some differences were observed between RHCs. For example, Itufa had transport (a bicycle and motor cycle) while Kaanja which is more remote had none. Kaanja with a smaller population catchment had relatively more equipment required for antenatal, immunizations and growth monitoring

services than Itufa. In both clinics the situation, is better than before but needs to be further improved

7.1.3. Availability of drugs

Before the introduction of the Health Reforms, the health sector was beset by shortages of drugs and other essential supplies. According to the providers who participated in the study, conditions in the health centres have improved since the implementation of user fees. Districts now control part of the financial resources committed to these centres, they are able to expend part of this on improving the clinic conditions and ensuring a steady supply of drugs. The drug situation was reported to have improved tremendously as a result of cost sharing. Intermittent shortages of drugs were however, still being experienced and the community expressed dissatisfaction especially because they are paying for the services. A Ward Secretary for the ruling political party at Itufa said: "I do not like the introduction of user fees because sometimes a person pays but is not given medicines." An out-of-school youth looked at it from another angle: "In the past, we did not pay for medical fees, but then medicines were available, so why should the Government not continue paying for us." "The intermittent shortages of drugs could be improved by increasing the number and type of drugs in the kit" (male teacher at Itufa Primary School). An unemployed out-of-school youth concurred with this view saying "For standards of services to be improved, drugs should be made available to patients at all times. Sometimes patients are discharged from hospitals when they are still sick." The community also complained that, drugs should be made available every time people paid for services, because they got demotivated if after paying, they do not get drugs. "What is the purpose of paying if medicines are not available" one participant asked. The foregoing statement clearly indicates that people attach a lot of importance to the issue of drugs, and that availability of medicines is a fundamental determinant of their reactions to user fees.

7.1.4. Accessibility of health facility

As already indicated, the community in rural areas was generally satisfied with their relationship with providers at RHCs. Another positive feature of the RHCs reported by the community is that, health providers are within reach even outside official working hours. If one falls sick during the course of the night, he/she can easily seek attention of a provider from their homes. Providers stay within the vicinity of health centres and as such can easily be contacted by the community when the need arises. However, although providers stayed within the vicinity of health centres, distance, scattered nature of settlements in the province and lack of transport remain major problems limiting utilisation of health services. CHWs and TBAs, who are supposed to serve people living far

from RHCs are also constrained by lack of transport for outreach activities. Even if distance was not a factor, widespread poverty could still impede accessibility of the community to health facilities. With the payment of user fees and lack of knowledge about the exemption scheme, report of people deciding not to visit health centres when sick were common.

The two RHCs in the study are understaffed resulting in increased or heavy workloads for the staff. The research team observed long queues at Itufa because of the limited number of providers. Kaanja clinic for instance had only one clinical officer who worked with two CDEs. In such a case, accessibility of health workers could obviously be improved by recruiting additional staff.

Box 7.1: Community views about quality of care

An unmarried female user of the General clinic at Itufa:
"The standard of health services is good, except that the male ward has no lamp. Patients stay in darkness at night. To improve the standards of services, the clinic should buy a lamp and make sure that drugs are available at all times - this is a major problem, medicines are sometimes not available."
A female user of the general clinic at Kaanja:
"The clinic should have lamps. At times they have lamps, but there is no paraffin. The clinic should buy paraffin or electrify the clinic".
A male teacher at Itufa:
"The standard of services could improve if more drugs are included in the kit".
A petty business man at Itufa:
"They should employ CDEs to wash blankets and sweep the floor, because the clinic is dirty".
Female user of general clinic - Kaanja:
"They should increase the number of drugs at RHCs. They only give us chloroquine for all illnesses. Chloroquine has stopped working, other effective drugs for malaria are needed".
A female teacher at Kaanja Open Day Secondary School:
"The standard of services is not up to date because patients are not given food and they are asked to pay for the services."

Urban conditions

7.15. Provider attitudes and interaction with the community

As opposed to rural areas where provider attitudes were described positively, in urban areas staff attitudes were found to very negative. Providers were frequently criticised for rudeness and negligence: "Nurses think they are superior or bosses, yet they are employed to serve us, so they should not be rude." One woman seemed to have some understanding or explanation for the nurses' rude behaviour. "Nurses are supposed to be compassionate people but

Box 7.2: Providers' views about quality of care

Senior CDE; Kaanja RHC:
"The clinic is too small; The maternity wing is being used as a store room The building has no proper doors, keys and windows."
Senior District Family Health Nurse:
"The only improvement is the supply of drugs. Transport is still a big problem. At the hospital, the floor, linen are clean together with wards and the entire system has changed because of user fees."

Clinical Officer in charge at Kaanja:
"The standards of service that is provided here is good, but the sanitation situation here is very poor and the health centre structure where we conduct services is very poor."
PHC Coordinator:
"Factors which contribute to poor performance of RHC are poor conditions of service and low salaries. Living conditions for the staff and the public are very poor, the houses in which they live are not conducive for human habitation, some staff do not even have accommodation, they live in class rooms or temporal traditional structures. As a result the staff spend more of their time on day-to-day survival activities than on work".

most have lost this because there are too many people passing through their hands."

On the other hand health workers at the two urban RHCs complained that patients had too high expectations and lacked understanding. Some health workers, however, pointed out that it is normal that when people are sick, they become irritable and anxious. One nurse linked the tense relationship to the user fees: "Ever since the introduction of user fees we have become 'servants' as everyone wants to be attended to at once, all because they pay for services." The interaction between users and health workers was found to be unpleasant in the two urban health centres particularly in connection with STD patients. Pregnant women with STDs felt very uncomfortable and reacted sharply to some questions asked by nurses such as "Where did you get the STDs from? STD infections are associated with promiscuity and as such trigger harsh interactions between people.

7.1.6. Physical conditions of health centres and infrastructure

Physical conditions of health centres form an important aspect of care. Space, sanitation, water and power supplies, communications and transport were examined. The study found that the two urban health centres had adequate and sufficient space for activities relating to MCH registration, examination, injection administrative and consultations. Sitting facilities were also found to be adequate, though at peak times of the month, some people had to wait

standing in long lines. Sanitation at the two RHCs was found to be poor. One woman: "The toilets are so dirty as if they are not part of the clinic, one can even get a disease from this toilet." The impact of lack of water on the operations of the health centres especially with regard to hygienic practices is summarised in the woman's quotation given above. Her perception of a health centre is that of a place where cleanliness is paramount. What obtained in the health centre with regard to water supply and level of cleanliness was far from what she had expected.

Health centres had almost all the equipment necessary for provision of basic health services. According to health workers, equipment in the two health centres was adequate and in good working condition. Chilenje health centre, which operates day and night had more equipment than Kabwata health centre which operates only during the day. In addition, Chilenje health centre had few equipment specific for special services such as dental surgery, X-ray and laboratory facilities which are not offered at Kabwata health centre.

7.1.7. Availability of drugs

As in rural areas, availability of drugs was the dominant criterion by which study participants judged the quality of care. The general view of both the provider and the community was that availability of drugs had improved over the years. However, occasional shortages of drugs were still reported. Health workers were more optimistic about the improvement in the availability of drugs than the community. Users maintained that people were still being sent away with only prescriptions to buy medicines from drug stores. A secondary school teacher in Lusaka said: "Medicines are not sufficient and at times you are given prescriptions to buy your medicines." Contributing to the discussion about drug availability a woman at Chilenje said "We want medicines to be given according to illnesses and not routine panadols." The preoccupation with availability of drugs is so high that it undermines the improvements made in other aspects such as general cleanliness of the facility. Some participants maintained that because of the shortages in drug availability, the general standards of care had not improved. In order for the community to appreciate some of the positive changes at HCs it is imperative that the supply of drugs be

Improved since it is the most important yardstick against which they gauge the standard of services.

7.1.8 Accessibility of health facility

Access to health centres in Lusaka is quite easy. The catchment areas of the two health centres are well served by public transport. Availability of public transport facilitates access to health centres. However, lack of transport money

proved another limiting factor especially at night when only transport for hire was operating.

Discussion about whether the community has access to UHC staff or not, revealed that operational hours in urban health centres are not flexible as found in rural areas. Both providers and the community reported that access is restricted to official working hours. At Kabwata where the HC operates during the day only, the community bitterly complained that, if one fell sick after operating hours, one had to seek medical care from the hospital or wait until the health centre opens the following day. This is a major problem especially for people who do not have transport money to get to the hospital. It means they cannot get medical attention while there is a HC nearby.

When discussing the workloads in the two health centres, the providers reported that all patients who come for service were attended to and no one was sent away. On the other hand the community said nurses were not very busy, they are just fond of chatting instead of attending to patients promptly.

Another aspect that affected utilisation of services was lack of accommodation for staff within the HC premises. Unlike the rural areas, where the staff stays within the health centre's premises, staff in urban areas stays off the health centre grounds. Both providers and the community agreed that this type of arrangement limits access to health facilities. The staff expressed that they would prefer to live within the vicinity of the HCs.

The number of staff in the two centres was found to be adequate, but the people from the community complained: "There are many nurses here but we have to wait very long before we are helped," said a male patient waiting himself. One user looked at the issue differently and said: "If nurses become friendly, the standards of care will improve. Doctors should not be harsh and very sick people should be given priority and attended to quickly." Although general health workers with no special training discharge their duties normally, it was observed that patients preferred to be attended to by health providers with higher skills. This is contrary to what was obtained in the rural areas where professional qualifications seemed not to be an issue.

7.1.9. Intermittent conclusion and hypotheses

Improved quality of care is the ultimate goal of the Health Reforms. Considerable attention was therefore given to this issue during the exploratory phase of the research. The concept of 'quality' proved rather complex from the onset. During the first phase the concept was broken down into four aspects. In the second phase, the operationalisation of 'quality' was further refined.

The following hypotheses were derived from the exploratory research. They reflect the main conclusions of the exploration.

- Providers are more likely to report that cost-sharing has improved the quality of care than users.
- Users in urban areas have a higher expectation of quality of care than their rural counterparts.
- User-provider interactions are more positive (friendly and understanding) in rural areas than in urban areas.
- Availability of drugs is considered the most important element of good health care by users and to a lesser extent by providers.
- Providers are more positive about the quality of services (i.e., availability of drugs) at health centres than users.
- There is no marked difference in the availability of drugs between rural and urban areas.

These hypotheses constituted the starting point of the evaluative research.

7.2. Findings from the evaluative phase

As pointed out in the exploratory phase of this work, 'quality' is a subjective and complex issue conceived differently by individuals and groups of people. Therefore, the question, what is 'quality of health care' gives rise to another question: who is speaking about 'good' or 'bad' quality of care? Providers and clients in particular are likely to carry with them different views of 'quality of care'. To deal with this complex concept, the evaluative research distinguished seven aspects of quality of care, (i) user-provider interactions; (ii) waiting time; (iii) availability of drugs; (iv) physical conditions of health facilities; (v) access to health services; (vi) staff competence; and (vii) perceived treatment outcome. Opinions related to these topics were collected both from providers and from the community (household survey and exit polls).

7.2.1. General standard of health care

Before evaluating the seven aspects of quality of care specified in the foregoing paragraph, the study attempted to asses the general standard of health care. To measure the general standard of health care, respondents in the household survey were asked to indicate how they rate the standard of services provided at various health facilities. Table 7.01 shows that in general the standard of service was described as good. Over 70% of the total sample of the respondents who participated in the household survey, reported that the standard of services in government and private health facilities is good. Respondents from rural areas were more likely to report that the standard of services was good than urban

respondents. This finding suggests that people in urban areas are more critical and expect higher standards of services than those in rural areas.

Table 7.01: Household respondents' views about the standard of services offered at health facilities, by area

	good	*not so good*	*bad*	*do not know*	*total (n)*
Health centre					
Urban	32%	60%	7%	1%	552
Rural	51%	37%	11%	1%	593
Total	42%	48%	9%	1%	1145
Hospital					
Urban	83%	11%	1%	5%	419
Rural	59%	34%	7%	0	187
total	*76%*	*18%*	*3%*	*3%*	*606*

7.2.2. Patient-provider interactions

To examine patient-provider interactions, community members were asked how they rate the quality of explanations they receive from providers and whether providers are friendly and respect clients' privacy. The answers in Table 7.02 show that the majority of the users gave positive appreciation for health workers; 85% of the respondents in the household survey reported that staff in government hospitals are friendly while corresponding figures for health centres and private clinics are over 70%.

Results of this study indicate that in general health workers communicate well with users of health services and that patients' privacy is respected. As can be seen from Table 7.03, over 50% of the total sample rated the quality of explanations given by health workers as good. An overwhelming majority of the household respondents reported that patients' privacy is respected (Table 7.04).

To assess current perceptions about patient-providers interactions, patients who had just received care from health facilities were asked questions about their interactions with providers during exit interviews. Table 7.05 shows that patient-provider interactions were generally good. Nearly all (93%) patients who had just received care reported that they were treated friendly while 87% said they were given a chance to fully explain their illness. However, about two thirds (60%) said they were not told what their illness was and about half (51%) said they were not given an opportunity to ask questions about their illnesses and treatment encounters. The large numbers of users who were not told their illnesses and/or given an opportunity to ask questions suggest a communication barrier between providers and their clients.

Table 7.06 shows that health workers rated their interactions with clients more positive than members of the community. For example, 59% of the community respondents agreed that nurses are always kind and 58% that providers always explain illnesses and/or treatment to patients compared to over 80% of the providers. However, skills to listen to patients are low among health workers with about a quarter (24%) of the community agreeing that health workers do not listen to patients. Again note the disagreement between the community and providers on the listening skills of health workers with only 7% of providers agreeing that health workers do not listen to patients compared to 24% of community members.

Table 7.02: Household respondents' views about whether health providers are friendly, by health facility and area

are health staff in your health centre friendly?	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	81%	16%	3%	552
Rural	75%	25%	0	593
Total	78%	21%	1%	1145
Hospital				
Urban	89%	5%	6%	419
Rural	76%	22%	2%	187
total	*85%*	*10%*	*5%*	*606*

Table 7.03: Household respondents' views about explanations given by health providers, by health facility and area

	good	*not so good*	*bad*	*do not know*	*total (n)*
Health centre					
Urban	48%	43%	7%	2%	398
Rural	56%	34%	10%	0	456
Total	53%	38%	9%	0%	854
Hospital					
Urban	76%	18%	1%	5%	405
Rural	61%	32%	7%	0	180
total	*71%*	*22%*	*3%*	*4%*	*585*

Table 7.04: Household respondents' views about whether health providers respect patients' privacy, by health facility and area

do staff in your health centre respect patients' privacy?	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	92%	5%	3%	552
Rural	79%	20%	1%	593
Total	85%	14%	1%	1145
Hospital				
Urban	92%	2%	6%	419
Rural	87%	13%	0	187
total	*90%*	*5%*	*5%*	*606*

Table 7.05: Health facility users' views about patient-provider interactions during exit interviews (n = 381)

views	*yes*	*no*
Health worker revealed name of illness	40%	60%
Health worker treated patient friendly	93%	7%
Patient had chance to explain illness	87%	13%
Patient could ask questions	*49%*	*51%*

Table 7.06: Household respondents' (HHRs) and providers' views about patient-provider interactions (HHRs n=1145, Providers n=98)

	agree HHRs / Staff	*disagree HHRs / Staff*	*do not know HHRs / Staff*
Nurses are always kind/ understanding	59% 82%	36% 10%	5% 8%
Even when busy nurses take time for patients	55% 94%	38% 5%	7% 1%
Nurses do not listen to patients	24% 7%	69% 88%	7% 5%
Providers always explain Illness /treatment to Patients	58% 84%	37% 9%	5% 7%

7.2.4. Waiting time

When measured by waiting time, quality of care is bad in health centres and hospitals with 69% and 56% of respondents reporting that waiting time is long (Table 7.07). Very little rural-urban difference was observed on this aspect. Other data, not shown here, indicates that both household respondents and providers disagreed on the statement that "patients do not wait long". This finding is similar to that of other studies conducted in Zambia (cf., Macwan'gi 1997) and stresses the point that waiting time is really an issue that needs to be addressed.

Table 7.07: Household respondents' views about waiting time, by health facility and area

is waiting time long?	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	69%	30%	1%	552
Rural	68%	32%	0	593
Total	69%	30%	1%	1145
Hospital				
Urban	50%	44%	6%	418
Rural	72%	27%	1%	178
total	*56%*	*39%*	*5%*	*596*

7.2.5. Availability of drugs

Availability of drugs is the major criterion by which the community in the first phase of this study judged the quality of health care and it is also a major factor that determines peoples' attitudes towards cost-sharing. Therefore, the evaluative phase of this study, collected information on how the community and the providers rate availability of drugs.

Results of this study are consistent with those of the qualitative phase which suggest that it is of no use to go to a health facility if there are no drugs. Table 7.09 shows that 69% of the respondents in the household survey reported that a health centre without drugs is indeed useless and 70 % agreed that getting a prescription when medicines are not available at a health facility is a waste of time. With these attitudes, it is not surprising that quality of care (judged by availability of drugs) is perceived negatively. Only 16% of the 1145 community respondents indicated that drug availability at health centres is good while about a fifth (21%) said that availability of drugs is bad (Table 7.08). This finding is consistent with results from exit interviews which show that about a fifth (21%) did not obtain all prescribed drugs on the day of the study (Table 7.10). It is also important to observe that findings of this study support one of this study's stated hypothesis that quality of care at private and church institutions is better than care from government health facilities. None of the respondents who had experience with private and/or mission health institutions described availability of drugs in those institutions as bad while 21% reported that availability of drugs at government health centres is bad (Table 7.08).

Table 7.08: Household respondent's views about the availability of drugs, by health facility and area

	good	*not so good*	*Bbad*	*do not know*	*total (n)*
Health centre					
Urban	10%	67%	22%	1%	552
Rural	23%	57%	20%	0	593
Total	16%	62%	21%	1%	1145
Govt. Hospital					
Urban	76%	17%	2%	5%	419
Rural	53%	43%	4%	0	187
Total	68%	25%	3%	4%	606
Mission Hospital					
Rural	92%	8%	0	0	115
Private clinic					
Urban	72%	3%	0	25%	243

Table 7.09: Household respondents' (HHRs) and providers' views about availability of drugs (HHRs n=1145; Providers n=98)

drug Availability	*agree*		*disagree*		*do not know*	
	HHRs	*/ Staff*	*HHRs*	*/ Staff*	*HHRs*	*/ Staff*
People only get Panadol?	98 %	38%	2%	62%	6%	0
There is no point in coming to health centre if there are no drugs	69%	18%	27%	79%	4%	3%
Drugs are available at health centres most of the time	26%	63%	68%	34%	6%	3%
Drugs are only given to friends/relatives	26%	27%	41%	66%	33%	7%
Getting a prescription with no drugs is a waste of time	70%	27%	25%	66%	5%	7%

Table 7.10: Availability of drugs as reported during exit interviews

	yes	*no*	*total (n)*
Received all prescribed drugs	79%	21%	381
Intends to buy unavailable drugs	56%	44%	81

7.2.6. Physical conditions

During the exploratory phase of this research, the physical conditions and the infrastructure of health facilities were reported to have improved considerably since the introduction of the user fees. This finding was followed up in the evaluation phase by asking the community and the providers to rate the quality

of physical conditions of their health facility and whether they agreed on various quality of care related indicators. Consistent with the results from the qualitative phase, both the community and providers reported that physical conditions at health centres had improved. Health centres are described as clean and looking and/or smelling better than before. Table 7.11 shows that only a quarter and less than 5% of the household respondents and staff respectively agreed that health centres are always dirty. Further, the community and the providers (over 70%) agreed that the health centres look and smell better than before. However, the opinions of both staff and users on the quality of equipment and the availability of benches were less favourable.

Table 7.11: Household respondents' (HHRs) and staff's views about physical conditions of health facilities (HHRs n=1145, staff n=98)

Physical conditions of health centres	*agree HHRs / Staff*	*disagree HHRs / Staff*	*do not know HHRs / Staff*
Health centres are always dirty	21% 4%	74% 95%	5% 1%
Health centres always have water	46% 45%	42% 53%	12% 2%
Health centres look/smell Better than before	71% 75%	21% 18%	8% 7%
Equipment is in good Working condition	43% 60%	20% 38%	37% 3%
There are insufficient Benches	53% 63%	40% 32%	7% 4%

7.2.7. Access to health facilities and services

To measure access to health facilities and services, household respondents and providers were asked questions related to the distance of their residences to health facilities, availability of staff to attend to patients and transport to health facilities. A general question asking household respondents "How accessible is your nearest clinic/provider in terms of distance?" elicited mixed responses. In general health facilities are accessible to the majority of the population. None of the participants in the study reported that any of the health facilities included in the study were not accessible. However, some health facilities are more accessible than others. For example, Table 7.12 shows that over half (59%) of respondents reported that health centres were very accessible. Enormous rural / urban differentials were, however, observed. Almost all (96%) urban respondents reported that, in terms of distance, health centres are very accessible. The corresponding figure for rural respondents was only 25%. The respondents were less positive about the accessibility of hospitals. Only 20% of the rural respondents found the hospital

very accessible. It should be pointed out, however, that practically no respondents regarded health centres or hospitals as 'not accessible'.

At the same time, about half of both household respondents and health providers agreed that health centres are far from where most patients live (Table 7.14). The slight disparity between this finding and the earlier finding which showed that 59% of the household respondents reported that health centres are very accessible could be due to the subjective nature of the question.

Another access indicator examined in this study is availability of transport. About half (46%) of the household respondents and a third (32%) of the health care providers agreed that transport to health facilities is difficult. Access to health workers as shown on Table 7.14 is not very good. About half (45%) and two thirds (63%) of household respondents agreed that there staff to attend to patients. This means that a patient may get to a health facility but not get attended because there is no health worker available. Especially during the night people coming to a health centre have problems finding someone to take care of them (Table 7.14).

Table 7.12: Household respondents' views about geographical access to health facilities

geographical access	*very accessible*	*accessible*	*not accessible*	*do not know*	*total (n)*
Health centre					
Urban	96%	3%	0	1%	552
Rural	25%	73%	0	2%	593
Total	59%	39%	1%	1%	1145
Hospital					
Urban	47%	48%	0	5%	420
Rural	20%	79%	0	1%	186
total	*40%*	*57%*	*0*	*4%*	*606*

Table 7.13: Household respondents' views about access to health facilities and health care providers at night

access at night	*very accessible*	*accessible*	*not accessible*	*do not know*	*total (n)*
Health centre					
Urban	45%	14%	36%	5%	506
Rural	25%	30%	42%	3%	593
Total	32%	22%	39%	6%	1099
Hospital					
Urban	53%	35%	6%	6%	420
Rural	33%	33%	34%	0%	186
total	*39%*	*57%*	*0*	*4%*	*606*

Table 7.14: Household respondents' (HHRs) and staff's views about various aspects of access to health facilities (HHRs n=1145, Staff n=98)

	agree		*disagree*		*do not know*	
	HHRs	*/ Staff*	*HHRs*	*/ Staff*	*HHRs*	*/ Staff*
Transport to health centre is difficult	46%	32%	53%	66%	1%	2%
Staff is not always there to attend to patients	45%	63%	45%	34%	10%	3%
There are no health workers for emergency at night	37%	18%	48%	81%	15% 1%	
Health centre is far	*46%*	*54%*	*52%*	*44%*	*2%*	*2%*

7.2.8. Staff competence

Another indicator for the quality of care examined in this study is staff competence. To assess staff competence, community members in the household survey and exit interviews' were asked to give their opinions about staff knowledge and selected skills. Providers were asked parallel questions. Table 7.15 shows that the majority of the community members and the providers who participated in the study had a high opinion of health workers' knowledge: 90% and 86% of the community reported that health workers at government hospitals and health centres know their work. Table 7.16 further shows that the community and the providers in the study agree that health workers are knowledgeable, as expected more providers (95%) than community respondents (73%) rated health workers' knowledge high.

However, even though staff knowledge is rated high, the study shows that this knowledge is not always translated into good practice. For example, Table 7.18 indicates that in the community household survey, only about one third (37%) of the 917 respondents said that proper physical examinations were carried out at health centres. This is confirmed by another study finding presented in Table 7.15: 30% of the community against 7% of the providers agreed that health workers never touch patients. Even more concrete is that over half (59%) of the respondents in the exit interviews reported that they were not physically examined on the day of the interview (Table 7.17). Table 7.16 shows that although health workers do not always conduct physical exams, they do take temperature. Two thirds of the community respondents (62%) and three quarters (76%) of the providers agreed that health workers always take temperature of their patients.

People's experiences with diagnostic practices by health workers in hospitals are much better, however. Table 7.17 indicates that 80% of the community respondents reported that health workers in government hospitals do conduct physical examinations.

Table 7.15: Household respondents' views about health providers' technical knowledge, by health facility and area

staff is knowledgeable	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	90%	7%	3%	552
Rural	89%	16%	1%	593
Total	86%	12%	2%	1145
Hospital				
Urban	94%	1%	5%	419
Rural	80%	19%	1%	187
total	*90%*	*6%*	*4%*	*606*

Table 7.16: Household respondents' (HHRs) and staff's views about staff competence (HHRs n=1145, staff n=98)

indicators	*agree*		*disagree*		*do not know*	
	HHRs	*/ Staff*	*HHRs*	*/ Staff*	*HHRs*	*/ Staff*
Health staff know their work	73%	95%	12%	4%	15%	1%
Staff never touches patients	30%	7%	63%	93%	7%	0
Staff always take Temperature	37%	18%	48%	81%	15%	1%
Health centre is far	62%	76%	31%	18%	7%	6%

Table 7.17: Whether patients were examined as reported during exit interviews

were you examined?	*number of respondents*	*percentage of respondents*
Yes	225	59%
No	156	41%
total (n)	*381*	*100%*

Table 7.18: Household respondents' views about quality of physical examinations performed by health providers, by health facility and area

quality of examinations	*good*	*not so good*	*bad*	*do not know*	*total (n)*
Health centre					
Urban	41%	55%	3%	1%	512
Rural	53%	35%	11%	1%	405
Total	37%	37%	5%	20%	917
Hospital					
Urban	89%	5%	0	6%	420
Rural	59%	35%	5%	1%	186
Total	*80%*	*14%*	*2%*	*4%*	*606*

7.2.9. Treatment and perceived outcome

To measure treatment and perceived treatment outcome, respondents were asked whether they usually get the treatment they need from their respective health facilities and whether they usually get better after receiving care. Household respondents who had been sick during the month preceding the survey were asked if they had received the treatment they expected and whether they had recovered from the illness after the first treatment.

The answers in Tables 7.19 and 7.20 paint a rather negative picture. About half (48%) of the 1145 respondents in the household survey said that they usually did not get the treatment they expected at the health centre and about one third (32%) reported that they did not get better after receiving treatment in the health centre. In addition, Table 7.21 shows that a third (33%) of the 897 respondents who had someone sick in their household one month preceding the survey reported that the sick person had not recovered. This finding is similar to that presented on Table 7.20 which shows that about a third (32%) of the respondents reported that they usually do not get better after receiving care from a health centre. Table 7.21 shows a similar picture: about a quarter (23%) of the respondents who were seeking care on the day of the interviews were conducted did not receive the treatment they wanted. People were much more positive about hospital treatment. As Table 7.19 shows, 83% indicated that they usually did receive the treatment they wanted and 84% said they usually got better after having been treated at the hospital (Table 7.20). Respondents who had experience with a missionary hospital or a private clinic were still more complimentary about these institutions, but the difference between the centre and hospital is greater than between public and private. Apparently, the respondents judged the quality of treatment primarily on medical-technical criteria.

Table 7.19: Household respondents' views about treatment, by health facility and area

do you usually get the expected treatment	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	42%	56%	2%	552
Rural	58%	40%	2%	593
Total	50%	48%	2%	1145
Government Hospital				
Urban	86%	8%	6%	420
Rural	75%	24%	1%	186
Total	83%	13%	4%	606
Mission Hospital				
Rural	94%	5%	1%	114
Private clinic				
Urban	66%	8%	26%	230

Table 7.20: Household respondents' views about whether they usually get better after receiving treatment, by health facility and area

usually get better	*yes*	*no*	*do not know*	*total (n)*
Health centre				
Urban	62%	37%	1%	552
Rural	72%	28%	0	593
Total	67%	32%	1%	1145
Government Hospital				
Urban	89%	6%	5%	417
Rural	74%	25%	1%	186
Total	84%	11%	4%	603
Mission)Hospital				
Interviews	96%	4%	0	114
Private clinic				
Urban	69%	5%	26%	225

Table 7.21: Did you receive the treatment you needed today (patient exit)

	number of respondents	*percentage of respondents*
Yes	293	77%
No	88	23%
total (n)	*381*	*100%*

Table 7.22: Household respondents' reported treatment outcome

did the sick person recover after treatment	*number of respondents*	*Percentage of respondents*
Yes	549	61%
No	299	33%
Do not know	49	5%
total (n)	*897*	*100%*

7.2.10. Suggestions for improvement of quality of care

Both members of the community and health workers were asked whether they believed there had been some noticeable improvements in the health centre since the fees were introduced. Nearly two thirds (63%) of the health providers answered in the affirmative and nearly one third (30%) denied their had been any improvement. There was no significant difference between urban- and rural-based health providers. Seven percent had no opinion. Interestingly, there *was* a strong difference between rural and urban consumers of health care in their appreciation of the quality of care after the introduction of user fees; 72% of the Lusaka inhabitants who were interviewed said there had been a noticeable improvement while only 31% of the rural respondents shared that view (Table not reproduced here). People's views on how the quality of care could be improved in health centres are summarised in Table 7.23 which contains

household respondents' personal opinions on the matter. The emphasis on drugs is clear in the urban group of respondents, but far less prominent among rural dwellers. More research may be needed to explain this discrepancy, but one possible explanation could be that rural health centres face some additional problems (scarcity of personnel and limitation of services) which has led to a broader scale of suggestions for improvement of quality.

Table 7.23: Household respondents' suggestions to improve quality of care at health centres (percentages)

	rural	*urban*
Improve supply of drugs	15	52
Increase the number of staff	13	8
Extend facility	15	1
Improve health staff's attitudes towards patients	3	5
Provide water/taps	3	5
Provide resident doctor	1	2
Provide in-patients with food	4	0
Abolish user fees	3	4
Provide electricity / lamps	4	-
Provide bedding	2	1
Provide ambulance	3	1
Carry out proper examination / treatment	1	3
Form urban health centre	2	2
Improve general standard	2	1
Treat emergencies promptly	0	2
Others	4	11
Do not know	19	6
total (n)	*1310*	*786*

7.3. Conclusion

Results of this study show that studies on quality of care need to take into account the various aspects of care, type of health facility and different settings within which health facilities are located. The study underscores that the perceived quality of care varied by type of health facility. The study also notes major rural - urban differences in perceptions about quality of care. Where as in general, the results of this study show positive signs in the quality of care provided, household respondents from rural areas were more likely to report that the general standard of services for health facilities were good while urban respondents were more critical of services being offered at various health facilities. More remarkable than the rural - urban difference was, however, that users of health services had a much higher appreciation for hospitals than for health centres. The data of our survey suggest that people judge the quality of care foremost by criteria of technical competence and availability of drugs, two

conditions on which hospitals score higher than health centres, particularly in rural areas (see also Atkinson et al. 1999).

While a large picture may show positive signs, a critical examination of specific areas of care reveals some causes for concern. Only about one quarter of the household respondents reported that there were sufficient drugs available at health centres. This finding is confirmed by data from the exit interviews which show that: one quarter of respondents who were prescribed medicines did not get all their medicines on the day of the interview. Other indicators of quality of care which did not fare well were waiting time and communication between clients and health providers. Waiting time was generally reported to be long at all study sites and most of the household respondents reported that health workers do not usually tell patients what illness they have while patients do not get the opportunity to ask questions about their situations. In addition, access to health facilities especially in rural areas and at night are reported to be limited. Many respondents said that health centres are far from where patients live. Transport to rural health centres was reported to be difficult and often there is no health staff to attend to patients.

Health workers knowledge was rated well but this knowledge was not always translated into good practice. For example, about two thirds of respondents in the exit interviews reported that they and/or the patients they brought to the health facility were not examined. Data on treatment and perceived treatment outcome shows a negative picture that about half the respondents in the household survey reported that they usually do not get the treatment they expect and about one third of them complained that they do not get better after treatment.

Summarising this survey's findings on perceived quality of care, one must conclude that the picture is a mixed one. Community members express both positive and negative remarks about the quality of care in their health services. They seem to be most concerned about the provision of medicines and - in the rural areas - about insufficient personnel and deficient facilities. Understandably, the health staff's views are generally more positive about the quality of care they offer.

CHAPTER 8

TRENDS IN THE UTILISATION OF HEALTH SERVICES

8.1 General remarks

In order to determine provider and community perceptions about trends in the utilisation of health services since the introduction of cost-sharing at health institutions, both community and provider respondents were asked to state whether they believed there had been a decline in the number of people attending health services. Provider respondents from both rural and urban areas agreed that there had been such a decline in the health centres. In urban areas, 75% said there had been a decline in attendance, whereas 19% said there had been an increase. For providers in rural districts the corresponding figures were 84% and 7% (Table 8.1).

Household respondents were asked whether there they believed more people visited health centres now than was the case before the introduction of fees. Over half of the respondents from both rural and urban areas (55% and 58% respectively), said there had been a decline in the number of attendance, while 31% and 43% of urban and rural respondents respectively held the view that there had been an increase in attendance (Table 8.1).

Table 8.1: Household respondents' and providers' responses on whether utilisation of health facilities has declined

household respondents' views	*urban*	*rural*
Yes	58%	55%
No	31%	43%
Not stated	11%	2%
Total (n)	634	881
Providers' views		
Yes	75%	84%
No	19%	7%
Not stated	6%	9%
total (n)	*36*	*62*

In addition to data from individual respondents, attendance records from health institutions were collected. Utilisation of health services was assessed by reviewing attendance records of selected health facilities, over a four year period from 1991 to 1995. Service delivery records for in-patients and out-patients were reviewed. The records were segregated into under-five and above-five years population groups. The record review was carried out for those health facilities where exit polls were conducted.

Tables 8.2, 8.3 and 8.4 show aggregated utilisation data for rural and urban areas. Utilisation increases up to 1993. Thereafter is a decline in attendance which is especially marked for the years 1994. After 1994, there is an increase in attendance, although this does return to the pre-1994 level. A detailed presentation of findings on utilisation in specific districts and health centres is shown further below.

Table 8.2: Out-patient attendance under five years of age, by area

year	*urban*		*rural*	
	pumber	*percentage*	*number*	*percentage*
1991	14,823	14%	25,188	16%
1992	17,206	17%	31,292	21%
1993	22,200	22%	27,686	18%
1994	13,789	13%	23,047	15%
1995	13,780	13%	25,080	17%
1996	21,645	21%	19,752	13%
total (n)	*103,443*	*100%*	*153,398*	*100%*

Table 8.3: Out-patient attendance over five years of age, by area

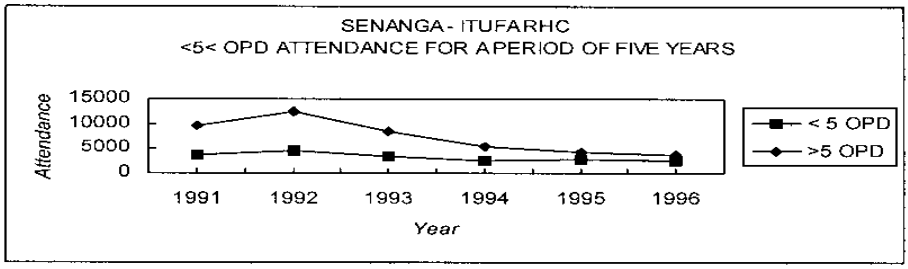
year	*urban*		*rural*	
	number	*percentage*	*number*	*percentage*
1991	8,718	9%	977	13%
1992	18,317	20%	1,218	17%
1993	19,360	21%	1,241	17%
1994	13,298	14%	1,336	18%
1995	15,723	17%	1,531	21%
1996	16,936	18%	1,010	14%
total (n)	*92,352*	*100%*	*7,313*	*100%*

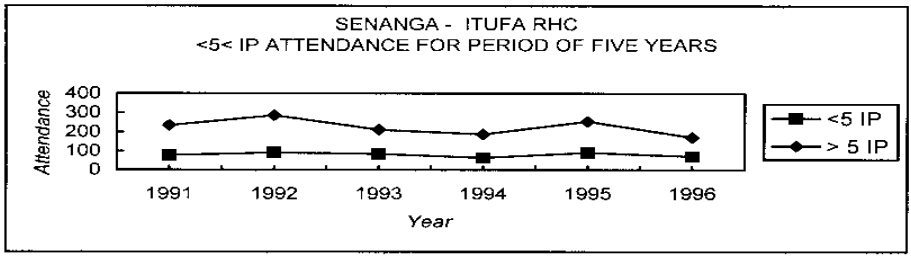
Table 8.4: In-patient attendance in rural areas

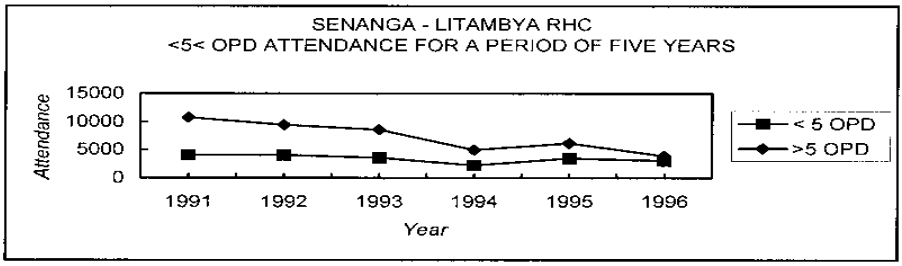
year	*number of patients*	*percentage of patients*
1991	60,279	22%
1992	63,672	23%
1993	52,985	19%
1994	36,683	13%
1995	36,546	13%
1996	23,629	8%
total (n)	*273,794*	*100%*

NB. Data on admission rates in urban health centres are not available.

Figure 8.1: Out-Patient Department (OPD) / In-patient Attendance for Selected Health Centres in Senanga District; 1991-mid 1996







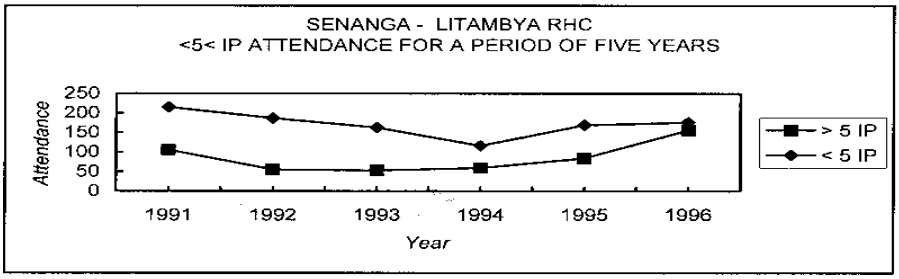


Figure 8.2: Out-Patient Department (OPD) / In-patient Attendance for Selected Health Centres in Mwinilunga District; 1991-mid 1996

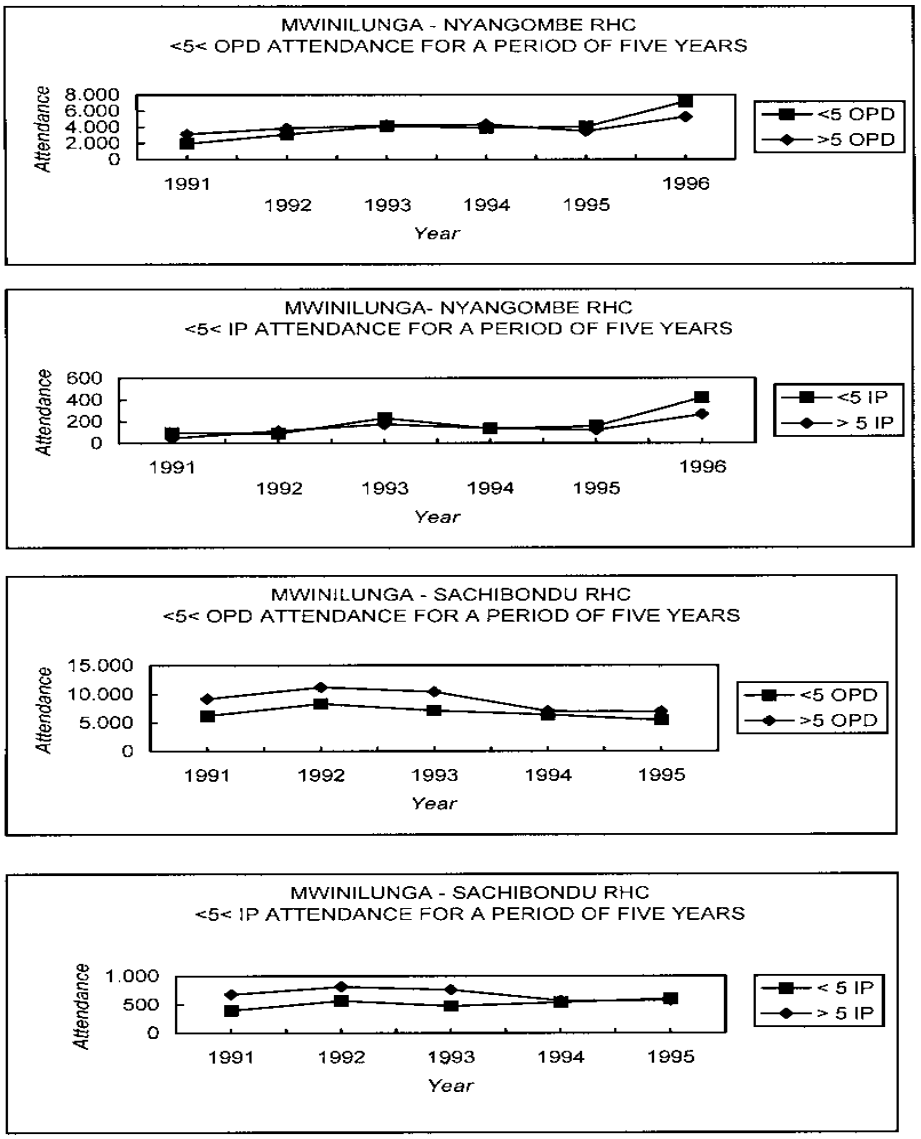
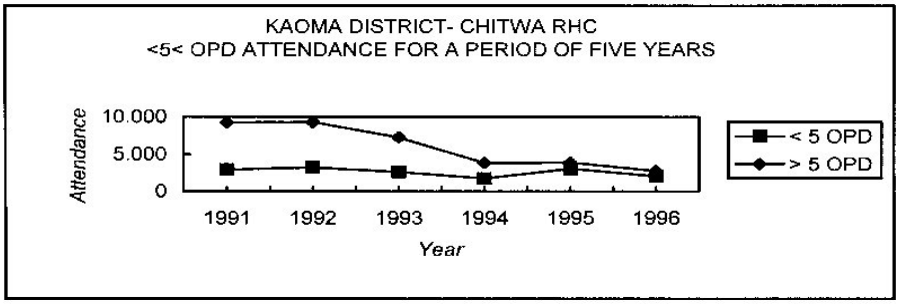
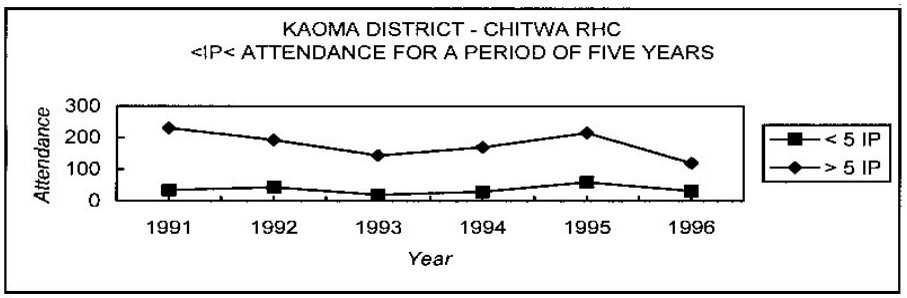
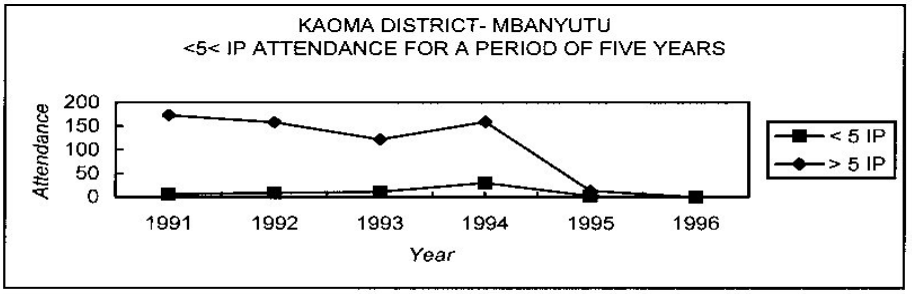


Figure 8.3: Out-Patient Department (OPD) / In-patient Attendance for Selected Health Centres in Kaoma District; 1991-mid 1996







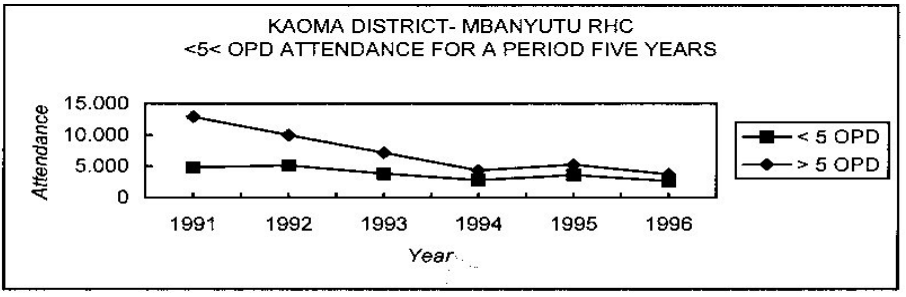
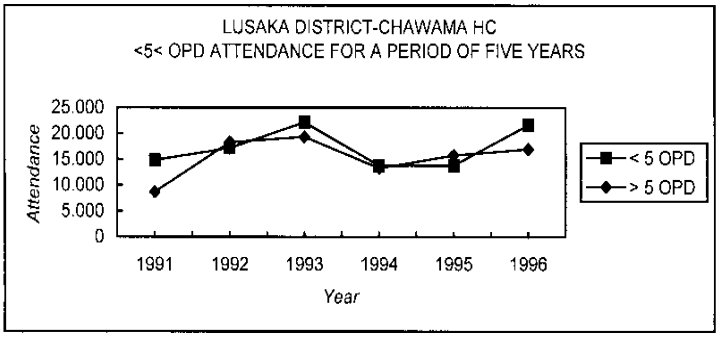


Figure 8.4: Out-Patient Department (OPD) Attendance for Selected Health Centres in Lusaka District; 1991-mid 1996



8.2 Utilisation trends in various districts

Mwinilunga District

Nyangombe Rural Health Centre

Nyangombe Health Centre recorded a steady increase in out-patient utilisation levels for the population aged under five, prior to 1993 after which a minimal downturn was observed, reaching the lowest level in 1994, before ascending again. For in-patient attendance, 1991 started on a low note, continuing in the next year and then rising in 1993 before declining the following year. The subsequent years witnessed a rise in utilisation levels.

Utilisation levels and trends for the population aged five and above showed a consistent rise in utilisation except for 1994 and 1995 when a decline was recorded. In-patient attendance started on a low note, with only about 50 patients being admitted and thereafter peaking up and reaching close to 160 admissions in 1994, after which a decline was observed, before resuming the ascendance 1996. Out-patient attendance followed basically the same pattern of utilisation, except that the 1995 fall in attendance was steeper. The initial years of 1991, 1992 and 1993 registered a steady increase in utilisation which reached a climax in 1993, before falling and resuming the upward trend to reach the highest level in 1996.

Sachibondo Mission Rural Health Centre

In-patient attendance for under-five children showed an irregular pattern over the years. In 1991, just under 400 under five children attended in-patient services. This number increased to slightly over 550 in 1992 before registering a decline to less than 500 in 1994, after which a steady increase in attendance was noted for the following years.

Except for the initial year 1991, when attendance was very low, out-patient attendance for children aged less than five years, showed a consistent decline throughout the period of reference. From 1991, utilisation increased to slightly over 8000 in 1992 and then declined to a low of slightly over 5000 by 1995. For the population aged above five, attendance declined after 1992, both for in- and out-patients, and stabilised after 1994.

Senanga District

Litambya Rural Health Centre

The general trend for under-five in-patient attendance was a decline until the latter years of the reference period. Litambya Health Centre shows a consistent decline in-patient attendance for the population aged less than five from 1991 onwards reaching the lowest in 1993, after which a steady ascendancy is registered. Out-patient attendance data for the same age group, on the other

hand also showed a steady decline reaching the lowest in 1994, before peaking up again.

For the population aged five years and above, out-patient attendance also showed consistent decline from 1991 through to 1994, before ascending by 1995. In-patients attendance statistics exhibit the same pattern. A steady decline in attendance was registered up to 1994, after which an upturn was recorded.

Sioma Mission Rural Health Centre

Under five out-patient attendance figures for Sioma Mission Health Centre show a steady rate of increase in attendance all the years reviewed. Although the figure shows a decline after 1995, this is just a reflection of missing data for the last six months of 1996. In-patient attendance reflects the same picture.

An examination of out-patient utilisation data for the population aged above five years, on the other hand shows a different picture. While an increase in utilisation was registered from 1991 to 1992, the following years exhibited a steady decline in attendance. In-patient utilisation data shows a mixed picture. Started off at higher note, 1991, attendance declined in the following year and picked up afterwards, to reach a high level in 1994 before declining again.

Itufa Rural Health Centre

Out-patient attendance for the under-five group was low in 1991, and then ascended to a high level in 1992, after which a consistent downward trend is observed. In-patient attendance showed an irregular pattern. The trends start off on a low note, and rose to a relatively high level in 1992, before declining and reaching a very low level in 1994. The following year saw a resurgence in attendance to match utilisation level almost at par with the 1992 level.

Out-patient utilisation for the population aged over five years registered a steady decline after 1992. In-patient utilisation in the same population exhibited an irregular pattern. At the beginning of the reference period, the attendance was low and rose quite markedly in 1992, before falling to the lowest level in 1994 and thereafter ascending once again.

Kaoma District

Chitwa Rural Health Centre

Under-five OPD attendance registered a steep decline in 1994, when attendance declined from a high of over 3000 attendants to a low of 1600 by the year 1994. Thereafter, attendances increased again to almost their 1992 level. A similar picture is observed for in-patient attendances, although the decline was recorded earlier than was the case for out-patients. After 1993, an ascendance in attendance was registered as well and reached about 60 in 1995.

While the under-five out-patient statistics showed a steep decline over the years, the decline in respects of the population aged over five years was gradual, but also reached the lowest level in 1994 which was maintained even for the next year (1995). In-patient attendances on the other hand exhibited a more irregular pattern. Starting off from a high point of utilisation, the lowest was recorded in 1993, after which a steady increased was recorded.

Mbanyutu Rural Health Centre

Data for Mbanyutu shows a consistent decline in attendance for under five in-patient attendance reaching the lowest level in 1994, after which slow increase in attendance was recorded, which however, did not result in much significant increase. Paradoxically attendance figures for under five in-patient attendance shows a different picture, with the highest level of utilisation having been observed in 1994, and thereafter a steep decline to levels lower than the pre-1994 ones.

The trend in respect of OPD attendance for the under five population was not any different. A steady decline was observable from 1991 onwards, reaching the lowest level in 1994 when the facility recorded an all time low utilisation level of 4000 only. Although in-patient attendance also showed a general decline, the initials lowest level was recorded in 1993, after which utilisation peaked before ascending and thereafter registering a very steep in fall in 1995.

Lusaka District

Chawama Health Centre

The health facilities covered in Lusaka had very limited data due of poor record keeping. It was also not very comparable to that from rural sites. The data collected shows the same picture as that portrayed for the other health facilities discussed above. A slump in out-patient attendance was observed in 1994, after which recovery was restored especially by 1996. Data was collected on number of people assisted through the Social Welfare Department and number of referrals to UTH. Although 1993 registered a peak in the number of people assisted by the Social Welfare Department, this fell in 1994 before rising again. While both the number of person attending out-patient services and obtaining assistance from the Social Welfare declined in 1994, referrals to the University Teaching Hospital actually increased in 1994.

8.3 Conclusion

Both household and provider respondents agreed that there had been a decline in the number of people going to health institutions after the introduction of cost-sharing. These responses tally with other data from households which show that a high proportion of respondents said that if they had no money and fell ill, they would just stay at home and not go to a health institution.

The Social Welfare Scheme under which economically destitute individuals can be assisted is not well known. Further, the scheme is beset by operational problems which diminishes its capacity to cater for the needy. The findings on utilisation are supported by statistics from health centres which consistently show a decline in attendance at health institutions after the introduction of user fees. However, the downturn was in most cases only temporary as the level of utilisation rose after a year. Regrettably, our data only cover the period up to 1996 which renders it impossible to draw more definite conclusions about the utilisation pattern after 1994.

While the introduction of fees does not seem to have had a sustained negative impact on the utilisation of health services, the weaknesses of the Social Welfare Scheme, under an environment of economic adversity is likely to lead some people to forego health care because they cannot afford the fees and are not aware of the help the scheme can offer.

PART III

CONCLUSIONS

CHAPTER 9

DISCUSSION AND CONCLUSIONS

9.1 Cost-sharing

Ability to pay for health care

As was expected more rural than urban dwellers reported that they were unable to pay for the costs of health care. The subsistence nature of the rural economies means that they have very little capacity for meeting additional costs. Expressions of inability to pay for health care by the community may indicate that the community respondents were unhappy with the services offered to them and, therefore, expressed their dissatisfaction by saying that they were unable to pay. It is no surprise that people express their dissatisfaction regarding the payments since they had been used to obtaining health services free of charge.

Providers on the other hand consider the fees that people pay to be token payments in relation to the real costs of providing health care. They are convinced that most patients can afford the fees. In addition revenues from fees have augmented health facility finances and providers would like this to continue. Views from the providers could also be an indication of their different values and economic status which is generally higher than that of the community. Incidentally, health workers themselves do not pay for the services which, they say, the people should pay for.

Payment mode mix and equity of access to health care

The study revealed that prepayment while being a common mode of payment in urban areas, was not practised in the rural areas, where user fees and cash payments predominate. However, requiring rural communities to pay for health care every time they seek health care is incompatible with the means of sustenance prevailing in rural areas. Rural populations mostly derive their means of livelihood from farming and it would, therefore, be easier for them to pay for health care at the time when they harvest and be covered for a longer period until the next harvest. In doing so, rural communities will not be unduly restricted from accessing health care because of lack of money at the time when they seek health care. The experiments with prepayment should, therefore, be expanded to cover rural areas.

The mode of payment for health care can be used to maximise the up-take of health care. Although recognised as an appropriate medium of payment especially in rural areas, in-kind payment is not common. It is hardly practised in urban areas and relatively rare in rural places. This mode of payment could, however, improve people's access to health care, especially for rural dwellers. Rural communities essentially derive their livelihood from agriculture and their

incomes are seasonal. However, having an agricultural harvest does not automatically translate into a cash income. The possibility to pay in kind would raise additional resources for the health facilities while at the same time enabling the rural communities to have access to health care through appropriate means of payment.

Harnessing consumers' willingness to pay
Although a high proportion of the community respondents said that they were opposed to paying fees, those who agreed to cost-sharing are worthy of scrutiny. Respondents who were not opposed to fees, the majority of whom were from urban areas, said fees for health services are acceptable as long as drugs are readily available. They complained that it did not make sense to pay for health care when one was not assured of drugs. They insisted that they ought to be provided with drugs as a tangible form of a health care product for the money paid. People, especially those from urban areas, were willing to pay for health care as long as it was backed by the supply of drugs. In view of the high premium attached to drugs, it would, therefore, be ideal to tie fees to provision of tangible health care, especially medicines. This would restore the community's confidence in the system as people would be getting their money's worth and this would in turn increase the number of people paying for health care.

9.2 Community participation
Is community participation a paper construction with attractive terms like 'District Health Board', 'Area Board' and 'Neighbourhood Health Committee', or are members of the community really involved in decisions concerning health care in their area? The research observed and analysed people's perception of their participation.

Institutionalising fees as a form of community participation
Whereas community respondents from both rural and urban areas contribute by way of cash towards the costs of health care, people did not consider their contribution as a form of involvement in the delivery of health services. For them, community participation meant physical contributions at health facilities. Hence, they do not perceive themselves as participants in the delivery process at the health centres. Communities ought to be appraised about the different levels of involvement so that they perceive themselves as active participants in the delivery of health care.

Breaking individual powerlessness
The fact that people generally do not perceive themselves to be active participants in the process of delivering health care is also borne out by responses on what the

household respondents could do as individuals to improve the quality of health care at their local health facility. A high proportion of respondents said that they did not know what they could do to help improve conditions at health centres. This confirms the observation that communities mainly perceive their contribution in the form of labour inputs rather than, for example, taking part in planning health care. This sense of non-involvement and individual lack of power could be a result of insufficient orientation on the part of the authorities to sensitise the communities about the various level of participation that communities could engage in to improve conditions at their local health facilities. It could also be a legacy of the previous highly centralised system which viewed the community as merely consumers of health services instead of active participants.

9.3 Decentralisation

Decentralisation of essential functions is one of the major elements of the Health Reforms aimed at revitalising PHC. According to the 1992 Health Reforms Policy Documents, power and management of finances will be delegated to the district and health centre levels. It is envisaged that this process will create structures that will facilitate active involvement of providers at peripheral health facilities and users in health matters, decision making and planning in particular.

Mixed knowledge levels

Results of the evaluative phase of this project support one of the major findings of the exploratory phase which shows that decentralisation is the least understood objective of the current Health Reform among the study participants. The decentralisation process is still at its initial stage. Knowledge levels about elements of decentralisation reform process vary by subject and show a mixed picture. For example, most health workers in the study were well aware that money collected through user fees is supposed to assist the government to meet some of the costs such as procurement of drugs and equipment in order to improve the quality of health care provided at health facilities. At the same time, the majority of them did not know the reasons why some health workers do not get bonuses. However, although the knowledge indicators show gaps, there is definitely a change in knowledge levels since 1995 when the exploratory study was conducted to 1997 when the evaluative phase was undertaken. A definite indicator that the decentralisation process has not yet taken root is that health workers are not involved in planning and decisions about how the funds they collect through user fees should be utilised. The study shows that very few staff are trained in basic accounting to facilitate financial management whereas, at the same time, most staff members say they are supervised in accounting.

Why is decentralisation so slow in being implemented compared to cost-sharing?
As indicated in the first phase of this study, it must be understood that, world-wide, people do not relinquish power easily especially as it relates to financial issues. This may be one of the reasons why the transfer of power from central and provincial levels of the MOH to the districts and community levels has not yet fully begun. The study, observed that although the district and the health centres are expected to plan and manage their financial affairs, the staff at all study sites were not trained in health management and there were no structures to effectively collect user fees especially in the rural areas. This is contrary to the government vision that the Health Reforms must create structures that will facilitate active involvement of providers at peripheral health facilities and users in health matters especially decision making and planning. Factors such as reluctance to take up new responsibilities can also account for the slow process of decentralisation. The personnel at district and health centre level may see their new role as a burden rather than a 'welcome' challenge and they may not have the skills and knowledge to take up their new responsibilities. This is evidenced by providers' complaints that they are not being paid for added responsibilities and that they have not been trained in book keeping and accounts and that very few are trained in basic financial management. Yet they are expected to handle finances in the health facility.

Managerial capacity
What we learn from this study is that devolution of power to lower levels of the health care system raises issues pertaining to local managerial capacities. It is imperative that as local people take on these additional roles, they are equipped with the knowledge and skills required for discharging their duties. We also learn that for the reform process to take ground, the environment must be supportive.

9.4 Quality of health care
Improved quality of care is cardinal to the Zambian Health Reforms process but it is also its most problematic criterion. In a critical essay on the feasibility of reforming the health care structure, Chabot (1998: 147) remarks: it appears that the goals of the health reforms are to reconcile the irreconcilable. In fact, they try to arrive at a 'fit' between general and widespread access to health care (equity) of acceptable standard (quality), which is effective and affordable (efficiency). The problem is that when costs for the government are reduced by increasing the contribution of the population (Bamako Initiative), equity and coverage suffer. On the other hand, when efficiency is improved through decentralisation and increased sense of ownership, as was tried in Zambia, quality might be sacrificed.

Chabot concludes his remark in a rather 'open-ended' way: "Finding creative and practical answers to this sort of contradictions is the secret of successful and

sustainable reforms. In this study the 'contradictory' forces of the Health Reforms have been taken together and analysed on the ground: how do providers and consumers of health care view the quality of care in the light of cost-sharing, decentralisation and community participation?

It is assumed that improved quality of care will increase utilisation of basic health care services. In turn increased utilisation of health services is expected to have a positive impact on community morbidity and mortality. Therefore, this study attempted to assess the quality of health care provided at basic health care services. However, it must be noted from the onset that 'quality' of care is a complex issue (cf., Haddad et al. 1998) and asking people whether the Health Reforms process have led to an improvement in the quality of health care may generate various questions. What is 'quality' of care and what do qualifications as 'good' and 'bad' mean? Responses to these questions are bound to be subjective. The study, therefore, focused on people's perceptions about quality of care rather than on objective indicators. Seven specific elements judged to constitute 'quality of health care' were identified and examined; (i) client - provider interaction, (ii) waiting time (iii) availability of drugs; (iv) physical conditions such as equipment and general cleanliness of health facilities; (v) access to health services (distance to the centre, presence of staff) (vi) staff competence and (vii) treatment and perceived outcome.

Client-provider interaction

Five indicators were used to assess the quality of patient-provider interactions: whether staff are friendly; the quality of information received from health staff; whether patients' privacy is respected; whether patients received information on their illnesses; and whether they were given the opportunity to explain their illness and ask questions. Based on these indicators, the results of this study give reasons for optimism and show marked differences as well as similarities between urban and rural communities. In general, both actual and potential users in the study sites perceived staff attitudes and practices in a more positive manner. Most of the household respondents described the staff at various health facilities as friendly and the quality of information received from health staff as satisfactory. In addition, respondents reported that privacy of patients is respected at health facilities. These findings support the exploratory phase results which show that the community even sympathised with the health workers' situation to the extent that negative elements observed in staff attitudes such as rudeness were attributed to the poor working environment, drug shortages and lack of medical requirements (Macwan'gi et al. 1996).

Effective communication between providers and patients is one of the key indicators of good quality care. Although, other indicators show positive results, quality of care judged by communication between clients and providers is poor.

About two thirds of the respondents were not told about their illnesses and about half of them were not given an opportunity to ask questions. This finding reflects that the pre-service training for health workers does not emphasise communication. The limited interaction between providers and their clients could mean that health workers consider medicine too technical for ordinary members of the community to comprehend.

Waiting time

Waiting time is one of the key indicators of quality of care according to the users in this study. The study shows that patients have to wait long at government health facilities, while the majority (66%) of the respondents said that waiting time at private clinics is not long. Reasons for waiting long at health facilities vary. 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.

Availability of drugs

The results of this study show that availability of drugs is the 'overriding' criterion for judging quality of care. All other forms of care and technical competence are secondary. People's preoccupation with drugs negates preventive and promotive health aspects emphasised in PHC. A marked contradiction between providers and users was noted. Providers were more optimistic and positive about the drug situation. They reported that availability of drugs at health centres has improved since the introduction of user fees for health services but users, especially those in Lusaka still complained about lack of medicines.

What is the basis for these contradictions? Availability of medicines in health centres may have improved but the term 'improvement' is relative. The level of improvement may not meet the growing demand of the customers who are now paying for the services and who have become more critical. Some of them demand better drugs. Patients, for example, complained about receiving panadols all the time instead of 'good' drugs. Since the availability of drugs is the most important criterion by which people judge the quality of health services, sporadic shortages of drugs may lead people to say that the Health Reforms have not improved the quality of care. 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 them. Moreover, negative experiences, such as lack of drugs, in the past may be remembered for a long time. Providers' more positive views about the availability of drugs is understandable, they are insiders, professionally and emotionally. Drugs, one could say, are their means of livelihood. By giving a more positive description of the availability of drugs in their institution they defend the quality of their own institution.

Access to health services

As stated earlier in this chapter, the current Health Reforms aim at providing Zambians with quality health care close to the household. Inequities between rural and urban populations must be diminished. Consequently, this study examined how accessible the health services are to the communities included in the study. Two factors were used to examine community access to basic health care services; (i) distance to the health centre; and (ii) availability of staff.

About half of all respondents, both household members and providers, said that the health centre was far from where people lived, but hardly anyone complained that for that reason the centre was not accessible to them. The respondents were more critical about the availability of staff members. In rural areas the non-availability of staff is likely to be due to their scarcity.

In spite of the scarcity of health workers in rural districts, people in Senanga reported more access to the health centre and staff than people in Lusaka. In rural areas, the staff are integrated in the community. When someone falls sick at night, relatives are welcome to consult the health workers at his/her home. In Lusaka it is not possible to get access to a clinic and its staff once the clinic is closed. This leads us to a few remarks on urban/rural differences.

Urban/rural differences

Explanations for the observed inequities between rural and urban areas are largely due to government imbalances in developmental policies. Clearly, the government has not invested enough in developing the infrastructure and social amenities in rural areas. The roads in rural areas are almost impassable, the health centres have no electricity and are not supplied with piped water. Further, communication facilities in rural areas are usually poor. These conditions make working in rural areas unattractive for highly qualified personnel, especially doctors and health workers with special training. Another factor which pushes staff from rural to urban areas is that health workers in rural areas do not receive enough incentive and are usually left out when promotion and/or further training is considered.

Over-staffing in urban areas could also be a result of over-specialisation. In Lusaka, specific tasks such as registration, physical examination, laboratory tests, and dispensing of drugs are performed by designated staff. This resulted in users perceiving staff as "lazing" around because after performing one task for a patient, the staff moves on and/or waits for the next patient.

A final factor leading to over-staffing of urban health centres is the right of female health workers to be appointed to places where their husbands are employed. Many female nurses do indeed have partners who have a government job in Lusaka and other urban centres.

Physical conditions of the health centre and infrastructure

To assess physical conditions of health centres, household respondents and health providers were asked parallel questions. In general, quality of care as judged by health facility physical conditions is perceived satisfactory. Both household respondents and health providers reported that health centres are cleaner and smell better than before. However, the availability of water and sitting benches is considered inadequate.

Apparently, the improvement of physical conditions of health facilities was more easily achieved than other aspects of quality of care such as staff attitudes and behaviour. Furthermore, the improvement of physical conditions can serve a political purpose. It is visible and politicians can use the improvements to demonstrate and justify their performance.

Staff competence and performance

To assess the health workers' performance, household respondents and health providers were asked questions related to health workers' knowledge and skills. The study found that most users perceive health workers to be competent. However, staff knowledge is not always translated into good practices. Most patients are not physically examined and many health workers do not even touch their patients. Only taking patients' temperature appears a common routine. The poor performance of health workers could perhaps be explained by the fact that the environment in which they operate is not supportive. They may be under-staffed and therefore unable to carry out diagnostic activities. It is also possible that lack of motivation and effective supervision affects everyday practices.

One finding of this study is that health staff tend to overrate their competence. This difference between users and health providers underscores the importance of triangulation of research methods to gain a more profound understanding of staff competence and performance.

Overall comments on quality of care

Rural respondents had a higher appreciation of health services than their urban counterparts. This difference can partially be explained by the fact that the rural population realises that they have limited and/or no other alternatives. The urban population is more critical of health services because they have more alternatives. Those who are not satisfied with services at one health facility (i.e. government health centre) can opt to go to other facilities such as hospitals or private clinics. The observed rural-urban difference in the appreciation of health services could also be due to the fact that the urban population is more aware of its rights including access to health care. They are more likely to make demands.

Differences in the socio-economic context between rural and urban areas, probably account for most of the reported rural-urban variations and between

providers and users. The urban social environment is generally more hostile than the rural setting. The population in urban areas, Lusaka in particular is more heterogeneous and life is busier and more structured than in rural areas. Hence the tension and irritations between health workers and the users, may be a reflection of the overall difficult circumstances obtaining in urban areas.

In rural communities, life is more relaxed despite the poverty and general hardships people experience. Health workers and people in the community respect each other and there is more reciprocity in their mutual contacts. Various factors may explain this more positive relationship. The rural population is generally homogenous, health workers are from the same province sharing the same culture and language with the population they serve. However, although health workers and the community have much in common, a social distance exists between them and this could further account for this observed positive relationship. Health workers in rural areas constitute an elite class of people and enjoy special esteem and people in the community look up to them. Hence, the interactions in rural areas is more of respect than in urban areas where the health workers are regarded to be on the same footing or sometimes even lower than the users.

Further, differences in workloads between the study sites could also explain the way providers and users interact. More people reported to urban clinics resulting in congestion. Such heavy workloads make provision of care and treatment more hectic. There are long queues and users jostle each other as health staff cannot cope with the work. The differences between users' and providers' perceptions are much higher in the urban centres than in the rural ones. A plausible explanation could lie in differences in users' expectations. Users in rural areas are more tolerant while those in urban areas expect more than the services can provide, especially since they are paying for the services. If people are paying they expect better service. The more positive attitude reported in rural sites is a very important finding because most studies on health staff attitudes report negative findings. Research on this subject, therefore, need to be community specific and findings from such communities should be interpreted with caution.

9.5 Utilisation of health services

Disseminating information on the Social Welfare Scheme

One disconcerting finding of this study was the high proportion of community respondents who said they would just stay at home and not seek health care if they had no money. This finding shows that most community respondents were not aware of the Social Welfare Scheme which is meant for helping the destitute who are not able to pay for health care. The scheme has not been well publicised and there is a need to step up publicity of the scheme so that people will have access to health care even when they do not have the necessary means.

Identifying the drops in health care utilisation: a transitory phase?

Both providers and community respondents confirmed that there had been a decline in attendance at health facilities. Providers said the decline in utilisation had helped reduce the irrational use of health care, whereas communities argued that people now resorted to self-medication or just died at home because they did not have money.

Attendance records of shows a clear fall in attendance for 1994, immediately following the introduction of fees. Fortunately, the drops observed in utilisation were temporary since attendance rose again after 1994, probably a reflection of people getting used to paying for health services. Nonetheless, in some cases, the restoration of high utilisation levels did not reach the pre-1994 figures and points towards the need for education programmes to inform people about the choices at their disposal in accessing health care even when they do not have the means for paying.

9.6. Discussion and conclusion

Two topics dominated the interviews and conversations with community members and health care providers: user fees and medicines ('drugs'). The topic of user fees engendered the liveliest discussions during our research but people did not talk about it in the context of community involvement. In their eyes, user fees had nothing to do with it. How could they regard the fees as a form of involvement if they had not even been involved in the decision to introduce them? People complained that the fees had been forced upon them. Nearly all users of health care who took part in the research saw the fees as proof that health care was something that was planned and organised from outside, somewhere high-up in the Ministry.

The fees were always mentioned when we asked people if they knew any recent changes in the health care system. The fees occupied their minds, and nearly always in a negative sense. Very few people expressed support for it. Most informants denounced the new measure which they had come to see as the sobering truth behind the attractive slogans of the Health Reforms.

The topic of user fees is also the focus of a report by a team of Zambian and British researchers who studied its implementation and people's reactions to it in five locations of the country (Booth et al. 1994). They highlight two main objectives in the government's policy of cost-sharing: to raise additional resources which can be used to improve the quality of the services and to break the passivity of the service's users and to change their 'dependency syndrome' into active involvement and a greater sense of 'ownership' of public health care. The objective of increasing a sense of ownership proved a 'red herring', however:People are affronted by the proposal that they must now pay for the services of the clinical staff because they feel they have already contributed a

great deal to the establishment and maintenance of the clinics. In fact, they already have a strong sense that the clinics ... are 'theirs', on the grounds that most of the labour and materials that have gone into their construction and upgrading since the 1960s have been provided free by community members (p.46).

People felt 'cheated' by the government's new decision that they had to pay for the services. One person in our own research expressed the same irritation when he asked: "If it is our clinic, why are we told to pay?"

The introduction of user fees was not seen as a way to involve the users in the service but rather as a sign that they were 'disowned' and excluded from having a say in the running of the centre. They simply viewed the government's decision as a trick to get more money and to help it to pay staff salaries. In their cynical comments on the users fee scheme, people simultaneously revealed their own concerns. They too were short of money and for that very reason rejected any measure which cost them money. The denouncement of any increase of costs reflected their own precarious financial condition. They acted as critical consumers who , quite naturally, wanted to pay as little as possible.

Interestingly, people in Zambia do not always object to paying for health care. Missionary and church-related hospitals have a long tradition of raising fees and they are well attended by people who are willing to pay for their services. The understanding is that they get their money's worth. These non-profit private institutions have the reputation of providing relatively good services and being well stocked with medicines (cf. Soeters 1997).

People are also prepared to pay traditional practitioners and faith healers. The latter abound in the independent spiritual churches in urban areas. As a matter of fact, the costs of traditional healers may well turn out to be substantially higher than those of biomedical institutions. Forsberg (1990:10) reports that in the Western Province 82% of health care expenses involved traditional healers (cited in Booth et al. 1994:1-5). Indeed, paying for health care is nothing new in Zambia, nor in Africa as a whole (cf. Van der Geest 1992a).

So why did people object to paying for public health services? Firstly, they have always been 'free' and no one likes to start paying for what he was used to get free of charge (cf., Waddington & Enyimayew 1989/1990). We have put 'free' between inverted commas since it is well-known that in the past people were often paying informally for the scarce medicines or ended up paying at a commercial pharmacy or drug store for medicines that were not available in the government health centre. Secondly, as is shown in the examples above, people felt betrayed because, they said, they already had paid in the form of voluntary labour. They demanded free services in reward. Politically conscious citizens in Lusaka added that they had paid taxes, so they were entitled to free care. User fees amounted to double paying.

But the strongest reason was probably that people had little confidence that they would get better quality of care after paying. If they would get proper treatment, in particular good medicines, most of them would probably be happy to pay the fees. Their scepticism about a possible improvement after the introduction of the user fees was expressed in many comments., some of which have been cited in this report. Some said that they were cheated because after paying the fees they discovered that the medicines they needed were not available. They had paid for 'nothing' and were only given a prescription which meant they would have to pay again at a pharmacy. As has also been demonstrated in studies elsewhere (see e.g., Gilson et al. 1994, Haddad et al. 1998, Litvack & Bodart 1993), drugs are the key element in the appreciation of 'quality of care'.

An insurance scheme was introduced a few years after the user fees had been implemented. The scheme seemed in many ways more attractive to health care users than the user fees. The required payment was 500 kwacha per month per person. For those who had joined the scheme by paying its membership, all services were free. Those who were not members of the scheme, had to pay 2,500 kwacha when they visited a health centre.

During the research little insight could be gained about people's views on insurance as compared to fees for service. Community members in the rural areas were not familiar with the phenomenon. Most urban respondents who *were* familiar with insurance preferred it to user fees, clearly for financial reasons. In the end, the insurance would be more economical for them. Their preference was 'rational'; they wanted more medicine for less money. Health workers fit in that pattern. They would rather pay nothing to get their medicines. As one of them remarked: the prepayment system should be installed, but "members of staff should be excluded from paying for health services and be attended free of charge." The questionnaire research showed that those who were familiar with prepayment -those in the towns - preferred it in overwhelming numbers (75 % of the health workers and 85 % of the community members). In order to better understand the logic of their choice, we take some clues from two other studies on cost sharing in Zambia.

A research in Lusaka (Atkinson et al. 1995) showed that many people have a positive appreciation of the scheme although some complain that they paid for nothing in the months they did not use the medical services. Health workers, however, pointed out that people have already discovered various ways to abuse the scheme. Some people do not join the scheme until they fall sick, some use other people's cards, some visit several health centres with the same card in an attempt to obtain more medicines. They believe that in general the scheme will lead to over-utilisation of services as people want maximal benefit from their

membership. It seems likely, therefore, that the scheme will not yield much financial relief to the government.

In a recent study of the effects and options of the Health Reforms in the Western Province, Soeters (1997) also found that an overwhelming majority of the local population preferred a health insurance to a system of user fees. As we have just said, from a consumer's point of view, the preference makes sense. This does not mean, however, that a health insurance, at this stage, is the best policy option. The self-interest of the consumer in a market situation is mostly a matter of 'negative reciprocity': getting the maximum of health care for the minimum price (cf. Criel 1998: 65-67). People calculate that an insurance system will allow them more room to pursue their interests than paying user fees. Insurance, after all, is a public fund which can be (mis)appropriated by individuals in the same way as public health facilities in the pre-Health Reforms era. An insurance system will yield attractive short-term benefits to consumers but it is doubtful that it will serve them best in the long run. Positive experiences with church-related private/non-profit medical services suggest that a system of user fees, although disliked by the community, is a better guarantee for sustainable health care in Zambia.

To what extent have the Health Reforms led to a greater interest in preventive health care among users of health services? That question was hardly addressed directly during discussions with staff and users of health care but in an indirect way at lot was said about it.

Whatever we asked, members of the community brought the issue to the availability of drugs at the health centre. Whether we talked about decentralisation, user fees or quality of care, people linked it immediately to drugs. To them medicines were the *raison d'être* of the health centre and health care in general. "As long as the drug supply … is not guaranteed, perceived quality is not likely to improve", Chabot (1998: 160) remarked. A competent and kind nurse or doctor who does not have drugs to dispense becomes useless. The health worker, wrote Alland (1970) many years ago with some exaggeration, is the adjunct to medicines. You have to see him because it is through him that you will acquire the desired medicines. The doctor's value lies in the drugs he or she provides. After all, they believe, it is the drugs which make medicine work, not the doctor or the nurse.

This way of reasoning has its consequences for user fees and insurance. The fees and the insurance only make sense if they are instrumental in obtaining drugs. The greatest dissatisfaction with the user fees lies in the fact that they are no guarantee for getting medicines. If they were, most people would probably be much more inclined to accept them, as they also did at missionary health institutions. A teacher in Lusaka criticised the fees because: "After all there is no real improvement to the services. Medicines are still out of stock and nurses are

still rude. "So what are we paying for?" And another teacher: "You pay money but no medication."

Conversely, those who were more positive about the Health Reforms based their appreciation upon the fact that they did now get the medicines they wanted. Soeters (1997:92) in his research in the Western Province, reaches the same conclusion: "Availability of drugs is probably *the* most important indicator to assess the performance of health institutions."

If drugs are still regarded the acid test for judging the quality of health care, we do not have to look much further for an answer to the question about preventive care. People's outlook on health and health care is still overwhelmingly curative. The Health Reforms have not been able to change that attitude.

As we have seen, from the users' point of view Health Reforms is mainly a matter of user fees and drugs. People are preoccupied with these two issues and the former is only justified by the latter. Clearly, in the eyes of most consumers that justification does not yet obtain. The drug supply is unreliable, therefore, the fees are unjust.

The injustice of the situation also takes a prominent place in the report by Booth et al. (1994) in which the authors hold a passionate plea for more humaneness to the very poor. What could one advise to a beleaguered government which finds itself between the rightful claims of its citizens and the restrictions of a failing economy? Should it abolish the fees and return to the equally depressive situation before the Health Reforms? Should it replace the fees by an insurance scheme? Obviously, the rejection of user fees because of lacking drugs will also hit the insurance scheme if the drugs don't come.

Interestingly, after having reported so much critique and misuse of cost-sharing, Booth and his colleagues do not conclude that the practice should be abolished and we agree with them. The history of 'free' health care in Africa has almost everywhere been a testimony of failure (see e.g. Hours 1985, Van der Geest 1988, Abel-Smith & Rawal 1992) which was exacerbated by the simultaneous presence of a relatively well functioning system of non-profit private health institutions, usually managed by religious organisations. Everybody who studies this unplanned experiment of two managerial systems objectively will come to the conclusion that a lot can be learned from the way the churches were able to deliver reasonable health care, even without government support. Their health care was affordable for most citizens and they tended to be merciful to those who could not afford. History shows that people who had the means, were willing to pay because they got their money's worth. Other studies of the implementation of user fees confirm this (cf. Waddington & Enyimayew 1989, 1990).

The Bamako Initiative was an implicit recognition that African governments have indeed learnt their lesson from this public/private mix in health care. Until further notice, we believe that governments are right to pursue the route of moderate payment for health services and that this route will enhance the chances of sustainability. However, there are at least three conditions.

The first one, also suggested by Booth et al. (1994:106) is that the burden of charges be transferred from registration or consultation to the provision of drugs and other forms of concrete treatment. People should pay for what they feel is worth the money; not for being allowed to see a doctor or a nurse, but for receiving something palpable which will do the trick of curing: a drug, a dressing, an operation. That may look like giving in to the curative bias of patients and their preoccupation with medicines, a move which progressive health workers may resent. It can also be regarded, however, as a temporary recognition that we take the patient's perspective seriously. When in due time consumers in Zambia became more critical at the blessings of medicines, the policy will change by itself. For now it will take away the main complaint of patients: that they must pay and still don't get drugs. As a matter of fact, that is exactly what the church hospitals and clinics always have understood; they let people pay for what they thought deserved payment, namely drugs and operations.

A second condition, which we also share with Booth et al. (1994), is that no one should be sent away because of inability to pay without having been seen by a health worker who is able to judge his/her condition.

Our third suggestion is mainly an elaboration of the first. If in the eyes of the public drugs are the test of good health care, why not allow health institutions greater independence in buying and selling drugs instead of forcing them to depend on the often irregular and inadequate drug supplies coming from the Ministry? If patients are to pay for medicines, health workers should make sure that they have always a good stock of essential medicines. The proceeds of sales should enable them to replenish their stocks before they are exhausted. Basic health care workers render a poor service to the people if they send them away to buy their medicines in expensive pharmacies (for which they, moreover, may have to make a long journey if this happens in rural areas). It would be in everyone's - except the pharmacist's - interest if health workers were allowed to supply those medicines themselves, for a much lower price (cf., Van der Geest 1992b). This would indeed be a sensible form of decentralisation, which - after all - was one of the principles of the Health Reforms.

Have the Health Reforms rekindled the PHC ideals of a democratised health care, based on virtues such as self-reliance, community participation, equity, decentralisation and prevention? Much has changed in the past twenty years and reviving PHC in its old, somewhat romantic form, seems highly unlikely. A new

style of community participation and democratisation - unromantically called 'cost-sharing' - is a possibility, provided the promise of good quality health care is kept and applied in a humane way. For the users of health services, in rural as well as in urban areas, good quality means first of all more and better drugs. The question is whether health policy makers in the country are willing and able to meet this popular demand.

9.7 Zambia and Uganda: A comparative note

When the conclusions of this study are compared with the parallel research in Uganda (Munene et al. 1997), the similarities between both countries are striking. In both studies consumers express doubt that the introduction of cost-sharing will indeed improve the quality of health care, although Ugandans prove slightly more optimistic than Zambians. Neither study was able to produce solid data on the acceptability and feasibility of health insurance. The concept of prepayment was insufficiently known in both countries and could therefore not be used in the interviews. Respondents in both studies regard the availability of drugs as the key condition for good quality of care and in both studies respondents also complained that health workers do not communicate properly with patients about their illness. Exemption schemes in both countries do not seem to work. In spite of ideals of community participation and decentralisation both health providers and consumers indicate that they have not been involved in decisions which now affect them in the field of health and health care.

The studies suggest that recent health reforms have indeed contributed to some measure of revitalisation of Primary Health Care, but that both countries still have a long way to go in their attempts to make health care better and more sustainable. In spite of popular criticism of cost-sharing, this principle is likely to stay, but consumers will only accept this new policy if they see its results: better health care, in particular more drugs.

For the time being, the greatest challenge for both countries is how to move from an almost exclusively curative health care system to a preventive one without violating their own principle of community participation.

9.8. Recommendations

The general objective of this research project was to contribute to the improvement of basic health care in both rural and urban Zambia through understanding community factors that inhibit and/or facilitate the government's Health Reforms. Having arrived at the end of this report we must address the question about what measures must be taken to improve the quality of basic health care in the country. We shall present our recommendations following the five domains dealt with in this report.

Cost-sharing

The research has shown that both community members and health providers object to the introduction of cost-sharing, but it also turned out that community respondents are willing to accept the idea of payment if they are sure to get proper health care, in particular sufficient and appropriate drugs. If the government wants to pursue its policy of cost-sharing, it should, therefore, take effective measures to guarantee a better quality of health care, particularly a steady provision of essential drugs. Decentralisation of management - allowing health workers to buy the medicines - could be the most effective way to realise this objective.

The research was not able to draw conclusions as to what system of cost-sharing - user fees or prepayment - is to be preferred. Prepayment was unknown to respondents in rural districts, so it was not possible for rural respondents to compare the two options. At this instance we can only recommend further research into the pros and cons of both types of cost-sharing.

We expect that comparative research will show an overriding preference for prepayment (as was the case in the urban samples). A prepayment scheme will be regarded as less costly and allowing more freedom to 'manoeuvre'. If, however, a prepayment system would lead to misuse of community funds (opportunistic joining and over-consumption by members), this will have an adverse effect on the sustainability of basic health services, one of the main objectives of the Health Reforms.

A final option for either user fees or prepayment should, therefore, be based on solid research which takes into account not only what people *say* but also - and more so - what they *do* in actual practise.

Four concrete recommendations regarding cost-sharing which follow from this research are:

1. In kind payments, though not widely used, would be ideal for rural populations. Therefore, it is recommended that this mode of payment should be formalised especially in rural areas where people are better placed to pay in kind than cash. A piloting scheme to determine the best way of effecting the system should be carried out.

2. Health centres should be given more responsibility in buying and selling their own medicines. A revolving funds for the procurement of drugs should be managed at the level of the health centre. If medicines are the key element of quality of care and paying for medicines the most acceptable form of cost sharing, then responsibility for the management of the medicines stock is the most basic form of decentralisation.

3. In order to raise the morale of health workers, the Ministry of Health should consider exempting health workers from paying for health care or charge them reduced rates. This would be in conformity with other employers with workplace-based health facilities which offer full or partial waivers for their employees requiring medical care and/or continuing with their education respectively.
4. Knowledge about the Social Welfare Scheme is generally low among the community and health workers. There is therefore, a need to increase community awareness about services provided under the Social Welfare Scheme. However, increased awareness about the Scheme will call for establishing a viable system to meet the demands that will be created through increased knowledge.

Community participation

The concept of community participation is clearly not understood by the community. Generally in the minds of people community participation means provision of labour. Cost-sharing is not perceived as community participation and involvement in planning and decision making by the community is non-existent. 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 should utilise existing community institutions (i.e. Neighbourhood Health Committees, Community Health Workers, traditional authorities and District Health Management Boards).

Cost-sharing, however resented at first, holds the promise of raising people's awareness of ownership. The are no more passive receivers of services handed down to them by government representatives; they are consumers of services for which they have duely paid. Such a reversal in people's perception of government health care is likely to have the greatest impact on both 'community participation' and sustainability of health services.

Decentralisation

Given the low knowledge levels about decentralisation, it is recommended that awareness is raised among both health workers and communities. To achieve this, DHMTs should design specific information flow strategies between health centres and DHMTs. Such strategies should include regular and interactive information sharing systems for key actors (i.e. DHMT and HC staff and community recognised structures). Other avenues such as dissemination of key print materials should also be expanded and strengthened. To reach the community, existing local structures such as Neighbourhood Health Committees

and community established institutions such as local authorities should be expanded and strengthened to disseminate Health Reforms information.

All information dissemination strategies should be accompanied by a well developed and institutionalised system of monitoring and evaluation to assess whether intended recipients of information receive and utilise it.

In order to intensify the involvement of staff in decision making, there should be more interaction with local health workers so that they feel that they are active participants in the decision making process. Through such interactions health centre staff capacities will also be enhanced.

Quality of care

The research has demonstrated that the Health Reforms, including the introduction of cost-sharing, are judged mainly by their effects of the quality of health care. 'Quality of health care' means first and foremost the constant availability of good drugs. It further includes positive interaction between health worker and client, the accessibility of the health centre and its staff, professional competence of the health workers and decent physical conditions at the health centre.

Health workers should develop a new attitude towards patients and their relatives. They must realise that patients are clients who have to be served properly. The medical services should be made more attractive to them in order not to loose their clientele.

The research has shown that private and semi-private, church-related, health institutions, which have a long tradition of cost-sharing, are generally regarded of higher quality. The government health institutions can benefit from their example and draw lessons from their long experience with cost-sharing and thus raise their standards of care.

Utilisation of health services

The drop in utilisation of health services after the introduction of cost-sharing need not disturb health planners unduly. Firstly, this drop appears to be temporary; secondly, higher utilisation figures are not necessarily a good sign. A large number of health providers held the view that in the past the absence of payment often led to erratic and irrational use of health services. Payment for service is likely to reduce unnecessary medical consumption and to encourage appropriate use of the facilities. Additional research is needed to gain a better understanding of the true character of the fluctuation on utilisation rates.

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