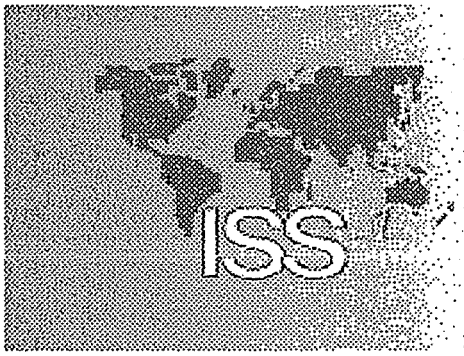

Institute of Social Studies

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THE IMPACT OF USER FEES ON THE USE OF HEALTH SERVICES IN ZAMBIA: A GENDERED LOOK

By
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Dedication

To my mother Nelly Mulenga Mfunda and my late father Samson Mwape for making me see the sun.

Abstract

Faced with budgetary constraints, rising population, external pressure, and deteriorating health services, the Zambian government through its Ministry of Health, embarked on a health reform programme with an effort of providing to the Zambians equity of access to cost-effective quality health care as close to the family as possible. Part of the health reforms has been the introduction of user fees on medical services. While others may argue that user fees can lead to an improvement of quality of care, efficiency and equity of access to health care, user fees can act as a disincentive to patients and can lead to some people not attending health facilities because they cannot afford. This paper focussed on a gendered assessment of the impact of user fees on health facility use. The main arguments were that the introduction of user fees has resulted in the decline of use of health facilities and that user fees are more likely to affect women than men.

The introduction of user-fees has led to a decline in the use of health services in Zambia. This decline has been reflected in the following indicators: life expectancy at birth, maternal mortality ratio, infant mortality rate, as well as under five-mortality rate. Both men and women have been affected with the introduction of user fees. The impact is great for women than men because women utilize health facilities more than men either as patients or as non-patients with children. Child delivery at home has gone up compared to deliveries in health facilities both in rural and urban areas. In 1992, 78.8% of the total deliveries took place at health facilities and 20.9% at home in urban areas compared to 26.3% in health facilities and 72.7% at home in rural areas. In 1996, of the total deliveries, 77% were at health facilities, 23 % at home in urban areas compared to 27% at health facilities and 73.2% at home in rural areas. The decline in the use of health facilities is higher in rural areas than in urban areas.

In an effort to look for extra income to cover for the short fall, some men and women, especially in urban areas, have engaged themselves in petty business like selling food stuffs, second hand clothes and shoes popularly known as "Salaula", in the markets or along the streets. This has resulted in poor sanitation characterized by pools of stagnant water, litter and human refuse. This poses a health hazard and may result in outbreaks of diseases such as cholera, typhoid and darrhoea or dysentery. The introduction of user fees has affected women more than men because, women have poor access to funds. In a patriarchal society like that of Zambia, majority of the women depend mostly on their male relatives, friends, fiancés or husbands for cash income. This is so because men have more access to income than women. Their benefit from such cash income in the control of men depends on how it is spent by men. Women who depend on agriculture have their own problems, such as lack of collateral to get loans, expensive fertilizers and seeds, coupled with droughts at times. In an effort to look for extra income to cover for the short fall, some women have extended their working time in that they have to work in the markets and attend to domestic chores.

Poverty in Zambia is high and contributes to low capacity to pay. Poverty level was 69.7% in 1991, 73.8% in 1993 and 69.2% of the total population in 1996. Poverty is

more concentrated in rural areas than in urban areas. It is also high among female-headed households than in male-headed households. Therefore, in a country with high poverty profiles like Zambia, user fees act as disincentives to the use of health services. Failure of government to institute a sound exemption system has resulted in denial of access to most of the poor people, especially women and children.

Access to safe water and sanitation and child nutrition have deteriorated. Life expectancy at birth was 42 in 1960 compared to 43 years in 1994; population with access to safe water was 42% between 1975-1980 compared to 27% in the period 1990-1996. Underweight for children below the age of five was 17% compared to 28% during 1990-96. The rural provinces have a higher proportion of children under weight compared to the urban provinces.

Due to low capacity to pay by most of the poor household families, especially women, people have reduced using Public Health Care. There is no evidence from private facilities to compare with in order to see whether the decline in the use of government health facilities has led to the shift in the use of private health facilities. A survey to compare the two facilities before and after the introduction of user fees is highly recommended. If people have resorted to private health facilities, especially in urban areas, this might be alright. But if they resort to staying away or self-prescription, there are high risks and long term consequences that may contribute to deteriorating socio-economic indicators.

The assumption that user fees may help health facilities meet some of their recurrent expenditures and lead to improvement in quality and equity of care cannot yield well intentioned positive results when introduction of user fees does not accompany improvement in quality of care. Those who are willing and have the capacity to pay might not do so if the services are still poor.

Also, when implementing policies, planners must be gender sensitive rather than being gender neutral because men and women are likely to be affected differently. Combating child malnutrition, improving access to safe water and sanitation can play a significant role in improving health of the majority Zambians thus, reducing on curative costs.

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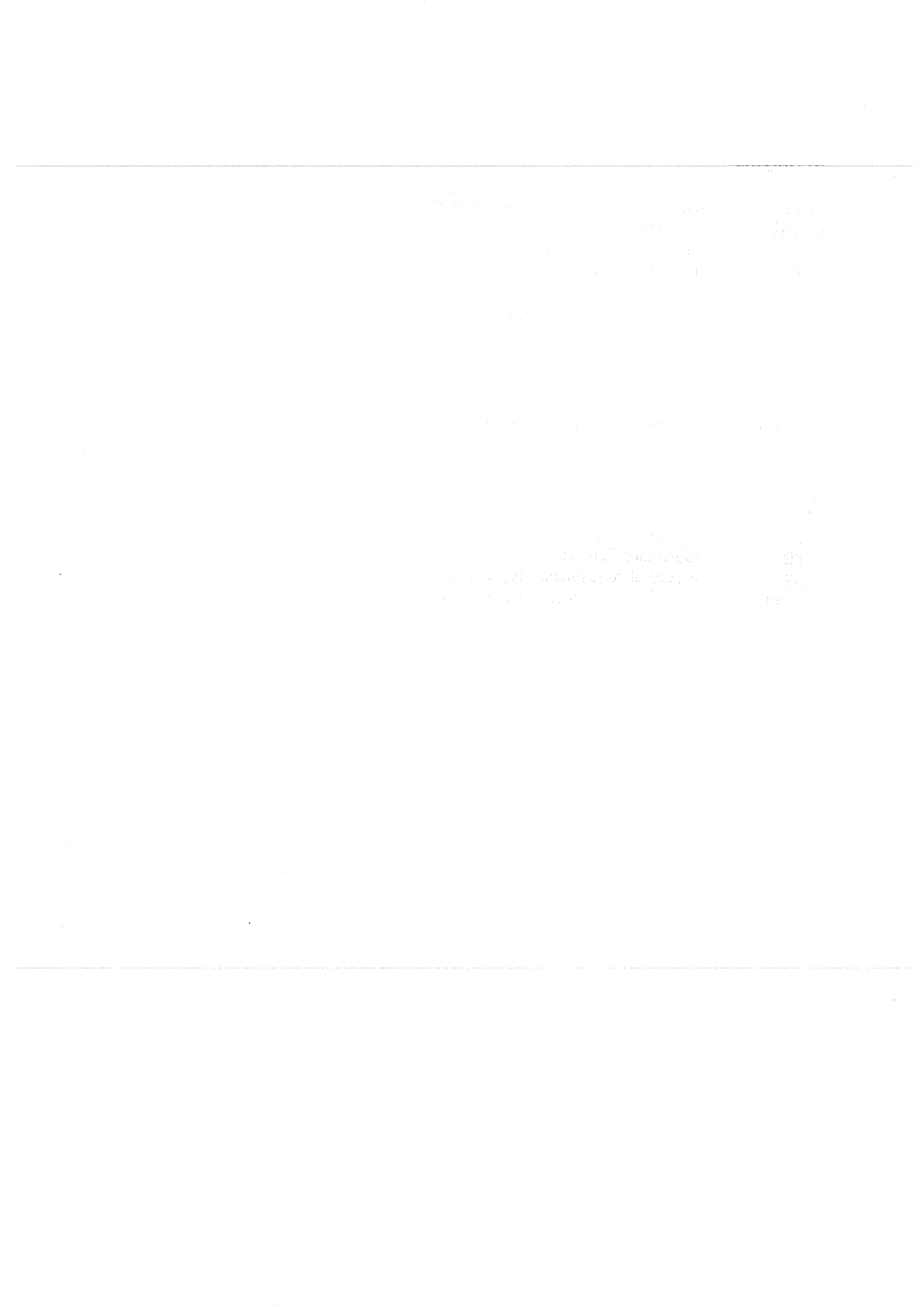
Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CBOH	Central Board of Health
CSO	Central Statistical Office
GDP	Gross Domestic Product
GNP	Gross National Product
GRZ	Government of the Republic of Zambia
HIV	Human Immuno Virus
IMF	International Monetary Fund
IMR	Infant Mortality Rate
MMD	Movement for Multi-party Democracy
MCDSS	Ministry of Community Development and Social Services
MOH	Ministry of Health
NGO	Non-Governmental Organization
PMO	Provincial Medical Office (r)
PS I	Priority Survey I (1991)
PS II	Priority Survey II (1993)
PTB	Pulmonary Tuberculosis
SAP	Structural Adjustment Programme
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIP	United National Independence Party
URTI	Upper Respiratory Tract Infection
UTH	University Teaching Hospital
VAT	Value Added Tax
WHO	World Health Organization
ZCBC	Zambia Consumer Buying Corporation
ZDHS	Zambia Demographic and Health Survey



Chapter One

Introduction

1.1 Statement of the Problem

Faced with budgetary constraints, rising population, external pressure, and deteriorating health services, the Zambian government, through its Ministry of Health (MOH) embarked on a health reform programme. Its policy goal is summarized as "to provide Zambians with equity of access to cost-effective quality health care as close to the family as possible" (MOH, 1992:28).

Changes in health financing, through the introduction of user fees or health insurance, have been the main instrument of change in many developing countries. In Zambia, broadening health financing through charging patients has been an important component of the reform agenda. Introducing a National Health Insurance system has been proposed in the election manifesto of the Movement for Multi-party Democracy (MMD). From the perspective of the general public, the requirement to pay higher levels of fees in the public sector is closely associated with the introduction of the health reforms (Milimo and Choongo, 1995:23). It has to be noted that the health reforms are donor driven, implying that the initiative and major funding is coming from donors. Availability of medicines including medical equipment in most of the clinics and hospitals, if not all depends on donor support. For example, the World Bank can assist the government if certain conditions are met. For instance, it has been argued that some people can afford to pay health services (World Bank, 1993). Therefore, health services should not be provided free of charge to everyone.

Considering the major theories behind user fees that user fees lead to increase in the rate of utilization of health facilities, improves the quality of health services and improves equity of health care delivery, as the Ministry of Health in Zambia wishes to achieve, the introduction of user fees may not lead to these objectives because some people will be denied access to medical services. There are some poor family households who cannot afford to pay for user fees, thus equity of access to quality care may not be guaranteed. If people are denied

access to health care when they need it, then there is no point in taking health as close as possible to the households when they cannot afford it.

The major focus in this research is on the introduction of user-fees and pre-payment scheme, the impact it has on the use of health services in Zambia, particularly on women. Until in the recent past, Zambians, especially the urban poor, have enjoyed free social services. Provision of free services has been challenged. For example, when considering the international development context, Booth and others (1994:13) have observed that the provisioning of free medical services depends only a little on the traditional economic argument to the effect that free services cause allocative inefficiency or promote wasteful consumption. The key arguments are about budgetary constraints on one hand and social equity on another. The budgetary argument is that, even with generous donor support, governments in the poorest countries (like Zambia) cannot afford to pay for basic elements of a public health and education service. The equity argument says that, especially in countries with a weakly developed and not very progressive tax system, those users who can well afford to pay for the services should do so in order not to reduce the resources available to help the poor. Providing a free or heavily subsidized service to all is, thus, both financially prohibitive and unfair, as well as in particular respects wasteful.

1.2 Background to the Problem

Zambia, whose major economic survival has been heavily dependent on copper, enjoyed a sound economy during the first decade after independence on October the 24th 1964, from the wealth of copper. Administratively, the country is divided into nine provinces, Central, Copperbelt, Eastern, Luapula, Lusaka the capital city, Northern, North-Western, Southern and Western. Of the nine provinces, Lusaka, Copperbelt and Central may be considered as urban provinces while the rest are rural provinces because they are largely rural.

Zambia's economy started experiencing a decline since the mid-1970s. The decline was triggered off by the increase in oil prices coupled with the decline in copper prices on international markets over which, Zambia has no control. The impact of the decline in the economy was that social services started declining, there was acute shortage of foreign exchange, poor development of non-traditional exports, short supply of essential commodities and services, high levels of inflation and the slow pace of industrialization. The government's highly dependence on copper mining industry led to the less contribution of the agricultural sector. From mid 1970s, the government borrowed massively. Much of this money was used for consumption as against investment, assuming that copper price would pick up, but only ended up entering into an economic crisis. Due to growing economic crisis, Zambia sought assistance from the IMF and the World Bank and has been left with a debt. The debt crisis that Zambia is facing hampers the sustainability efforts of development programmes. In 1989, Zambia's debt was US$6.7 billion and it rose to US$7.2 billion in 1997 (CSO). Other negative impact of the decline have been that real gross domestic product (GDP) and per capita consumption started declining, poverty started increasing, infant mortality rate (IMR) and child nutrition have been deteriorating. For example, in 1975, IMR was 96, ten years later it rose to 107, by 1996; it was 109 deaths per 1000 live births, more than it was in 1970. In 1996, GDP per capita (in constant 1977 prices) was estimated at K208 (Zambian Kwacha) per person compared to K409 in 1964. Table 1.1 gives more details.

Table 1.1: Zambia's socio-economic indicators

Indicator	YEAR						
	1965	1970	1975	1980	1985	1991	1996
Real GDP per capita	409	410	396	359	304	260	208
Real consumption per capita	283	318	333	294	252	201	N/A
Private consumption per capita	237	230	224	199	184	150	N/A
Poverty headcount (ii)	N/A	N/A	33.9	49.0	N/A	67.4	75.0
Infant mortality rate (IMR)	141*	106	96	97	107	107	109
Child Mortality Rate	N/A	N/A	N/A	N/A	N/A	94	98
Under Five Mortality Rate	N/A	N/A	N/A	179	167	191	197
Child malnutrition	N/A	24(i)	20	6	14	23	N/A

Note: (i) 1972, (ii) 1980 data will not be strictly comparable, but 1991 and 1996 are. * Refers to 1962 as reference period.

Source: White and Nzovu (1997:17), CSO (1993) and CSO (1997b:94-95).

Real GDP grew at 13% in 1960s. It declined to 2.6% in the period 1973-78 and to 1.4% in 1985-91 and later to 2.3% between 1992 and 1997. The country's population growth rate was estimated at 3.3% between 1969 and 1980, 3.5% during the period 1980-1990 and 3.2% per annum between 1990 and 1997. This is more than the real GDP growth in the same period. At the time of independence, Zambia had a population of about 4 million people. This population rose to 5.7 million in 1980 and later to 7.8 million in 1990. Today, the population is estimated at 10.1 million people with an estimated annual population growth rate of 3.3% between 1995 and 2000. The population is expected to reach around 11 million by the year 2000 (CSO, various sources). From the above statistics, one can see that GDP grew faster than the population from 1960s and the mid-1970s. Population started growing faster than GDP from the 1980s up to today. Milimo and Choongo (1995) have observed that GDP grew faster than the population between 1964 and 1973 but between 1974 and 1990, Zambia's GDP grew at an average rate of 1% per year while during the same period, the population grew at over 3% per year. They have pointed out that failure to diversify the economy meant that, while copper continues to account for the majority of export earnings (90% in 1989), its contribution to the government revenues has dropped from 40% to less than 1% today. The situation was made worse in that, instead of introducing necessary economic reforms, the UNIP Government resorted to borrowing from both the domestic and international markets. An overvalued currency, price controls, export restrictions, and consumer subsidies characterized the state-dominated economy of the 1970s and 80s, such that by 1993, the external debt stood at more than US$7 billion. In addition, food subsidies to urban areas, as well as the failure to develop agricultural policy induced rural-urban migration and led to a growing concentration of population and services in urban areas.

The rising population is not fully being absorbed into formal employment. The government is financially constrained and cannot cope up with the rising population. Fewer people are being employed in the formal sector while retrenching others from the same sector. Formal employment rose from 362,000 workers in 1986 and reached the peak of 546,000 in 1992 and later to 472,000 in 1996. Unemployment was estimated at 15% in 1996. The informal

sector, defined by three main characteristics, (i) absence of paid leave, (ii) lack of entitlement to pension or any other formal social security arrangement; and (iii) with five or less people working in or running a business, is increasing in Zambia. A lot of households are working in this sector. In 1993 and 1996, 59% and 61% households respectively, were working in the informal sector (Ministry of Community Development and Social Services-MCDSS, 1996:153). Self-employed and small employers in the open markets or along the streets basically carry out the informal sector. The negative impact of this is that there is deterioration in sanitation standards, pools of stagnant water and human refuse. This poses a health hazard. Internal migration, which had a rural-urban trend since independence, was found to have a reverse trend of urban-rural drift since the 1990s (CSO, 1996:153). This could have been provoked by the structural adjustment programme (SAP) measures being implemented. But some towns like, Lusaka, are still attracting a lot of people due to pull factors, such as job opportunities, career advancement and market for all sorts of merchandise. Unemployment and drought make people vulnerable to poverty. People become insecure when they lose jobs. Formal employment is a form of security because it allows someone to buy food or an asset on credit. Formal employment acts as an assurance. People without formal employment are likely to be more vulnerable to poverty than those with formal employment as they may lack this kind of assurance. Unemployment is higher among the women than men (CSO, 1996). This implies that women have less access to cash.

Although copper mining is Zambia's major economic activity, people's livelihood depends on agriculture. Agriculture contributes 15% of Zambia's, and employs 75% of the labour force. Ninety percent of the farming population consists of the small-scale farmers, less than 10% are medium–scale farmers and less than 3% are large-scale farmers. And maize is the country's staple and cash crop (CSO, 1997b). The drought affects a lot of people in Zambia. During a drought, people's incomes decline, like among those who entirely rely on farming, particularly the female headed households in rural areas, or those who depend on agriculture as a supplement.

Inflation also affects people's lives. It erodes people's income, the currency depreciates and prices go up. The lowly paid workers, the employed in the urban areas and the small-scale producers are affected by inflation (CSO, 1997b). Basically, this is the category where you find more women than men. Inflation has been high in Zambia. It was recorded at 37% in 1986, 55% in 1988, 137% in 1993 and later to 18.6% in 1997 (CSO, various sources). Inflation can affect money collected (user fees) for medical services if not put into good use.

Poverty in Zambia is high and is at unacceptable levels. According to the MCDSS (1996:153), it stood at 69.7% in 1991, 73.8% in 1993 and 69.2% of the total population in 1996. The rural areas are worse off than the urban areas. Poverty is higher in the informal sector than in the formal sector and more women are found in the informal sector than in the formal sector. The World Bank (1996:67-71) has identified the groups that are most likely to be poor as follows:

- Belonging to a large or single-parent family. Single parents are predominantly women.
- Being out of work. Households headed by an unemployed person are likely to be poor.
- Lacking education. In most cases, a person with less formal education is likely to be poorer than someone with a university education. In Zambia, more men are educated than women. Basically, education also goes with wage labour or formal employment, implying that more men are in the formal jobs than women.
- Being old, very old people particularly those living alone such as widows and widowers are at risk of being poor.
- Lacking access to assets, women, especially widows, are at risk.

Health facilities were neglected during the pre-independence era in both the rural and urban areas, although there are better health facilities in urban areas than in rural areas. The task after independence was to build more health facilities throughout the country, especially at district level, so as to reduce distance of travel for people seeking treatment. Medical services were provided free of charge (White and Nzovu, 1998). More attention was concentrated on curative rather than on preventive measures of diseases. For example

access to safe water and sanitation and child nutrition have deteriorated. According to the Human Development Report (1997:167), life expectancy at birth was 42 in 1960 compared to 43 years in 1994, population with access to safe water was 42% between 1975-1980 compared to 27% in the period 1990-1996. Underweight for children below the age of five was 17% compared to 28% during 1990-96. The rural provinces have a higher proportion of children under weight compared to the urban provinces.

The deterioration of the economic performance reduced the government's capacity to adequately provide free medical services to all. As a result of the economic decline, there was a deterioration of health facilities, declining staff morale and poor delivery of services. HIV/AIDS epidemic is serious and has affected the whole country. Its impact is adverse. HIV prevalence was at significant levels in mid 1980s and at high levels in 1990s.

Attempts to introduce reform began in the UNIP government during the Kaunda regime in 1985, but little progress was made. Most of the economic measures since independence until 1990 were either cancelled, suspended or interrupted due to a number of factors such as political interference or being unable to fulfill the IMF and World Bank agreements by the government. In the second republic, the MMD government after winning the elections in 1991 embarked on the adjustment measures seriously. Since then, the adjustment programme have not been interrupted, though not so smooth either. The following are some of the economic measures introduced by the MMD:

a) Removal of subsidies on Food and Agricultural Inputs and price controls

All subsidies have been removed on items such as mealie (maize) meal, cooking oil and on seeds and fertilizers and prices have been decontrolled. This is in order to allow competition and to let the market set the price. People were affected after the removal of subsidies particularly the urban poor.

b) Liberalization of the economy
- Trade liberalization
- Foreign market liberalization and
- Financial market liberalization

c) Privatization

The MMD government sold and is still selling parastatal companies. For example, government shops (the Zambia Consumer Buying Corporation, ZCBC and Mwaiseni Stores) which were through out the country together with the government airline (the Zambia Airways) have been sold out.

d) Restructuring

- *Public sector reform Programme*

The public sector is being restructured. The whole point is to make it small and efficient by laying off some workers.

- *Tax reform programme*

In order to promote good collection of taxes, the Zambia Revenue Authority is in-charge of collecting revenue for the government. The Value Added Tax (VAT) of 20% has been introduced.

- *Social sector reform programme*

The government is pulling out in the running of the education, health, and communication sectors. It has already pulled out of the transport sector.

In the case of the health sector, health boards have been formed and have been mandated to hire and fire its employees and to set its conditions of service. Planning has been decentralized to district level. User fees have been introduced in order for the Ministry of Health to be self-sustained. According to Soeters (1997:55), before the introduction of user fees, the proportion of public expenditure for health care remained high at 6%, but declined gradually due to the poor economic performance. An over-emphasis on tertiary care and administration that received 70% of the government expenditure, while primary and secondary health care facilities or preventive measures received only 30%, led to the deterioration of health facilities. Deterioration of health facilities was further exacerbated by the tendency to protect salary expenses at the expense of non-salary recurrent expenses. For example, vaccinators could not reach their communities due to lack of fuel resulting into health facilities remaining without drugs or health facilities collapsing due to failure of

preventive maintenance. Low wages for medical staff or general poor working conditions contributed to the deterioration of health facilities.

1.3 Purpose of the Research

The main objective of this research is to provide a gendered look on the impact of user fees on the use of health services in Zambia. The argument is that, the introduction of user fees has caused a decline in the use of health services. The introduction of user fees has affected women more than men. The decline in the use of health services has contributed to the deteriorating socio-economic indicators such as life expectancy at birth, maternal mortality ratio, infant mortality rate, as well as under five-mortality rate. This research will also seek to address the extent to which the women are more likely to be affected than men with the introduction of user fees on medical services.

Contribution

The research will contribute to the suggestions for the improvement of equity, quality, accessibility, and affordability of the health services in Zambia. The research will further contribute to the policy makers, the necessity of carrying out a pilot survey before implementing a project and further, to be gender sensitive to the policies being implemented. Other contributions of the research are to enlighten the reader about the status of health facilities in Zambia, why paying for medical services and whether user fees are beneficial. Since this research is about looking at the impact of user fees on the use of health services in Zambia, for both men and women, it entails that we have to look at disaggregated data of before and after the introduction of user fees. The research will then contribute to the necessity of having well documented gender-disaggregated data. The research will contribute to the importance of keeping maternal mortality data. This indicator can help monitor and improve maternal health care services. Availability of IMR and maternal mortality rate (MMR) data will contribute to assessing Zambia's health and wealth status since IMR is considered to be an (inverse) indicator of health and wealth (Wuyts et al, 1998). Maternal mortality can as well be used as an inverse indicator of health and wealth of a nation.

1.4 Scope and Limitations of the Paper

This research paper will focus on the impact of the health reforms introduced in Zambia. Particular attention will be paid to the gender impact. The period of focus will be between the 1980s and to around mid 90s during which Zambia embarked on adjustment programme following the economic crisis and the growing debt. The period prior to 1980 will also be looked at in order to give a more comprehensive picture of the social, economic, and political trends.

1.5 Research Questions

The research will attempt to answer the following questions:

- What has been the position of the health services before and the Health Reforms?
- Who pays and for what?
- Has the reduction on spending on the health sector affected the capacity to cope up with the rising demand for health services?
- What is the general impact of the user fees?
- What are the coping strategies?

1.6 Methodology and Sources of Data

My interest in this work has been influenced by my active participation in the Zambia Demographic and Health Survey (ZDHS) in 1996 and in the Franchising Market Study in 1997. During the ZDHS, I was based in Luapula Province while the franchising market study was done in Lusaka. The franchising market study was a study about the status of health care with regard to pre-payment scheme. Experience during these two periods show that some people are unable to pay for medical services and resorted to all sorts of care they can afford, especially traditional herbs. Distance to health centres also varies. Some people stay very far away from health centres and do spend hours or a day before they can reach it, while to others, it is a matter of minutes, either by car or walking.

During my study at ISS, much of my interest was on gender, SAP as well as project designing, monitoring and evaluation. Studies and experience have shown that women are assigned different duties in society and that women's work and their role is quite often neglected by policy makers, community and their family at large. It is against this background that I developed an interest in assessing the gender impact of the health reforms.

In this paper, I will look at what the situation was in Zambia before and after the introduction of user fees. I will look at who used to provide the health services, public, private or missionary and whether it was free. I will also focus on who pays and for what with the introduction of user-fees and or pre-payment scheme (health reforms). Attention will also be paid on the quality of health services particularly, people's perception of before and after the reforms. The gender impact of user fees will be assessed. Coping strategies of people will be analyzed now that user fees have been introduced for medical services in public clinics and hospitals.

There has been no study in Zambia so far to assess the gender impact of user fees on medical services. This study will be used as a basis for further assessment of the situation. Basically, assessing the gender impact of user fees requires serious and careful analysis of disaggregated data from health facilities and a household survey over time, that is before and after the introduction of user fees. However, most of the data on utilization is scanty and inadequate for serious analysis. Sometimes, data is available but not classified by gender and/or age, and this may hamper adequate analysis of data.

This research will rely on qualitative and quantitative secondary data and literature on user fees and gender. Materials will be obtained from the Institute of Social Studies (ISS) library and other libraries in the Netherlands. Other sources of data the Government of the Republic of Zambia (GRZ), especially from the Ministry of Health and the Central Statistical Office and Non-Governmental documents. Much of this research will be based on surveys undertaken in Zambia, particularly, the Booth et al (1994) study. Other surveys

include; those done by Milimo et al, Likwa et al, Ngwengwe et al, Soeters (1997); the Franchising Market Study (CSO, 1997a); the two ZDHSs conducted in 1992 and in 1996, respectively, as well as the census data. I will look at the following indicators to show trends: attendance at clinics or hospitals, maternal health, infant mortality rate (IMR), under five mortality rate and life expectancy at birth. I shall conclude the research by providing my own analysis based on empirical and qualitative data, observations, examples and refutations. In order to illustrate and back up a point where possible, tables, graphs and diagrams will be presented.

1.7 Organization of the Paper

The research paper is written in five chapters. Chapter One introduces the nature of the research and the design while Chapter Two gives the theoretical and conceptual framework. Chapter Three discusses user fees and recent trends in health care use and provisioning. In Chapter Four, user fees in health services are re-examined while Chapter Five gives the conclusion and recommendations.

Chapter Two

Theoretical and Conceptual Framework

2.1 Introduction

This Chapter gives the theoretical and conceptual framework of this research whose objective is to assess the impact of the introduction of user-fees in Zambia, particularly in urban areas. The chapter is organized as follows: first is the literature review on user fees and gender. Then, an overview of understanding the interaction of the state, the market and households in the economy is discussed. The concept of health, gender and households are presented in this chapter and a summary is given at the end. In analyzing data, regional variations that is, provincial, rural and urban will be highlighted.

2.2 Literature Review on User fees

As mentioned in Chapter One, government reduction on spending on the health sector led to the deterioration of health facilities, equipment and quality of service. An introduction of user fees is likely to worsen the situation for two major reasons, either due to lack of income or poverty worsened by SAP measures put in place. Griffin and Shaw (1995) have observed that reduced government spending on health leads to deterioration in the quality of available services and have argued that an introduction of user fees would result in the low utilization of health facilities and gave an example of Ghana. In Ghana, from 1973 to 1987, health service utilization fell by half. The number of outpatients fell from well over ten million to five million. However, they have attributed the decline in the utilization of health facilities not entirely on user fees but on other factors such as, household income levels, quality of service, availability of drugs at health facilities, and distance to the health facilities. Further, they have noted that poor people are more likely to reduce their utilization of modern health facilities than rich people because the burden of price changes is more significant when household incomes are low. ' Women and children in households headed by women are thought to be particularly susceptible.

Booth and others (1994) acknowledge the problem that the poor people are likely to face in Zambia but supports a cost recovery system provided there is a proper exemption scheme in place. Booth shows some concern regarding whether the imposition of new or increased user charges in basic health and education can contribute to an improvement, and will not result in a significant deterioration, in the quantity and quality of basic services to the poorest people. While official Zambian policy statements invariably maintain that the poor can benefit from a policy that requires most people to pay more, the truth is that no one has really thought through the way this is to happen (Booth et al, 1994:15). The Booth study has found that utilization of public health services in Zambia has declined with the introduction of user fees and that user fees have contributed to deaths because some people have been denied access to health services.

Although no analysis has been given on the gender implications of user fees, the conclusions from studies carried out by Booth and others (1994) and Griffin and Shaw (1995) may however be used to infer gender implications as a result of the introduction of user fees. For example, Griffin and Shaw have not shown how women and children in female-headed households are likely to be particularly susceptible with the introduction of user fees. Booth and others and Griffin and Shaws' discussion has generally been centred on the poor. They have acknowledged the fact that the poor are more likely to be affected than the rich. Poverty assessment may lead to assessing how women are likely to be affected with the introduction of user fees. This is discussed in the next chapters.

2.3 User fees

In 1987, the World Bank recommended that the principle of cost recovery be incorporated into an agenda for financing publicly provided health services in developing countries. In the countries of Sub-Saharan Africa, agreement is growing that some kind of cost sharing is needed in view of escalating health costs and the limited capacity of the ministries of health to finance or deliver subsidized health care to all citizens. The government's ability to finance and expand health services has been undermined by the unstable economic performance, unprecedented rates of population growth, and the immense cost that the

AIDS epidemic is beginning to impose on public health budgets (Shaw and Ainsworth, 1995:1). Thus, in Zambia, budgetary constraints and economic considerations and inefficiency may be the justification for the introduction of user fees in public health facilities. The argument put forward by the World Bank of not letting government provide free services to everybody including the rich who can afford is another justification for the introduction of user fees.

What is the logic behind user fees? The main goals of user fees are to mobilize revenues, promote efficiency, foster equity, increase decentralization and sustainability, and foster private sector development. By sending right signals, user fees are assumed to make referral system work better and help improve efficiency of health care delivery. The logic behind user fees is that user fees in public health facilities help to promote equity because the demand for health care rises proportionately with income. The rich are more able and willing to pay for the expensive services than the poor. So, charging the rich for the services they demand for and are able to pay for them and pool those revenues to subsidize the poor is a way of improving health care delivery among the poor suffer (Shaw and Griffin, 1995:33).

The assumption that the rich will be charged for the services they demand for might not work effectively. The rich might reduce the use of public health facilities or reduce frequency to the health facilities because most of the diseases are prevented from attacking them compared to the poor. For instance, the poor lack access to sanitation and safe water, thus, are at high risk of suffering from diarrhoea. The poor are the ones who are likely to utilize health facilities more than the rich. When people the poor reduce utilizing medical services when they need them, the well-intentioned benefits of user fees will not be achieved. Griffin and Shaw (1995:33) have pointed out that if high prices result in people not utilizing modern health care when they really need it, then both the individuals and society are deprived of an important investment in human capital.

The current payment system in government health facilities in Zambia is in two ways, (i) you prepay for health services and obtain treatment when you fall sick, and (ii) you pay there and then when you are sick and you get health services like what happens in private health facilities. But at times, if you are a customer of a particular private clinic and in formal employment in some cases, you can be treated on credit, provided you pay some deposit and finish up later. The former (i) applies to all health facilities in urban areas while the latter (ii) only applies to major hospitals, like the University Teaching Hospital (UTH) in Lusaka. In Lusaka, UTH is a referral hospital. You only go there when you are referred from a health centre. In the former, despite your prepayment, you pay for other services such as laboratory and x-ray services from your own pocket, that are not available at a health centre but that may be available at a referral hospital. Members of the community are encouraged to take up the prepayment system. In the prepayment system, previously, there used to be an initial payment for joining the medical scheme and a monthly contribution. The initial amount used to be higher than the monthly contributions like you pay K750 for joining, which even covered that month you are seeking medical attention, and K500 monthly. Unconfirmed information indicate that today, one is asked to pay K1,000 whether for joining the medical scheme or as a monthly contribution referred to as renewing membership.

2.3.1 Demand Reduction Effect versus Demand Diversion Effect

There seems to be a problem with the introduction of user fees in public health facilities. Here we have to analyze what the motive is from two angles, demand diversion effect and demand reduction effect. Demand diversion effect refers to a situation whereby demand for medical care is diverted from government to non-government facilities. Demand reduction is when the government tries to reduce unwarranted use of medical services by those who could have benefited from previously free government facilities. It is this "demand reduction effect" and not the "demand diversion effect" that is the source of much concern about user fees in low-income countries. The negative effect of user fees have on demand is over stated when diversion effects are not considered. Similarly, the positive

consequence of user fees in terms of revenue generation is exaggerated when demand reduction effects are ignored (Griffin and Shaw, 1995:40).

In assessing the gender impact of user fees in Zambia, I will consider the reduction effect as opposed to diversion effect. Major reasons for these are poverty and gender inequality between men and women. An example of the reduction effect could be as follows, women were receiving free services, take for instance antenatal and postnatal services. The introduction of user fees on such services implies that some women who cannot afford would reduce the use of such services. Men and women who cannot afford to pay user fees would resort to all sorts of alternatives. The alternative is to go for cheaper sources, like traditional herbs in both rural and urban areas, or buying cheap medicines from the streets. This may either lead to overdose or under-dose. Alternatively, drugs from the streets might be expired. This poses a health hazard. It is dangerous and treatment is therefore, not fully guaranteed. Other people who cannot afford to pay user fees will resort to stay at home and then buy (cheap) medicine from the streets or shops or consult traditional healers or use traditional herbs. Staying at home will imply increasing the burden on women who are already overloaded with other domestic roles by looking after the sick at home. This, then, does not mean that the government have diverted the services to full utilization, but people have reduced the utilization of services. The impact of this reduction effect would be that mortality rate for both children and adults will rise and life expectancy at birth will decline. Women's health and that of their children may deteriorate and their production will decline, poverty will perpetuate and socio-economic indicators will continue to deteriorate.

2.3.2 The concept of Gender and Health

Gender refers to the socio-cultural relationships between males and females in a given setting. Women are generally less socially privileged than men. Women have less access to education, capital, income, property, and credit. Moore (1994) has pointed out that there is a gender inequality in ownership of assets, employment history, and control over family history and assets. Gender relations heavily affect the women's entitlement to goods and services.

The concept of gender and health stems from the notion that males and females have different health opportunities and hazards. What are commonly accepted as the typical attributes for males and females differ over time between cultures, societies and classes (Choongo, 1996:7). Some of the health problems that affect women are different from those affecting men. Because of this, seeking and utilization of medical care differs between men and women. Gender roles differ for men and women. The World Health Organization has observed that worldwide, women experience poor health and have inadequate access to health care. These are reflected in the high levels of maternal mortality and morbidity, widespread prevalence of reproductive tract infections, malnutrition, anaemia and various forms of violence such as, harmful customary practices, wife battering, sexual abuse and rape (WHO, 1993). Although the above applies to the whole world, some of them can apply to Zambia. Women's poor health is also as a result of much of the workload they carry. In rural areas of Zambia for example, women carry heavy bundles of firewood, cassava, bags of maize and heavy buckets of water on their heads. Drawing of water is actually a daily routine. Distance from home to the fields or source of water differs from community to community. However, it is generally far.

The social divisions of labour in most of Zambia's households leave women with roles where they spend most of their time without cash payment. These include drawing water, cooking food, washing clothes and beddings, collecting fuel, cleaning the house, looking after the sick, bearing and rearing children. By so doing, they are left without cash income. Men are in control of cash. Women lack access to property, they lack collateral and thus they cannot get loans. They lack access to land although they may cultivate on husbands' lands or pieces of land given to them by their fathers, brothers or uncles. Therefore, even when they fall sick, with the introduction of user fees, they have to turn to men for money.

2.3.3 Exemption from user fees

In Zambia, some households cannot afford to pay for user fees. The exemption system should take care of the poor but does not. A survey of official cost-recovery policies for health care systems in African countries suggests that exemptions are remarkably

uncommon, see Table 2.1. Out of the 21 countries, only one country, Zimbabwe, has an official income ceiling below which people are exempted. Twelve of these have a national health policy that provides for exemptions but have no clear criteria for determining who qualifies for them.

Table 2.1: Crude Classification of Countries by Exemption Policy

Exemption Policy	Country
National policy and income ceiling criteria	Zimbabwe
National policy, but criteria not clear (for example, unable to pay, indigent paupers)	Burundi, Congo, Ethiopia, The Gambia, Ghana, Kenya, Lesotho, Mauritania, Mozambique, Nigeria, Rwanda, Swaziland
Local policy (for example, community decisions tied to a local project)	Cameroon, Central African Republic, Equatorial Guinea, Guinea-Bissau, Nigeria, Uganda, Zaire, Zambia

Source: Griffin and Shaw, (1995:42).

Zambia falls under the remaining eight countries that provide exemptions only as part of local projects or facilities, and the criteria is determined on an ad hoc or by the community. Griffin and Shaw (1995:42) have observed that, the limited capacity to administer exemptions in most African countries may well be the most important explanation for their infrequency and ineffectiveness in reaching the truly poor.

An effective exemption system in Zambia is not there. The exemption system has got its own problems, such as the question of rationale and fairness, for instance, who should qualify for exemption? Other hardship cases like members of poor household headed by females, who cannot afford to pay for health care, might be denied treatment. An exemption policy may fail to play a meaningful role in promoting equity when those who can pay are exempted, for example when medical personnel and their dependants are exempted. Deciding which services should be publicly subsidized or exempted from fees and which authority should carry out and administer any exemption policy may create problems. Th way it is done in Zambia where choosing of who should be assisted is

supposed to be done by the local community members who know one another better as indicated in the table is a good one. This simple kind of identification can only work well in rural areas unlike in urban areas. The Ministry of Community Development and Social Services if properly funded is the right ministry to administer the exemption programme. While the church may be needed to do this kind of work, there have been too many churches and this might lead to which church should assist. Assistance from non-governmental organizations (NGOs) to combine efforts with the above said ministry is welcome. In Zambia, according to Booth et al (1994:63), all infectious diseases, including tuberculosis (TB), measles, cholera and dysentery were to be treated free of charge. Preventive measures like immunization were provided free. Other exemptions are based on age (the under five and the above 65 years of age), mental and physical handicap. Life threatening conditions resulting from accidents, obstructed labour, asthmatic attacks, and the like, should be treated first and payment to be discussed after the person is out of danger. There is lack of information among the people and some health workers do not follow the Ministry of Health (MOH) laid down guidelines, especially in rural areas. People in all these categories stay away in the belief that they would be made to pay.

The best way to handle the exemption policy might be through targeting of medical services at certain people. Targeting, which refers to the design of interventions to restrain resource transfer only to the target population and to achieve minimum leakage of programme benefits to the non-target population, may be hampered by the poor distribution of health services where they are needed most. There are two errors of targeting, F- and E-mistakes (Cornia and Stewart, 1995:350-381). The former is that of failing to reach the target population while the latter is the one made when an intervention reaches the non-target population. Although targeting has been applied to food subsidies, the same can be applied to medical services. The lesson we learn from targeting errors is that depending on the poverty profile, by trying to reduce one error, the other error is increased. But then you have to ensure that the target population is reached with minimum leakage to the non-target population.

Targeting of medical services in Zambia, especially among women can be difficult. This is so because women seem to be evenly distributed in Zambia, such that administrative costs will be high. Poverty may also affect the targeting system because the 'vocal ones', though they might be rich, may benefit from such services. Targeting would be difficult also in that it will be costly to identify who should qualify, say based on age, marital status, and geographical location. Lack of physical infrastructures such as roads and communication facilities and lack of capital can affect easy operations of the target system. In sum, institutions to carry out a thorough targeting system or an exemption policy are either not fully established, poorly funded or do not exist at all and where they exist, their impact is minimal.

2.3.4 Ability versus willingness to pay

Ability to pay is not the same as willingness to pay. However, people must have the ability and willingness to pay in order for the user fees to have the intended positive effects. If people reduce their utilization rate especially if their utilization rate has already been low, and especially if these people are poor, then, the positive effects of user fees will not be achieved. Equity in delivery of health care would suffer also. Griffin and Shaw (1995:30) have found that there is considerable evidence of ability to pay, willingness to pay, and actual payment of medical care costs among the rich and the poor alike in Africa.

Results from the Franchising Market Study (CSO, 1997a) show that in Lusaka, health facilities are easily accessible as most people can easily walk to a health care facility. Ninety six percent of the people who usually visit a government facility do so for proximity reasons. Low cost was not given as a reason that can influence one's choice of a particular health facility. Virtually no one of the people interviewed gave low cost as a reason for choosing a particular facility. However, not all services i.e. medicines, equipment and tests were said to be available in the usual sources of care, thus people go for other alternatives. The study further reveals that people are reluctant to pay huge sums of money for medical services. People might be reluctant to pay because they are poor. More people were recorded for the services requiring a charge of less than K5,000. Of those who received

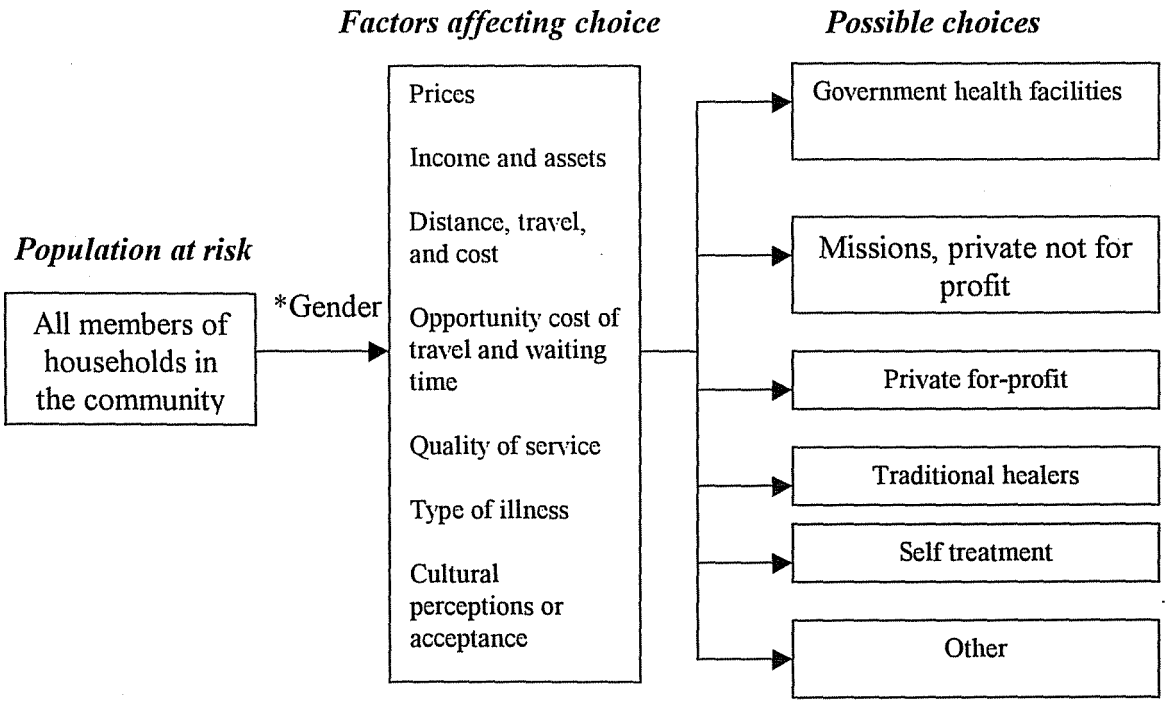
treatment at less than K5,000, twenty eight percent used government facilities while 71.4% used private facilities. Regarding the question of who pays for the medical scheme (medical fees), results are that about 86% of the people interviewed had their medical scheme prepaid for by one of the members of the household. About five percent were found to have other means of paying or pay for themselves. This kind of a pattern can be attributable to the fact that traditionally in Zambia, less privileged people (including the unemployed) depend on privileged relatives (those having formal employment) for any kind of financial assistance. Among those paying for their own scheme, or having other means of paying for medical fees, there are more males (82%) than females (18%). This is a natural trend where unemployed men are more active in trying to engage themselves in some informal activities to earn some income than are female who are usually expected to attend to household chores. About twenty one percent had their scheme prepaid for by the employer of one of the household members.

As part of evidence on the ability to pay, there are some people who are able and willing to pay. In the past, although there are no statistics to prove this, people used to consult both the modern and traditional health services or both the private and public health services. However, consulting both the private and public was as a result of lack of essential drugs in public health services, waiting for a long time before being attended to, and avoiding both transport and time costs. In a situation where the nearest health facility is on your way to town where you can find private clinics, sometimes one is better off going straight to town and pay for quality service rather than dropping on the way and only to be referred to a drug store in town. Consulting both traditional and modern health services may however, not necessarily mean that the people will pay the user fees.

There are a lot of factors that determine the source of care for a household as presented in Figure 2.1 and what makes people seek more than one source of care. Presentation of factors may also imply that the willingness to pay may not necessarily result in the ability to pay. These factors affecting choice can be gendered. Griffin and Shaw (1995) did not look at the gender dimension of factors affecting choice. Let us see how these factors can

be gendered with the introduction of user fees. A mother may not seek medical attention because of family responsibilities. This is so because, although there is no data to support this in Zambia, sometimes even when a woman is sick, she has to cook for the family and ensure that everyone is fed at home. Money might be spent on food rather than on medical services. Thus a woman can forego medical attention in the interest of the family. This also sometimes can be as a result of distance and or cost of travel to the facility or price of the services. Lack of access to cash income by most women can affect their choice. The price of medical services can affect choice of care. If the price is higher than can be afforded, and given the high poverty profile in Zambia, men and women who lack access to income will be affected, though the majority will be women.

Figure 2.1: Factors affecting type of curative and preventive health care



Note: * Included by author

Source: Griffin and Shaw, (1995:34)

Some diseases are viewed as *ingulu* (a Bemba term) meaning spiritual, such that if the health clinic fails to cure the disease, a traditional healer is consulted. Barrenness is sometimes viewed as a disease caused by spirits. If a couple stays for a long time (specified by elders not necessarily the couple sometimes), the elders may suspect that a woman has got spirits (*ingulu*) in her womb. The man's infertility is not in most cases questioned. The relatives, then, have to look for the traditional healer to remove the spirits. Sometimes, madness is also believed to be caused by *ingulu*. These are beliefs in Zambia that are orally passed. These days, even HIV/AIDS patients do consult traditional healers because it is sometimes viewed that somebody has been bewitched and can be cured by a traditional healer. Experience has shown that sexual transmitted diseases (STDs) also lead to consulting both traditional and modern health services. If you are treated for an STD at a health centre or hospital, it is believed that the disease is still in your blood until you take some traditional herbs which make you vomit and have some diarrhoea of some sort, then it means that you are fully cured.

When considering rural and urban differences, in rural areas, households largely depend on (subsistence) farming. Income is not easily accessible. Widows and single women are largely poor. User fees are likely to hit them hardest. They mostly lack income or assets that they can use to generate income. Because of these women and their dependants are likely to use traditional herbs or rely on other relatives to assist them. In rural areas, distance to health facilities is longer than in urban areas. Thus, women will consider the distance cost. According to Booth and others (1994:57) distance to be traveled to the nearest health facility range between 2-5 km. CSO (1994:28) confirms this distance and further adds that while the majority of the households are found within the radius of 5 Kilometres (km), a substantial proportion (37%) of households in rural areas are found within 6 and 15 km radius of a nearest health facility. Nearly 100% of all households in urban areas are found within 5 km radius of a nearest health facility. Transport is not cheap and easy to get in rural areas.

The above discussion imply that price of medical services, income and assets, distance to the facility, type of illness, and whether it is culturally acceptable to seek modern, or traditional health care would affect men and women differently. The impact is likely to be high among women than among men. However, the quality of service cannot be affected by gender because everyone (man or woman) wants good quality of care. When all factors are considered, income seems to be the major determinant of choice. Men and women who lack income are likely to go for cheaper alternatives, such as staying away from seeking medical attention, traditional herbs and self-treatment, though with detrimental consequences. The gender of the head of the household has to be taken into account as well. This is so because as we shall see later in Chapter Four, poverty is high among female-headed households than in male-headed households.

Ability and willingness to pay for those who can afford is also based on the quality of service expected and offered.

2.4 Interaction between the State, Market and Women

In order to understand how user fees may have a gender impact, we have to look at the interaction of the state, market and the women in the economy. The interaction of the three is complex. According to Elson (1991:42) the state does not always operate in the interests of women, and the market does not always operate against the interests of women. However, the state frequently plays a major role in perpetuating social, economic and ideological processes that subordinate women. It creates an enabling environment through perpetuating social, economic and ideological women subordination, and treats women as dependants of men and upholds the patriarchal family in which women have no same access to income as men. The market seems to treat women as individuals in their own right who can reduce their burden and have access to income by selling their labour or products in the market. However, women cannot compete on equal basis with men due to the double burden women carry of unpaid work in the home and paid work in the production of goods and services. Market benefits are limited to women because of the

gender imbalance. Women raise children and care for the family members, factors not responsive to market effects.

Policy changes introduced in the economy by the state affect households including men and women differently. The way households respond to measures taken by the state (external shocks) differs according to residence; that is rural or urban; age of the household head; sex of the household head; level of education; and occupational category of the household head. I have considered the characteristics of the head of the household because, in most cases, available data is only applicable to household heads. However, household member characteristics also matter as they form part of the survival strategies. Similarly, the impact of the introduction of fees may take different forms for women in rural and urban areas. An introduction or an increase in educational and health charges is likely to reduce the girls access. To compensate for the reduction in purchased resources women bear the main burden in that they have to extend their unpaid labour. Their unpaid labour will be increased because cheaper food for example will be bought that will require long preparation time. Elson (1991:44) has observed that when the household decides to reduce food consumption due to rising prices, consumption of women and girls will be reduced more than that of men and boys.

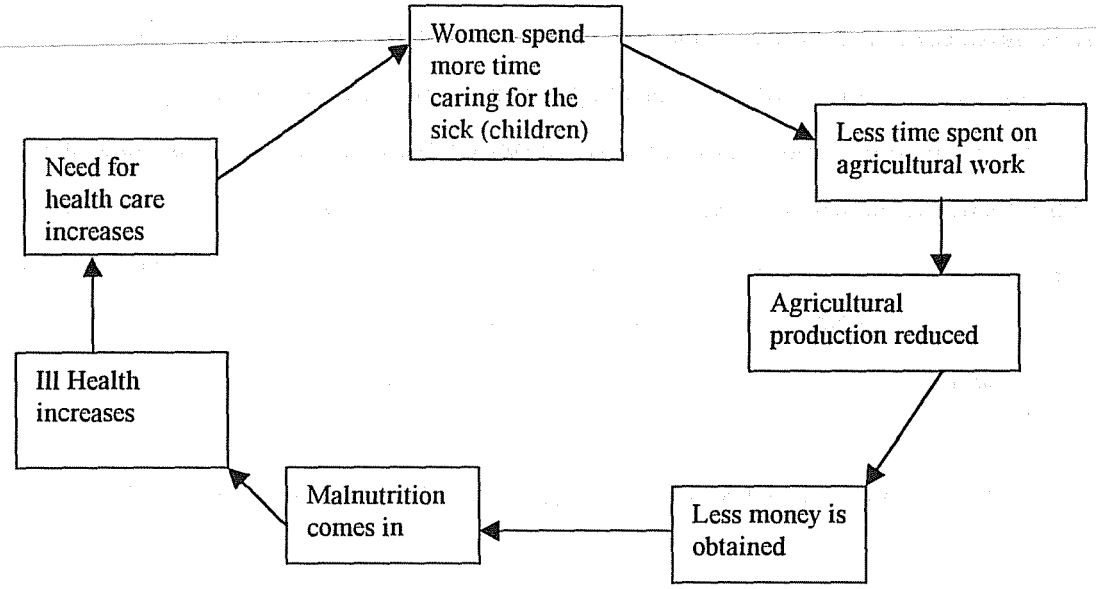
In Zambia, the removal of food subsidies, trade liberalization, privatization, health reforms including user fees, and many others as discussed in Chapter One, have affected households differently. Households respond to such changes differently. Women are more involved in the unpaid labour than men. Although women may take part in the cash crop production, men or their husbands control cash income. This implies that women can benefit from this money depending on how it is spent. Women who are involved in agriculture also have their own problems, such as not being able to get loans because they have no assets to declare to the banks.

Subjecting medical care to market conditions affect women in the sense that an additional cost is introduced in a home. This has to be paid for by an increase in the salary or by producing more farm crops for consumption and for sale or by doing some kind of business. If the wife cannot work in the wage labour, then she has to do farming or selling. Again depending on which area, other women will become fishmongers and girls will be engaged in selling fried fish in rural areas. People may not be able to pay for medical services and will remain at home. The women will take care of them. In urban areas, to reduce time and travel costs, some women sell their merchandise on the street just outside their homes. Alternatively, especially in rural areas, the other option is to have more children so as to share the work, not realizing that the burden is being increased.

With the introduction of user fees, Hanmer (1994:21) has observed that in a situation where some people in rural areas benefit from remittances, if less money is remitted to them, as a result of harsh economic conditions (including the introduction of user fees), women in rural areas might be affected. If costs hamper women from attending rural clinics, a vicious circle may be created, see Figure 2.3, where women have to spend more time at home nursing the sick children, thus, having less time to spend on agricultural work. Agricultural production will decline resulting in less money which can result in malnutrition (due to decreased purchases of essential foods such as cooking oil and vegetables) which further promotes ill health and increases the need for health care services, thus having a welfare loss within the family. Vicious circles showing how user fees may take different forms on women in rural and urban areas are presented as Figures 2.2 and 2.3, respectively.

In Figure 2.2, a vicious circle is created when women spend more time at home nursing the sick children. Less time is spent on agricultural work. Agricultural production declines resulting in less money. This results in malnutrition (due to decreased purchases of essential foods such as cooking oil and vegetables). Ill health increases and the need for health care services results in a welfare loss within the family (Hanmer, 1994:21).

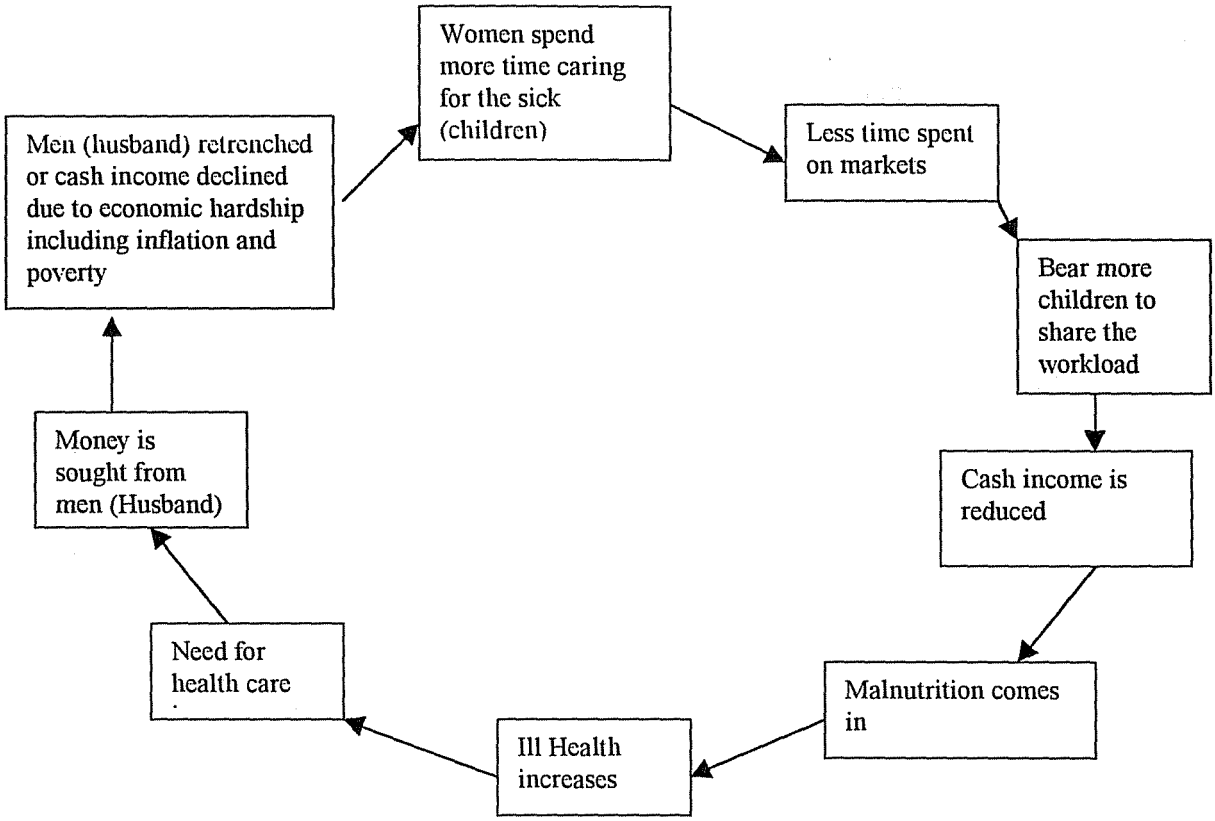
Figure 2.2: Vicious circle in the rural area



In Figure 2.3, a vicious circle is created when women spend more time at home nursing the sick children. Less time is spent on markets. (To reduce on time and transport costs, foodstuffs and other sorts of merchandise are sold along the streets. This results in filthy and causes outbreaks of diseases such as cholera). Since less time is spent on the market, cash income declines. In order to reduce the workload, there is a desire to have more children. The desire to have more children also applies in the rural areas. More children and declined cash income result in malnutrition (due to decreased purchases of essential foods such as cooking oil and vegetables). Ill health increases and the need for health care services give rise to a welfare loss within the family. Money is sought and particularly from men. The men's cash income is declined due to economic hardships, which include loss of job, inflation, transport costs and user fees.

Getting an exemption also requires travelling. Long distance to walk, transport costs, and especially lack of information regarding who should be exempted, make those who are supposed to obtain the exemption letter or card ignore it. Therefore, market forces generally, may not necessarily solve most of the socio-economic problem as perceived. If anything, they just increase the sufferings of the poor men and women.

Figure 2.3: Vicious Circle in the Urban Area



Although there is no data for Zambia to support the argument, the cut in educational expenditure by the state means that education has become expensive. Fewer girls are then sent to school than boys because it is generally viewed that male relatives or husbands would take care of the women. Due to inflation and poverty, people's income declines and fewer people seek medical care. Women reduce health service utilization. Girls and women then spend more time looking for the sick. Lower utilization of health services by women (and especially services that also improve children' health) leads to higher infant, child and maternal mortality rates.

2.5 Summary

Benefits of user fees have been elaborated in a general sense. While steps are there to follow before implementing user fees, carrying out a pilot survey to assess the impact before the introduction of user fees is very important. As we have seen in Chapter Two, basically what matters is instituting an effective exemption system and improving quality of

health service. Constant availability of essential drugs, availability of equipment such as laboratory equipment, and improvement of medical personnel morale, will lead to a successful health reform programme. Starting with user fees and hoping to improve health services later and without an effective exemption system to help the vulnerable in Zambia can lead to low utilization of health services. The lacking component in the discussion of user fees is the women's contribution in health reforms. Review of literature only shows how generally the people will benefit from user charges without really assessing the impact it has on women that seem to be the major consumer of health care, either as sick people or as healthy people. As we shall see in the next chapters, women health problems and their general constraints in their lives put them in a difficult situation. They are at risk of consulting medical care more than men. Improving quality of health service and empowering women, especially through formal education, are the only alternatives to improve the poor demographic and economic indicators in Zambia.

Some questions still remain unanswered. Has use of public health services declined? If so, does this represent diversion to other health services or a decline in demand based on inability to pay? In a nut shell, I have discussed how gender differences can patterns of use of health services and capacity to pay. More information is provided in the next chapters.

Chapter Three

User fees and recent trends in health care use and provisioning

3.1 Introduction

This chapter presents the health service provisioning in Zambia. Utilization of health services, reasons for the introduction of user fees, household response to external impacts are also discussed. A summary is given at the end.

3.2 Health Service Provision in Zambia

In Zambia, health services are provided by; (a) the government who accounts for 51.2%, followed by (b) the Missionaries accounting for 34.5%, and (c) the parastatal together with private enterprises who provide 14.3% of the total health services (CSO, 1996:120). Private health facilities are found in urban areas while mission hospitals and clinics are more concentrated in rural than in urban areas. Government health facilities are found both in rural and urban areas. The number of facilities is shown in Tables 3.1.1 and 3.1.2. In pre-independence era, private health facilities were mainly concentrated in urban areas, particularly the mining areas on the Copperbelt province. These were run by the expatriate workers and were separated for Europeans and African mine workers and their families. Government health facilities were as well established along the line of rail to cater for the settlers, while missionaries established hospitals and health centres mainly in rural areas. The quality of services offered by missionaries were good but their facilities were few and only catered for the few rural dwellers. The rest relied on traditional methods as a coping strategy for diseases. In urban areas, better quality of service was offered to white settlers than to Africans (White and Nzovu, 1997:20).

In the post-independence era, with the increase in population, the government had a task of expanding and providing health services to all, both in rural and urban areas. As a result, a number of health services were constructed. For example, the number of hospitals rose from 48 in 1964 to 72 in 1970 and to 79 in 1975 while that of health centres rose from 306 to 501 and later to 631 during the same period, refer to Table 3.1.1. Results from the two

tables indicate that the growth in the number of health facilities does not match with the rise in population. Table 3.1.1 further reveals that the number of hospitals has almost stagnated since 1980, whereas the number of health centres has been rising by hundred since 1970. Table 3.1.2 also shows that the number of mission hospitals has stagnated while that of health centres has been rising at a very low rate. The increase in the number of beds and cots in health facilities presented in Table 3.1.2 does not also match with the increase in population.

Table 3.1.1: Number of Health Facilities in Zambia, 1964-1996

Year	Number of		Total number of
	Hospital	Health Facility	Hospital & Health Centre
1964	48	306	354
1970	72	501	573
1975	79	631	710
1980	81	721	802
1985	82	856	938
1990	82	942	1,024
1996	84	1,261	1,345

Source: White and Nzovu, 1997:21

The increase in the number of health centres could be as a result of the construction of health facilities on self-help basis with the help of donor funds. What normally happens under self-help basis is that the community provide labour and some financial support to some extent to build a health centre. Then it is equipped with some medicine in the initial stage, and then expect the government to maintain it. Such clinics, just like schools, have been built and the people have relied on the government to supply medicines and personnel, and this has worked. Survival of such projects relies on donor support. If donor funds run out, it means that the health facility will start experiencing problems such as running out of drugs and tools to treat the patients.

Table 3.1.2: Number of Health Facilities in Zambia, 1980-1994

Health facility	Year											
	1980	1981	1982	1983	1984	1985	1986	1987	1988	1990	1992	1994
Hospitals	81	81	81	82	82	82	82	82	82	82	84	84
Government	42					42				42		
Mines	11					11				11		
Mission	28					29				29		
Health Centres	721	758	779	801	847	856	883	912	923	942	1037	1110
Government	589					716				796		
Mines	66					75				94		
Mission	66					65				72		
Hospitals and Health Centres	802	839	860	883	929	938	965	994	1005	1024	1121	1194
Beds and cots in hospitals	14889	15108	15183	15267	14885	15629	15200	15831	16306	16921	17507	17264
Beds and cots in health centres	5630	5633	6233	6300	6953	6222	6514	7081	7691	7631	8195	9539
Total Number Beds and cots	20519	21416	21416	21567	21808	21851	21714	22912	24497	24572	25702	26803
Number of Leprosaria	15	15	15	15	15	15	15	15	15	15	-	-

Note: (-) Shows no data

Source: MOH (1992:2)

Shortage of human resources in the health sector is also a source of worry. Table 3.1.3, which shows the number of health personnel, reveals that the number of doctors and nurses does not correspond with the increase in population. For example in 1991, of the 959 required doctors, there were only 508 doctors giving a shortfall of 451. And in 1991, there were 508 physicians and 5,204 nurses compared to 531 physicians in 1995 with 9,952 nurses serving the population. Population per physician deteriorated from 7,100 persons in 1985 to 13,000 in 1991 (MOH, 1992). When you consider the population of 1990 that was about eight million, then this gives a clear picture that physicians are lacking in the country. Population figures are presented in Table 3.3. A low number of physicians coupled with less equipment and less transport imply that the services are likely to be of low quality. The low number of physicians is attributed to qualified Zambian personnel leaving for greener pasture in neighbouring countries. Improving the working conditions will result in maintaining qualified personnel and will in turn result in efficiency among them and in service provisioning. Otherwise, user fees are not likely to produce the positive results.

Table 3.1.3: Health personnel in government and mission health facilities

Category	1991			1993			1995
	Establishment	Actual	Shortfall	Establishment	Yearly output	Shortfall	Number
Doctors	959	508	451	1159	40	531	531
Clinical Officers	1693	1372	321	2093	80	481	12093
Registered nurses/midwives	1673	2307	+634	2573	198	+328	2901
Zambia enrolled nurses/midwives	3531	6309	+2778	4781	250	+2278	7051
Pharmacy technicians	52	61	+9	102	9	32	300

Source: Ministry of Health (1992:11)

3.3 Introducing user fees in Zambia

Problems in the health sector started as a result of the economic crisis, dealt on in Chapter One. The poor economic performance from the 1970s created a decline on the health expenditure, see Tables 3.2 and 3.3. Table 3.2 shows the government's expenditure on health from 1986 to 1990. Government's budget on the Ministry of Health since 1970 has been less than 10% and a bigger share of this is spent on salaries and recurrent departmental costs.

Table 3.2: Government Expenditure on Health in Zambia, 1986-1990 (At 1980 Constant Prices)

Year	Total Government Expenditure (Million Kwacha)	Health Expenditure	Health Expenditure as a % of Total Government Expenditure	Components of Health Expenditure (%)			
				Personal Emoluments	Grants	Capital	Recurrent Dept. Charges
1986	949.5	39.4	4.2	38.4	27.7	7.7	26.8
1987	558.3	28.7	5.1	26.7	30.3	5.2	37.7
1988	716.8	55.6	7.8	26.9	26.4	5.4	41.3
1989	576.2	40.7	7.1	22.9	23.7	15.3	37.6
1990	289.0	28.5	9.9	18.0	31.7	10.1	39.7
1991				34.0	25.3	13.4	25.9

Source: CSO (1995b:7) and MOH (1992:6)

Table 3.2 shows that the health sector has suffered as a result of the declining expenditure by the government. Total expenditure on the health sector, particularly capital and recurrent departmental charges as well as salaries, has declined to the levels where the sector's capacity to deliver quality and adequate services has been undermined (CSO,

1995b:7). The decline in the expenditure resulted in deteriorating physical infrastructure, chronic shortages of drugs and medical supplies, recurrent epidemics of cholera and dysentery as well as unfavourable working conditions that demoralized the health workers. It is difficult to get data in order to show the decline in the quality of health services, but it requires one to travel and perhaps see it him or herself. Booth et al (1994) confirms the deterioration and argue that user fees have led to the increase in the number of deaths.

According to Soeters (1997:54), total public expenditure reduced by 58% between 1980 and 1993 and the per capita decreased even more as a result of the population growth, see Table 3.3. Government increased their real health expenditure in 1994. Donor support as a percentage of total health expenditure increased from 24% in 1983 to 39% in 1994. If donor support is included, the per capita health expenditure could rise above $12, which according to the World Bank is sufficient enough to finance the basic public health and clinical services package for the population. It seems, therefore, that Zambia has the capacity to improve the health status of its population if the existing health resources are put to good use.

Table 3.3: Trends in health expenditure by the Zambian Government (excluding donor contributions)

Category	Year			
	1984	1990	1992	1994
Total gov't expenditure	$112 million	$92.9 million	$70.8 million	$92 million
Population	6.4 million	8.1 million	8.6 million	9.1 million
Per capita gov't expenditure	$17.5	$11.4	$8.2	$10.1

Source: Soeters, (1997:55)

Other than from the private clinics, medical services have been provided free of charge at the government clinics and hospitals. However, it was not all that free because quite often, hospitals and clinics ran (and still run) out of drugs and people were told to buy medicine from private pharmacies. But due to limited resources faced by the government of Zambia to provide quality health services and faced with an increase in demand for medical services due to the rising population, the government was prompted to introduce user fees as part

of its reform programme. The circular issued by the Permanent Secretary in 1993 to all Provincial Medical Officers (PMOs) and mission hospitals cited generation of income as a basis for charging. "The simple reason why Zambians are now being asked to contribute towards health care costs is that the Government of the Republic of Zambia has limited resources with which to continue to provide free medical care and improve the run-down limited infrastructure" (Milimo and Choongo, 1995:24). User fees were introduced in 1993. In order to avoid payment at the time of sickness and to avoid a situation of paying at a time when a person has no money, given the nature of poverty, prepayment was also introduced.

Table 3.4 shows trends over time of health status indicators in Zambia. The table shows that IMR and under five mortality rate including malnutrition, have been rising. Access to safe water has also deteriorated. In urban areas of Zambia, according to CSO (1994:29) 86% of the urban households get water from taps while 77% of the rural households get water from unprotected wells and rivers and lakes.

Table 3.4: Trends of health status indicators in Zambia

Indicators	Year		
	1970	1985	1990
Infant mortality rate (per 1000 live births)	147	97	107 (1992)
Under-five mortality rate (per 1000 live births)		152	191
Crude death rate	21	16	
Life expectancy (average for men & women)	43	48	11.9%
Low birth weight (% less than 2500g)		10.2%	25-28%
Under weight (wt/age)	23%	14%	56%
Access to safe water (% of total population)		54%	51%
Access to sanitation (% of total population)		52%	

Source: Soeters, (1997:54)

A comparison of Zambia with other low-income countries shows how bad the health situation is in the country. For example, China with a low GNP/capita has a higher life expectancy at birth than the rest of the three African countries. Kenya has also a higher life expectancy at birth than Zambia and Togo despite Kenya's low GNP/capita, see Table 3.5.

Table 3.5: Comparing Zambia with other countries with similar GNPs/capita

Country	GNP/capita	IMR	Life expectancy
Zambia	$420	107	48
Kenya	$340	51	59
Togo	$410	86	55
China	$370	35	71

Source: Soeters, (1997:54)

3.4 Utilization of Health Services

Both men and women, children and the old ones, do utilize health services. Utilization of health services is provided in the tables below. Table 3.6 shows a combination of hospital and health Centre attendance records for outpatient top ten causes of morbidity in Zambia in government health facilities in the period 1989–1994. The data has been indexed at 1990 in order to get a clear picture of change over time.

Table 3.6 shows that between 1989 and 1993, the number of people seeking treatment from health facilities did not show much difference but a fluctuation in the trend. However, in 1994, some decline is observed. For example in the case of malaria, in 1989, it was below the base year at 55%. It was 53% above the 1990 figure. The highest peak was in 1993 when the attendance record was 83% above the 1990 figure, but later dropped to 48% above the 1990 figure, see Table 3.6 for further details. Results from the table show some improvement in attendance for some diseases. The decline is seen mainly in 1991 when records show below 100 of the 1990 base year. However, when diseases are looked at individually, then we can see some major declines. For example, diseases under the category of "all other diagnosed and other gastro-intestinal diseases", fever, skin infections and injuries show a decline below the base year. The decline in attendance at health facilities implies that utilization of government health facilities that used to offer services practically free of charge has declined. However, there is no data to show whether the decline in the use of government health facilities has resulted in the shift to the use of private health facilities or have resorted to traditional herbs. In fact, another notable feature observed from Table 3.6 is that since the user fees were introduced in 1993, people were then willing and able to pay for medical services. Thus, in 1993, there was a rise in

the number of people seeking treatment from the public health facilities, but later declined in 1994.

Reasons for the decline in the number of people seeking medical attention are many. One of the reasons is that to those who are able to pay, the medical services received after paying was less than what would have been expected. Shortages of essential drugs and equipment in health facilities, especially laboratory equipment, is another contributing factor. This is so because, in the absence of laboratory equipment and or essential drugs, people are made to pay twice or thrice as was observed by Booth and others (1994:57). They pay for consultations (only) and then, they are referred to a drug store and or a health facility that has laboratory equipment or x-ray equipment where they are made to pay again. The decline observed in 1994 can as well be attributable to some economic hardships brought about by the economic recovery programme currently being pursued in the country as discussed in Chapter One. Lack of cash income by some men, women and children who rely so much on working relatives or husbands, who could have lost employment or have difficulties in finding good money for survival due to the new economic policies put in place, could be another reason for the decline.

Table 3.6: Records for Outpatient Top Ten Causes of Morbidity, Zambia, 1989–1994.

Disease	1989	1990	1991	1992	1993	1994
Malaria	55	100	111	153	182	142
URTI	128	100	94	135	157	130
Diarrhoea	119	100	93	99	139	107
All other Diagnosed Diseases	118	100	83	95	69	60
Fever (undiagnosed)	156	100	69	93	117	73
Eye Diseases	111	100	74	107	111	110
Other Gastro-intestinal	143	100	75	102	99	73
Skin Infection	94	100	124	180	151	95
Injuries/Poisoning	133	100	73	102	101	80
Round/Other Worms	113	100	100	151	135	119

Note: Figures for this table were obtained from Milimo and Choongo (1995:26). In order to see change over time, figures have been indexed at 1990.

Table 3.7 shows the percentage distribution of outpatient cases in government health facilities for adults aged 15 years and above. Although the table does not provide

information of before and after the introduction of user fees, it gives a present picture of utilization of the services by men and women in Zambia. The table shows that in Central Province, more males utilize health facilities than women. One of the reasons for this could be that men might value their health more than that of women because men are seen as bread winners and therefore, may be seen as the only workers. The work of women is not very much appreciated because it is seen as not contributing to cash income.

In Copperbelt Province, utilization of health services does not give a big variation between males and females. This is so because this province is a mining area. This implies that in the mining sector, mine workers and their dependants are covered by the health insurance policy, thus utilization is on equal basis between men and women. For the rest of the provinces, except for Eastern, Lusaka and Western provinces, more males than females utilize health services. The reason why more men than women seem to be utilizing health services could be as a result of the dangerous jobs that men do, such as cutting trees, driving vehicles and fishing. Women also do these jobs but at a lower scale than men. In Eastern, Lusaka and Western provinces, more women utilize health facilities than men do. This could be due to the fact that women may engage themselves in some kind of business such as fish mongering or selling of some merchandise, or in farming and or brewing beer. These are some of the sources of income to most of the women in Zambia. And from this, they do make some money for user fees.

Table 3.7: Out-Patient Adult Cases (15 Years and above), by Province and Sex, Zambia, 1996

Province	Sex		Total
	Male (%)	Female (%)	Number
Central	69.8	30.2	8,358
Copperbelt	51.8	48.2	9,859
Eastern	43.0	57.0	1,250
Lusaka	42.2	57.8	1,199
Northern	51.3	48.7	1,045
North-Western	54.6	45.4	4,379
Southern	55.8	44.2	8,845
Western	46.1	53.9	2,019

Source: Choongo, 1996:30

A decline in the utilization of health services has given rise to poor demographic indicators. Infant mortality rate has deteriorated between 1980 and 1996, see Tables 3.8.

Table 3.8: Trends in Infant Mortality, 1980-1992.

Age group	1980	1990	1992	1996
0-4	98.7	123.3	107.2	108.9
5-9	106.5	96.0	87.6	106.2
10-14	112.5	102.5	79.5	92.2

Source: CSO (1993:81), CSO (1996:115) and CSO (1997b:21).

Table 3.9 shows the top five causes of death for people aged 15 years and above. Results from the table indicate that men are more affected by the first four diseases, malaria, pulmonary tuberculosis (PTB), diarrhoea and pneumonia, than women. This brings us back to the question of curative and preventive measures discussed in Chapter One that the government can address in order to assist the poor. For example, improving access to clean water and sanitation can prevent diarrhoea and other water borne diseases. In rural areas were access to safe water and sanitation is poor, diarrhoeal diseases and malaria are likely to be higher than in urban areas

Table 3.9: Top Five Causes of Death for Persons 15 Years and Above, in Health Institutions, 1996

	SEX				TOTAL	
CAUSES	Male	%	Female	%	%	Number
Malaria	149	54	126	46	100	275
PTB	123	53	109	47	100	232
Diarrhoea	83	63	48	37	100	131
Pneumonia	46	62	28	38	100	74
URTI	16	42	22	58	100	38

Source: Choongo (1996:35)

Although data might be scanty due to poor records at health facilities, a study carried out by Booth and others (1994) in Zambia reveals that utilization of health facilities declined during the introduction of user fees at health facilities, for example see Table 3.10. The table shows combined monthly outpatient registrations and admissions at Arthur Davison Hospital for Children in Ndola, Zambia between 1989 and 1994. Although statistics in this table only refers to children, the results can tell us what has happened to the parents who

take their children to health facilities. The decline or increase in attendance can be applied to adults who take the children. When one month is compared with the same month but in the other year, a fluctuation of utilization is observed. Since 1989 and 1994, absolute numbers and an average monthly records show a declining trend. Booth and others (1994:49) further noted a decline at mission hospital in Jumbe after the introduction of user fees. From a peak of over 3,500 in March 1989, it went down to as low as barely 500 in August 1993 when the hike went up from K50 to K250. Since then, the attendance has remained below 1,000. Deliveries of babies at the hospital fell by half between 1991 and 1993. According to Booth (1994:52), attendance at Lewanika General Hospital in Mongu also declined after the introduction of user fees. Total admissions fell between 1993 and 1994 from 1,075 to 543 (49%), with larger declines in the children's and male wards (65% and 55%) than in female and maternity wards (47% and 20%).

Table 3.10: Out-Patient Registrations and Admissions, 1989-94

Month	1989	1990	1991	1992	1993	1994
January	11,360	11,265	4,653	7,719	7,760	4,941
February	11,898	11,502	5,995	4,868	5,474	4,718
March	10,323	10,244	8,239	6,196	6,204	5,266
April	8,821	8,614	6,557	6,200	5,818	4,349
May	8,372	6,481	5,827	5,497	6,599	4,055
June	6,455	7,198	4,636	3,813	4,734	2,940
July	6,580	7,883	3,327	5,784	4,627	3,369
Annual Totals	**63,809**	**99,187**	**39,234**	**40,077**	**41,216**	**29,638**
Monthly Averages	**9,116**	**9,027**	**5,605**	**5,725**	**5,888**	**4,234**

Note: Only data for the first seven months have been used because the month of December only went up to July.

Source: Booth and others (1994:48)

A comparison of two ZDHS results for 1992 and 1996 (with each survey results referring to five years prior to the survey), show a decline of mothers delivering from medical health facilities. More women delivered at home than at health facilities, see Tables 3.11.1 and 3.11.2 for details which show place of delivery or rather the percentage distribution of births by selected backgrounds of mothers. The tables give more insight on what type of women are likely to be affected with the introduction of user fees. From 1988 to 1991

(given as 1992 in the tables), women used to deliver more from health facilities than homes. But between 1991 and 1995, the reverse regarding place of delivery was observed. The difference between 1992 and 1996 regarding the place of delivery, i.e. between home and health facility is greater than between 1988 and 1991. Slightly above half of the deliveries (51%) were at the health facilities and 49% at home in 1992 compared to 47% of all deliveries at health facilities and 53% at home in 1996.

Table 3.11.1 shows that majority of the women who are not utilizing modern health facilities are mothers above the age of 20 years and women with two or more children. Women in rural areas have basically not changed their place of delivery at all. They deliver mostly at home were well above 70% of deliveries take place at home and around 26% at health facilities.

Table 3.11.1: Place of Delivery by Mother's Age and Residence in Zambia, 1992 and 1996.

Background Characteristics	1992					1996				
	PLACE OF DELIVERY			TOTAL		PLACE OF DELIVERY			TOTAL	
	Health Facility	At Home	Other	%	Number of births	Health Facility	At Home	Other	%	Number of Births
Mother's Age at Birth										
< 20	50.6	48.9	0.5	100.0	1,327	48.9	50.8	0.2	100.0	1,525
20-34	52.2	47.2	0.7	100.0	4,095	47.3	52.3	0.3	100.0	4,819
35+	43.1	56.1	0.8	100.0	788	37.4	62.1	0.5	100.0	815
Birth Order										
1	57.9	41.4	0.7	100.0	1,390	55.6	44.2	0.2	100.0	1,566
2-3	49.6	50.1	0.4	100.0	1,917	48.4	51.3	0.2	100.0	2,438
4-5	50.4	48.9	0.7	100.0	1,242	43.7	55.9	0.4	100.0	1,512
6+	46.1	53.0	0.9	100.0	1,662	37.8	61.7	0.5	100.0	1,643
Residence										
Urban	78.8	20.9	0.3	100.0	2,885	76.7	22.8	0.5	100.0	2,858
Rural	26.3	72.7	0.9	100.0	3,326	26.5	73.2	0.2	100.0	4,301

Source: CSO (1993:93 and 1997b:107)

The reason why mothers do not deliver either in a health facility, whether it be government or private, or at home need to be investigated. If delivering in a bush is under the category of other place of delivery, IMR and MMR are likely to increase in case of complications. But insisting on "payment first treatment later", could be one of the reasons for some women who may end up delivering in the bush especially in rural areas. This can be done say on the way from the clinic or hospital where medical attention could have been denied

due to lack of money for user fees. The times of Zambia reported one incident that happened in Lusaka where a woman was denied medical attention and delivered in a nearby bush. Lack of communication facilities to call for an ambulance or a qualified medical personnel and lack of transport to take the patient to a health facility, especially in rural areas, can lead to women delivering in unfavourable conditions some of which are classified as other place of delivery in Tables 3.11.1 and 3.11.2. Infant mortality rate (IMR) and maternal mortality rate (MMR) are likely to rise if these groups of women continue with their low rate of health facility utilization. Under utilization of health facilities by women is not only bad for the health of their babies, but also they risk their lives.

Men also face similar problem when "payment first, treatment later" is insisted. The Times of Zambia reported an incident in which the Lusaka City Council complained about University Teaching Hospital (UTH) staff who demanded cash payment before taking X-rays of three injured council firemen who were hit by a car while trying to rescue another road accident victim. A cruising motorist ploughed through the accident scene, injuring the three council firemen who were battling to remove a man trapped in a mangled vehicle. The Lusaka Town Clerk said that staff at the UTH demanded K6,000 cash from each of the firemen. He further said that the behaviour of the UTH staff was shocking because, that was not the first time they did that. They refused to attend to an officer who was choked when Society House in Lusaka was gutted. He said that the firemen were only attended to after sympathizers, mostly fellow council employees donated the required money (Times of Zambia, Friday, August 21, 1998).

Provincial variations in Table 3.11.2 reveal earlier suggestion that men are in control of cash and decide how it should be spent. Of the three urban provinces, Central, Copperbelt, and Lusaka, women in Central Province deliver more at home than in health facilities. In Copperbelt Province, employees and their relatives are covered by the insurance scheme, thus women deliver more in health facilities than at home. In Lusaka, some women are involved in wage labour while others are involved in some business and hence, they can

afford to pay user fees. The rest of the provinces have a low delivery rate at health facilities. However, North-Western Province show a surprise picture whereby delivery at health facilities has actually improved thus giving a decline of delivery at home. The table shows that delivery at health facilities rose from 54.1% in 1992 to 56.5 in 1996. These results are subject to investigation because thorough conclusions cannot be drawn now. Table 3.11.2 further shows that mothers with no formal education and those with primary level of education utilize health facilities less than those with secondary level of education and above.

Table 3.11.2: Place of delivery by Province and Level of Education of Mothers in Zambia, 1992 and 1996.

Background Characteristics	1992					1996				
	PLACE OF DELIVERY			TOTAL		PLACE OF DELIVERY			TOTAL	
	Health Facility	At Home	Other	%	Number of births	Health Facility	At Home	Other	%	Number of Births
Province										
Central	39.2	60.8	0.0	100.0	595	37.0	62.6	0.5	100.0	587
Copperbelt	79.7	20.0	0.3	100.0	1,429	75.2	24.3	0.6	100.0	1,347
Eastern	36.3	60.4	3.4	100.0	669	33.3	66.0	0.7	100.0	1,103
Luapula	36.1	62.9	1.1	100.0	419	27.7	72.3	0.0	100.0	671
Lusaka	76.2	23.7	0.1	100.0	935	73.8	25.7	0.5	100.0	1,076
Northern	19.2	80.7	0.2	100.0	647	24.3	75.7	0.0	100.0	863
North-Western	54.1	45.4	0.4	100.0	172	56.5	43.3	0.2	100.0	287
Southern	33.9	65.8	0.3	100.0	1,008	27.7	72.3	0.0	100.0	764
Western	32.8	66.4	0.8	100.0	337	37.3	62.7	0.0	100.0	460
Mother's Education										
No Education	22.4	76.5	1.2	100.0	1,061	24.0	75.7	0.3	100.0	982
Primary	48.1	51.3	0.6	100.0	3,907	40.7	58.9	0.4	100.0	4,604
Secondary	81.8	17.9	0.3	100.0	1,138	76.2	23.6	0.2	100.0	1,437
Higher	95.7	4.3	0.0	100.0	103	93.5	5.9	0.6	100.0	135

Source: CSO (1993:93 and 1997b:107)

3.5 People's perceptions about medical services

After the introduction of user fees in public health facilities, people's attitudes about the health services are diverse. But generally, they view the services provided as poor (Booth and others, 1994) and CSO, 1997a). People expected value for money but are made to pay, for example, for consultation, and if they are referred to another health centre for an x-ray, they go and pay. And if they have been told to buy some medicines from a drug store, they also go and pay. It is this lack of drugs and some facilities such as laboratory

and x-ray equipment that make the services poor. Some people therefore, wonder where the money they contribute goes. This is so because people would like to know how the money is being spent and why there are no medicines. Others also view the introduction of user fees as a punishment for the poor. Those who cannot afford and cannot be helped in one way or another to have access to health services have not seen the relevance of user fees. Due to lack of information on how best the user fees can work and who should be exempted from fees, some people are denied access of the benefits of user fees. The other problem is that user fees where introduced without establishing social security systems or improving upon the already existing ones like the bursaries committee and the Ministry of Community Development and Social Services. People's income is low for them to continue paying from their pockets whenever money is demanded from them. Physical infrastructures are also deteriorating. Health centres are almost constructed in the same way, such that when people demand for privacy, this will mean renovating the health centres. Staff morale is low and some staff are said to be rude to patients. Due to inability to pay by some people and due to poor quality of service provided, utilization of government health services has declined.

3.6 Summary

In this chapter, I have looked at health service provision in Zambia and utilization of health services. It has been observed that utilization of health services has declined since the introduction of user fees. Reasons that have been identified for the decline are low capacity to pay by some men and women while to some; it is due to poor quality service. Although there is no data to show deterioration of health facilities after 1993, the decline in the utilization of health services has also been attributed to the deterioration of health facilities.

One aspect, which has not been discussed, is the health personnel motivation towards user fees. Medical personnel need to be motivated by look into their working conditions. The morale of medical personnel is low thereby, resulting in poor services. Morale of the staff has also deteriorated due to lack of equipment and drugs together with low salaries including poor housing situation. Some medical staff have left for greener pastures in

neighbouring countries and Zambia has no foreign exchange to hire expatriates to fill up the gap. This implies that the introduction of user fees has just worsened the situation. People expect good quality for money.

Although some people who have the capacity to pay would like to utilize health facilities, poor services put them off. Information regarding exemptions is not fully disseminated. Even those who are supposed to be exempted do not know.

The emphasis in Zambia has been on making a payment first before you receive treatment. Some expecting mothers who cannot afford user fees but wishing to deliver from health facilities are turned away. This could be another reason for having high infant and maternal mortality.

Poverty has also been identified as a reason for low utilization of health facilities. The restructuring programme currently being pursued in the country has led to sufferings to a number of people. Some people have lost jobs and are currently finding it difficult to get income for survival including for user fees.

Chapter Four

Re-examining User Fees in Health Services

4.1 Introduction

This chapter is organized in four parts, diversion of health services based on quality of service, reduction of demand for health services as a result of poverty; failure of the exemption system and a summary is given at the end.

4.2 Diversion based on quality of service

As discussed in Chapter Two, demand diversion effect refers to a situation whereby demand for medical care is diverted from government to non-government facilities. Demand reduction is when the government tries to reduce unwarranted use of medical services by those who could have benefited from previously free government facilities.

The diversion effect can work well depending on poverty levels and access to cash income. It may work well in urban areas were private health facilities already exist or where the choice is wide unlike in rural areas. Due to a wide choice in urban areas, availability of cash income and easy transportation, some people have reduced attending government health facilities and resort to private facilities where quality for money seems to be guaranteed. There is no enough evidence to show whether the decline in the use of government health facilities has resulted in the use of private health facilities. This is so because data for private health facilities is lacking that can be used to compare before and after the introduction of user fees. However, data from CSO (1997a:16) show that in Lusaka, the majority (69%) of people who made use of other facilities other than their usual ones used private facilities compared to 31% who used government facilities. Again, there is no data to show gender or regional differentials. Diversion can only be true for the rich or rather those with formal employment. Some poor family households have been denied access to medical services and have opted for other alternatives mentioned in the previous chapters. The diversion effect has not worked well in Zambia. This is due to low income among men and women and high poverty levels.

If the demand diversion effect is considered, government's role then becomes that of regulating the services. If people feel cheated from private facilities and they do not get quality of service for money at public health facilities, they are likely to reduce utilization of health services. The decline in the utilization of user fees then remains low capacity to pay due to low incomes and high poverty. To those who can afford, the decline is a result of poor quality service in public health facilities, such as lack of drugs.

4.3 Demand Reduction based on Poverty

As already discussed in the previous chapters, poverty is high in Zambia. However, it is higher in rural areas than in urban areas. It is higher in big female-headed households than in male-headed households. Further, poverty is more concentrated in households headed by very young and very old household heads. For example, in 1991, 75% and 83% of households headed by very young and very old people respectively, were found to be poor while 68% of the households headed by males compared to 77% headed by females were poor. For further details, refer to Table 4.1 which shows the percentage distribution of household's poverty level by age and gender of household head and size of the household.

Table 4.1: Households Poverty Level by Age and Gender of Household Head and Size of the Household

Category	1991				1993			
	Poor		Rich	Total	Poor		Rich	Total
	Extremely	Moderate			Extremely	Moderate		
Age of Household Head								
13-19	62	13	25	100	76	3	21	100
20-29	49	11	40	100	65	9	26	100
30-39	52	10	38	100	66	10	24	100
40-49	61	10	29	100	75	8	17	100
50+	76	7	17	100	84	5	11	100
Gender of Household Head								
Male	58	10	32	100	72	8	20	100
Female	70	7	23	100	80	5	15	100
Household Size								
1 Person	54	9	37	100	61	9	30	100
2 -3 Persons	58	8	34	100	69	7	24	100
4-5 Persons	60	9	31	100	74	8	18	100
6-9 Persons	62	11	27	100	77	8	15	100
10+ Persons	61	11	28	100	78	8	14	100
All Households	60	9	31	100	74	8	18	100

Source: CSO (1992:136 and 1994:117)

Poverty is also high among agricultural households and is more concentrated among the small-scale farmers than large-scale farmers. Table 4.2, which shows the distribution of household poverty level by socio-economic group and province, sheds more light. The urban provinces, Central, Copperbelt and Lusaka, have a higher percentage of rich households compared to the rest of the rural provinces. North-Western and Western Provinces are the poorest provinces in Zambia, see Table 4.2. According to CSO (1995b:102), the highest proportion of households headed by females was recorded in Western Province. A look at the income distribution in Zambia shows that the distribution is skewed. More male than female-headed households are found in the high-income bracket. This is shown in Table 4.3. The mean income for male headed households was K36, 000 (Zambian Kwacha) compared to K24,000 for the female headed households.

Distribution of household heads by their marital status presented in Table 4.4 shows that there are more widowed, divorced, and separated females than males and more married males than females. This trend is not so surprising though it is a source of worry. Males have a higher chance of remarrying after divorce or after the death of a wife. Females who are less educated have less access to cash income and assets which are more concentrated among males. This leaves women more vulnerable than men.

A lot of female-headed households are in the small scale-farming category and in rural areas, see Table 4.2. This puts women in a vulnerable situation. What they produce are basically crops for consumption and little for sale. More over, the poor infrastructure in most of the remote places of Zambia hampers the sale of crops produced by the small-scale farmers. At times, when these farmers have access to the markets, their production cost in terms of labour, time to travel and transport costs, is more than the selling price, which further perpetuates their vulnerability.

4.4 Failure of the Exemption System

As discussed in Chapter Two, failure of a well established exemption system can lead to the decline in the utilization of health services after the introduction of user fees. Although Booth and others (1994) suggested that an exemption policy could work in Zambia, it is difficult for exemption system to work in Zambia. Some of the reasons are that most of the people are poor and lack income, see Tables 4.2 and 4.3 for details. Because of high poverty levels, exemption cannot work. Majority of the people are poor in Zambia, thus a lot have to be exempted. Fairness on who qualifies to be exempted, when, how and who should carry out the exemption exercise becomes a problem to solve. Another reason is that of lack of physical infrastructure such as communication facilities. The country is largely rural hence, communication is a problem. Thus coordination of an exemption system is likely to be very expensive that may arise from administrative costs. Failure of the exemption system to cover the vulnerable in society has led to the decline in the utilization of health services. Perhaps the best to be done is to add a health tax to the already existing taxes to those with formal employment. Then the money can be used to subsidize the poor, particularly women and children.

Table 4.2: Distribution of Households Poverty Level by Socio-Economic Group and Province

Category	1991				1993			
	Poor		Rich	Total	Poor		Rich	Total
	Extremely	Moderate			Extremely	Moderate		
Socio-economic group								
Small scale farmers	81	6	13	100	88	4	8	100
Medium scale farmers	59	10	31	100	84	7	9	100
Large scale farmers	20	3	77	100				
Non Agricultural households	57	13	30	100				
Low-cost areas	38	14	48	100	53	15	32	100
Medium-cost areas	35	13	52	100	50	16	34	100
High-cost areas	27	12	61	100	37	11	52	100
Province								
Central	52	14	34	100	66	7	27	100
Copperbelt	45	14	41	100	56	14	30	100
Eastern	76	5	19	100	86	4	10	100
Luapula	62	10	28	100	80	8	12	100
Lusaka	26	12	62	100	49	12	39	100
Northern	78	7	15	100	87	5	8	100
N/Western	73	8	19	100	90	4	6	100
Southern	64	10	26	100	81	7	12	100
Western	80	5	15	100	90	4	6	100
Rural	78	7	15	100	87	4	9	100
Urban	36	13	51	100	50	14	36	100
All Zambia	60	9	31	100	74	8	18	100

Source: CSO (1992:137 and 1994:118)

Table 4.3: Percentage Distribution of Households by Monthly Income, Residence and Gender of Household Head

Category	1991							1993							
	Less than 1000	1000 to 5000	5001 to 10000	10001 to 15000	15001 to 20000	20001 and above	Mean Income	Less than	5000 to 10000	10001 to 25000	25001 to 50000	50001 to 75000	75001 to 10000	100 000 +	Mean Income
Residence															
Rural	49	36	8	3	1	3	3,634	33	23	27	10	3	1	3	21,509
Urban	10	37	26	11	5	11	10,738	7	8	31	28	11	5	11	55,257
Gender															
Male	27	39	17	7	3	7	7,250	20	17	30	18	6	3	6	36,044
Female	54	26	11	4	2	3	4,417	38	22	22	10	4	2	4	23,917
All Zambia	33	36	16	6	3	6	6,690	24	18	29	16	6	3	6	33,607

Source: CSO *(1992:104 and 1994:92)*

Table 4.4: Percentage Distribution of Household Heads by Marital Status, Sex and Residence, Zambia, 1990

Marital Status	Total Zambia		Rural		Urban	
	Male	Female	Male	Female	Male	Female
Never Married	3.8	8.1	2.5	5.1	6.0	15.2
Married	83.6	13.2	82.3	13.2	85.5	13.3
Widowed	1.0	35.9	1.1	39.8	0.9	26.6
Divorced	1.6	27.8	1.6	27.0	1.8	29.5
Separated	0.9	11.3	0.9	11.5	0.9	10.8
Not Stated	9.1	3.7	11.7	3.4	4.9	4.6
Total: Percent	100	100	100	100	100	100
Households	**1,103,088**	**224,010**	**678,294**	**157,530**	**424,794**	**66,480**

Source: CSO (1995b:175)

4.5 Summary

In sum, poverty data would seem to indicate that women are more affected with the introduction of user fees than men. Those who are more affected are the poor single female-parents and the old. Due to market forces currently introduced in the country, obtaining cash income has become a major problem. Since (mostly) men are losing jobs, thus, increasing poverty in most of the households, some women have then taken up measures to meet the cost of living. What then has happened is that women have increased their time for work and have increased the workload. Women attend to domestic chores at home and go into the fields or markets.

Although women and men utilize health services, some health problems affecting women are different from that of men. Given the gender imbalance that exists, women lack access to cash income, education, land, loans, production equipment, property like a house, and many others. Women's roles are basically domestic duties of which they are mostly paid in

kind through say, food and clothes bought for them. They are not paid in cash and lack control over cash. The assumption that household resources are pooled together and then shared equally in a household is questionable. Sharing of resources in a household depends on gender, relationship to head of household and age. Power negotiation between male and female when it comes to decision making needs to be addressed.

Because women's health problems are different from that of men, and because men are mostly in control of cash, paying for user fees when a female member of household falls sick has to be negotiated for. While a female may view taking somebody to a clinic as an urgent thing, a man may decide to delay a bit and see whether that person can get better. And since a woman may have no control over cash, she will sit back. But when it becomes serious, that is when they will decide to rush to the health facility. It might be too late to save the life.

The market economy puts women at a disadvantage because they are mostly in the informal sector and in the small scale-farming category. Women do not have collateral and may therefore, not get loans compared to men. Women cannot increase their agricultural output at the same pace as men. Distance to the market, especially in remote areas, hinders small-scale farmers from selling their crops. Their produce ends up being only for consumption. Women are therefore, affected through access to cash and the frequency in utilizing health services. This inability to have access to cash income implies less access to health facilities because nowadays, people are supposed to pay for medical attention. Still more, the poor families need access to health services. Where will the money to cover for them come from? Again, the answer is to institute an exemption system to cover the most vulnerable in society. Otherwise, utilization of public health facilities in Zambia is low. Improving quality of health care, implementing an exemption system, especially in urban areas and empowering women are the only alternatives to achieve equity of cost effective health care and will result in the improvement of health for all and improve the poor demographic and economic indicators in Zambia.

Chapter Five

Conclusion and Recommendations

5.1 Working towards improvement

The benefits of the user fees have been elaborated in a general sense. Review of data shows that what matters is improving quality of health service and instituting an effective exemption system. Constant availability of essential drugs, availability of equipment such as laboratory and x-ray equipment, and improvement of medical personnel morale, will lead to a successful health reform programme, otherwise, user fees may lead to low utilization of health services. But these may not work independently without improving the welfare of most of the households. Unemployment, poverty, low income and inflation, all these things, individually or put together are likely to hamper the benefits of well-intentioned policies like user fees. Men, women, the old and the children are affected as a result of the introduction of user fees. However, women are affected more than men due to poor access to income, poverty and by extending their working time to compensate for income needed for user fees.

There is a decline in the utilization of health services in Zambia in government health facilities. While the low attendance at health facilities may be attributed to user fees, other factors are at play. The socio-economic indicators in Zambia are worrying. IMR, MMR, and life expectancy at birth are deteriorating. Lack of safety nets and effective exemption policy to help the vulnerable people in society will lead to low utilization of health facilities in Zambia. Good communication and reliable information, especially among those who are supposed to be exempted from paying medical fees, will improve utilization of health services. Those who cannot pay are likely to stay at home even when they can be treated.

Women health problems and their general constraints in their lives, which are different from that of men, put them in a difficult situation. They are more likely to suffer when the introduction of user fees does not go with the improvement of health services. Some services likely to benefit women and the children, such as antenatal and postnatal care and immunization, need to be subsidized. Paying for medical services will not only improve the

health services in the health sector, but also will indirectly enable people realize that having many children is expensive. This will lead to a reduction in fertility, thereby improving the health quality of women who bear or who should have had a lot of children. Not only will their health improve, they will have more time to concentrate on productive ideas. With more time, then they will need "few hands" to work with than having a lot of children.

Women empowerment in form of education, together with the help of some NGOs in ensuring that some traditional beliefs that perpetuates gender imbalance are reduced or removed altogether, is an achievement on its own. This may reduce the frequency for women in utilizing health services such as arising from having too many children.

The decline in the utilization of health services cannot only be attributed to the introduction of user fees. Poor health services such as, waiting for a long time before being attended to, lack of essential drugs, laboratory and x-ray equipment in (some of the) health facilities, all add up to low utilization of health services. Other contributing factors to low utilization include, ever rising transport costs, loss of jobs, distance to health facilities (in some areas), as well as poverty provoked by the current economic conditions in Zambia. Women are likely to suffer more than men due to their low access to cash and women utilize health services more than men. The absence of essential drugs, in the public health facilities, which are many particularly in rural areas, will affect women more than men.

There are risks and long term problems when the use of health services declines. It is better for people to consult qualified medical staff than self-prescription or resorting to cheap traditional herbs or cheap drugs from the streets. If people avoid health facilities, in case of complications, chances are that they may end up dying. And if STDs are not fully treated by qualified medical personnel, Burns and others (1997:3) have observed that it may lead to disabling pain, severe pelvic inflammatory disease (PID), infertility, problems during pregnancy, and an increased risk of cervical cancer

Due to problems in targeting health services, it is better for each community together with the responsible ministry in Zambia, especially MOH and MCDSS, to work out a programme of exemption in order to fall within the given budget and to reach the target group.

There is potential among the Zambians to pay for medical fees. Those who cannot afford to pay can be exempted from paying. But lack of information to those supposed to benefit from exemption seems to be lacking. The idea of subjecting health services to market conditions has resulted in low utilization of public health facilities. Another contributing factor to note is that Zambians have been subjected to 'free' health services for quite sometime. The shift from free services implies that it has to take some bit of time to respond to market forces.

User fees have affected the poor, especially women who lack access to income. As for those who can afford, user fees has resulted in the decline of use due to the fact that user fees have not been accompanied by improvement in quality of service. Medicines and equipment, such as laboratory and x-ray equipment including power generators in case of power failure, are still lacking in government facilities.

5.2 Recommendations

1. The distribution of health facilities and medical personnel in Zambia does not correspond with the distribution of population. Health services are more accessible in urban areas than in rural areas. In view of this, I will recommend that the government concentrate on improving the existing health facilities by renovating them and ensuring constant supply of drugs, and purchase of equipment like x-ray and laboratory equipment. The government can borrow money specifically for renovations, drugs and equipment for the current health facilities.

2. There are problems in the application of the exemption system. A good exemption system need to be put in place in order to help the vulnerable in society who are being denied access to health services. In view of situations where patients, including expecting mothers, are denied treatment even before they are seen by a qualified medical personnel, I would recommend that staff be retrained. This will help in identifying those who are supposed to be exempted and will lead to consistence in making charges. The MOH, the CBOH, the MCDSS together with the Bursaries Committee's efforts need to be well coordinated. Funding need to be improved to these institutions in order to help the vulnerable.

- In order for recommendations 1 and 2 to work effectively, I recommend that the government should first suspend all forms of user fees for some time, say for six months or a year and work on recommendations 1 and 2. Then coupled with recommendation 3, the well-intentioned benefits of user fees will be achieved.

3. The government through its Ministries of health and energy and water development should improve on the access to safe water and sanitation. This will reduce the spread of some preventable diseases like cholera and diarrhoea.

4. In order to have a good picture of the gender impact of user fees on the use of health services, I recommend that CSO carry out some surveys. This should focus on men and women in low and high income urban and rural households, men and women with different occupations and their use of health services before and after the introduction of user fees. A balanced gendered look will be provided if data for the utilization of medical services for both men and women before and after the user fees is available.

5. Because women health problems and their general constraints in their lives are different from that of men, services likely to benefit women and the children, such as antenatal and postnatal care and immunization, need to be subsidized, but not free. Paying for medical services will not only improve the health services in the health

sector but also will make having many children expensive. And because men and women are affected differently in society, policy makers have to be gender sensitive whenever they are implementing policies rather than being gender neutral. Policies may fail to produce fruitful expected results when gender impact is ignored.

6. The decline in the utilization of health services cannot only be attributed to the introduction of user fees. The government, through its Ministries of Transport, Labour and Health, must look into other contributing factors to low utilization such as ever rising transport costs, loss of jobs, distance to health facilities (in some areas), poor working conditions of medical personnel, availability of drugs in health facilities. It is better for people to consult qualified medical staff than self-prescription or resorting to cheap traditional herbs or cheap drugs from the streets due to risks and long term problems involved when the use of health services declines.

Bibliography

Atkinson B. Anthony and Stiglitz E. Joseph (1980): Lectures on Public Economics, McGraw-Hill Book Company Limited, Maidenhead, UK.

Bennet S. et al (1997): Private Health Providers in Developing Countries, Serving the Public Interest? Zed Books Limited, 7 Cynthia Street, London N1 9JF, UK.

Booth David et al (1994): Coping with Cost Recovery, A Study of the Social Impact of and Responses to Cost Recovery in Basic Services (Health and Education) in Poor Communities in Zambia, Report to SIDA, Commissioned Through the Development Studies Unit, Department of Social Anthropology, Stockholm University.

Burns A. Augustus (1997): Where Women Have no Doctor, A Health Guide for Women, Hesperian Foundation, Berkeley, California, USA.

Central Board of Health (1997): "Reproductive Health News", A Quarterly Newsletter, Issue 3, Vol. 1, December, Central Board of Health, P. O. Box 32588, Lusaka, Zambia.

Central Statistical Office, CSO (1992): Social Dimensions of Adjustment, Priority Survey I, Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (1993): The 1992 Zambia Demographic and Health Survey, University of Zambia, Central Statistical Office, Lusaka, and Macro International Inc., Maryland USA.

Central Statistical Office (1994): Social Dimensions of Adjustment, Priority Survey II, Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (1995a): Demographic Projections 1990-2015, 1990 Census of Population, Housing and Agriculture, Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (1995b): Zambia Analytical Report, 1990 Census of Population, Housing and Agriculture, Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (1996): National Dissemination Seminar Report of the 1990 Census of Population, Housing and Agriculture, Central Statistical Office, Lusaka, Zambia.

Central Statistical Office (1997a): Franchising Market Study, A Study of the Status of Health Care with Regard to Pre-payment Scheme, A Report Submitted to ABT Associates Inc. in Collaboration with Partners in Health Reforms (PHR), Population and Demography Division, Central Statistical Office, Lusaka, Zambia (Unpublished).

Central Statistical Office (1997b): The 1996 Zambia Demographic and Health Survey, University of Zambia, Central Statistical Office, Lusaka, and Macro International Inc., Maryland USA.

Centre for Health, Science and Social Research - CHESSORE (1995): Health Reforms Programme in Zambia, Baseline Findings on the Performance of Health Services in Four Provinces, A Research Report Prepared for the Health Reforms Implementation Team (HRIT), CHESSORE, P. O. Box 320168, Woodlands Post Office, Lusaka, Zambia.

Choongo D.E. (1996): Gender and Health, Ministry of Health, Lusaka, Zambia.

Eatwell John, Milgate Murray, and Newman Peter (1991): The New Palgrave, Allocation, Information and Markets, Macmillan, New York.

Eklund Per and Stavem Knut (1995): in R. Paul Shaw and Martha Ainsworth (eds), Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance, Case Studies From Sub-Saharan Africa, World Bank Discussion Papers 294, Africa Technical Department Series, The World Bank, Washington, DC.

Ellis R.P (1987): "The Revenue Generating Potential of User Fees in Kenyan Government Health Facilities", Social Science and Medicine, 25(9), pp995-1002.

Ellis Stephen (1996): Africa Now; People, Policies and Institutions, Heinemann, 361 Hanover Street, Portsmouth, New Hampshire, 03801-3912, USA.

Elson Diane (1991): "Structural Adjustment: Its effect on Women" In Tina Wallace and Candida March (Eds), Changing Perspectives, Writings on Gender and Development, Oxfam, 274 Banbury Road, Oxford OX2 7DZ.

Elson Diane (1995): Male Bias in the Development process, Manchester University Press, Manchester.

Evans Alison (1989): Gender Issues in Rural Household Economics, Discussion Paper No. 254, Institute of Social Studies, P.O. Box 29776, 2502 LT, The Hague, The Netherlands.

Goodman Hilary and Catriona Waddington (1993): Financing Health Care, Oxfam Practical Health Guide No. 8, Oxfam, 274 Banbury Road, Oxford OX2 7DZ.

Government of the Republic of Zambia - GRZ (1992): "The 1992 Budget Address", Government Printers, Lusaka, Zambia.

Garfield Richard and Williams Glen (1989): Health and Revolution: The Nicaraguan Experience, Oxfam, 274 Banbury Road, Oxford OX2 7DZ.

Griffin C. Charles and Shaw R. P.(1995): in R. Paul Shaw and Martha Ainsworth (eds), Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance, Case Studies From Sub-Saharan Africa, World Bank Discussion Papers 294, Africa Technical Department Series, The World Bank, Washington, DC.

Hanmer Lucia (1994a): Equity and Gender Issues in Health Care Provision, The 1993 World Bank Development Report and its Implications for Health Service Recipients, Working Paper Series No 172, Institute of Social Studies, P.O. Box 29776, 2502 LT, The Hague, The Netherlands.

Hanmer Lucia (1994b): What Happens to Welfare When User Fees Finance Health Care? The Impact of Gender on Policy Outcomes; Theory and Evidence From Zimbabwe, Working Paper Series No 180, Institute of Social Studies, P.O. Box 29776, 2502 LT, The Hague, The Netherlands.

Hanmer Lucia et al (1997): Poverty in Sub-Saharan Africa, What Can We Learn From the World Bank's Poverty Assessments? Institute of Social Studies, P.O. Box 29776, 2502 LT, The Hague, The Netherlands.

Harrison K.A (1997): "Maternal Mortality in Nigeria: The Real Issues", African Journal of Reproductive Health, March, 1(1), pp7-13.

Hoare G (1987): "Policies for Financing the Health Sector", Health Policy and Planning, 2(1), pp1-16.

Hodgkin D (1996): "Household Characteristics Affecting Where Mothers Deliver in Rural Kenya", Health Economics, July-August, 5(4), pp333-340.

Hsiao W.C (1995): "The Chinese Health Care System: Lessons for Other Nations", Social Science and Medicine, October, 41(8), pp1047-1055.

Leighton C (1995): "Overview: Health Financing in Africa", Health Policy and Planning September, 10(3), pp213-222.

Lewis M.A (1993): "User Fees in Public Hospitals: Comparison of Three Country Case Studies", Economic Development and Cultural Change, April, 41(3), pp513-532.

Lewis P. John (1988): Strengthening the Poor: What Have We Learned? Overseas Development Council Policy Perspectives, Transaction Books, New Brunswick USA and Oxford UK.

Likwa R. Ndonyo and Ngwengwe M. A (1998): Health Sector Reforms Review, Phase 1 Study, Research Findings, An Exploratory and Qualitative Approach on Performance of Neighbourhood Health Committees in Kabwe Urban and Chongwe Rural Districts, Central Board of Health, P. O. Box 32588, Lusaka, Zambia.

Litvack J.I. and Bodart C (1993): "User Fees Plus Quality Equals Improved Access to Health Care: Results of a Field Experiment in Cameroon", Social Science and Medicine, August, 37(3), pp369-383.

Mbungua J.K. et al (1995): "The Impact of User Charges on Vulnerable Groups: The Case of Kibwezi in Rural Kenya", Social Science and Medicine, September, 41(6), pp829-835.

McPake B (1993): "User Charges for Health Services in Developing Countries: Overview of the Economic Literature, Social Science and Medicine, June, 36(11), pp1397-1405.

McPake B (1994): "Initiative for Change", Health Action, June-August, (9), p7.

Milimo John T. and Choongo Debbie E. (1995): Decentralization and Health Systems Change, Zambia Case Study, Ministry of Health.

Milimo John T. and Sumaili Fanuel (1996): Health Sector Review, A Report From The Participatory Assessment Group (PAG), P. O. Box 51080, Lusaka, Zambia.

Ministry of Community Development and Social Services (1996): National Population and Development Programme of Action, Lusaka, Zambia.

Ministry of Health (1992): National Health Policies and Strategies, Implementation of Health Reforms, Zambia.

Moore Henrietta (1994): Is there a Crisis in the Family? UNRISD, Occasional Paper, World Summit for Social Development 3, (UNRISD/OP/94/3), Geneva.

Moses S. et al (1992): "The Impact of User Fees on Attendance at a Referal Centre for Sexually Transmitted Diseases in Kenya", Lancet, August, 340(8817), pp463-466.

Mwabu G.M and W.M. Mwangi (1986): "Health Care Financing in Kenya: A Simulation of Welfare Effects of User Fees", Social Science and Medicine, 22(7), pp 763-767.

Mwabu Germano (1996): Health Effects of Market-Based Reforms in Developing Countries, United Nations University/World Institute for Development Economics Research - UNU/WIDER, Katajanokanlaituri 6B, 00160 Helsinki, Finland.

Mwabu Germano (1997): User Charges for Health Care: A Review of the Underlying Theory and Assumptions, United Nations University/World Institute for Development Economics Research - UNU/WIDER, Katajanokanlaituri 6B, 00160 Helsinki, Finland.

Mwanza Allast (1997): "The Poverty Phenomenon in Zambia", Southern African Political and Economic Monthly, Vol. 11, No. 1, pp28-30.

Pearson Ruth (1992): "Gender Matters in Development", in T. Allen and A. Thomas, (Eds), Poverty and Development in the 1990s, Oxford, University Press in Association with the Open University.

Reinke J et al (1996): "Quality Assurance in Zambia", Q.A. Brief, Summer, 5(1), pp8-11.

Shaw R. Paul and Ainsworth Martha (eds) (1995): Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance, Case Studies From Sub- Saharan Africa, World Bank Discussion Papers 294, Africa Technical Department Series, The World Bank, Washington, DC.

Soeters Robert (1997): Rapid Assessment of Health Reforms in Africa: The case of Zambia, EPOS-Health Consultants, Hindenburgring 18, 61348 Bad Homburg, Germany.

Stanton B and J. Clemens (1989): "User Fees for Health Care in Developing Countries: A Case Study of Bangladesh", Social Science and Medicine, 29(10), pp1199-1205.

The Times of Zambia (1998): "UTH Workers Shock Mwiimbu", August 21, Lusaka, Zambia.

Turshen Meredeth (1989): The Politics of Public Health, Zed Books Limited, 57 Caledonian Road, London N1 9BU.

UNDP (1997): Human Development Report, Oxford University Press, Inc., New York.

UNFPA (1997): The State of World Population, The Right to Choose: Reproductive Rights and Reproductive Health, UNFPA, 220 East 42nd Street, New York, N.Y. 10017, USA.

Weaver M. et al (1996): "Willingness to Pay for Child Survival: Results of a National Survey in Central African Republic", Social Science and Medicine, September, 43(6) pp985-998.

Wheelock Jane (1996): in M. Mackintosh et al, Economics and Changing Economies, Milton Keynes, The Open Universty, London, International Thomson Business Press.

White Howard and Nzovu Ingu'tu (1998): "How can we Explain the Rise in Mortality Amongst the Under Fives in Zambia?" Summary of a Longer Report on the same topic, Institute of Social Studies, Korternaerkade 12, 2518 AX, The Hague, The Netherlands.

WHO (1994a): UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Challenges in Reproductive Health Research, Biennial Report 1992-93, WHO, Geneva.

WHO (1994b): Implementation of the Global Strategy for Health for All by the Year 2000, Second Evaluation, Eighth Report on the World Health Situation, Volume 2, WHO, Geneva.

WHO (1995): Expanding Family Planning Options, An Assessment of the Need for Contraceptive Introduction in Zambia, Research on the Introduction of Technologies for Fertility Regulation, Health Reforms at work, UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, WHO, Geneva.

World Bank (1993): World Development Report, Investing in Health, Oxford University Press Inc., 200 Madison Avenue, New York, NY 10016.

World Bank (1996): World Development Report, Oxford University Press Inc., 200 Madison Avenue, New York, NY 10016.

Wuyts M. et al (1992): Development Policy and Public Action, Oxford University Press in Association with the Open University, Walton Street, Oxford OX 2 6DP.

Wuyts M. et al (1998): Econometrics and Data Analysis for Developing Countries, Rouledge, 11 New Fetter Lane, EC4P 4EE London.

Yoder R.A (1989): "Are People Willing and Able to Pay for Health Services?" Social Science and Medicine, 29(1), pp35-42.